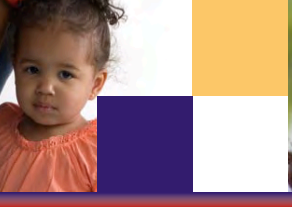
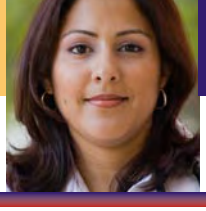

Reform Matters

Making Real Progress for Women and Health Care


November 2008

Dear Advocate:

Each day, our current health care system fails to meet the needs of far too many women, especially low-income women and women of color. Comprehensive reform that addresses the many challenges of our health care system—and that guarantees accessible, affordable, quality health care for all—will positively impact women's health, work, and financial well-being. With a new federal administration and Congress, and with a growing number of states starting to debate this issue, women have never had more at stake.

The *Reform Matters Toolkit* provides women's advocates with the resources they need to be full participants in the fight for health care reform that meets the unique needs of women and their families. This toolkit provides an overview of the distinct challenges women face in our current health care system, analyzes the impact that various national and state health reform proposals would have on women's access to health care, and presents options for how to promote high-quality affordable health care for all.

Public opinion polls consistently show that the majority of Americans, and women in particular, believe that addressing our health care crisis should be one of the nation's top priorities. We look forward to working with you to ensure that comprehensive health reform takes precedence for policymakers, so that **all** women and their families get the care they need to lead healthy lives. Together, we can—and will—succeed.

Please do not hesitate to contact us if we can provide technical assistance, or if you need additional information about any of the materials in the toolkit.

Sincerely,

Judy Waxman

Judy Waxman
Vice President, Health and Reproductive Rights
National Women's Law Center

NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle NW ▪ Suite 800 ▪ Washington, DC 20036 ▪ 202.588.5180 ▪ 202.588.5185 (fax) ▪ www.nwlc.org

About the Center

The National Women's Law Center is a Washington, D.C., nonprofit organization working to expand opportunities and eliminate barriers for women and their families, with a major emphasis on women's health and reproductive rights, education and employment opportunities, and family economic security.

Authors

The *Reform Matters Toolkit* was a collaborative endeavor that relied upon the work of many individuals. Brigette Courtot, Lisa Codispoti, and Judy Waxman were primary authors, along with Gretchen Borchelt for the "Reproductive Health Care and Health Reform" section; Adrienne Ammerman for the "Dos and Don'ts: Talking About Health Care Reform" section; Jen Swedish for the "Women and Employer-Sponsored Insurance" and "The Individual Insurance Market: A Hostile Environment for Women" sections; and Golda Philip for the "Bare-Bones Health Plans: Is Something Better Than Nothing?" section. These authors were greatly assisted by Marcia Greenberger, Joan Entmacher, Lisa M. LeMair, Julia Kaye, Ellen Newcomb, Sarah McGinnis, and Diana Santos.

The National Partnership for Women and Families authored the "Ensuring Quality Health Care in Health Reform" and "Health Information Technology: A Key Component of Health Reform" sections. The "Glossary of Terms" section was adapted from a health care glossary created by Families USA. Families USA also created the "Upper Public Program Eligibility Levels for Children and Adults" section. Celinda Lake of Lake Research Partners developed the "What Women Want: How to Talk to Women Voters about Health Care" section. Copyright for these materials is that of the respective authors.

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Disclaimer

While text, citations, and data, are, to the best of the authors' knowledge, current as this report was prepared, there may well be subsequent developments, including recent legislative actions, that could alter the information provided herein. This report does not constitute legal advice; individuals and organizations considering legal action should consult with their own legal counsel before deciding on a course of action. In addition, this report does not constitute medical advice. Individuals with health problems should consult an appropriate health care provider.

Reform Matters

Reform Matters: Making Real Progress for Women and Health Care

NWLC has developed the tools and resources to make a difference!

Addressing barriers to women's access to health care is more important than ever before. Health reform presents an opportunity to ensure that all women have access to affordable, high-quality comprehensive health care. Women's advocates must be active and vocal in this fight. Make a difference—get the most current and up-to-date information, tools, and resources from the National Women's Law Center (NWLC) and our *Reform Matters* project.

Reform Matters Toolkit: What Advocates Need to Know

The *Reform Matters Toolkit* provides resources to assist women's advocates to be full participants in the health care reform movement and policy debates at the state and national levels. Building on our long-standing work on women's health and health care coverage, this resource explores various health care reform proposals and their impact on women's access to comprehensive, affordable, quality care.

Reform Matters Conference Call Series

NWLC convenes monthly conversations among women's health care and reproductive rights advocates to focus on health care reform policy at the state and national levels, provide an on-going forum to learn from one another, and share experiences and questions that have come up in addressing various health care reform proposals. Calls take place the second Thursday of every month.

Technical and Informational Assistance

NWLC can provide your organization with technical assistance on the current policy debates taking place on the national and state levels. Our assistance can include: written analysis of policy proposals, researching and answering specific questions, drafting testimony, giving presentations, or hosting meetings.

National Women and Health Care Coalition

NWLC hosts a broad coalition of national organizations including reproductive rights advocates, women's advocates, women's health advocates, labor unions and health advocates, to respond to various federal, health-related issues as they impact women. The coalition gives members the opportunity to share educational materials, strategic analyses, and the latest developments both nationally and in the states.

Health Care for America Now!

NWLC has joined an unprecedented national effort on health reform—and we hope you'll join, too. Health Care for America Now is working toward a bold new solution that gives women, and all people, real choice and a guarantee of quality coverage they can afford: keeping their current private insurance plan, picking a new private insurance plan, or joining a public health insurance plan.

To learn more about the *Reform Matters* project, visit our website www.nwlc.org/reformmatters, email the project team at reformmatters@nwlc.org, or call (202) 588-5180.

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Reform Matters

Receive Updates to Your Reform Matters Toolkit

Receive updates for your *Reform Matters Toolkit*!

Make sure that you are armed with the most current policy knowledge of women's unique relationships with the health care system. Keep your copy of the *Reform Matters Toolkit* up-to-date so that you can fully participate in health care reform movements at the state and national levels. To receive updates for your toolkit:

Go to ***http://action.nwlc.org/reformmatterstoolkitupdates*** to complete a form with your contact information,

OR

Fill out the form below and fax it to the National Women's Law Center at ***202-588-5185*** (Attention: Thao Nguyen).

Please enter your contact information:

Name:	
Email:	
Street 1:	
Street 2:	
City / State / Zip:	
Phone Number:	
Organization / Company:	

_____ Yes, please send me additional information and updates from National Women's Law Center!

To learn more about our *Reform Matters* project, visit www.nwlc.org/reformmatters, or contact the project team at reformmatters@nwlc.org or 202-588-5180.

To learn more about the National Women's Law Center, visit www.nwlc.org.

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Women and Health Reform: An Introduction to the Issues

Health care reform is an important and personal issue for women. Each and every day, millions of women provide care in hospitals and physician offices, visit their own health care providers, or make decisions about the health care that their family members receive. Just as women's health care needs are unique, so is their relationship with the health system. Yet, our current system for financing and delivering health care does not adequately meet the needs of women. Too many women struggle to get necessary health care or go without that care altogether, and the consequences of this failure of the system can greatly damage women's health, work, and financial well-being.

As a growing number of national and state leaders make efforts to address the failing health care system, there have never been so many opportunities to ensure that women have access to the health care they need. Women's advocates can play an integral role in making sure that health reform plans address the specific health needs that women have and the unique challenges that they face in getting high-quality, comprehensive, and affordable health care.

Why Does Health Care Reform Matter for Women?

There are a number of reasons that health reform is a women's issue:

- **Women have distinct health care needs.** Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers. They are more likely to have chronic conditions that require continuous health care treatment.[1] They also use more prescription drugs on average, and certain mental health problems affect twice as many women as men.[2, 3]

- **Health insurance is a critical factor in making health care accessible, but women face unique barriers to obtaining coverage that is affordable.** The relationship between health insurance coverage status and access to health care is well-documented.[4] Yet, 18 percent of all women in the United States are uninsured.[5] Even women who have insurance are more likely than men to be underinsured, with insufficient coverage that leaves them vulnerable to financial risk and unmet health needs.[6] Women are less likely to have access to health insurance through their own jobs and are more likely to depend on their spouse's employer-provider coverage or purchase individual market coverage directly from insurers. Coverage available through the individual market is costly and often excludes services that are essential to women's health.

- **Regardless of whether they have health insurance or not, women are more likely than men to report problems getting health care due to cost.** On average, women have lower incomes than men, and a greater share of their income is consumed by out-of-pocket health care costs.[7] Both insured and uninsured women are more likely to delay or avoid getting the care they need because they cannot afford it, and they are also more likely to struggle with medical debt or bills.[8] Health plans that do not provide comprehensive benefits or that shift more costs to women and their families will only make this situation worse.

- **Women have a major stake in decisions about health care for their entire families, and they often play a significant role in the health care that their children, spouses, or parents receive.** According to the Department of Labor, women make approximately 80 percent of all family health care decisions.[9] Six in ten women report that they assume primary responsibility for decisions about health insurance plans for their families.[10] An even greater proportion, nearly 80 percent, chooses their child's doctor.[11] More women than men care for a family member—most often a parent—who is chronically ill, disabled, or elderly; in this role, they typically provide assistance with medical finances such as bills or insurance paperwork in addition to making decisions about medical care.[12]

To address the unique health care challenges that women face, plans for health reform must create opportunities for women to obtain health insurance that meets their needs. Reforms that provide the most comprehensive benefits at the most affordable cost will go the farthest to improve women's health and financial security. Some proposals to reform the health care system, however, could actually result in higher out-of-pocket expenses, more limited benefits, and other outcomes that would be particularly harmful to women's health.

What Are Comprehensive Benefits?

To be comprehensive, health insurance must cover the services that women need to stay healthy and to treat physical and mental illnesses at all stages of life. Health reform plans should set a standard for health benefits that requires coverage for all necessary care, including preventive care and a full range of needed reproductive health services. This standard must incorporate maternity care as a basic health benefit rather than a separate set of services available for an additional price (sometimes called a *maternity rider*), and similarly not segregate other women's health needs for second-class treatment.

If health plans do not cover a comprehensive set of services, women may have to delay or even forgo necessary health care not reimbursed by their health plans. Some may even go into medical debt or sacrifice other basic necessities to pay for the cost of uncovered health services.

What Is Health Care Reform?

The phrase 'health care reform' is used broadly to describe any proposal that will change the way medical care is paid for and delivered to a population. While there is a growing consensus that change is necessary in our health care system, there is not agreement among stakeholders—including policymakers, insurance companies, employers, health care providers, and consumers—on exactly what that change should be or how it should happen. These stakeholders may, for example, have very different ideas about the best way to cover the uninsured or about the appropriate role for government in the health care system.

How Does Health Care Reform Happen?

Federal vs. State Health Care Reform Health care reform may be pursued at either the federal or the state level. Policymakers in Washington, DC and in state capitals around the country are currently exploring options for delivering better health care to all. Federal and state health care reform proposals might contain many common elements—such as an expansion of Medicaid, the joint federal-state public insurance program for low-income people—but they obviously differ in scope (i.e. state reforms will affect a much smaller

Three Approaches to National Health Reform

Many different approaches to health reform have been introduced at the state and national levels. Over the past several years, leaders in Congress and the White House, advocacy groups, and presidential candidates have put forward various plans to change the health care system. Some would build on the current system, which involves a combination of employer-sponsored and publicly-sponsored health insurance programs. Others would drastically change the existing health system, such as through the creation of a single government-administered health insurance program. The following summaries provide three broad examples of national health reform plans that have been promoted by policymakers.

The Single-Payer Approach replaces existing public and private health insurance plans with a single public health plan, in which residents would automatically be enrolled. Under this approach, health care is paid for by a single entity—the government—that collects and distributes health care funds. Proponents of this approach predict much lower administrative costs than the current health care financing and delivery system. The public plan would typically be financed through an employer/employee payroll tax increase and income tax surcharge or some other revenue-generating mechanism.

Because taxes are collected from individuals and employers, the collective source of funding in the single-payer approach would be considered public. Single-payer does not necessarily denote a system of universal coverage for which everyone is eligible. While many single-payer proposals do aim for universality, by definition the single-payer approach refers only to the way care is financed and organized.

The Hybrid Public and Private Coverage Approach, as its name implies, incorporates a mix of public and private health insurance coverage options. It might expand public coverage programs for low-income people, maintain the role of private employer-sponsored coverage (as the majority of Americans are currently insured this way), and create a new health insurance marketplace where individuals and small businesses can choose between several different private and public health plan options.

To maintain the primary role of job-based coverage, the approach may require employers who do not provide employee health insurance to contribute to the cost of coverage (usually as a percent of payroll or per employee) through a new public insurance plan. It may also include government subsidies—typically income-related—to help low- and moderate-income families purchase coverage.

This approach could involve insurance market reforms to increase access to private coverage, including regulations that prohibit insurers from denying coverage or excluding treatment for pre-existing conditions, and rules that prevent insurers from charging people more based on factors such as age, gender, or health status.

The Free Market Approach involves a system in which individual consumers purchase health coverage in a free market with little government regulation, under the premise that de-regulation will increase competition among private insurance companies and therefore decrease health care costs .

This approach may include plans to reform the federal tax code by eliminating the current tax break for employer-sponsored health insurance (i.e. so that worker health benefits are reported as taxable income) and by establishing new individually-targeted tax subsidies to offset the costs of insurance, either through a standard health insurance deduction or health insurance tax credit. These tax reforms would likely bring about a shift from employer-sponsored group coverage to individual market insurance coverage.

The free market approach typically includes the privatization of public insurance programs (e.g. Medicare, Medicaid, and SCHIP) and the use of tax subsidies to encourage low-income uninsured people to purchase private coverage instead of expanding coverage through existing public programs. So-called "consumer-directed health care"—which is a combination of health plans with high deductibles and tax-sheltered health savings accounts—is also a variant of this approach.

population). There are other major differences between state and federal efforts to change the health care system:

- One difference concerns a federal law that limits how much states can regulate employer health plans, known as the Employee Retirement Income Security Act of 1974 (ERISA). ERISA was enacted to make it easier for multi-state employers to administer employee benefits like health insurance uniformly across states.

  Court challenges continue to define ERISA's limits for states that seek to reform health care by regulating employer-sponsored health insurance. For example, states may face challenges if they require employers to contribute to the cost of health care for their workers. In 2006, the Fourth Circuit Court of Appeals struck down a Maryland reform law that would have required certain large employers to either contribute to employee health benefits or pay a fee to the state, ruling that the law violated ERISA.[13] In September 2008, however, a three-judge panel of the Ninth Circuit Court of Appeals upheld a San Francisco law that requires employers to make minimum expenditures for employee health care, either by providing benefits directly to employees or by making payments to the city's own health care program.[14] If employers pay the city, their employees have a choice of enrolling in the city's program, and employers do not need to provide their own benefits or alter existing employee plans.[15]

  While the Ninth Circuit distinguished its decision from the Fourth Circuit's decision, given the likelihood of an appeal, the United States Supreme Court may ultimately decide the question of what state or local governments can and cannot do with regard to requiring employers to contribute to their workers' health care.

- A state's capacity to implement health reform is also limited by its state budget situation. Nearly every state must, by law, balance its budget each fiscal year. When states experience decreasing revenues, they typically respond by containing costs in program areas such as transportation, education, law enforcement, and health. As most health reforms require ongoing funding—and perhaps a substantial initial investment—a weak economy and a lean budget could seriously hamper reform efforts at the state level.

  In the state of California, for example, a bipartisan plan for comprehensive health reform failed to gain approval of the legislature. Among the reasons for this failure were the release of a legislative analysis which projected that the plan would be more expensive than policymakers originally thought, combined with a weakening state economy and a forecasted $14.5 billion state budget deficit.[16]

Incremental vs. Comprehensive Health Care Reform. Some health care reform proposals are *incremental*, and address just one piece of the health care landscape—for example, in 1997 Congress passed legislation to establish the State Children's Health Insurance Program, which provided affordable access to health care for millions of uninsured poor or near-poor children. Since then many states have moved to expand public health coverage for children. Though these efforts did not focus on problems in the individual insurance market or address the quality of health care, they are important steps in the struggle for comprehensive and affordable health care for all Americans.

Other reform proposals are *comprehensive*, and address several different parts of the health care system at once. Building on incremental reforms enacted throughout the 1980's and

1990's, the state of Massachusetts succeeded in passing a comprehensive plan for health reform in 2006. The Massachusetts reform plan, for instance, expanded eligibility for public insurance programs, created a health insurance exchange (called the Connector) to help individuals and small businesses enroll in private coverage, and established a statewide Racial and Ethnic Health Disparities Council to monitor disparate health outcomes among minority populations.

Health Care Reform Matters for Women: What Can Women's Advocates Do?

Women's advocates can make a strong case for health reform by using available data on the status of women's health in their state and at the national level.
The 2007 edition of *Making the Grade on Women's Health: A National and State-by-State Report Card* (available online at http://hrc.nwlc.org) is the fourth in a series of reports on the current state of women's health status and various policies that affect women's health.

Making the Grade—which contains health status and policy indicators for women at both the national and state levels—demonstrates that the nation as a whole and many individual states are falling further behind in their quest to reach national goals for women's health. National and state-by-state report cards indicate the need for improvements in women's access to health insurance and access to health care providers and services, including critical reproductive health services.

Making the Grade is a useful tool for advocates who wish to highlight the need for change in the health care system. These examples of 2007 report indicators reveal some areas where progress can be made:

- The entire nation received a failing grade for the number of women without health insurance;
- The country exhibits stark ethnic and racial disparities related to health insurance coverage—for example, the proportion of uninsured Hispanic women is nearly double that of U.S. women overall;
- Most states have low Medicaid eligibility levels for working parents, with a majority covering only those at or below 74 percent of the federal poverty level (or less than $16,000 annually for a family of four);
- Over a third of all states have weak or nonexistent policies mandating that private insurers offer all or some contraceptive coverage as a benefit in employer-sponsored insurance plans;
- Over three-quarters of states had weak or harmful policies related to whether mental health conditions would be covered under insurance plans to the same extent as physical health conditions.

These and other *Report Card* indicators point to the need for comprehensive health care reform at both the federal and state levels.

Fitting Principles for Health Reform into a Broader Agenda to Improve Women's Lives

The National Women's Law Center's (NWLC) broad *A Platform for Progress* (August 2008) incorporates a set of basic principles for health reform, recognizing that good health is essential to a woman's well-being. Other women's advocates should consider how health reform fits into their organization's mission and vision, and adopt a set of principles that promote comprehensive health reform to improve the lives of women and their families.

The NWLC Platform to Guarantee Accessible, Comprehensive Health Coverage

To meet the health care needs of women and their families, health reform should ensure that our nation's health care system meets basic standards and fulfills certain principles: the system should be simple to use and understand, be sufficiently and fairly financed, and leave no one out. The system should guarantee patients a choice of doctors and health care providers, as well as the option of a publicly run health plan. There must be adequate provider reimbursement and steps taken to address provider shortages in rural and urban areas alike. In addition, health reform proposals must:

Ensure Equity in Health Care Coverage. Health reform must ensure there are no gaps in access to care, and work to root out disparities in health care access that currently exist. An unacceptable 18 percent of all women are uninsured, and nearly 23 percent of Black Non-Hispanic women, 35 percent of American-Indian/Native Alaskan women and 38 percent of Hispanic women are without coverage. Reform plans must ensure that care is available for patients who have diverse cultural and linguistic needs. Regardless of age, race, gender, disability, geographic location, or employment status, there must be equity in health care access, treatment, research, and resources.

Ensure That Health Care Is Affordable for All. Health reform should ensure that individuals, as well as businesses, have affordable and predictable health costs. Currently, more than one in four women report being unable to pay their medical bills. Health insurance premiums should not be based on factors such as gender or health status. Rather, premiums—as well as out-of-pocket health costs like copayments and deductibles—should be based on a family's ability to pay for health care.

Ensure Comprehensive Benefits. Health reform should ensure comprehensive coverage of health care services that people need both to stay healthy and to be treated when they are ill—regardless of the individual's stage of life. This includes coverage of preventative services; a full range of reproductive health services including abortion; treatment needed for serious and chronic diseases and conditions; and appropriate end-of-life-care.

Build Accountability Into Any Health Care System. Any plan for health reform should include a watchdog role for government to ensure that risk is spread fairly among all health care payers, and that health insurance companies do not improperly delay or deny coverage for health care, turn people away, establish or raise rates, or drop coverage based on a person's health history, age, or gender.

Effectively Control Health Care Costs. The current rate of growth in health costs is unsustainable. Between 2000 and 2006, health insurance premiums increased by 87 percent—more than four times as much as wages during that time. To address the rising cost of health care, health reform plans must adopt effective cost controls that promote quality, lower administrative costs, and provide long-term financial sustainability. Provisions should include use of standard claims forms, secure electronic medical records that adequately protect patient privacy, the use of the public's purchasing power to instill greater reliance on evidence-based protocols and lower drug and device prices, and better management and treatment of chronic diseases.

Women's advocates can partner with other health advocacy groups in their state to work on health reform.
Health advocacy groups exist in every state, from groups that focus on the needs of health consumers in general to those that work on health issues specific to certain populations like children or people with disabilities. Women's advocates can find out which health advocacy groups in their community are working on issues related to health reform, and partner with groups that share the goal of high-quality, comprehensive, and affordable health care for all. By coordinating their efforts, advocacy groups can reach a broader audience, use resources more effectively, and build a stronger base of support for progressive health reform.

Women's advocates can analyze current reform efforts to determine whether they would benefit women through increased access to comprehensive, affordable, and high-quality health care.
Armed with the knowledge of women's unique relationships with the health care system, advocates can use the *Reform Matters Toolkit* to analyze current reform proposals in their states and to make informed assessments about how these reforms would affect women.

Women's advocates can communicate what they know about the potential impacts of various health reforms to state and national policymakers, as well as the communities they serve.
The "Talking about Health Reform" toolkit section provides resources for helping women's advocates to spread the word about how national or state-level health reform proposals could change health care for women and their families.

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Questions to Ask about Health Reform Plans

The National Women's Law Center has developed a list of questions that women's advocates can ask as they consider whether state or federal health reform proposals address women's distinct health care needs and the challenges women face in the current health care system:[1]

- **Does the plan expand access to ensure that health coverage is available to all?** Health insurance coverage provides women with greater access to health care and improves health outcomes. But millions of women remain uninsured and underinsured in the current health care system. Health reform plans must expand access to health coverage to all women, regardless of age, disability, geography, sexual orientation, income, health, work, or marital status. A truly inclusive health care system is one in which no one is left out.

- **Does the plan provide care that is affordable?** Women have lower incomes than men, in general, and a greater share of their income is consumed by health care costs.[2] Regardless of whether they have health coverage, women are more likely to delay or avoid getting the care they need because they cannot pay for it.[3]

  Health coverage must be affordable relative to income. Moreover, affordability should be based on all the costs of a woman's health care, including her insurance premiums and out-of-pocket costs like deductibles and copayments. There should be adequate subsidies for those who are ineligible for programs like Medicaid but can't afford the total cost of their health coverage.

- **Does the plan ensure comprehensive health coverage?** Health insurance must cover the services that women need to stay healthy and to treat physical and mental illnesses at all stages of life. Health reform plans should set a standard for health benefits that require coverage for all necessary care, including preventive care and a full range of reproductive health services.

- **Does the plan adopt insurance market reforms to end unfair practices?** Women and their families are often at the mercy of insurance companies, especially if they must purchase coverage directly from the insurers through the individual insurance market. In many states, insurers can deny coverage to people with pre-existing health conditions; charge people more for their coverage because of their gender, age or health status; raise premiums significantly without oversight; refuse to cover treatment for certain conditions; and even revoke insurance policies for people who have been paying premiums for years.[4]

  Reform proposals must end these unfair practices and promote a strong watchdog role for government to ensure that the reforms are implemented. Importantly, while state-level insurance market reforms can begin to address these problems, more than half of all people with job-based insurance are covered by health plans that are not subject to state insurance regulations. Only federal regulations will have an impact on the coverage that this sizeable population receives.[5]

- **Does the plan preserve or expand the role of public health insurance programs?** Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) currently provide publicly-funded health insurance for nearly 50 million women.[6] These public coverage programs serve as a vital health safety-net for low-income women and their families, and they must be preserved or expanded as part of any comprehensive health reform proposal.

  Since the majority of uninsured Americans are low-income, public coverage expansions have the potential to significantly reduce the ranks of the uninsured. Moreover, health reform proposals should establish an affordable public plan option in which anyone—regardless of income level, family, or job status—can participate. Even higher-income families and those who already have private health insurance should have the choice of purchasing coverage under a public health insurance plan.

- **What is the role of employer-sponsored health coverage?** Proposals that rely on the current system of job-based health insurance must help employers and workers alike. For example, the plan should help small or low-revenue business owners who want to provide health coverage to their employees but cannot afford the cost, and it should capture contributions from employers who don't provide health coverage. Given that more than 20 percent of uninsured women work part-time[7], health reform plans should also help part-time employees and their partners or dependents access comprehensive coverage.

- **Does the plan address health disparities faced by women in minority groups, as well as those women who live in rural and underserved areas?** Access to quality health care is not equal among women. Women of color are more likely to be uninsured than their white counterparts; over a third of all Latinas lack health insurance, for instance, which is more than double the proportion of uninsured white women.[8] Rural communities experience higher rates of chronic disease and have poorer overall health than their urban counterparts.[9] Health reform plans should promote equity in health care access, treatment, research, and resources for all people in order to eliminate disparities in health outcomes and improve health and life expectancy for all.

- **Does the plan take steps to control costs, while ensuring quality care?** Health reform can only be sustainable if plans address rising health care costs without compromising the quality of health care. Plans can promote effective cost controls that will also improve care, including secure electronic medical records, an emphasis on preventive health care, greater reliance on evidence-based protocols and lower drug and device prices, and better management and treatment of chronic diseases.

Using these questions as a guide, women's advocates can use the ***Reform Matters Toolkit*** to analyze current reform proposals to make informed assessments about their potential impact on women, and they can support health reform that will provide high-quality, comprehensive, affordable health coverage for all.

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Health Reform: An Opportunity to Address Health Disparities among Women

A woman's access to quality health care in the U.S. is a function of where she lives, her race and ethnicity, her family income, and her citizenship status, among other things. Millions of women experience comparatively worse health outcomes because they do not have equal access to the nation's health resources.

These health disparities are due, in large part, to differences in rates of health insurance coverage. Women of color, poor women, and women who live in rural areas, for instance, are all at greater risk of being uninsured and in turn, they suffer from higher rates of illness and unmet health needs. But some health disparities—particularly those between whites and racial or ethnic minorities—persist even when people are insured. These health disparities are a consequence of lower-quality care and problems with the way health care is delivered.

Health reform presents a unique opportunity to address the health disparities that have long troubled the U.S. health care system. Women's advocates can work to ensure that health reform proposals include measures that will make the health system more equitable, so that health disparities among women are eliminated.

What Are Health Disparities?

Health disparities are differences in health outcomes that result from unequal distribution of or access to the resources that promote good health. Health disparities are not the result of biological risk or any other natural cause—they are the consequence of harmful public policies and unequal access to health care for certain populations.[1]

Which Populations Experience Health Disparities?

Populations that experience health disparities include (but are not limited to) women of color, women who are poor, disabled women, those who live in rural areas, immigrant women, and women who identify as lesbian, gay, bisexual, or transgender (LGBT). Examples of the health disparities that exist for a few of these groups are highlighted below.

Women of Color

Over the last decade, the issue of racial and ethnic health disparities, in particular, has received growing attention. In the United States, people of color are more likely to lack health insurance, receive lower-quality care, and suffer from worse health outcomes. Compared to whites, they often have poorer access to care, are more likely to receive lower-quality health care, and experience higher rates of injury, illness, and premature death.

The National Women's Law Center's 2007 edition of *Making the Grade on Women's Health: A National and State-by-State Report Card* demonstrates that the nation as a whole and many individual states are falling further behind in their quest to reach national goals for women's health. The report's findings related to racial and ethnic health disparities are particularly dismal. Consider these statistics:

- In the **United States**, nearly 86 percent of white women receive first trimester prenatal care (i.e. within the first 12 weeks), compared to just 71 percent of American Indian/ Alaskan Native women.

- In **Ohio**, the average life expectancy for white women is 79 years, compared to 74 years for black women.
- In **California**, only 73 percent of Asian/Pacific Islander women received a Pap test (i.e. screening to detect cervical cancer) in the past three years, compared to 82 percent of white women.
- In **Louisiana**, the death rate for coronary heart disease is 135.5 per 100,000 for white women, compared to 191.7 per 100,000 for black women.

For more information about health disparities among women of different racial and ethnic populations, visit the interactive website for the *Making the Grade* report, at **http://hrc.nwlc.org.**

Women Living in Rural Areas

Women living in rural areas of the United States face unique barriers to accessing health care. They are more likely to be uninsured or underinsured (i.e. with health coverage that leaves them vulnerable to financial risk and/or unmet health needs).[2] Research demonstrates that rural residents are more likely than their urban counterparts to be self-employed or to work for small or low-revenue employers that do not offer job-based health insurance. They are also more likely to purchase coverage directly from insurers through the individual insurance market, where women face many obstacles to obtaining comprehensive and affordable coverage.[3,4]

Regardless of their insurance status, rural women have more trouble finding a health provider near their home. Rural residents are four times more likely to live in a medically underserved area, since health care facilities in rural parts of the country have more trouble attracting and retaining doctors, nurses, and other health providers.[5] Providers practicing certain specialties, such as those in the obstetrics/gynecology field, are particularly lacking in rural areas; this often presents a major barrier for rural women who need reproductive health services.

Long travel distances and limited transportation options create additional obstacles to rural women's access to health care. If a woman needs a health service that is only offered by a very limited number of providers in the area, such as reproductive or mental health care, transportation is especially problematic. For instance, a woman and her family may need to travel for hours—sometimes by multiple modes of transportation—in order to reach a pharmacy that stocks contraceptives, an abortion provider, or a mental health provider that can treat depression. Rural women and men have higher rates of chronic disease, including cancer and cardiovascular disease.[6] To maintain good health, it is essential that chronic diseases are well-managed, but the provider shortage and transportation issues described above make effective disease management more difficult for rural residents.

Women in the LGBT Community

Women in the lesbian, gay, bisexual, and transgender (LGBT) community experience health disparities. Research indicates that LGBT people are more likely to be uninsured and to lack a regular health provider than the general population.[7] Lack of formal recognition of same-sex relationships poses a major barrier to insurance coverage, as a majority of employers do not sponsor health benefits for their workers' same-sex partners as they do for married spouses. Even when they are available, domestic partner health benefits do not receive the same favorable tax treatment as other employer-provided coverage for workers' family members.[8]

The LGBT population is also more likely to face barriers in access to care and preventive services.[9] With an insufficient number of health care providers who can sufficiently treat this population—either due to outright discrimination, ignorance, or misinformation—it is often more difficult for women in the LGBT community to get comprehensive care, and they may actually be less willing to seek care if they cannot find a provider who can adequately meet their needs.[10] One large-scale study of health risks for older women, for instance, found that lesbian and bisexual women are significantly less likely to receive regular cancer screenings such as mammography and the Pap test.[11] Women of color who identify as LGBT face multiple levels of discrimination related to both racism and homophobia.[12] To increase rates of preventive screening and counseling among the LGBT population, the health provider workforce should be trained to provide culturally-competent care. Such training will help providers be more informed, accepting, and supportive of this population.

Why Do Health Disparities Exist?

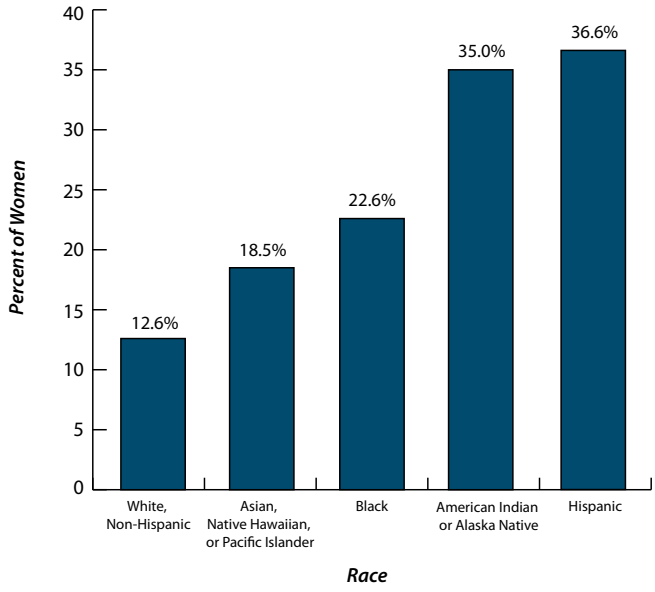
Unequal health outcomes are caused by inequities in the structure of the health system itself, including differences in access to health coverage and in the quality of health care that some populations receive. Health disparities are also influenced by a range of social and environmental determinants of health, which are typically outside the purview of health reform plans—these include access to adequate and safe housing, nutritious food, education, and transportation.

Differences in Access to Health Coverage

Women with health insurance are more likely to seek timely preventive care, to effectively manage their chronic conditions, and to have a usual source of health care.[13] The relationship between coverage and positive health outcomes is well-documented. Yet women of color are considerably more likely to be uninsured than their white counterparts, as demonstrated in Figure 1. Hispanic women, for example, were roughly three times as likely as white women to be uninsured in 2007 (36.6 percent vs. 12.6 percent, respectively).

Differences in access to health coverage contribute to the persistent health disparities between racial and ethnic groups. Unequal access to health coverage is also an important factor in the health disparities that exist for people living in rural areas of the United States and for those living at or near the federal poverty level.

Figure 1. Women Ages 18-64 Without Health Insurance, 2007



Source: National Women's Law Center analysis of Current Population Survey's (CPS) March 2007 Annual Social and Economic Supplement, using the U.S. Census Bureau 'CPS Table Creator,' http://www.census.gov/hhes/www/cpstc/cps_table_creator.html, on August 15, 2008.

Connecting the Dots between Health and Wealth. In general, populations that suffer from the worst health status are also those that have the highest poverty rates. Those who have the fewest resources in the United States also report worse health outcomes, regardless of whether the measure is mortality, the prevalence of acute or chronic diseases, or untreated mental health problems.[14] Unsurprisingly, women in populations that experience health disparities—including women of color and those living in rural areas—are also more likely to have lower incomes.[15] Lower-income women are, in turn, disproportionately represented among uninsured women, who are more likely to delay or go without necessary medical care than their insured counterparts. Considering the connections between poverty, poor health, and insurance status, it is critical that health reform plans prioritize access to high-quality and **affordable** health coverage so that poverty-related health disparities are eliminated.

Differences in Health Care Quality

Health insurance is the single most significant factor in determining an individual's access to health care. Even for people who have health coverage, however, health care delivery may be inequitable, contributing to disparate health outcomes. In a landmark 2003 report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, a panel of scientists and doctors assembled by the Institute of Medicine (IOM) concluded that "minority patients are less likely than whites to receive the same quality of heath care, even when they have similar insurance or the ability to pay for care."[16] Quality health care (which is discussed in more detail elsewhere in the *Reform Matters Toolkit*) is often described as the **right care**, at the **right time**, for the **right reason**.

Indeed, there is a growing body of evidence that people of color receive lower-quality care, on average, than white people. The most recent National Healthcare Disparities Report (an annual assessment conducted by the U.S. Agency for Healthcare Research and Quality) details the range in health disparities resulting from differences in health care quality—these differences in health outcomes exist even for those who are insured. For instance: [17]

- In 2004, the rate of lower extremity amputations in diabetic adults was over three times higher for blacks than whites (104.0 per 1,000 compared with 27.6 per 1,000);
- In 2005 the proportion of Medicare patients with pneumonia who received recommended hospital care was lower for blacks (69.5 percent), Asians (68.7 percent), and Hispanics (66.2 percent) than for whites (74.6 percent);
- In 2004, blacks and Asians were more likely than whites to report they had poor communication with their health providers (11.3 percent for blacks and 14.3 percent for Asians compared with 9 percent for whites).

According to the IOM's *Unequal Treatment* report, inequitable health care delivery is primarily due to two sets of factors, 1) health care systems' operating environments (e.g. cultural or linguistic barriers, provider incentives to contain costs such as spending a minimal amount of time with a patient) and 2) provider uncertainty, bias, or stereotyping when treating patients of racial or ethnic minority groups.

Strategies to Eliminate Health Disparities

As federal and state policymakers develop proposals to address myriad gaps in the current U.S. health system, they must take advantage of the important opportunity to incorporate health reform provisions that could eliminate the nation's persistent health disparities. These efforts, which are described in greater detail below, include measures to: expand affordable health insurance; improve the health care infrastructure in medically underserved communities; increase provider diversity and cultural competency; obtain the data that is necessary to document and address inequitable health outcomes; promote the medical home model; and address social and environmental determinants of health. More information about these and other reform provisions for equitable health care can be found in a 2008 report prepared by the Opportunity Agenda and Families USA, titled *Identifying and Evaluating Equity Provisions in State Health Care Reform*.

- **Expand Affordable Health Coverage**. A health system that provides high-quality, affordable health coverage for all will go a long way to eliminate the inequitable distribution of health care resources. If people of color, rural residents, and low-income people have equitable access to health insurance, they will be able to seek timely care—including preventive care—before a health problem becomes complicated and costly. Moreover, in a system where everyone has high-quality health coverage, hospitals and other health care providers have equal incentives to serve wealthy and poor communities alike.[18]

The Importance of Public Coverage Programs.
People of color are disproportionately represented in Medicaid, the health insurance program for low-income people that is jointly funded by the federal and state governments. Racial and ethnic minorities comprise about one-third of the total U.S. population but more than half of all Medicaid recipients.[19] Consequently, policy changes to the Medicaid program have disproportionate impacts on communities of color. Program expansions and enhancements can serve as an effective tool to improve health access and to target health disparities; at the same time, cuts and restrictions to the Medicaid program are especially harmful.

In particular, inadequate provider reimbursement is a persistent problem in the Medicaid program, which typically reimburses providers at a considerably lower rate than both private insurance companies and Medicare. This inequity contributes to health disparities. Providers will not agree to participate in Medicaid if reimbursement rates are too low, which makes it more difficult for Medicaid enrollees to find health providers when they need care. States have the authority to increase these rates, which has the potential to reduce health disparities.[20]

- **Improve the Health Infrastructure.** Communities that are predominantly minority, as well as those that are located in rural areas, have fewer health care resources such as hospitals, primary care providers, outpatient clinics, and nursing home facilities.[21] States must continue to direct resources and incentives to improve provider availability in these underserved areas, and they must support new initiatives for correcting the imbalance of health resources. These initiatives include graduate medical education programs that focus on medically underserved areas, as well as loan forgiveness or

scholarship programs that require service in such areas. Safety-net hospitals and other providers (i.e. those that serve a high proportion of uninsured, publicly-insured, and other underserved communities) serve as critical links to health services for many communities of color, and reform plans can ensure that these institutions receive adequate financial support from the government so that they are not financially vulnerable.

- **Increase Provider Diversity.** Increasing the number of minority health care providers has proven effective in improving the quality of care delivered to racial and ethnic minorities.[22] Health care providers of color, for instance, are more likely to work in minority or underserved communities, therefore increasing the availability of health resources in those communities. Minority populations are also more likely to report satisfaction with care delivered by racially diverse providers.[23] Yet these types of providers are under-represented in the health care workforce. In 2004, for example, over 80 percent of registered nurses in the United States were white.

- **Promote Cultural Competency.** It is equally important that federal and state reform initiatives promote cultural competency among health care providers. For example, in a recent study that found unequal health outcomes for black and white diabetes patients treated by the same doctor, authors concluded that such disparities do not result from overt racism, but rather a "systemic failure to tailor treatments to patients' cultural norms."[24] They recommended basic cultural competency for diabetes management—that is, that health providers learn more about treating minority communities and tailor strategies for educating minority patients about managing a chronic disease.

  By improving provider-patient communication and supporting the delivery of care that accommodates patients' cultural factors, training in culturally-competent medicine can eliminate racial and ethnic health disparities. Ensuring that patients with Limited English Proficiency (LEP)—including those in the immigrant community—have access to accurately translated health-related materials that they can comprehend (sometimes referred to as linguistic competence) is another important component of delivering culturally-competent care.

- **Collect the Right Data to Document and Address Health Disparities.** Without accurate and complete data on health consumer demographics—including language status, race/ethnicity, sexual orientation, and income—and the different health outcomes that these consumers experience, it will be impossible to fully address health disparities. For public and private health systems to have the ability to monitor racial and ethnic, language status, and income-based health care disparities, federal and state governments must support the collection and regular analysis of disparity data, measured both in terms of health care access and quality.[25]

- **Promote the "Medical Home" Model.** A "medical home" (sometimes called a "health care home") generally refers to a centralized location for health care, with one personal health care provider who coordinates an individual's care. This personal provider is responsible for all of a patient's health care needs, including appropriately arranging care with other health professionals. Public and private health insurers have implemented medical home initiatives as strategies to improve health care quality and safety, and research demonstrates that when minorities have a medical home, their access to preventive care improves substantially (e.g. about two-thirds of all adults

who have a medical home receive preventive care reminders). Similar (and significant) proportions of white, black, and Hispanic Americans with medical homes report getting the care they need when they need it, indicating that these initiatives have the potential to reduce or even eliminate racial and ethnic disparities in access to care.[26]

- **Address the Environmental and Social Determinants of Health.** Disparate health outcomes are not solely a product of inequities in the health system. Unequal access to other resources in a woman's social and physical environment may also have a negative impact on her health. Poor housing conditions, a dearth of safe public spaces for outdoor activities, and a scarcity of grocery stores selling fresh fruits and vegetables, for example, can all contribute to poorer health outcomes among people living in minority communities. Some of the solutions to these problems are admittedly beyond the scope of even a very comprehensive health reform plan. But, health reform plans may incorporate community-level interventions that address multiple determinants of health—social, environmental, and health-related factors—as a starting point for incorporating these important issues into health reform. Community interventions supported through grant programs of the Center for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH 2010) and the Department of Health and Human Services' Office of Minority Health have effectively reduced racial and ethnic disparities in targeted subpopulations. These interventions—which include efforts to organize communities, provide mass and one-on-one health education, conduct screenings for risk factors, and reduce environment risk factors through local program and policy change—can improve overall quality of life for minority groups.[27]

Lessons from the States:

Statewide Councils on Health Disparities.

As an initial step to implementing reforms that would address unequal health outcomes among their residents, many states have created special entities expressly for the purpose of tackling health disparities. At least 35 states have taken such steps, including:[28]

- **Massachusetts:** As part of its broad 2006 health reform package, the state established the Health Disparities Council, charged with developing recommendations on several minority health issues including workforce diversity, disparate disease rates among communities of color, and social determinants of health.[29]
- **Pennsylvania:** The Office of Health Equity, established in April 2006 within the state's Department of Health, collaborates with state agencies, academic institutions and community groups to improve the health status of groups experiencing health disparities. The office does not limit its work to health disparities among racial and ethnic minorities, but also focuses on disparities in geographic areas and among socioeconomic groups.[30]
- **Washington:** In 2006, the state legislature created the Governor's Interagency Coordinating Council on Health Disparities. This council is charged with creating an action plan to address the contributing factors of health that can have broad impacts on improving health status, health literacy, physical activity, and nutrition.[31]

What Can Women's Advocates Do to Ensure That Health Reform Addresses Health Disparities?

Women's advocates should inquire how health reform plans will affect populations that experience health disparities.
Advocates must determine whether and how health reform proposals may differentially affect women of color, low-income populations, and other underserved groups that experience health disparities. Health reform plans that expand health insurance coverage but do nothing to improve provider availability, for example, may hold little benefit for women who live in rural areas with severe health provider shortages. Plans that enhance and sustain the Medicaid program, on the other hand, will have a positive impact on the health of communities of color and low-income populations, since these groups are particularly dependent on Medicaid for their care.

Women's advocates can promote health reform measures that explicitly address health disparities.
Health reform presents a unique and important opportunity to incorporate initiatives that could eliminate the nation's persistent health disparities. These include efforts to expand affordable health insurance; improve the health care infrastructure in medically underserved communities; increase provider diversity and cultural competency; obtain the data that is necessary to document and address inequitable health outcomes; promote the medical home model; and address social and environmental determinants of health.

Women's advocates can partner with groups that represent or serve groups that experience health disparities.
Many organizations are working at both the national and state level to address health issues that specifically affect those women most likely to experience health disparities, including women of color, rural women, women living in poverty, and women in the LGBT community. By joining forces with these groups, advocates for health reform can ensure that their work incorporates the interests of women who experience health disparities, and ultimately promote health reform plans that correct inequities in the health care system.

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"Unnatural Causes: Is Inequality Making Us Sick": This seven-part documentary series on health inequalities, which aired on PBS, is available (with supporting materials) at www.unnaturalcauses.org

The Rural Women's Health Project, http://www.rwhp.org/

The National Coalition for LGBT Health, http://www.lgbthealth.net/

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EXPANDING THE POSSIBILITIES

ISSUE BRIEF

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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.

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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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FamiliesUSA
The Voice for Health Care Consumers

GLOSSARY OF HEALTH CARE TERMS *

Adjusted Community Rating - A method of determining health care premiums where the premium is based on the average cost of health services used by all customers in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amounts of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan. *Adjusted community rating* allows some variation in premiums but limits the extent of the variation (for example, within a band no higher than 25 percent of average or lower than 25 percent of average).

Advanceable Tax Credit - As it relates to expanding health coverage, a tax credit provided to cover the cost of purchasing health coverage in the individual market where the monthly payments can be sent directly to a health insurance provider, and the recipient need not wait to file a tax return and receive the subsidy as a tax credit or refund.

Adverse Selection - The trend wherein people purchase insurance only when they become sick and have significant expenses. If people do not purchase insurance until they are sick and need it, the individual insurance market may become a pool only for the sick, with no healthy members. This drives up premiums in the individual market. Adverse selection can also occur when healthier individuals are siphoned into certain plans (generally with fewer benefits and lower premiums) and sicker individuals into other plans (which offer more benefits).

Beneficiary - A person who receives benefits. The term is commonly applied to anyone receiving benefits under the Medicare or Medicaid programs or who is covered under a private health insurance plan.

Benefit Cap - A dollar limit placed on the amount of coverage that can be provided to an individual in a given time period, which is usually one year.

Benefit Package - A group of guaranteed services provided by a health plan to its members.

Block Grant – A lump sum of money given to a state or local governing agency based on a formula to be spent on services such as health care coverage. Generally, the purposes of block grants are broadly defined, with few restrictions mandated by the funding source. Restrictions can be imposed by the re-granting agency.

Carve-Out – A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g. mental health services) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting for services to a special population. As it relates to Medicaid, a set of services (such as behavioral health services) that are provided separately, or a specific population (such as people with HIV or children with special needs) that is not required to enroll in a Medicaid managed care program. These services or populations are said to be "carved out" and handled separately, either in fee-for-service plans or through a separate managed care organization.

Case Management - A means of coordinating care for people with multiple, often complex health care needs. As it relates to managed care, a system that requires that a single individual in the provider organization be responsible for arranging and approving all services needed. Ideally, case management should increase consumers' access to appropriate care through specialists and ensure that full information about a consumer's health conditions follow him or her through the health care system. In the context of private managed care, case management by a gatekeeper can be inappropriately motivated by the goal of reducing their health care costs. In the context of Medicaid, case management and managed care delivery systems must be examined carefully to determine if cost concerns are overriding the positive goal of coordinating care.

Categorically Needy – As it relates to Medicaid, a beneficiary is deemed categorically needy if she is eligible for coverage because she meets certain income requirements and falls into a specific population category: families with children: pregnant women; and people who are blind, disabled, or over 65. People who do not fall into these categories cannot qualify for Medicaid, no matter how low their incomes (unless their state has obtained a federal Section 1115 waiver to cover additional groups).

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* The National Women's Law Center thanks Families USA for sharing this glossary of health care terms for inclusion in the *Reform Matters Toolkit*. This glossary is an excerpt of the full Families USA "Glossary of Health Care Terms" which can be found at: http://www.familiesusa.org/resources/tools-for-advocates/kits/glossary-health-care.html.

Centers for Medicare and Medicaid Services (CMS) - CMS is the name for the agency within the Department of Health and Human Services (HHS) that oversees Medicare and Medicaid. It was previously known as the Health Care Financing Administration (HCFA).

CHIP - see *State Children's Health Insurance Program (SCHIP)*

COBRA – *See Consolidated Omnibus Budget Reconciliation Act of 1985.*

Co-Insurance - The portion of covered health care expenses that must be paid, in addition to the deductible, by the health plan members. The figure is usually expressed in a ratio, such as 80/20, where the insurer pays 80 percent and the client pays the remaining 20 percent of the bill *(see Cost-Sharing)*.

Community Rating - A method of determining health care premiums where the premium is based on the average cost of health services used by all customers in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amounts of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan.

> **Pure community rating** requires insurers to set the same premiums for everyone in a community. Plans cannot vary premiums at all based on health status, claims history, or age, but they may be allowed to vary premiums within a state based on geographical location and/or family composition.
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> **Adjusted community** rating likewise prohibits insurers from varying premiums in a community based on health status or claims history, but it does allow them to vary rates based on more factors than geography and family composition. For example, it may allow some variation in premiums but limit that variation within a band no higher than 25 percent of average or lower than 25 percent of average.

Connector – This term originated with the Massachusetts Health Reform of 2006. A health insurance "connector" (also known as an "exchange") is a structure that facilitates enrollment of individuals, families, and small businesses in private health coverage. It creates a common marketplace where consumers can compare their health coverage options. It may also play a central role in outreach and education about newly available coverage and assist employers in establishing Section 125 pre-tax health plans for employees.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - A provision of this federal law requires that certain employers permit laid-off workers and their dependants to remain in the employee health plan for a specified period of time. Employees must pay the full cost of the premium (including the share formerly paid by the employer).

"Consumer Driven" Health Plans – This term is used by different people to mean different things. One of the more common ways this term is used is to refer to a high-deductible plan that may be linked to a Health Savings Account (HSA – see below). The term is also used to refer to a defined contribution plan (see below) in which an employer offers an employee an account with a fixed dollar amount of money in it that is used to pay for health care coverage or services. Both of these kinds of plans—while purportedly giving consumers more "choice" and "control" over their health care—really shift the risk of incurring high health care costs and out-of-pocket costs from employers and insurance companies to employees.

Continuous Eligibility – A policy that states can apply to children's Medicaid and SCHIP coverage that allows an individual to remain eligible for the program for a full 12 months regardless of changes in family income. This policy reduces the paperwork burden on families and helps prevent children from losing coverage as family situations change.

Copayment - The amount a plan member has to pay each time he or she sees a doctor, fills a prescription, or receives other medical services. For example, most health plans require enrollees to pay a set dollar amount for each physician office visit or each prescription drug. *(see Cost-Sharing)*

Cost-Sharing - A provision of private or public health coverage that requires the beneficiary to pay a portion of the costs of covered services.

Crowd-Out – A term used to describe the substitution of public coverage for private coverage. The term has also been used to convey the idea that, when expanding access to subsidized coverage in order to cover the uninsured, the expansion will prompt some privately insured individuals to drop their existing coverage and take advantage of the public subsidy. This issue has been particularly contentious in the children's health debate, as some have argued that large numbers of families drop private coverage in favor of SCHIP or Medicaid. Studies have found varying degrees of crowd-out in these programs, but most reports have found it to be minimal.

Cultural Competence – The capacity of service providers to respect and respond to individual and cultural differences when caring for diverse

populations.

Deductible - A set dollar amount that must be paid *before insurance coverage begins*. For example, many private insurance policies require payment of several hundred dollars out-of-pocket before the insurance will pay for medical care. Medicare also requires the payment of a deductible each year. In 2006, the deductible for Medicare Part A (hospitalization) is $952, and the deductible for Medicare Part B (physician and other outpatient non-pharmacy services) is $124. For Medicare's new drug benefit, Medicare Part D, the standard deductible is $250, but this varies by drug plan.

Deficit Reduction Act (DRA) - In February 2006, President Bush signed into law budget reconciliation legislation, known as the Deficit Reduction Act (DRA), that fundamentally alters many aspects of the Medicaid program. Some of these changes are mandatory provisions that states must enact and that will make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments.

Disparities in Health – Differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups.

Disparities in Health Care – Differences between two or more population groups in health care access, coverage, and quality of care *not due to different health needs*. This can include differences in preventive, diagnostic, and treatment services between population groups.

Dual Eligible - A low-income Medicare beneficiary who also receives full Medicaid benefits.

Employee Retirement Income Security Act of 1974 (**ERISA)** - A federal law governing employee benefit programs. As it relates to health insurance, ERISA includes general protections about benefits and about the disclosure of information to employees in the plan. ERISA also prevents states from regulating health insurance if the employer "self insures."

ERISA – *See Employment Retirement Income Security Act of 1974.*

Federal Employees Health Benefits Program (FEHBP) - The health benefits plan for employees of the federal government. The Office of Personnel Management (OPM), which administers FEHBP, approves a variety of health benefit plans from which employees may choose. All plans must offer similar core benefits, and plans can also offer additional benefits. The government pays no more than 75 percent of the cost of an employee's chosen plan, and the employee pays the rest.

Federal Match – For the Medicaid and SCHIP programs, the federal government matches what states contribute to these programs. These match rates vary by state and program.

Federal Poverty Level - Guidelines established by the Department of Health and Human Services that are used to determine an individual's or family's eligibility for various federal and non-federal programs. Federal poverty levels vary by family size and, to a small extent, location (Alaska and Hawaii have higher rates than the 48 contiguous states and the District of Columbia).

Fee-for-Service (or Indemnity) Insurance - Health insurance plans that reimburse physicians and hospitals for each individual service they provide. These plans allow clients to choose any physician or hospital. Managed care is an alternative to fee-for-service medicine.

FEHBP – *See Federal Employees Health Benefits Program.*

Freedom of Choice - A Medicaid provision that requires states to allow beneficiaries the freedom to choose providers. States can seek Section 1915 and 1115 waivers of the freedom-of-choice requirement.

Gatekeeper Physician - A primary care physician who controls the access of his or her HMO patients to specialty medical care.

Generic Drug – A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms. Generic drugs are FDA reviewed and must be bio-equivalent, which means that they must have the same active ingredients and be absorbed by the body the same way as their brand-name counterparts. Generic drugs usually cost significantly less than their brand-name counterparts.

Guaranteed Issue – A requirement (usually a state law) that insurers sell a policy to anyone who seeks one, regardless of the applicant's health status, claims history, age, or the industry in which he or she is employed. This requirement also guarantees that the coverage will be renewed as long as the premium is paid.

Guaranteed Renewal – A requirement that insurers renew the policies of policyholders. Such requirements are established to prevent insurers from dropping policyholders who become ill and have high medical bills.

Health Information Technology (HIT) - The use of electronic technology, such as computerized medical records, to provide comprehensive management of medical information and its secure exchange

between health care consumers and providers, as well as to streamline health care delivery.

Health Insurance Portability and Accountability Act (HIPAA) – A federal law that sought to improve the "portability" of benefits by making it easier for workers to move from job to job without the risk of being locked out of insurance or having to wait for coverage of preexisting medical conditions. The bill also prohibits insurers from discriminating against workers based on their medical history (or that of their dependents).

Health Maintenance Organization (HMO) - A type of managed care health plan that provides health care to insured people through a network of providers within a defined geographic area. The providers may be employees or contractors of the HMO. The HMO providers are responsible for an individual group of patients, and they generally receive a fixed amount of money per month to cover the care of each patient (this is called "capitation"). One advantage of HMO plans has been that they often did not charge deductibles and they often had lower co-insurance or copayments. HMOs were designed to control costs by limiting access to specialty care. In theory, the HMO gatekeeper or primary care provider would help the consumer avoid unnecessary specialist care, but in practice, it is argued that needed specialty care is unduly restricted. Thus traditional HMOs fell out of favor in the mid-1990s.

Health Savings Accounts (HSAs) – Health Saving Accounts (HSAs) were established as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). HSAs offer tax benefits for people who purchase insurance policies with high deductibles. To qualify for the HSA tax break, the policy must have a deductible of at least $1,000 (for an individual) or $2,000 (for a family), but the deductibles may run as high as $10,200. An HSA is a tax-preferred savings account. Deposits into the HSA may be deducted from income for federal income taxes. A maximum of $2,600 (for an individual) or $5,150 (for a family) can be deducted in one year. The tax-deductible contributions may be placed into an HSA by an individual, an employer, or both. Individuals can get a small tax advantage if they contribute to their HSAs, but the amount they save on federal taxes depends on their income, tax liability, and how much they (not their employers) contribute to their HSAs. For many people, an HSA will provide little or no tax break. Withdrawals from health savings accounts that are used to pay for out-of-pocket health care costs are tax free, while withdrawals for non-medical uses are subject to income tax and a 10 percent penalty for people under the age of 65. Money that is not used can be rolled over from one year to the next. Individuals over the age of 65 may withdraw money from their accounts—for any reason—without being taxed. Money in the accounts can be invested in stocks and bonds without incurring tax on the earnings.

High-Risk Pool – A nonprofit association created by states as an alternative for individuals who have been denied health insurance because of a preexisting condition or whose premiums are rated significantly higher than the average due to health status or claims experience. HIPAA (see above) allows states to use high-risk pools to satisfy the statutory requirements for ensuring access to health insurance coverage for certain individuals. By law, premiums are capped, and while they are somewhat higher than premiums charged to healthy people, they are not as high as premiums for unhealthy individuals. High-risk pools are subsidized in order to keep premiums within the state's cap.

HIPAA - *see Health Insurance Portability and Accountability Act.*

HSAs – *See Health Savings Accounts.*

Individual Mandate – A law requiring all state residents to obtain health insurance. Currently, Massachusetts is the only state with an individual mandate.

Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English are described as having limited English proficiency. An LEP individual has a limited ability to communicate in English at a level that permits the person to interact effectively with health care providers or social service agencies. According to the 2005 American Community Survey, more than 23 million individuals (8.3 percent of the population) speak English less than "very well."

Managed Care Organization (MCO) - A system of health service delivery and financing that coordinates the use of health services by its members, designates covered health services, provides a specific provider network, and directs the use of medical care services. The two most common types of managed care organizations are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Medicaid - The federal health insurance program established in 1965 through Title XIX of the Social Security Act. Medicaid pays for health services for low-income Americans under age 65, including children, pregnant women, and people with disabilities, and for nursing home care for impoverished older adults over 65. It is financed through both federal and state funds. Each state implements its own Medicaid program, and the amount allocated to each Medicaid program varies.

Medicaid Waiver – *see Waivers*

Medical Home – A primary care practice where a patient routinely seeks medical care and where a patient's health history is known. A medical home is a

place where health care should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Medical Loss Ratio – The percentage of premium dollars that health insurance companies spend on medical care, as opposed to administrative costs or retaining for profit.

Medicare - The federal health insurance program established in 1965 through Title XVIII of the Social Security Act that covers Americans who are age 65 or over, who are disabled, or who have been diagnosed with end-stage renal disease.

Medicare Advantage (MA) - Private Medicare health plans, usually managed care plans or HMOs, that have sometimes provided extra benefits that "traditional" Medicare did not cover. Plans may charge additional premiums. This program was formerly known as Medicare+Choice or Medicare Part C.

Medicare Part A (*also known as Hospital Insurance*) - Medicare Part A covers inpatient hospital care, home health care, hospice care, and limited skilled nursing care. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries must pay an initial deductible each time they are ill and a copayment for some services.

Medicare Part B (*also known as Supplementary Medical Insurance*) - Medicare Part B covers physician services, medical supplies, and other outpatient treatment such as laboratory tests and x-rays. Medicare beneficiaries must pay a monthly premium for Part B coverage.

Medicare Part D (*also known as the Medicare prescription drug benefit*) - Medicare Part D provides for an outpatient prescription drug benefit that began in January 2006. Beneficiaries can remain in traditional Medicare and enroll in a separate, freestanding, private prescription drug plan (PDP), or they can enroll in an integrated Medicare Advantage plan that includes prescription drug coverage.

Medicare Payment Advisory Commission (MedPAC) – An independent body established by Congress to advise it on issues affecting the Medicare program.

Medicare Prescription Drug Benefit - *see Medicare Part D.*

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) - Commonly known as the Medicare Modernization Act (MMA), this law most notably created a prescription drug program for Medicare beneficiaries, known as Medicare Part D. In addition, it increased the part B deductible, expanded private Medicare Advantage plans, and added new preventive benefits for beneficiaries.

Medigap (or Medicare Supplemental) Policy - A privately purchased insurance policy that supplements Medicare coverage. The policy must meet requirements set by federal statute and by the National Association of Insurance Commissioners.

Modified Community Rating – *see Adjusted Community Rating.*

Out-of-Pocket Maximum – The upper limit of how much individuals or families must pay out of pocket in deductibles and coinsurance for covered medical services during a benefit period.

Pay-for-Performance (P4P) - The idea that there should be a direct link, based on accepted measures, between what is paid for health services and the value of the services provided. Pay-for-performance uses payment methods and other incentives to encourage physicians and other health care personnel to provide higher quality and efficiency, rather than higher volume.

Pay or Play – Legislation designed to expand health coverage that requires employers (within certain parameters) to either "play" by contributing to their employees' health coverage or "pay" an assessment to the state which the state, in turn, uses to fund health coverage.

Preexisting Condition Exclusion – A policy of excluding certain people from obtaining insurance or treatment due to a preexisting medical condition.

Preferred Provider Organizations (PPOs) – A type of managed care plan in which enrollees can choose plan-selected providers who discount their fees. By visiting a PPO provider, a beneficiary will pay less money out-of-pocket for medical services than he or she would by visiting a non-PPO provider.

Premium - The charge (not including any deductibles or copayments) enrollees must pay for coverage under a health plan. Premiums are typically paid on a monthly basis.

Premium Assistance – The use of federal funds usually designated for public health coverage programs—especially Medicaid and SCHIP—to purchase (or subsidize the purchase of) private insurance.

Presumptive Eligibility - A policy that states can use in their Medicaid or SCHIP programs for children or pregnant women. This policy allows states to provide these individuals with immediate but temporary enrollment in Medicaid or SCHIP if they appear to meet program eligibility standards.

Prior Authorization - A requirement that an enrollee's physician or insurance plan (or Medicaid

program) give approval in advance before a particular drug or service will be covered.

Purchasing Pool – As it relates to health coverage, a group of people brought together to enhance their bargaining power as well as to pool risks across individuals—the sickest to the healthiest. All purchasing pool members pay the same premium for a given plan, regardless of their health status.

Rate Bands – The variation in insurance premiums that is allowed by state regulations, expressed as a ratio or as a percentage of the index rate or average rate. Rate bands are used to limit the variation in premiums among individuals.

Rate Regulation – The process of overseeing and regulating the premiums—or rates—that insurance companies charge to their customers. States and the federal government regulate different kinds of insurance.

Reinsurance – Reinsurance is insurance for insurance companies. Its basic structure involves a primary insurance company that transfers, or cedes, the risk of high-cost claims to another private carrier or to a government-sponsored program. The insurer or government-sponsored program then assumes this risk and pays for some or all of these high-cost claims. There are two major types of government-sponsored reinsurance programs: 1) the government pays for some or all of the claims through general revenues; or 2) state law establishes an association of insurance companies that may want to cede risk and requires these companies to pool their resources to pay high-cost claims.

Risk Pooling – Under this process, risk for all individuals—including the healthy and the sick—is combined into one risk pool or group, and the group's total expected claims are evaluated. This is used to try to calculate the required funding (raised through premiums and/or other subsidies) to support the payment of all expected claims for all members of the risk pool.

SCHIP – *See State Children's Health Insurance.*

Section 125 Cafeteria Plans – Plans that allow employees to set aside pre-tax dollars for a variety of benefits, including flexible spending accounts (FSAs) and health insurance. These plans are named after Section 125 of the Internal Revenue Service code. Some states encourage or require certain businesses to establish cafeteria plans so that their workers will be able to pay for their share of health premiums with pre-tax dollars.

Self-Insured Health Plan – A health plan in which the employer assumes the financial risk of covering its employees, paying medical claims from its own resources.

State Children's Health Insurance Program (SCHIP) - The BBA of 1997 established Title XXI of the Social Security Act, which created the federal block grant program known as SCHIP. SCHIP provides funds to states to establish a health insurance program for targeted low-income children in families with incomes below 200 percent of the federal poverty level. States can: (1) expand Medicaid to cover children in families with higher incomes, (2) create a new health insurance program for children, or (3) do both. The program is financed with federal and state funds, with the federal government paying a greater share than it pays for the state's regular Medicaid program. Each state has a different SCHIP program.

State Plan Amendment - A Medicaid state plan is the document that defines how each state operates its Medicaid program. Making any major change to a state's Medicaid program usually requires an amendment to the Medicaid state plan. Amendments to the state plan must be filed and approved by the Centers for Medicare and Medicaid Services (CMS) before changes can be implemented.

Tax Credits – A dollar-for-dollar reduction in the amount of taxes an individual owes. Some tax credits are "refundable," meaning that if an individual owes less in taxes than the amount of the credit, he or she receives a refund and benefits from the full amount of the credit. The Earned Income Tax Credit is an example of a well-known federal program that works in such a manner.

Trade Adjustment Assistance Reform Act of 2002 (TAARA) Health Insurance Subsidy - The TAARA is geared toward helping retirees, their families, and other workers who have lost their employer-sponsored health coverage as a consequence of trade practices or bankruptcies. This legislation provides a subsidy, via the tax system, that covers 65 percent of the cost of purchasing health insurance from certain specified sources.

Underinsured – People whose insurance does not cover their necessary health care services, leaving them with out-of-pocket expenses that exceed their ability to pay.

Waivers - Sections 1115 and 1915 of the Social Security Act define specific circumstances under which the federal government may, at a state's request, "waive" certain provisions of the federal Medicaid laws. The "waiver" is the agreement between the federal government and the state that exempts the state from these provisions, and it includes special terms and conditions that define to whom and when these exemptions apply. For example, some states use Medicaid waivers to extend Medicaid coverage to childless adults who are not blind or disabled, a group that does not ordinarily qualify for Medicaid under federal laws.

Home- and Community-Based Care *(also known as* 1915 *(c) or* 1915 *(d)*) - A home- or community-based care waiver allows states to offer community-based long-term care services to Medicaid beneficiaries who would otherwise require nursing home care or other types of institutionalized care. Under this type of waiver, states provide a broad range of home- and community-based services to people who are older than 65, developmentally disabled, or chronically ill. States must apply to the Department of Health and Human Services (HHS) for each specific program.

Section 1115 - Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services (HHS) to waive certain Medicaid requirements in order to allow states to establish demonstration projects that are "likely to further the goals of the Medicaid program." One major goal of Medicaid is to provide health care to people with low incomes. States submit a waiver application to HHS, which must approve the application before the waiver can take effect. Recent Section 1115 waiver proposals have largely sought to reduce the health care services available in Medicaid and to eliminate certain rights that people in Medicaid have to get care.

Section 1915 (b) - A Section 1915(b) waiver allows states to waive Medicaid rules regarding the freedom to choose a provider, the establishment of statewide programs, and the comparability of Medicaid benefits to different covered groups. Thus, states can require all or some categories of Medicaid beneficiaries to enroll in managed care, either throughout the state or in limited geographical areas. Since passage of the Balanced Budget Act of 1997, states can mandate managed care enrollment for many Medicaid beneficiaries without a Section 1915(b) waiver. A state must still, however, obtain such a waiver to mandate managed care enrollment for children with special needs, dual eligibles (people who are eligible for both Medicaid and Medicare), and Native Americans.

Health Insurance Flexibility and Accountability (HIFA) Waiver – This type of waiver is based on policy guidance issued by the Bush Administration in August 2001 that provides for fast-track approval of Section 1115 Medicaid and SCHIP waivers. HIFA gives states new flexibility to cut benefits and increase cost-sharing for some current beneficiaries. HIFA also requires states to include a private insurance component to their programs that would provide a subsidy to individuals for the purchase of available employer-sponsored or other private insurance instead of enrolling in the state's Medicaid or SCHIP program.

Wraparound Benefits – Benefits that Medicaid provides when it acts as a secondary insurer to Medicaid-eligible individuals who are enrolled in private plans (such as employer-based coverage) that do not cover all of the services that Medicaid covers.

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Medicaid and SCHIP: Strong Foundations for Health Reform

Medicaid and the State Children's Health Insurance Program (SCHIP) provide publicly-funded health insurance coverage for low-income children, pregnant women, and parents, as well as some elderly and disabled Americans. Together with Medicare (the federally-managed program that covers virtually all American seniors and some people with disabilities) these public programs provide essential health care to nearly 50 million women.[1] Since Medicaid and SCHIP are managed by the states, they have some flexibility in designing the programs to fit the needs of their residents.

States pursuing health reform often look to bolster public coverage programs as a first step, or they include a public coverage expansion as just one component of a larger and more comprehensive health reform plan. Either way, state health reform proposals might extend Medicaid or SCHIP eligibility to uninsured women who have not traditionally qualified for the programs, strengthen existing program policies to encourage enrollment among those who are already eligible, or improve access to care for women already enrolled in Medicaid and SCHIP.

Extending Eligibility Limits for Public Health Insurance Programs

In 2006, more than a third of all low-income women—those with annual incomes at or below 200 percent of the Federal Poverty Level (or FPL, $33,200 for a family of three in that year)—lacked health coverage.[2,3] State governments have the ability to extend Medicaid and SCHIP eligibility so that more of these uninsured low-income women qualify. There are several reasons that states might look to these important programs as a first step to providing health care to more women and their families:

Over two-thirds of all uninsured Americans live in low-income families—the very population that Medicaid and SCHIP were designed to serve. It makes sense to use Medicaid and SCHIP—programs created to provide health insurance to the nation's most vulnerable families—to expand coverage to the low-income uninsured. Nearly every state has expanded Medicaid and SCHIP eligibility to cover children in families with incomes at 200 percent

Three Types of Public Health Insurance

Medicaid is the joint federal and state-funded health insurance program for certain low-income parents, children, seniors, and people with disabilities. Medicaid is currently the largest source of health care funding for low-income people in the United States, and nearly 70 percent of the program's adult beneficiaries are women.

The **State Children's Health Insurance Program (called SCHIP or CHIP)** is also a joint federal—and state-funded program that provides health insurance to uninsured children in families with modest incomes that are too high to qualify for Medicaid. Some states also receive special permission from the federal government to cover adults with their SCHIP funds, including pregnant women, parents, and childless adults.

Medicare is a federal health insurance program that covers virtually all U.S. citizens age 65 or older, regardless of income. The program also covers younger people with certain disabilities or diseases.

of the FPL or higher, but for adults the states have generally adopted Medicaid eligibility levels far below even 100 percent of the FPL. For 2008, the median state Medicaid eligibility level in the U.S. is 63 percent of the FPL for working parents. There is a great deal of room for improvement here; by increasing the income limits for their public coverage programs states can realize significant reductions in the number of uninsured.[4]

States that expand their Medicaid and SCHIP programs to cover more uninsured residents can share the costs with the federal government. The federal government reimburses states for part of the costs of their Medicaid and SCHIP programs, based on a formula (called the Federal Medical Assistance Percentage, or FMAP) which depends on each state's per capita income, and therefore differs from state to state.

Generally, the federal reimbursement for Medicaid ranges from at least 50 percent for wealthier states to over 70 percent for the poorest states.[5] The federal government matches SCHIP spending at an enhanced rate—the FMAP for SCHIP might be as much as 10 to 15 percent more than the Medicaid FMAP.[6] Thus, when states increase their Medicaid and SCHIP eligibility levels, they take advantage of federal resources to help cover their uninsured population.

Medicaid and SCHIP provide comprehensive and affordable coverage for families. The Medicaid program was designed to meet the needs of low-income, vulnerable populations and provides comprehensive benefits. Medicaid covers a broad set of services that are important for women and their families, including inpatient and outpatient care, prescription drugs, long-term care, prenatal care, family planning, and preventive health services.[7] Though states have more flexibility in setting their SCHIP benefit package, they are subject to minimum benefit levels set by federal regulations and most states have also adopted comprehensive benefit plans.

States are allowed to require some low-income families enrolled in Medicaid and SCHIP to share the costs of their medical care (typically through premiums or co-payments). Yet allowable family contributions are regulated by the federal government, and health coverage obtained through these programs is still more affordable than private coverage. In the Medicaid program, certain health services such as pregnancy-related care and family planning are exempt from cost-sharing.[8] In the SCHIP program, a family's cumulative cost-sharing cannot exceed 5 percent of annual family income.

Federal Actions Could Limit State Efforts to Expand Medicaid and SCHIP

Lack of support by federal authorities can be a major hurdle to state health care reform efforts. If reform plans rely on expanding Medicaid and other public programs to cover uninsured families who do not currently qualify for coverage, federal support is crucial for their efforts. This is because the Centers for Medicare and Medicaid (or CMS, the federal agency that oversees these programs) must approve state proposals to expand public coverage programs that are funded jointly by federal and state governments.

Yet, policymakers have differing philosophies on how and to what extent public health insurance programs should play a role in expanding coverage to the uninsured. For example, the Bush Administration has advanced policies that would limit public coverage to only the "poorest of the poor." A directive issued by CMS in August 2007 effectively barred states from using SCHIP funds to cover children in families with incomes above 250 percent of the FPL.

Health care costs are lower for the government and consumers alike when coverage is provided by Medicaid or SCHIP rather than by private insurance. A recent study compared medical expenditures for low-income nonelderly individuals who were either uninsured, enrolled in Medicaid or SCHIP, or insured by private health insurance. After adjusting for health status and other demographic characteristics, researchers found that Medicaid/SCHIP coverage was associated with significantly lower per person medical spending and concluded that "efforts to expand health insurance coverage for low-income populations, whether conducted at the national or state level, would be less costly to society and much less costly to financially strapped beneficiaries if the expansions were based on public insurance like Medicaid and SCHIP."[9]

Medicaid and SCHIP Premium Assistance and Buy-In Programs

States can also use their Medicaid or SCHIP programs to offer premium assistance to families that cannot afford existing offers of employer-sponsored insurance (ESI). Employment-sponsored coverage continues to decline in the United States, especially among low-income workers. One study estimates that nearly half of the decline in ESI among low-income workers is attributable to a decline in take-up (that is, workers are offered health benefits by their employer but decline).[10] This is undoubtedly related to skyrocketing health insurance premiums; between 2001 and 2007, family premiums grew by 78 percent, on average, compared with 19 percent for worker earnings.[11]

Premium assistance programs subsidize some or all of an ESI premium for workers who are themselves eligible for Medicaid or SCHIP, or who have children who are eligible for one of these programs. The few states with premium assistance programs report relatively low enrollment in the programs, primarily because low-income working families have limited access to ESI—just an estimated 14-15 percent of low-income working families have an ESI offer that they are not taking up.[12]

Also, the private coverage subsidized through these programs may have benefit limits and burdensome cost-sharing requirements that could restrict low-income families' ability to access needed services. The families participating in premium assistance programs may not receive the same benefit and cost sharing protections available through Medicaid or SCHIP coverage.[13]

States can also implement policies that allow individuals or employers to *buy-in* to Medicaid or SCHIP. Under this arrangement, people with incomes too high to qualify for public health coverage are allowed to purchase health insurance through the state's Medicaid program or SCHIP, typically paying for all or most of the cost of that coverage. By December 2005, the seven states that had implemented SCHIP buy-in programs reported covering over 44,000 children; the majority did not impose an income eligibility limit for their programs, and most required families to pay the full cost of coverage for their children.[14]

While this represents a small fraction of SCHIP enrollment overall, these buy-in programs cost little for states to implement and fill an important coverage gap for families. Similarly, in 2006 thirty-three states covered over 80,000 working adults with disabilities through a special Medicaid buy-in program; these adults earn too much to qualify for public coverage but face challenges in securing adequate and affordable health coverage because of their disability.[15]

Lessons from the States:
Expanding and Strengthening Public Programs as the First Step to Reform

A number of states have recently expanded eligibility for Medicaid and SCHIP coverage as a first step in reforming their state health system. Some examples are:

- As part of the Massachusetts health reform effort, MassHealth (the state's Medicaid program) eligibility levels increased to cover children in families with incomes up to 300 percent of the FPL;
- Connecticut's Health First Connecticut and Healthy Kids Initiative legislation, passed in June 2007, increased Medicaid eligibility for parents up to 185 percent of FPL; and,
- In early 2008, Minnesota increased the eligibility limits for Minnesota Care (the state's Medicaid program) for childless adults to 200 percent of the FPL. By July 2009, eligibility will increase to 215 percent of the FPL.

States are also proposing Medicaid or SCHIP premium assistance and buy-in programs:

- Pennsylvania's "Cover All Kids" legislation, passed in 2006, allows families with incomes over 300 % of the FPL to buy coverage for their children (at full cost) through the state's SCHIP program.
- In January 2009, Kansas will begin implementation of a premium assistance program for low-income parents. When fully phased-in, the program will cover adults with incomes up to 100 percent of the FPL.

Making Enrollment Easier for Women and Families Currently Eligible for Medicaid and SCHIP

Studies indicate that at least 62 percent of all uninsured children, as well as two-thirds of uninsured parents living below the poverty level, qualify for programs like Medicaid and SCHIP but are not enrolled.[16] Over the past decade, states have taken great strides to simplify enrollment procedures for children's public coverage programs. Indeed, many simplification strategies, such as eliminating face-to-face interview requirements and continuing eligibility for a full year, have been adopted by the vast majority of states for their children's programs.[17] These efforts have greatly increased the proportion of eligible children enrolled in public coverage.[18]

States have taken far fewer steps to simplify adult enrollment processes, and there are still significant barriers in place when eligible adults (compared to children) apply for public coverage. By simplifying the enrollment process for qualified, low-income families, states can reduce the ranks of their uninsured.

Improving Access to Care through Adequate Provider Reimbursement

Some Medicaid enrollees face challenges in finding a provider that will accept their coverage. States have flexibility in setting Medicaid physician payment rates and, in most states, Medicaid reimbursement rates are lower than the rates that both Medicare and private insurers pay. Inadequate reimbursement rates may be a significant disincentive for providers to participate in public coverage programs; this, in turn, can affect program enrollees' access to health care services.

As part of their health reform efforts, states can address this barrier by adjusting the rate at which they reimburse participating Medicaid providers. Increasing Medicaid reimbursement rates has been shown to boost provider participation, which is sorely needed in many states.[19]

What Can Women's Advocates Do to Build and Strengthen Public Programs as a Foundation for Reform?

Advocates can support eligibility expansions of state Medicaid programs and SCHIP.
By increasing eligibility limits for these programs—especially for adults—states take advantage of an existing program structure and share the cost with the federal government. Since the majority of uninsured Americans are low-income, public coverage expansions have the potential to significantly reduce the ranks of the uninsured.

Advocates can promote changes that simplify Medicaid and SCHIP enrollment.
Too many women and their families are eligible for some type of public coverage program yet are not enrolled, and complicated and burdensome enrollment procedures may provide a disincentive for enrollment. By making it easier to apply for and keep public coverage, states can improve their insurance coverage rates.

Advocates can promote changes that encourage increased provider participation in public coverage programs.
Even when enrolled, Medicaid and SCHIP beneficiaries may have trouble getting the health care they need if they live in an area with few participating Medicaid providers. Inadequate reimbursement rates are often at the root of this problem—by raising these rates states can improve access for public coverage enrollees.

Advocates can challenge efforts by the federal government to restrict states' ability to expand and strengthen Medicaid and SCHIP programs in ways that will better meet their residents' health care needs.
Policymakers have differing philosophies on how and to what extent Medicaid and other public programs should play a role in health reform, yet federal support is crucial for states that plan to use these programs to cover uninsured families who do not currently qualify for coverage.

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Women and Medicaid

Medicaid, the national health insurance program for low-income people, plays a critical role in providing health coverage for poor women. Over 20 million women are covered through Medicaid, comprising the majority (69 percent) of the program's adult beneficiaries.[1] Women are more likely than men to qualify for Medicaid because they tend to be poorer and are more likely to meet the program's stringent eligibility criteria. Women are also more likely to hold low-wage or part-time jobs that do not offer employer-sponsored health benefits, so Medicaid may be their only possible source of coverage.[2,3]

One in ten women in the United States receives health care coverage through Medicaid.[4]

- Medicaid is the most important source of coverage for low-income women. In 2006, over one-fifth of all poor women were enrolled in the program.[5]
- Low-income mothers depend on the Medicaid program. Nearly two-thirds of the nonelderly women enrolled in Medicaid in 2004 had dependent children.[6]

Medicaid ensures that women have access to a comprehensive set of important health care services.

- Medicaid programs are required to provide certain health services to some covered populations—including family planning services, inpatient and outpatient hospital care, and pregnancy-related care—and the program has traditionally provided beneficiaries with a comprehensive set of health services. The Deficit Reduction Act of 2005, however, allows states to provide more limited benefit packages (without coverage for mental health or prescription drug services, for example) to certain enrollees.[7]
- Medicaid covers diagnosis and treatment of chronic illnesses including breast and cervical cancer and HIV/AIDS.[8]

Reproductive health services are a vital component of women's Medicaid coverage.

- In 2006, Medicaid provided basic health services to 7.3 million American women of reproductive age (15-44 years old).[9]
- Medicaid is the largest source of public funding for family planning services in the United States. In 2006, the program contributed $1.3 billion toward family planning, accounting for 71 percent of total public spending on these essential services.[10]
- Medicaid covers 41 percent all births in the United States. The program finances prenatal visits and vitamins, ultrasound and amniocentesis screenings, childbirth by vaginal or caesarean delivery, and 60 days of postpartum care.[11] Pregnancy-related services accounted for the largest share of Medicaid's hospital charges in 2004.[12]

Medicaid is important for low-income women of *all* ages.

- For elderly women who meet income eligibility requirements, the program covers high-cost services provided in a skilled nursing facility, as well as home and community-based health care for women who are entitled to nursing facility services.[13]
- More than a third of all female Medicaid beneficiaries were age 45 or older in 2006.

These women typically rely on the program for: health care related to a physical or mental disability or chronic condition; treatment for breast or cervical cancer; long-term care services; or, cost-sharing required under Medicare.[14]

Women and Medicaid: What Can Women's Advocates Do?

Women's advocates can support reforms that protect and improve the Medicaid program without sacrificing women's access to health care services.

Policymakers will continue to debate the role that Medicaid and other public coverage programs should play in the U.S. health care system. Advocates should understand Medicaid's significance for women and support health reforms that will strengthen this critical health insurance program and improve women's access to care.

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Women and Medicare

Established in 1965, Medicare is a federal health insurance program that covers virtually all U.S. citizens age 65 or older, regardless of income. The program also covers younger people with permanent disabilities or certain diseases, who make up about 15 percent of all Medicare beneficiaries.[1] Medicare is primarily funded through a combination of payroll taxes and federal revenues, but most Medicare participants also pay premiums, deductibles, and additional out-of-pocket expenses for their medical care. From a beneficiary's point of view, Medicare may not seem any different than traditional private coverage, since private health insurers administer Medicare program benefits. But unlike traditional private coverage—and with the exception of Medicare Advantage plans (described below)—medical claims for Medicare beneficiaries are ultimately paid for by the federal government.

The Medicare program is divided into four parts:

- Part A ("Hospital Insurance") covers inpatient hospital, skilled nursing facility, and hospice services (funded through payroll taxes);
- Part B ("Supplementary Medical Insurance") covers physician, outpatient, preventive, and other medically-necessary services. All but the poorest Medicare enrollees contribute to their Part B coverage via monthly premiums—in 2007, premiums were roughly $94 per month[2];
- Part C ("Medicare Advantage") allows enrollees to receive their Medicare Part A and Part B benefits through private insurance carriers[3]; and,
- Part D covers outpatient prescription drugs.

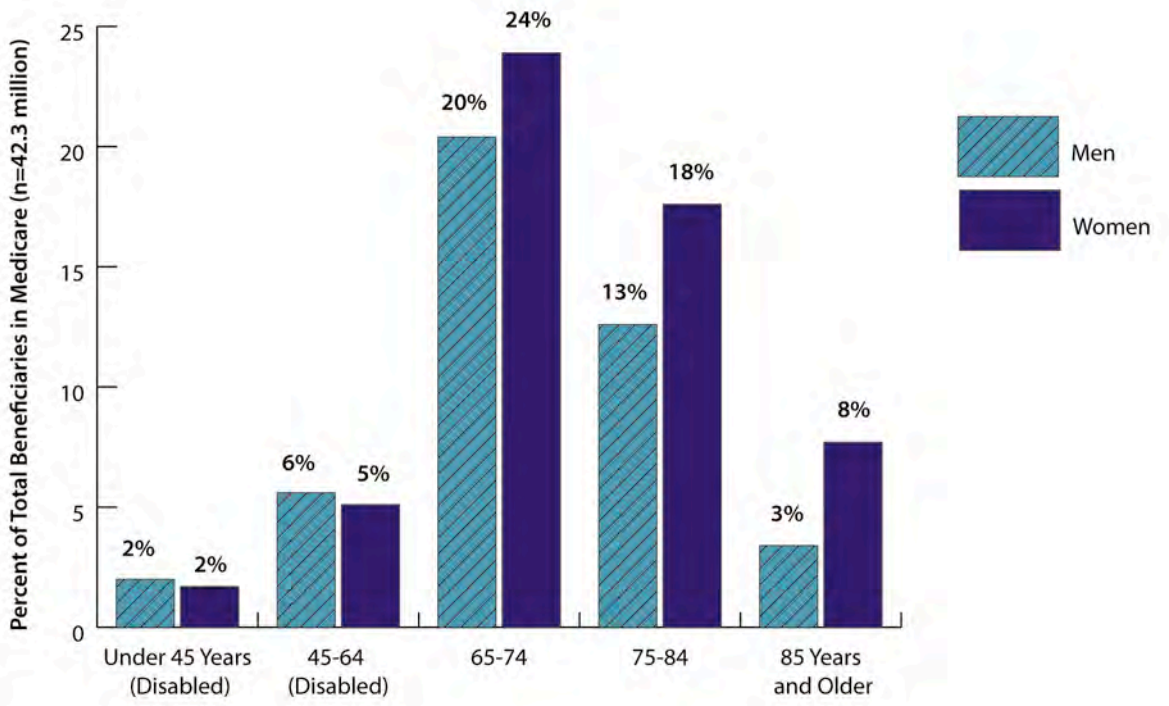
Basic Medicare does not cover certain services, such as long term care, dental care, or hearing aids. Many Medicare beneficiaries purchase additional health insurance to cover these services—typically through their employer or directly from the private insurance market. If Medicare beneficiaries have a low enough income, they may have "dual-eligibility," meaning that they also qualify for services available through the Medicaid program.

The Medicare Program Plays a Vital Role for Women

Medicare is a critical source of health insurance for women over age 65 and for certain eligible women with disabilities. In 2003, the program covered over 23 million women, including roughly 21 million women ages 65 and older and nearly 3 million younger women with disabilities.[4] Because women generally have longer life expectancies than men, they are disproportionately represented among those enrolled in Medicare. Consider these facts:

- Women accounted for 56 percent of all Medicare beneficiaries in 2003.[5]
- They comprised nearly 70 percent of all Medicare enrollees aged 85 years and older (Figure 1).
- Over two-thirds of all Medicare beneficiaries living in long-term care facilities are women.[6]

Figure 1
Medicare Beneficiaries by Age and Sex, 2003



Source:
NWLC Calculations using Centers for Medicare and Medicaid Services, *Detailed Tables from the Medicare Current Beneficiaries Survey Data* (2002), http://www.cms.hhs.gov/mcbs/downloads/HHC2002section1.pdf.

- Women in Medicare who are age 75 or older are more than twice as likely as men to have incomes of $10,000 or less, which is below the federal poverty level (Figure 2).
- Because of their lower income, women are over-represented among those who are "dual-eligible" for Medicare and Medicaid: more than 60 percent of all dual-eligible beneficiaries are women.[7]

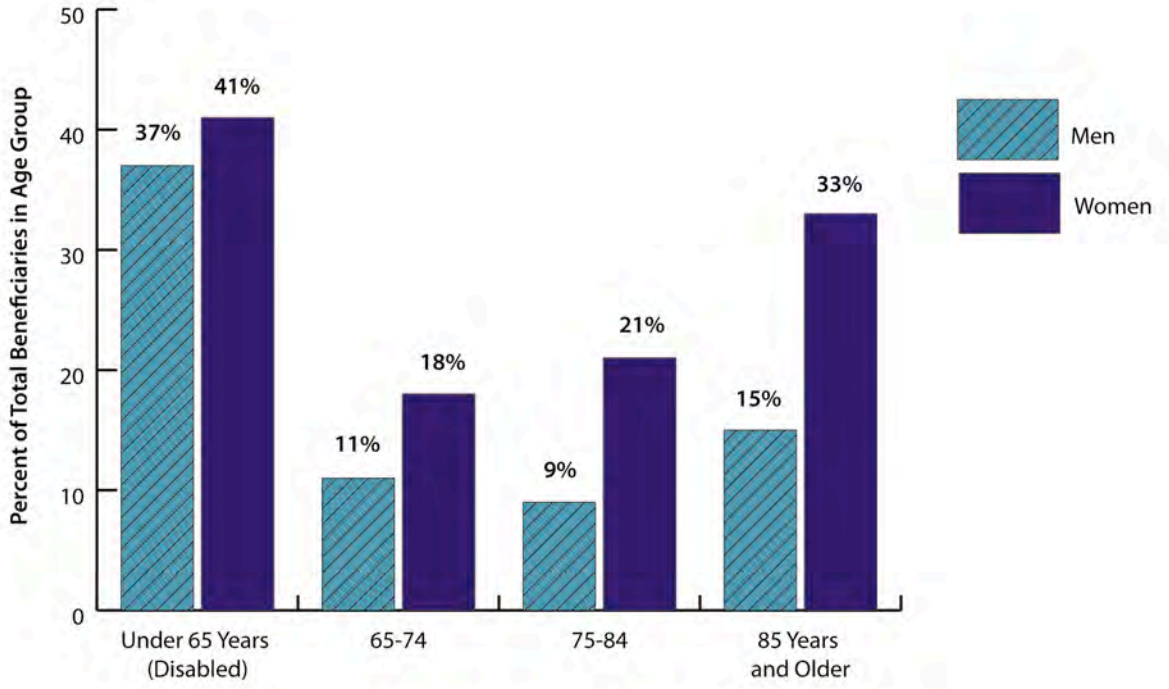
Cost-sharing in Medicare: A Barrier to Health Care for Many Women

Women in Medicare, when compared to men, pay a larger share of their income in out-of-pocket medical costs.[8] Cost-sharing in Medicare presents a potential barrier to health service access, especially for beneficiaries with few cash resources who might avoid or delay cost-effective preventive care if they cannot afford the out-of-pocket cost of that care. A recent study of rates of biennial breast-cancer screenings in Medicare plans with different levels of cost-sharing for mammography demonstrated that even nominal copayments were associated with significantly lower screening rates compared to plans with full coverage. These negative effects of cost-sharing were magnified among women living in low-income areas.[9]

Medicare Advantage and the Debate on the Future of Medicare

Over 44 million Americans currently participate in Medicare, and program participation is expected to experience rapid growth over the next two decades.[10] The total number of people enrolled in Medicare will nearly double between the years 2000 and 2030, eventually

Figure 2
Medicare Beneficiaries with Annual Incomes Below $10,000, by Age and Sex, 2003



Source:
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reaching about 79 million beneficiaries.[11] This projected increase in program enrollment, in combination with the rapid growth of health care costs and the declining ratio of workers (i.e. those who fund Medicare through payroll taxes) to beneficiaries, has prompted some policymakers to debate whether and how Medicare can be sustained in the future.

A philosophical question that is central to this debate relates to Medicare Advantage (also known as Medicare's Part C): should private and for-profit insurance companies be allowed to sell Medicare plans, or should the program continue to function as it has for over 40 years, as a traditional federal insurance program? Proponents of Medicare Advantage (MA) have claimed that by using private health plans, the program can contain costs and provide better health care for Medicare beneficiaries. But there is little evidence that MA plans have made good on their promise to provide better quality care or enhanced benefits, and there is ample evidence that the plans are significantly overpaid.[12] In 2008, private MA plans are being paid 13 percent more, on average, than it would cost traditional Medicare to cover the same beneficiaries.[13] MA overpayments have contributed to a rapid growth in private plan contracts; participation in these plans has grown from 5.3 million beneficiaries in 2003 to 8.7 million (or, about 20 percent of all beneficiaries) in 2007, with growth concentrated in the areas of highest overpayment.[14, 15]

These overpayments raise a number of concerns. They have accelerated rapidly-growing Medicare program costs, and private insurers offering MA plans have recently been under

scrutiny for preying on Medicare beneficiaries through aggressive and abusive marketing practices, arguably due to the overpayments.[16] Paying Medicare Advantage plans at rates equal to traditional Medicare could save an estimated $54 billion over five years.[17]

Medicare and Health Reform

One type of health reform proposal would expand Medicare so that most, if not all, Americans would be eligible to participate in the program. These "Medicare for All" plans would open Medicare to any American who wanted to buy-in to the program, while still allowing those who did not want to participate in Medicare to purchase private insurance.

Another type of proposal, which is typically just one component of a larger reform package, would lower the age of eligibility for Medicare (to age 55, for example). This type of reform could be of particular benefit to women. Since they are more likely to be married to an older spouse, women are at greater risk of losing dependent coverage and becoming uninsured when that spouse becomes eligible for Medicare (and therefore transitions out of job-based health insurance).[18] Indeed, among adults aged 50-64, women are more likely than men to be uninsured; for all other adult age groups this pattern is reversed.[19]

Women and Medicare: What Can Women's Advocates Do?

Women's advocates can support reforms that protect and improve the Medicare program without sacrificing women's access to health care services.

Debate around the future of Medicare is certain to continue, especially in the context of health reform. Advocates should understand the important role that Medicare plays in providing health coverage for women as well as the access barriers that low-income women with Medicare face, and they must support health reforms that address these challenges.

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Women and the State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP) is a public health insurance program created by Congress in 1997 to expand health care coverage for low-income children whose families cannot afford private insurance but whose income is too high to qualify them for Medicaid.[1] In addition to providing children's coverage, some states use SCHIP to cover low-income adults who do not otherwise qualify for Medicaid. In 2007, the program—which is jointly funded by the federal and state governments—covered an estimated 7 million children and over half a million low-income parents, pregnant women and other adults who would otherwise go without health insurance.[2] Together, Medicaid and SCHIP successfully provide health insurance to nearly 70 million of the nation's most vulnerable people.

Women's Health Insurance Coverage under SCHIP

When SCHIP was first implemented, some states had already expanded children's coverage through Medicaid and had limited ability to use SCHIP for children; consequently, these states were authorized to use their SCHIP allotments to expand coverage to poor adults. Other states have used SCHIP money to expand insurance coverage to adults as a strategy to reduce the growing number of uninsured Americans. Approximately 587,000 adults were enrolled in SCHIP in 2007, comprising about 8 percent of total program enrollment.[3,4] There are three categories of adults who can get coverage under SCHIP with special federal approval called a "waiver." Waivers allow states to use SCHIP money in ways that are not otherwise permitted by program rules. (Table 1 provides further detail on the states that have implemented each type of coverage):

- ***Parents:*** States can cover parents of Medicaid- and SCHIP-eligible children under SCHIP through a waiver. In 2007, 11 states used SCHIP to provide coverage for around 487,000 parenting adults who would otherwise be uninsured.[5]

- ***Childless Adults:*** Although states were also initially allowed to use their SCHIP funds to cover non-pregnant childless adults through a waiver, 2005 legislation prohibits any new waivers to cover this population. In 2007, four states used SCHIP to cover roughly 93,000 adults without children but for now, additional states cannot use SCHIP to expand coverage to more adults in this category.[6]

- ***Pregnant Women:*** States can cover pregnant women under SCHIP through a waiver. In 2007, five states had obtained waivers to cover a total of over 6,400 pregnant women under SCHIP.[7]

  Additionally, states can cover pregnant women without a federal waiver by amending their state SCHIP plans to include an option authorized by the SCHIP "unborn child" regulation. This regulation allows states to use federal funds to provide health care to fetuses carried by women who meet income guidelines but who are otherwise ineligible for public insurance programs. In practice, the rule extends eligibility primarily to pregnant women who do not meet the immigration status requirements of Medicaid. While a woman covered under the "unborn child" regulation may not have the necessary citizenship status to qualify for a public insurance program[8], the fetus will become a U.S. citizen upon birth and thus qualifies for SCHIP coverage during the gestational

period.[9,10] In June 2007, 12 states used the "unborn child" option to provide coverage to nearly 143,000 individuals.[11] Since then, one more state has received approval to implement this option.

SCHIP at a Crossroads

Since its creation over a decade ago, SCHIP has provided states with a unique opportunity to expand coverage for low-income children and adults at a time when rising health care costs and lack of health insurance are creating tremendous economic burdens for families. But in 2007, the reauthorization of this important program got caught in a broader debate about the role that SCHIP and other public coverage programs should play in the U.S. health care system and the best strategies for covering the uninsured. As part of this debate, President Bush vetoed bipartisan legislation reauthorizing SCHIP twice before agreeing to an 18-month program extension. Thus, while this successful public coverage program is currently viable, Congress will need to address SCHIP reauthorization again in early 2009.

Table 1: Adult Coverage Under the State Children's Health Insurance Program (SCHIP), 2007

State	Covered Population		
	Pregnant Women	*Parents*	*Childless Adults*
Arizona		■	
Arkansas	■*	■	
California	■*		
Colorado	■		
Idaho		■	■
Illinois	■*	■	
Louisiana	■*		
Massachusetts	■*		
Michigan	■*		■
Minnesota	■*	■	
Nevada	■	■	
New Jersey	■	■	
New Mexico		■	■
Oklahoma	■*		
Oregon		■	■
Rhode Island	■**	■	
Tennessee	■*		
Texas	■*		
Virginia	■		
Washington	■*		
Wisconsin	■*	■	
TOTAL	**17**	**11**	**4**

Notes:
* Denotes states that have used the "unborn child" regulation to cover pregnant women under SCHIP.
** Denotes states that have used both an 1115 waiver and the "unborn child" regulation to cover pregnant women under SCHIP.

Sources:
Congressional Research Service, *Revised Memorandum on Estimates of SCHIP Child and Adult Enrollees*, (May 30, 2008); Samantha Artiga and Cindy Mann, Kaiser Commission on Medicaid and the Uninsured, *Family Coverage Under SCHIP Waivers* (May 2007); Personal communication between SCHIP administrators and NWLC staff, (May 2008).

Women and SCHIP: What Can Women's Advocates Do?

Women's advocates can support legislation that reauthorizes and expands SCHIP, as well as reforms that would make it easier for states to use SCHIP to extend coverage to a greater number of uninsured residents, including adults.

Given the broader debate about the role of SCHIP in addressing our health care crisis, advocates should understand that SCHIP—while a small program in comparison to Medicaid—provides essential health coverage for hundreds of thousands of women who would otherwise be uninsured. They should support health reforms that will strengthen this critical public coverage program and improve women's access to health care.

For further reading, see:

National Women's Law Center, *The SCHIP "Unborn Child" Regulation* (Mar. 2007), http://www.nwlc.org/pdf/SCHIPUnbornChildRegulation2007.pdf.

Samantha Artiga and Cindy Mann, Kaiser Family Foundation, *Family Coverage Under SCHIP Waivers* (May 2007), http://www.kff.org/medicaid/upload/7644.pdf.

Kaiser Family Foundation, *A Decade of SCHIP: Experience and Issues for Reauthorization* (Jan. 2007), www.kff.org/medicaid/7574.cfm.

U.S. Government Accountability Office, *State Children's Health Insurance Program: Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States That Cover Adults*, (Nov. 2007), http://www.gao.gov/new.items/d0850.pdf.

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1 Forty-five states cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher (in 2008, this is $35,200 for a family of three) under Medicaid and/or SCHIP. Donna Cohen Ross et al., Kaiser Commission on Medicaid and the Uninsured, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles* (Jan. 2008), http://www.kff.org/medicaid/upload/7740_ES.pdf. See "The Federal Poverty Level: What Is It and Why Does It Matter?" in the *Reform Matters Toolkit* for further discussion of the federal poverty level.

2 Chris L. Peterson, Congressional Research Service, *Estimates of SCHIP Child Enrollees up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees* (Updated Mar. 2008).

3 *Id.*

4 This total does not include pregnant women who are covered under SCHIP's "unborn child" regulation.

5 Estimates of SCHIP, *supra* note 2.

6 *Id.*

7 *Id.*

8 Under current law federal funds are theoretically unavailable to provide prenatal care to undocumented immigrants or legal immigrants who arrived after 1997 and have not been in residence for five years.

9 One state, Wisconsin, is covering prisoners, who also meet the income eligibility but are not eligible because they reside in an institution.

10 National Women's Law Center, *The SCHIP"Unborn Child" Regulation* (Mar. 2007), http://www.nwlc.org/pdf/SCHIPUnbornChildRegulation2007.pdf.

11 Vernon Smith et al., Kaiser Commission on Medicaid and the Uninsured, *SCHIP Enrollment in June 2007: An Update on Current Enrollment and SCHIP Policy Direction* (Jan. 2008), http://www.kff.org/medicaid/upload/7642_02.pdf.

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The Federal Poverty Level: What Is It and Why Does It Matter?

The Federal Poverty Level (FPL) defines the income level under which an individual or family is considered to be "living in poverty." The FPL is the primary factor used to determine eligibility for many government programs, including Medicaid, SCHIP, and premium subsidy programs aimed at helping moderate- and lower-income families purchase private insurance plans.

Use of the FPL is often criticized for its failure to reflect a typical family in the modern world, as it's definition has not changed since its inception more than four decades ago.[1,2] For example, the FPL calculation does not take into account certain major costs like child care, because when the formula was established policymakers assumed that a family included at least one homemaker and that child care was not a typical item in the family budget. Moreover, the FPL does not reflect geographic differences in the cost of living.[3,4]

Adjusted annually to reflect inflation, the FPL for 2008 is $17,600 of income per year for a family of three. Income includes—among other things—general earnings, unemployment compensation, worker's compensation, income from Social Security payments, alimony or child support, and financial assistance from outside sources. In 2006, 17 percent of women—almost one in six—lived in families with incomes at or below 100 percent of the FPL.[5]

2008 Federal Poverty Level (FPL) Guidelines
(Valid In the 48 contiguous states and D.C.)

Number of Persons in Family or Household	100% FPL		200 % FPL	300 % FPL
	Income per ***Year***	Income per ***Month***	Income per ***Year***	Income per ***Year***
1	$10,400	$867	$20,800	$31,200
2	$14,000	$1,167	$28,000	$42,000
3	$17,600	$1,467	$35,200	$52,800
4	$21,200	$1,767	$42,400	$63,600
5	$24,800	$2,067	$49,600	$74,400
For each additional person	Add $3,600	Add $300	Add $7,200	Add $10,800

Source: U.S. Department of Health and Human Services, *2008 Federal Poverty Guidelines*, Federal Register Vol. 73 no. 15.

References

1 Gordon M. Fisher, *The Development and History of the U.S. Poverty Thresholds – A Brief Overview*, Newsletter of the Government Statistics Section and the Social Statistics Section of the American Statistical Association: 6-7 (Winter 1997).

2 International Union, United Automobile, Aerospace and Agricultural Implement Workers, *Making Ends Meet: New Approaches to Measuring Poverty*, http://www.uaw.org/publications/jobs_pay/01/0901/jpe02.html (last visited June 19, 2008).

3 Jessie Willis, Oregon Center for Public Policy, *How We Measure Poverty: A History and Brief Overview* (Feb. 2000), http://www.ocpp.org/poverty/how.htm.

4 Deborah Reed, *Poverty in California: Moving Beyond the Federal Measure*, California Counts: Population Trends and Profiles 7(4), (May 2006).

5 The Henry J. Kaiser Family Foundation: State Health Facts, *Adult Poverty Rate by Gender, States (2005-2006), US (2006)*, http://statehealthfacts.org/comparebar.jsp?ind=12&cat=1 (last visited June 19, 2008).

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FamiliesUSA
The Voice for Health Care Consumers

Upper Public Program Eligibility Levels for Children and Adults (DRAFT)

	Children (age 0-18)[1]	Parents/ Caretakers[2,3]	Childless Adults[3]
Alabama	200%	11%; 26%	
Alaska	175%	76%; 81%	
Arizona	200%	200%	100%
Arkansas	200%	14%; 18%	
California	250%[4]	100%; 106%	
Colorado	225%	60%; 66%	
Connecticut	300%	185%; 191%	
Delaware	200%	100%; 106%	100%
District of Columbia	300%	200%; 207%	
Florida	200%	21%; 56%	
Georgia	235%	30%; 53%	
Hawaii	300%	100%; 118%	
Idaho	185%	22%; 42%	
Illinois	200%[5]	185%; 191%	
Indiana	250%	20%; 26%	
Iowa	200%	30%; 89%	
Kansas	200%	28%; 34%	
Kentucky	200%	37%; 64%	
Louisiana	250%	13%; 20%	
Maine	200%	200%; 206%	100%
Maryland	300%	116%; 122%	
Massachusetts	300%	300%	300%
Michigan	200%	38%; 61%	35%
Minnesota	275%[6]	275%	
Mississippi	200%	26%; 32%	
Missouri	300%	20%; 39%	
Montana	175%	34%; 60%	
Nebraska	185%	48%; 59%	
Nevada	200%	27%; 94%	
New Hampshire	300%	44%; 55%	
New Jersey	350%	133%; 136%	
New Mexico	235%	27%; 63%	
New York	250%[7]	150%; 152%	100%; 150%[8]
North Carolina	200%	38%; 52%	
North Dakota	140%	37%; 63%	
Ohio	200%	90%; 94%	
Oklahoma	185%	33%; 50%	

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Oregon	185%	46%[9]	
Pennsylvania	300%	29%; 59%	
Rhode Island	250%	175%; 181%	
South Carolina	200%	50%; 93%	
South Dakota	200%	56%	
Tennessee	250%	69%; 80%	
Texas	200%	13%; 28%	
Utah	200%	41%; 47%	
Vermont	300%	185; 191%	150%
Virginia	200%	24%; 31%	
Washington	250%	38%; 76%	
West Virginia	220%	18%; 35%	
Wisconsin	300%	200%	
Wyoming	200%	41%; 55%	

[1] The eligibility levels for children reflect the upper eligibility level for Medicaid and/or CHIP.
[2] The two eligibility levels reflect the income eligibility levels for non-working and working parents, respectively.
[3] Parent and childless adult eligibility levels reflect Medicaid programs that provide comprehensive benefits and cost-sharing protections, offer an adequate provider network, and allow individuals to enroll regardless of an employer decision to participate.
[4] Infants in California (age two and under) are eligible for CHIP up to 300 percent of poverty if they are born to women on the Access for Infants and Mothers (AIM) program, unless the child is enrolled in employer-sponsored insurance or no-cost full scope Medi-Cal.
[5] Illinois covers children regardless of income, but subsidies for children with family incomes over 200 percent of poverty are paid for with state-only funds.
[6] Infants in Minnesota (age two and under) are eligible for coverage up to 280 percent of poverty.
[7] New York covers children in families with incomes up to 400 percent of poverty with state-only funds.
[8] NY Family Health Plus provides coverage for single childless adults up to 100 percent of poverty and childless couples up to 150 percent of poverty.
[9] The Oregon Health Plan provides coverage to parents and childless adults up to 100 percent of poverty, but is currently closed to new enrollees. "Categorically eligible" parents (those who qualify as a "mandatory eligibles") can still enroll. The income limit listed is subject to change as we gather more information.

Women and Employer-Sponsored Insurance

Most women in the United States get their health insurance through an employer. In 2007, nearly two-thirds of women aged 18 to 64—over 61 million women in total—received health benefits through their own (61 percent) or a family member's (39 percent) employer.[1] Employer-sponsored insurance (ESI) is viewed favorably by those who have it—when surveyed, most individuals with ESI rate their coverage as very good or excellent, and most believe that their employer does a good job selecting high-quality health plans.[2] ESI spreads health costs and risks among a group of people, and buying insurance through an employer makes it easy for employees to enroll, maintain coverage, and pay their premiums.[3] Employer-provided coverage is also an important source of financing in the current health system—in 2005, private sector employers spent a collective $370 billion on health insurance premiums.[4]

For all these reasons, ESI is likely to play a significant role in health reform. Employers represent a key health financing source, and employee groups offer a convenient way to pool risk. Most people covered through ESI want the option of keeping the health insurance they currently have. It is essential, then, that advocates recognize ESI's importance for women and how this type of health coverage fits into health reform efforts. This includes understanding how health reform plans can make it easier for women to obtain ESI. In particular, health reform plans might target health coverage for small businesses, which are considerably less likely than large firms to offer health coverage to their workers—most often citing cost as the reason.[5]

Different Types of Employer-Sponsored Health Insurance

The regulations that apply to employer-sponsored health coverage depend on the size of the employer. As a result, two distinct "markets" have emerged:

- The **small group market** is generally defined to include employers with two to 50 employees.[6] Due to their size, small groups are less able to spread risk and, thus, cost among employees, which makes insurance companies less inclined to sell them coverage. To counteract this, the federal and state governments subject the small group market to regulations generally designed to make it easier to access to health coverage. Still, the smaller an employer is, the less likely it is to offer health benefits to its employees.[7]

- The **large group market** is where employers with at least 51 employees purchase health insurance.[8] Unlike the small group market, the large group market is subject to little regulation, because large employers are presumed to have more clout and thus more ability to negotiate favorable terms for coverage on their own. While this tends to be true for very large employers, such as those with 1,000 employees, it may not always be true

How Small is a 'Small Business'?

Laws governing the small group insurance market vary from state to state, and some states use different definitions of "small business." While the majority of states and the federal government define "small businesses" as those with two to 50 employees,[10] twelve states allow self-employed people, or "groups of one," to purchase coverage in the small group market.[11]

for more moderate sized employers, such as those with 55 or 60 employees. Even so, large employers are the most likely to offer health benefits to their employees; over 95 percent of businesses with 50 or more employees offer health insurance.[9]

In addition to being distinguished by their size, employer-sponsored health plans are also characterized by the insurance arrangement of the employer: "fully-insured" or "self-insured." Fully-insured firms buy coverage from an insurance company. But many very large employers opt to self-insure instead. Under a self-insured health plan, the employer assumes the financial risk of covering its employees and pays medical claims from its own resources. Fully-insured health plans are subject to state and federal regulations for group health plans. Importantly, self-insured employer health plans are not subject to state law or regulation but instead are regulated by Federal law known as ERISA, the Employment Retirement Income Security Act of 1974.[12] Thus, even if a state adopted a law governing what health services must be covered in a health insurance plan, or how insurers can set premiums to charge employers, self-insured plans would be exempt from such state laws. In 2006, 45 percent of workers with health insurance were covered by a fully insured group health plan sold in the small or large group market, and 55 percent were covered by a self-insured health plan.[13] Because some self-insured employers may use a health insurance company to process paperwork for employees, many people often don't realize that their employer is self-insured.

Characteristics of the Small Group Health Insurance Market

Existing federal law addresses the availability of health insurance for small businesses.
In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA provisions extend rights and protections to workers of small businesses with two to 50 employees.[14] The law requires small group insurance carriers to offer coverage on a "guaranteed issue" basis, which means that neither small employers nor their employees may be denied health insurance based on health status-related factors, such as medical history, claims experience, and health status.[15] HIPAA also mandates "guaranteed renewability" of small employer policies, meaning that an insurer may not cancel coverage for a group that has experienced high-cost claims.[16] Notably, while HIPAA does increase the availability of health insurance coverage in the small group market, it does not address another major barrier for small firms—the cost of that coverage.

In most states, insurance companies consider the characteristics of each employee when determining a small business' overall premium rate.
When a small business applies for health insurance, the majority of states allow insurance companies to determine the premium that will be charged using a process known as "medical underwriting." During the underwriting process, employees provide information such as their health status, prior medical claims, age, gender, and smoking status. Insurers use the information about each member of the group to determine the overall premium to charge a small group.[17]

Medical underwriting occurs in the large group health insurance market as well, but insurers underwrite the group as a whole rather than considering the health-related factors of each employee.[18] Underwriting in a large group considers the entire group's claims history, age distribution, industry, and geographic location, but employees are not required to complete medical questionnaires as they are in the small group insurance market.[19]

Small group insurance companies tend to set premiums based on the gender, age, and health status make-up of a small business's workforce.
If a majority of a small firm's workers are women, are older, or have prior health insurance claims or a history of health problems, the small business and its employees may not be able to afford health coverage. Indeed, the following insurance industry practices may make it more difficult for businesses to find affordable coverage in the small group insurance market:

- **Gender Rating.** Insurance companies in most states are allowed to use the gender make-up of a small business as a rating factor when determining how much to charge for health coverage. Under the premise that women have higher hospital and physicians' costs than men, insurers may charge small firms more for health coverage if they have a predominantly female workforce. From the employee's perspective, this disparity may not be apparent, since employment discrimination laws prohibit an employer from charging male and female employees within a firm different rates for their ESI.[20]

  While state and federal anti-discrimination laws prohibit most small businesses from charging male and female employees different premiums, gender rating in the small group insurance market can be an insurmountable obstacle to affording health coverage for a small firm with a disproportionately female workforce. If the overall premium is not affordable, a small business may forgo offering coverage to workers altogether, or shift a greater share of health insurance costs to employees.

- **Age Rating.** Insurers often base a small business's overall health insurance premium on the age make-up of its employees. Unless prohibited by state law, insurance companies tend to charge higher rates to small groups with older workforces, since older people are more likely to need and use health care services.[21] Age rating serves as a financial barrier to health coverage to a small business with an older workforce.

- **Health Status Rating.** Although the federal HIPAA law prohibits insurers from rejecting small group insurance applications due to health status of its employees (known as "guaranteed issue"), it does not restrict insurers from using health status as a factor upon which to base premiums. Insurance companies often charge small groups higher premiums if their employee members have pre-existing health conditions. As a result, a small business employing even just a single worker with a history of health problems—such as breast cancer or diabetes—may find it difficult to afford health insurance coverage.

Addressing Affordability in the Small Group Health Insurance Market

Because the regulation of insurance has traditionally been a state responsibility[22] there is no existing federal law regulating the premiums charged to small businesses for health coverage. A handful of states, however, have taken steps to increase the affordability of health insurance in the small group market. States have:

- Prohibited the use of certain rating factors through an outright ban;

- Limited the amount a particular rating factor (such as gender, health status or age) may be used through a "rate band," which sets limits between the lowest and highest premium that a health insurer may charge for the same coverage based on certain rating factors;[23] and

- Prohibited the use of rating factors through the imposition of "community rating." Community rating is a method of calculating health insurance premiums based on the average or anticipated health costs of the entire community rather than the particular costs of one small firm.[24] Under "pure community rating," an insurer must set the same premium for all small groups with the same coverage regardless of their employees' gender, age, health status, or occupation.[25] Under "modified community rating," an insurer is prohibited from setting premiums based on employees' health status or claims history but allows variation based on limited demographic characteristics, which can include gender, age, and geographic location.[26]

Protections Against Gender Rating

Unless prohibited by state law, insurers generally charge higher premiums to small groups consisting of more female than male employees. As demonstrated in Table 1, 34 states and the District of Columbia permit the use of gender as a rating factor in the small group insurance market. Of the remaining states:

- Twelve have banned gender rating in the small group market. The majority of these have adopted community rating; New York imposes pure community rating in its small group market, while Maine, Maryland, Massachusetts, New Hampshire, Oregon, and Washington ban gender rating under modified community rating. California, Colorado, Michigan, Minnesota, and Montana specifically prohibit insurers from considering gender when setting health insurance rates in the small group market.[27]
- One state, Iowa, prohibits gender rating unless a small group insurance carrier secures prior approval from the state insurance commissioner.
- Three states—Delaware, New Jersey, and Vermont—limit the extent to which insurers may vary premium rates based on gender through a rate band.

The SHOP Act: Proposed Federal Legislation Could Ban Gender Rating for Small Groups

Introduced in Congress in 2008, the Small Business Health Options Program, or SHOP Act,[28] aims to make health insurance more affordable by:

- Allowing small employers to join purchasing pools designed to lower employee premiums,
- Providing tax credits to help offset the cost of health coverage, and
- Outlawing the use of rating based on health status and claims experience beginning in 2011.

As part of the a nationwide small employer purchasing pool, the SHOP Act proposes default rating rules for all insurance plans offered through the pool, which includes modified community rating that would prohibit gender rating and give states incentives to adopt similar small group rules.

Protections Against Age Rating

Overall, 49 states and the District of Columbia allow insurers to use age as a rating factor in the small group market. (See Table 1.) Only one—New York—bans the use of age as a rating factor through pure community rating rules for small groups. Six additional states limit the use of age rating in the small group market through a rate band.

Protections Against Health Status Rating

The federal HIPAA law states that an employer may not charge individual employees higher premiums based on health status.[29] For instance, an employee with a chronic health condition like arthritis cannot be charged more for ESI than a "similarly situated" coworker (e.g. they are both full-time workers) without arthritis.[30]

However, HIPAA does not address how much a small business may be charged for its overall health insurance premium. Unless prohibited by state law, insurers tend to charge higher premiums to small groups whose employees have poor health status. As shown in Table 1, 40 states and the District of Columbia permit health status rating in the small group market. However, ten states prohibit health status rating through community rating rules and virtually every other state imposes a rate band to limit how much insurers can vary rates due to health status in the small group market.[31]

What Can Women's Advocates Do?

Women's advocates can learn about the importance of employer-sponsored coverage for women, and identify the different types of employer-sponsored health insurance.
Most people in the United States obtain their health insurance from an employer. ESI is rated favorably by those who have it, and employers represent an important source of funding for health benefits. Considering these factors, ESI is likely to play a key role in health reform plans, and advocates must be informed about this type of coverage. Specifically, it is important for women's advocates to understand characteristics of large and small group insurance markets, as well as the difference between fully-insured and self-insured health plans.

Women's advocates can support regulations in the small group insurance market that will make coverage easier and more affordable to obtain, namely prohibitions on gender rating.
Despite the important role that ESI currently plays in the United States health care system and the role it is likely to play in future health reform, women who own and work for small businesses may encounter particular barriers to obtaining high-quality and affordable health coverage in the small group insurance market. While affordability is a problem facing all small businesses, for instance, gender rating makes it even more expensive for small employers with predominantly female workforces. Already, those small businesses that do not offer health coverage tend to have larger proportions of female workers.[32]

Gender rating serves as a financial barrier to health coverage for small businesses with a predominantly female workforce. All but 13 states allow gender rating by small group insurance carriers—the remaining states and the District of Columbia should enact laws prohibiting the use of gender as a rating factor, through outright bans on the practice or community rating requirements.

Women's advocates can learn about and promote other efforts that will make it easier for women and their families to obtain and afford ESI, in general.
There are many other ways that health reform plans can improve the availability and affordability of employer-provided health benefits, regardless of whether they are offered by a large or small business. Health reform plans might, for example, require that employers contribute to health care for their workers through a "pay or play" mandate. Or, health reform might create new tax incentives that make it easier for employers to offer—and employees to purchase—health coverage. These reforms are discussed elsewhere in the *Reform Matters*

Toolkit, namely the "Women and Employer Mandates" and "Women, Tax Policy, and Health Reform" sections.

For further reading, see:

Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* (Apr. 2008), http://www.kff.org/insurance/upload/7766.pdf.

Families USA, *Issue Brief: Understanding How Health Insurance Premiums Are Regulated* (Sept. 2006), http://familiesusa.org/assets/pdfs/rate-regulation.pdf.

Community Catalyst, *Access to Affordable Insurance for Individuals and Small Businesses: Barriers and Potential Solutions* (June 2005), http://www.communitycatalyst.org/doc_store/publications/access_to_affordable_insurance_for_individuals_and_small_businesses_jun05.pdf.

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2 Sara R. Collins, et al., The Commonwealth Fund, (Sept. 2006), *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=402531

3 Cathy Schoen et al., *Building Blocks for Reform: Acheieving Universal Coverage with Private and Public Group Health Insurance*, Health Affairs 27(3): 646-57 (May/June 2008).

4 Employee Benefits Research Institute, *EBRI Databook on Employee Benefits, Chapter 34: Employer Spending on Health Insurance* (Sept. 2007), http://ebri.org/pdf/publications/books/databook/DB.Chapter%2034.pdf

5 Health reform plans might require that employers contribute to health care for their workers through a "pay or play" mandate, or plans might create new tax incentives that make it easier for employers to offer—and employees to purchase—health coverage. See the *Reform Matters Toolkit* sections on the "Women and Employer Mandates" and "Women, Tax Policy, and Health Reform" sections of the *Reform Matters Toolkit* for further discussion of these types of health reform.

6 *See, e.g.*, 42 U.S.C. § 300gg-91(e)(4) (2008).

7 Dawn M. Gencarelli, Nat'l Health Policy Forum, *Background Paper: Health Insurance Coverage for Small Employers* 3 (Apr. 2005), www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf; Paul Fronstin & Ruth Helman, Employee Benefit Research Inst., *Issue Brief No. 253, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey* 11 (Jan. 2003), http://www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.

8 *See, e.g.*, 42 U.S.C. § 300gg-91(e)(2) (2008).

9 Kaiser Family Found. & Health Research and Educ. Trust, *Employer Health Benefits 2007 Annual Survey* 5 (2007), http://www.kff.org/insurance/7672/upload/76723.pdf.

10 42 U.S.C. § 300gg-91(e)(4) (2008).

11 Colorado, Connecticut, Delaware, Florida, Hawaii, Maine, Massachusetts, Mississippi, New Hampshire, North Carolina, Rhode Island, and Vermont allow self-employed people to purchase small group insurance coverage. *See* Colo. Rev. Stat. § 10-16-102(40)(a) (2008); Conn. Gen. Stat. § 38a-564(4)(A) (2008); Del. Code Ann. tit. 18, §§ 7202(34), 7207(3) (2008); Fla. Stat. § 627.6699(3)(v) (2008); Haw. Rev. Stat. § 431:2-201.5(b) (2008); Me. Rev. Stat. Ann. tit. 24-A, § 2808-B(1)(D) (2008); Mass . Gen. Laws ch. 176J, § 1 (2008); Miss. Code Ann. §§ 83-63-3(m), 83-63-6 (West 2008); N.H. Rev. Stat. Ann. § 420-G:2(XVI)(a); N.C. Gen. Stat. § 58-50-110(22) (West 2008); R.I. Gen. Laws § 27-50-3(kk), (m) (2008); Vt. Stat. Ann. tit. 8, § 4080a(a)(1) 2008).

12 Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.).

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14 Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C. § 300gg-91(e)(4) (2008)).

15 42 U.S.C. §§ 300gg-11(a)(11), 300gg-1(a)(1) (2008) ("health status-related factors" include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability).

16 42 U.S.C. §§ 300gg-12 (2008).

17 Nat'l Ass'n of Health Underwriters, *Consumer Guide to Group Health Insurance* 1, http://www.nahu.org/consumer/groupinsurance.cfm (last visited July 16, 2008).

18 *Id.*; Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* (Apr. 2008), http://www.kff.org/insurance/upload/7766.pdf.

19 *Id.*

20 42 U.S.C. § 2000e-2(a)(1) (2008) (Title VII of the Civil Rights Act of 1964 makes it an unlawful employment practice "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex or national origin"). *See also Ariz. Governing Comm. for Tax Deferred Annuity & Deferred Compensation Plans v. Norris*, 463 U.S. 1073 (1983) (holding that the use of sex-based actuarial tables, which resulted in the employer providing lower annuity payments to women who contributed the same amount as men violated Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e); U.S. Equal Employment Opportunity Comm'n, Directives Transmittal No. 915.003 EEOC Compliance Manual Section 3: Employee Benefits (Oct. 3, 2000), available at http://www.eeoc.gov/policy/docs/benefits.html ("health insurance benefits must be provided without regard to the race, color, sex, national origin, or religion of the insured. An employer must non-discriminatorily provide to all similarly situated employees the same opportunity to enroll in any health plans it offers. An employer must also ensure that the terms of its health benefits are non-discriminatory").

21 *Id.* at 6.

22 McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (2008).

23 Typically, an insurer will establish an average premium, or "index rate," and the rate band will set a floor below and a ceiling above that index rate to designate the amount by which an insurer can vary premiums based on the specified factor(s). For example, State X's rate band allows an insurer to vary premiums from the index rate by plus or minus 25 percent. If an insurer's index rate is $400, then the lowest premium allowed under the rate band would be $300 and the highest allowable premium would be $500. *See*: Deborah J. Chollett & Adele M. Kirk, The Henry J. Kaiser Family Foundation, *Understanding Individual Health Insurance Markets* 43-44 (Mar. 1998).

24 Mila Kofman & Karen Pollitz, Georgetown University Health Policy Institute, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Chance* 3 (Apr. 2006), http://www.pbs.org/now/politics/Healthinsurancereportfinalkofmanpollitz.pdf.

25 N.Y. Ins. Law § 3231(a) (McKinney 2008).

26 Connecticut, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Oregon, Vermont, and Washington impose modified community rating. For statutory citations, please see each state's notes accompanying Table 1.

27 Montana's "unisex insurance law" is not limited to health insurance; it prohibits insurers from using gender as a rating factor in any type of insurance policy issued within the state. *See* Mont. Code Ann. § 49-2-309(1) (2008).

28 S. 2796, H.R. 5918, 110th Cong. (2d Sess. 2008).

29 42 U.S.C. § 300gg-1(b) (2008); 26 C.F.R. § 54.9802-1 (2008).

30 Families USA, *Issue Brief: Understanding How Health Insurance Premiums Are Regulated* (Sept. 2006), http://familiesusa.org/assets/pdfs/rate-regulation.pdf.

31 Thirty-eight states impose rate bands limiting health status as a rating factor, while the remaining three states—the District of Columbia, Hawaii, and Pennsylvania—allow the use of health status as a rating factor because they impose no rating restrictions at all in the small group market.

32 Fronstin & Helman, *supra* note 7, at 10-11.

2008

Table 1: State Laws Protecting Against the Use of Gender, Age, and Health Status as Rating Factors in the Small Group Market

See Table 1 notes for statutory citations.

State	Gender	Age	Health Status
Alabama	✕	✕	⊖
Alaska	✕	✕	⊖
Arizona	✕	✕	⊖
Arkansas	✕	✕	⊖
California	●	✕	⊖
Colorado	●	✕	⊖
Connecticut (modified community rating)	✕	✕	●
Delaware	⊖	✕	⊖
District of Columbia	✕	✕	✕
Florida	✕	✕	⊖
Georgia	✕	✕	⊖
Hawaii	✕	✕	✕
Idaho	✕	✕	⊖
Illinois	✕	✕	⊖
Indiana	✕	✕	⊖
Iowa	●	✕	⊖
Kansas	✕	✕	⊖
Kentucky	✕	✕	⊖
Louisiana	✕	✕	⊖
Maine (modified community rating)	●	⊖	●
Maryland (modified community rating)	●	✕	●
Massachusetts (modified community rating)	●	✕	●
Michigan	●	✕	⊖
Minnesota	●	⊖	⊖
Mississippi	✕	✕	⊖
Missouri	✕	✕	⊖
Montana	●	✕	⊖
Nebraska	✕	✕	⊖
Nevada	✕	✕	⊖
New Hampshire (modified community rating)	●	✕	●
New Jersey (modified community rating)	⊖	⊖	●
New Mexico	✕	✕	⊖
New York (pure community rating)	●	●	●
North Carolina	✕	✕	⊖
North Dakota	✕	✕	⊖
Ohio	✕	✕	⊖
Oklahoma	✕	✕	⊖
Oregon (modified community rating)	●	⊖	●
Pennsylvania	✕	✕	✕
Rhode Island	✕	✕	⊖
South Carolina	✕	✕	⊖
South Dakota	✕	⊖	⊖
Tennessee	✕	✕	⊖
Texas	✕	✕	⊖
Utah	✕	✕	⊖
Vermont (modified community rating)	⊖	⊖	●
Virginia	✕	✕	⊖
Washington (modified community rating)	●	✕	●
West Virginia	✕	✕	⊖
Wisconsin	✕	✕	⊖
Wyoming	✕	✕	⊖

Key

● Protections exist

⊖ Limited protections exist (use limited through rate band)

✕ No protections exist

Notes to Table 1

Alabama: Gender and age: Ala. Admin. Code r. 482-1-116-.05(a)(1) (2008). Health status: Ala. Admin. Code r. 482-1-116-.05(a)(5)(b). Health Status Rate Band: ± 20%

Alaska: Gender and age: Alaska Stat. § 21.56.120(a)(9) (2008). Health status: Alaska Stat. § 21.56.120(a)(1) (2008). Health Status Rate Band: ± 35%

Arizona: Gender and age: Ariz. Rev. Stat. Ann. §§ 20-2311(B)(1), 20-2301(A)(8) (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: Ariz. Rev. Stat. Ann. § 20-2311(A) (2008). Health Status Rate Band: ± 60%

Arkansas: Gender: Ark. Code Ins. R. 19(8) (Weil 2008) (allowing small employer insurance carriers to use gender as a rating factor, provided that the rate differential is based on actuarial statistics). Age: Ark. Code Ann. §§ 23-86-204(b), 23-86-202(4) (West 2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: Ark. Code Ann. § 23-86-204(a)(2) (West 2008). Health Status Rate Band: ± 35%

California: Gender: Cal. Ins. Code §§ 10714(a)(2), 10700(t)–(v) (West 2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, and family size, in addition to the benefit plan selected by the employee). Age: Cal. Ins. Code §§ 10700(v) (West 2008). Health Status: Cal. Ins. Code §§ 10714(a)(1) (West 2008). Health Status Rate Band: ± 10%

Colorado: Gender and age: Colo. Rev. Stat. §§ 10-16-105(8)(a), 10-16-102(10)(b) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, family size, smoking status, claims experience, and health status). Health status: Colo. Rev. Stat. § 10-16-105(8.5)(a)(II) (2008). Health Status Rate Band: +10%, -25%

Connecticut: Gender and age: Conn. Gen. Stat. § 38a-567(5)(A) (2008) (allowing small employer insurance carriers to vary the community rate based on age and gender). Health status: Conn. Gen. Stat. §§ 38a-567(5)(A) (2008), -564(27) (requiring community rating that excludes the use of claim experience, health status, and duration of coverage as rating factors).

Delaware: Gender: Del. Code Ann. tit. 18, § 7205(2)(a) (2008) (allowing small employer insurance carriers to vary premium rates based on gender and geography combined by up to 10 percent). Age: Del. Code Ann. tit. 18, §§ 7202(9), 7205 (2008) (allowing the use of age as a rating factor if actuarially justified). Health status: Del. Code Ann. tit. 18, § 7205 (2008). Health Status Rate Band: ± 35%

District of Columbia: D.C. Code §§ 31-2801 to -3851.13 (2008), D.C. Code Mun. Regs. tit. 26, §§ 100–8899 (2008) (no statute or regulation imposes any rating restrictions on the small group market).

Florida: Gender and age: Fla. Stat. § 627.6699(6)(b)(1) (2008). Health status: Fla. Stat. § 627.6699(6)(b)(5) (2008). Health Status Rate Band: ± 15%

Georgia: Ga. Code Ann. § 33-30-12(b), (d) (West 2008). Health Status Rate Band: ± 25%

Hawaii: Haw. Rev. Stat. §§ 43:1-100 to 435E-46 (2008), Haw. Code R. §§ 16-1-1 to 16-304-3 (2008) (no statute or regulation imposes any rating restrictions on the small group market).

Idaho: Gender and age: Idaho Code Ann. § 41-4706(1)(h) (2008). Health status: Idaho Code Ann. § 41-4706(1)(b) (2008). Health Status Rate Band: ± 50%

Illinois: Gender and age: 215 Ill. Comp. Stat. 93/25(a)(6), 93/10 (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: 215 Ill. Comp. Stat. 93/25(a)(2) (2008). Health Status Rate Band: ± 25%

Indiana: Gender and age: Ind. Code §§ 27-8-15-17, 27-8-15-6 (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: Ind. Code § 27-8-15-16(1) (2008) Health Status Rate Band: ± 35%

Iowa: Gender and age: Iowa Code § 513B.4(2) (2008) (prohibiting the use of rating factors other than age, geographic area, family composition, and group size without prior approval of the insurance commissioner). Health status: Iowa Code § 513B.4(1)(b) (2008). Health Status Rate Band: ± 25%

Kansas: Gender and age: Kan. Stat. Ann. §§ 40-2209h(7)(A), 40-2209h(a)(9) (2008). Health status: Kan. Stat. Ann. § 40-2209h(2) (2008). Health Status Rate Band: ± 25%

Kentucky: Gender and age: Ky. Rev. Stat. Ann. § 304.17A-0952(6) (West 2008). Health status: Ky. Rev. Stat. Ann. § 304.17A-0952(4) (West 2008). Health Status Rate Band: ± 50%

Louisiana: Gender and age: La. Rev. Stat. Ann. § 22:228.6(B)(3) (2008). Health status: La. Rev. Stat. Ann. § 22:228.6(B)(2)(b) (2008). Health Status Rate Band: ± 33%

Maine: Gender and health status: Me. Rev. Stat. Ann. tit. 24-A, § 2808-B(2)(B) (2008) (prohibiting small employer insurance carriers from varying the community rate based on gender, health status, claims experience or policy duration of the group or group members). Age: Me. Rev. Stat. Ann. tit. 24-A, § 2808-B(2)(D), (D-1) (2008). Age Rate Band: ± 20%

Maryland: Md. Code Ann., Ins. § 15-1205(a)(1)-(3) (West 2008) (allowing small employer insurance carriers to adjust the community rate only for age and geography).

Massachusetts: Mass. Gen. Laws ch. 176J, § 3(a)(1), (2) (2008) (allowing small employer insurance carriers to adjust the community rate only for age, industry, participation-rate, wellness program, and tobacco use).

Michigan: Gender and age: Mich. Comp. Laws § 500.3705(2)(a) (2008) (prohibiting commercial small employer insurance carriers from setting premium rates based on characteristics of the small employer other than industry, age, group size, and health status). Health status: Mich. Comp. Laws § 500.3705(2)(c) (2008). Health Status Rate Band: ± 45%

Minnesota: Gender: Minn. Stat. § 62L.08(5) (2008) (prohibiting the use of gender as a rating factor for small employer insurance carriers). Age: Minn. Stat. § 62L.08(3) (2008). Health status: Minn. Stat. § 62L.08(2) (2008). Age Rate Band: ± 50%, Health Status Rate Band: ± 25%

Mississippi: Gender and age: Miss. Code Ann. §§ 83-63-7(1)(g), -3(d) (West 2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: Miss. Code Ann. § 83-63-7(1)(b) (West 2008). Health Status Rate Band: ± 25%

Missouri: Gender and age: Mo. Rev. Stat. § 379.936(1)(10) (2008). Health status: Mo. Rev. Stat. § 379.936(2) (2008). Health Status Rate Band: ± 35%

Montana: Gender: Mont. Code Ann. § 49-2-309(1) (2008) ("It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits"). Age: Mont. Code Ann. §§ 33-22-1809(1)(f), -1803(9) (2008) (allowing all rating factors except gender, claims experience, health status, and duration of coverage). Health status: Mont. Code Ann. §§ 33-22-1809(1)(b) (2008). Health Status Rate Band: ± 25%

Nebraska: Gender and age: Neb. Rev. Stat. § 44-5258(1)(j) (2008). Health status: Neb. Rev. Stat. § 44-5258(1)(b) (2008). Health Status Rate Band: ± 25%

Nevada: Gender and age: Nev. Rev. Stat. § 689C.145 (2008). Health status: Nev. Rev. Stat. § 689C.230(2) (2008). Health Status Rate Band: ± 30%

New Hampshire: N.H. Rev. Stat. Ann. § 420-G:4(1)(e)(1) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics of the small employer other than age, group size, and industry classification).

New Jersey: N.J. Stat. Ann. § 17B:27A-25(a)(3) (West 2008) (providing that the premium rate charged by a small employer insurance carrier to the highest rated small group shall not be greater than 200% of the premium rate charged to the lowest rated small group purchasing the same plan, "provided, however, that the only factors upon which the rate differential may be based are age, gender and geography"). Rate Band for Age, Gender & Geography: ± 200%

New Mexico: Gender and age: N.M. Stat. § 59A-23C-5.1(A) (2008). Health status: N.M. Stat. § 59A-23C-5(A)(2) (2008). Health Status Rate Band: ± 20%

New York: N.Y. Ins. Law § 3231(a) (McKinney 2008) (requiring all small employer insurance plans to be community rated and defining "community rating" as "a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation").

North Carolina: N.C. Gen. Stat. Ann. § 58-50-130(b)(1) (West 2008). Health Status Rate Band: ± 25%

North Dakota: Gender and age: N.D. Cent. Code §§ 26.1-36.3-04(2)(g), 26.1-36.3-01(6) (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: N.D. Cent. Code § 26.1-36.3-04(2)(b) (2008). Health Status Rate Band: ± 20%

Ohio: Gender and age: Ohio Rev. Code Ann. § 3924.01(E) (West 2008). Health status: Ohio Rev. Code Ann. § 3924.01(A)(1) (West 2008). Health Status Rate Band: ± 40%

Oklahoma: Gender and age: Okla. Stat. tit. 36, § 6512(7) (2008). Health status: Okla. Stat. tit. 36, § 6515(A)(4) (2008). Health Status Rate Band: ± 25%

Oregon: Or. Rev. Stat. § 743.737(8)(b)(B) (2008) (providing that small employer insurance carriers may only vary the community rate by ± 50% based on age, employer contribution level, employee participation level, the level of employee engagement in wellness programs, the length of time during which the small employer retains uninterrupted coverage with the same carrier, and adjustments based on level of benefits).

Pennsylvania: 40 Pa. Cons. Stat. §§ 1–6701 (2008), 31 Pa. Code §§ 11.2–303.1 (2008) (no statute or regulation imposes any rating restrictions on the small group market).

Rhode Island: Gender and age: R.I. Gen. Laws § 27-50-5(a)(1) (2008). Health status: R.I. Gen. Laws § 27-50-5(2) (2008). Health Status Rate Band: ± 10%

South Carolina: Gender and age: S.C. Code Ann. §§ 38-71-940(B), 38-71-920(5) (2008). Health status: S.C. Code Ann. § 38-71-940(A)(2) (2008). Health Status Rate Band: ± 25%

South Dakota: Gender: S.D. Codified Laws §§ 58-18B-3, 58-18B-1(4) (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Age: S.D. Codified Laws § 58-18B-17 (2008). Health status: S.D. Codified Laws § 58-18B-3(2) (2008). Age Rate Band: 3:1, Health Status Rate Band: ± 25%

Tennessee : Gender and age: Tenn. Code Ann. §§ 56-7-2207(b)(7), 56-7-2203(6) (West 2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: Tenn. Code Ann. § 56-7-2209(b)(2) (West 2008). Health Status Rate Band: ± 35%

Texas: Gender and age: Tx. Ins. Code Ann. §§ 1501.210(a), 1501.210(c) (Vernon 2008). Health status: Tx. Ins. Code Ann. § 1501.204(2) (Vernon 2008). Health Status Rate Band: ± 25%

Utah: Gender and age: Utah Code Ann. §§ 31A-30-106(1)(h), 31A-30-103(6) (West 2008). Health status: Utah Code Ann. § 31A-30-106(b)(i) (West 2008). Health Status Rate Band: ± 30%

Vermont: Vt. Stat. Ann. tit. 8, § 4080a(h)(1) (2008) (prohibiting the use of the following rating factors when establishing the community rate: demographics including age and gender, geographic area, industry, medical underwriting and screening, experience, tier, or duration); Vt. Stat. Ann. tit. 8, § 4080a(h)(2) (2008) (providing that upon approval by the insurance commissioner, insurers may adjust the community rate by a maximum of 20% for demographic rating including age and gender rating, geographic area rating, industry rating, experience rating, tier rating, and durational rating).

Virginia: Gender and age: Va. Code Ann. § 38.2-3433(A)(1) (West 2008) (allowing insurance carriers offering essential and standard plans in the small employer market to use age, gender, and geography as rating factors). Health status: Va. Code Ann. § 38.2-3433(A)(2) (West 2008). Health Status Rate Band: ± 20%

Washington: Wash. Rev. Code § 48.21.045(3)(a) (2008) (providing that small employer insurance carriers may only vary the community rate based on geographic area, family size, age, and wellness activities).

West Virginia: Gender and age: W. Va. Code §§ 33-16D-5(b), 33-16D-2(d) (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: W. Va. Code § 33-16D-5(a)(2) (2008). Health Status Rate Band: ± 30%

Wisconsin: Gender and age: Wis. Stat. § 635.02(2) (2008). Health status: Wis. Stat. § 635.05(1) (2008). Health Status Rate Band: ± 35%

Wyoming: Gender and age: Wyo. Stat. Ann. § 26-19-304(a)(xi) (2008). Health status: Wyo. Stat. Ann. § 26-19-304(a)(iii) (2008). Health Status Rate Band: ± 35%

The Individual Insurance Market: A Hostile Environment for Women

Most people get their health insurance from an employer. But in 2007, over six million women between the ages of 18 and 64 obtained health insurance through the individual insurance market, where consumers purchase health insurance directly from an insurance company. The individual market is an unwelcoming environment for consumers in general, and for women in particular. In most states, insurance companies that sell individual market policies are allowed to charge people different premiums based on factors such as gender or age, and insurers are often permitted to refuse to sell coverage altogether to those with pre-existing health conditions. In contrast, federal and state law generally bar employers from charging their workers different premiums based on gender or age.

Why Focus on the Individual Insurance Market?

The majority of women—and of Americans in general—receive their health coverage through an employer. In 2007, nearly two-thirds of all women ages 18-64 were covered through their own or a family member's job-based health plan. A smaller proportion of women were covered through public health insurance programs like Medicaid, the State Children's Health Insurance Program (SCHIP), or Medicare.

Individual market insurance is the least common type of coverage; in 2007, just 7 percent of women ages 18-64 had individual market coverage. Yet, this market is a growing part of the current health care landscape. The individual market may be the only coverage option—albeit an undesirable one—for those women who do not have access to employer-sponsored health insurance (ESI) and who do not qualify for public health insurance programs.

Who might be stuck in the individual market?

- A woman who works part-time with no employer coverage;
- A young adult who takes her first job—without benefits—after graduating from college;
- A self-employed single mother;
- A woman who loses dependent coverage when her husband qualifies for Medicare two or three years before she does; or
- A woman working for an employer who decides he can no longer offer his employees health coverage, but instead provides a stipend to employees to purchase insurance on their own.

These women must choose between becoming (or remaining) uninsured or trying to get coverage in the deeply-flawed individual insurance market.

Some health reform proposals would expand the individual market. But given the many problems in the individual insurance market, health reform should reduce or eliminate the need for the individual market by making it easier for people to obtain employer coverage, and by creating medical insurance pools large enough to accommodate anyone who needs coverage.

The Individual Insurance Market for Women: Unaffordable, Unequal, and Inadequate

Women applying for individual insurance coverage face challenges related to their gender, age, and health status, which may prove to be insurmountable obstacles to getting and affording health insurance. Generally, when a person applies for coverage in the individual market, an insurance company decides whether to sell the applicant insurance and then what premium to charge the applicant based on various criteria, including gender, age, medical history, and occupation. This process is known as "medical underwriting." Insurers also decide which services to cover, such as whether to cover maternity care.

1. Deciding Whether to Sell Applicants Insurance

Insurers can reject individual insurance applicants for a variety of reasons, such as having any health history—but many reasons are particularly relevant to women.

It is still legal in nine states and D.C. for insurers to reject applicants who are survivors of domestic violence.

In the early 1990s, advocates discovered that routine insurance practices discriminated against survivors of domestic violence, when insurers regularly denied applications for individual coverage submitted by women who had experienced domestic violence.[1] Since 1994, 40 states have responded by adopting legislation prohibiting health insurers from denying coverage based on domestic violence.[2] Arkansas, Idaho, Mississippi, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Wyoming and the District of Columbia should join these states by passing laws to protect access to health insurance for survivors of domestic violence.[3]

Insurers can also reject women for coverage simply for having previously had a Cesarean section.

Women who have given birth by Cesarean section (C-section) may also encounter challenges in the individual market, according to a recent *New York Times* investigation.[4] If, during the medical underwriting process, the insurer discovers that an applicant underwent a past C-section, it may charge her a higher premium, impose an exclusionary period during which it refuses to cover another Cesarean, or reject her for coverage altogether unless she has been sterilized or is above childbearing age.[5] Presumably, insurers do this because a woman with a previous C-section is more likely to have another C-section,[6] and insurers do not want to take on that financial risk.[7] This practice could affect the growing number of women who have C-sections. In 2006, 31% of all recorded U.S. births were delivered through C-section—a rate that has climbed 50 percent over the last ten years.[8] Individual insurance providers should not be permitted to treat women differently based on a previous C-section by denying them insurance coverage when they need it most.

2. Deciding What Premium to Charge

Gender Rating: A Financial Barrier to Health Coverage

In most states, insurance companies generally charge women higher premiums than men until around age 55, after which point many insurers charge men more than women.[9]

One might assume that higher premiums for women are based on women's reproductive capacity, in case a woman gets pregnant and requires additional health care services. But while the cost of maternity coverage plays a role in the increased cost of health care for women,[10] this does not explain the difference because most individual health insurance policies exclude maternity benefits.[11] In fact, research conducted by NWLC—and available

in the report *Nowhere to Turn: How the Individual Insurance Market Fails Women*—showed that only 6 percent of examined plans that gender-rated included maternity coverage.[12]

The insurance industry argues that gender rating reflects actual differences in the cost of providing health insurance to women versus men; premiums are higher because women have higher hospital and physicians' costs than men.[13] Many states that allow gender rating require that any difference in premiums between women and men be "justified by actuarial statistics,"[14] which means that the difference must be based on statistically based variations in health costs between women and men.[15]

However, in the aforementioned *Nowhere to Turn* report, NWLC demonstrates that the range of differences in premiums between women and men varies dramatically, raising real questions about how arbitrary gender rating is in practice. The premiums charged to men and women for the same coverage can differ significantly. For example:

- At age 25, women are charged between six and 45 percent more than men for insurance coverage;
- At age 40, women's monthly premiums are between four and 48 percent higher than men's monthly premiums; and
- At age 55, the premiums women are charged range from 22 percent lower to 37 percent higher than the rates men are charged.

NWLC found that even within a single zip code, great variation in premiums exists. For example, the ten best-selling individual market insurance plans available in Phoenix, Arizona each use gender as a rating factor; one plan charges 40-year-old women only 2 percent more in monthly premiums than men while another plan charges women 51 percent more than men for the same coverage.[16] (See Table 1.)

Women are even less able to afford the higher premiums charged for individual coverage because today, women earn only 78 cents for every dollar that men earn.[17] The use of gender as a rating factor is unjust and serves as a barrier to health care.

Age Rating: More Expensive Coverage for Older Applicants

Insurers in the individual market often decide how much to charge an applicant based on age. Unless prohibited by state law, insurance companies charge higher rates to older applicants.

Do Your Local Health Insurance Plans Gender-Rate?

Advocates can find out whether health insurance plans in their area charge women more than men for the same coverage. To obtain this information, follow these five simple steps:

1. On the internet, visit http://www.ehealthinsurance.com/.
2. Enter your zip code and click "Get quotes."
3. Input a date of birth for a female applicant and hit "Get quotes." Make a note of the various premiums charged for different health plans.
4. Go back to the previous screen and now input the same date of birth for a male applicant and click "Get Quotes." Make a note of the various premiums charged for different health plans.
5. Compare the different rates. If the same plan charges a different rate for a woman than for a man, that plan gender rates.

Presumably, higher rates are charged because older people are more likely to need health care services; on average, the expected health costs of people over age 50 are more than twice as high as the expected health costs of people under age 20.[18] Nevertheless, age rating may have a particularly onerous effect on women in the individual market, because older women ages 55 to 64 are more likely to purchase individual insurance than men of the same age.[19] These women may be more likely to seek individual coverage because their older spouses qualify for Medicare, causing them to lose dependent coverage and become uninsured.[20]

Health Status Rating: A Barrier to Access and a Contributor to Higher Premium Rates

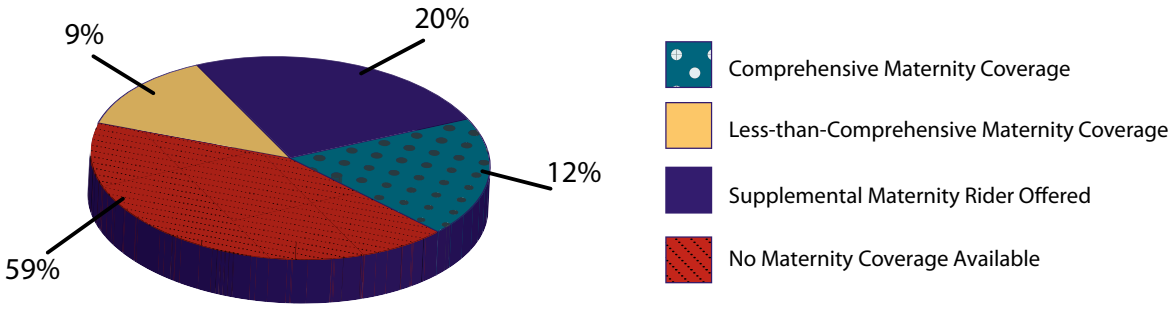
Unless prohibited by state law, when a person applies for coverage directly from an insurance company, the insurer is free to deny coverage if the applicant has prior health insurance claims, health conditions, or a history of health problems. If offered coverage, these applicants are more likely to have pre-existing conditions excluded from coverage and they are usually charged higher premium rates than healthier people. Because women are more likely than men to need health care services throughout their lifetimes[21] and are more likely to have chronic conditions requiring ongoing treatment such as arthritis and asthma,[22] they may find it more difficult to access and afford coverage in the individual health insurance market.

3. Deciding Which Services to Cover

Maternity Coverage in the Individual Market: Expensive, Limited and Difficult to Obtain

Although most women with job-based health insurance receive maternity benefits due to state and federal anti-discrimination protections, no such protection exists in the individual insurance market. In this market, women face multiple challenges in obtaining comprehensive or affordable health insurance that covers maternity care. For example, insurers may consider pregnancy as grounds for denying a woman's application, or as a pre-existing condition for which coverage can be excluded. Moreover, the NWLC *Nowhere to Turn* report shows that a majority of individual market health insurance policies fail to cover maternity care at all (see Figure 1 below). In some states, NWLC found that women may be able to purchase supplemental maternity benefits (called a "rider") for an additional premium. This coverage, however, is often limited in scope and can be prohibitively expensive; a rider may cost a woman far more than her monthly health insurance premium.

Figure 1: Availability of Maternity Coverage in Individual Market Insurance Policies



n=3,512 policies (offered in 47 states and D.C.)

Comprehensive maternity coverage includes coverage for prenatal care, labor, delivery, and postnatal care, for both routine pregnancies and in case of complications.

SOURCE: National Women's Law Center, *Nowhere to Turn: How the Individual Insurance Market Fails Women* (2008). Please see report for details on research methdology.

The importance of adequate maternity care—especially prenatal care—cannot be overstated. If a woman visits a healthcare provider early and regularly during her pregnancy, birth defects and other complications can be prevented or appropriately managed. But a precursor to timely care is having the finances or insurance coverage to pay for it; when pregnant women are uninsured, they are considerably less likely to get proper prenatal care.[23] Adequate and affordable maternity coverage is essential for the health of mothers and their children—it should not be a luxury to which only some women have access.

What Can States Do to Address Problems in the Individual Market?

Because the regulation of insurance has traditionally been a state responsibility,[24] there are few federal laws governing the individual market—and no federal law addresses gender rating in the individual insurance market. A few states have taken steps to increase the affordability of and accessibility to individual health insurance coverage, by regulating health insurance premiums in one of two ways:

- Prohibiting the use of different factors such as gender, age or health status in setting premiums
  - A few states have adopted laws or regulations to simply ban the use of different rating factors outright, such as gender.
  - A few more states have used "community rating" to prohibit the use of different rating factors. Community rating is a method of calculating health insurance premiums based on the average or anticipated health costs of a whole community, rather than based on an individual's particular needs.[25] Under "pure community rating," insurers must set the same premium for everyone who has the same coverage, regardless of age, health status, or gender.[26] Under "modified community rating," insurers are prohibited from varying premiums based on the insured individual's health status or claims history, but are allowed to use certain other rating factors, which can include gender, age, and/or geographic location.[27]
- Limiting how much insurers can vary premiums based on different rating factors through a "rate band"
  - Some states have limited how much an insurance company may use rating factors to vary a premium through a "rate band."[28] In general, a rate band sets limits between the lowest and highest premium that a health insurer may charge for the same coverage based on certain rating factors, such as gender, health status, and age.[29]

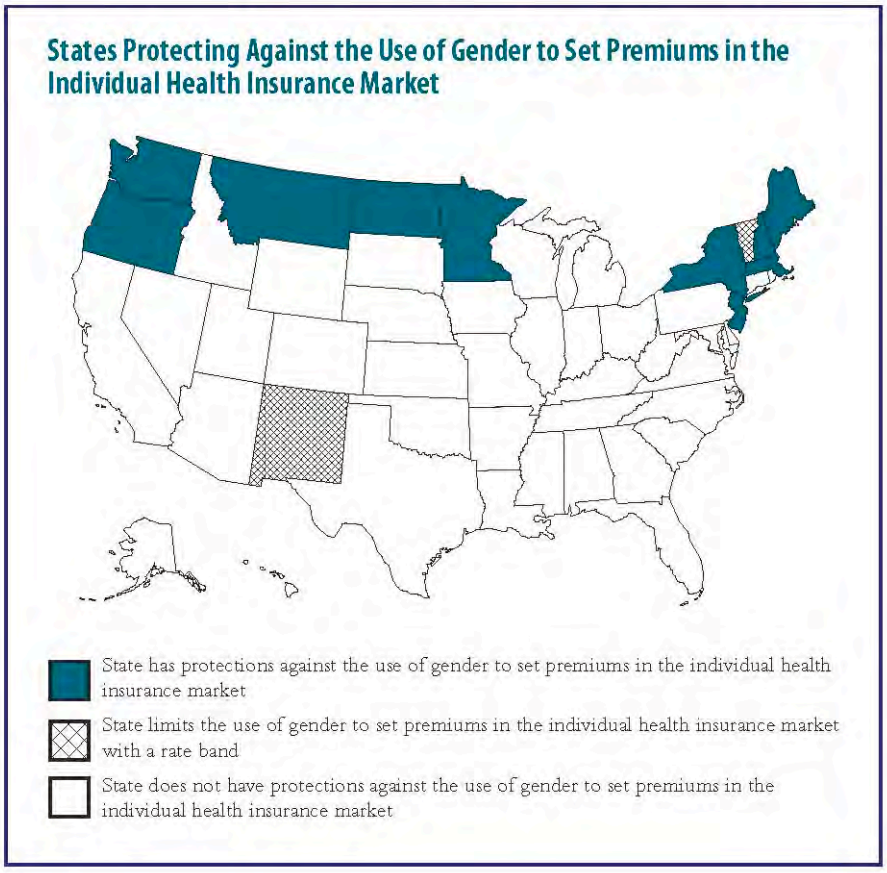
How Have States Used Premium Regulations?[30]

A limited number of states have used the two methods of premium regulation described above to address obstacles in the individual market.

Protections Against Gender Rating

Overall, 40 states and the District of Columbia allow individual insurers to gender rate. (See Table 2 and map on next page.) There are ten states that have adopted protections against gender rating.

- Outright ban on gender rating: Four states—Minnesota, Montana, New Hampshire, and North Dakota—prohibit insurers from using gender to determine premiums for individual health insurance.



- Gender rating prohibited through community rating: Six states prohibit the use of gender as a rating factor under community rating statutes: New York imposes pure community rating, and Maine, Massachusetts, New Jersey, Oregon, and Washington require modified community rating, under which gender rating is prohibited along with rating based on health status.
- Limiting gender rating through rate bands: New Mexico and Vermont limit how much insurers can vary premiums based on gender through a rate band.

Protections Against Age Rating

Unless prohibited, insurers generally charge older applicants higher premiums for individually-purchased health insurance.

- Only one state, New York, bans the use of age as a rating factor through pure community rating requirements.
- Seven states—Maine, Massachusetts, Minnesota, New Hampshire, North Dakota, South Dakota, and Vermont—have enacted rate bands to limit insurers' ability to vary rates based on age. (See Table 2.)

Protections Against Health Status Rating

Unless prohibited by state law, health status rating contributes to higher premiums in the individual market for those with a history of health problems.

- Seven states prohibit the use of health status as a rating factor through community rating for individually-purchased insurance: New York, Maine, Massachusetts, Oregon, Vermont, New Jersey, and Washington.
- Eight additional states impose rate bands to limit how much insurers can vary rates based on health status. (See Table 2.)

Limiting Rejection of Insurance Applicants: Guaranteed Issue Requirements[31]
In most states, insurers in the individual market can refuse to sell health insurance to applicants who have health conditions or a history of health problems. Five states—Maine, Massachusetts, New Jersey, New York, and Vermont—prohibit this practice through "guaranteed issue" requirements, which mandate that individual insurance providers accept **anyone** who applies for coverage, regardless of health status. Although these laws prohibit insurers from denying coverage, they do not address the premiums that may be charged. These five states also prohibit insurers from charging different individuals higher premiums based on health history (under community rating)—but affordability can still be a challenge as premiums in these states may still be higher than other states.

What Can Women's Advocates Do?

Women's advocates can support efforts to eliminate or reduce the need for the individual market.
The individual market is deeply flawed. Even in the states that have taken incremental action to address its many challenges, this market remains an expensive, difficult way for women to obtain health coverage. Advocates should support proposals that:

- **Make employer-sponsored insurance easier to obtain.** The primary vehicle for health insurance coverage in the United States is through the workplace, where women enjoy important workplace protections. But the number of Americans receiving coverage through their employer continues to decrease.[32] In fact, the decline in employer-sponsored insurance coverage is the dominant factor underlying the growth in the number of uninsured Americans.[33]

  For too many part-time employees, employer health insurance coverage is either not offered or unaffordable. Uninsured women are more likely than uninsured men to work part time.[34] State or federal assistance to employers that provide affordable health benefits to these employees will help expand health coverage.

  Efforts to make employer-sponsored health insurance easier to obtain should focus on small businesses because they are less likely than their larger counterparts to offer health benefits.[35] And women are more likely than men to work for small businesses who do not offer health insurance.[36] There are a variety of ways to help small businesses provide health insurance, such as offering financial help and/or tax incentives, or creating purchasing pools. For example, Montana offers refundable tax credits to small businesses with two to nine employees that are currently providing health insurance to their workers.[37]

- **Create health insurance pools large enough to accommodate everyone who needs coverage.** Some states, such as Massachusetts, have merged their individual and small group markets to create one large pool.[38] This approach spreads risk among a larger group of insured people, thus saving administrative costs, and, by building on the current insurance system, it gives people the ability to keep their existing coverage.[39] Early reports out of Massachusetts suggest that the new pool has decreased the cost

and increased the number of plans available to people purchasing individual health insurance.[40] This model could be adopted by other states, or it could be applied nationally by the federal government.

In the short term, until adequate alternatives to the individual market exist, women's advocates should support efforts that make individual insurance coverage easier to obtain and afford.

Insurers should be prohibited from using gender to set premiums in the individual market. Premiums for individual coverage also should not be based on age or health status, and insurance companies should not be permitted to reject applicants because they have pre-existing health conditions or a history of health problems. States should either ban gender rating or adopt pure community rating that requires insurers to set the same premium for everyone who has the same coverage. Because pure community rating can, however, result in higher premiums, affordability must also be addressed to ensure true access to coverage.[41]

Women's advocates should support efforts to ensure that all health insurance policies sold include comprehensive coverage for vital health services such as maternity care.

Health reform proposals must ensure that women have access to comprehensive health benefits that meet their needs; adequate maternity coverage must certainly be part of every plan.

For further reading, see:

Families USA, *Failing Grades: State Consumer Protections in the Individual Health Insurance Market* (June 2008), http://www.familiesusa.org/assets/pdfs/failing-grades.pdf.

Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* (Apr. 2008), http://www.kff.org/insurance/upload/7766.pdf.

America's Health Insurance Plans, *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (Dec. 2007), www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.

Families USA, *Issue Brief: Understanding How Health Insurance Premiums Are Regulated* (Sept. 2006), http://familiesusa.org/assets/pdfs/rate-regulation.pdf.

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1 *See, e.g.*, 142 Cong. Rec. S2422, S2429-30 (Mar. 20, 1996) (statement of Sen. Wellstone); 142 Cong. Rec. E1013-13 (June 5, 1996) (statement of Rep. Pomeroy) ("the Pennsylvania State Insurance Commissioner surveyed company practices in Pennsylvania and found that 26% of the respondents acknowledged that they considered domestic violence a factor in issuing health, life and accident insurance"); 141 Cong. Rec. E2199-02 (Nov. 16, 1995) (statement of Rep. Sanders) ("An informal survey by the House Judiciary Committee in 1994 revealed that 8 of the 16 largest insurers in the country were using domestic violence as a factor when deciding whether to issue and how much to charge for insurance").

2 Women's Law Project & Pennsylvania Coalition Against Domestic Violence, *FYI: Insurance Discrimination Against Victims of Domestic Violence, 2002 Supplement* 2 (2002), http://www.womenslawproject.org/brochures/InsuranceSup_DV2002.pdf. Since 1994, the majority of states have adopted legislation prohibiting health insurers from denying coverage based on domestic violence, but nine states and D.C. offer no such protection to survivors of domestic violence. Even though Vermont lacks legislation specifically prohibiting discrimination against domestic violence survivors, the state requires guaranteed issue of all individual insurance plans. *See* Vt. Stat.Ann. tit. 8, § 4080b(d)(1) (2008).

3 *Id.*

4 Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, The New York Times, June 1, 2008, at A26.

5 *Id.*

6 Physicians Committee for Responsible Medicine, *Section Three: When is Surgery Unnecessary?*, in *Medicine and Society Curriculum*, http://www.pcrm.org/resources/education/society/society3.html (last visited June 5, 2008) ("An estimated 35 percent of all cesareans are repeat procedures based on the belief that a rupture in the uterine scar may occur if vaginal birth is attempted").

7 In 2005, a routine C-section cost nearly twice as much as a hospital-based vaginal birth without complications. *See* Childbirth Connection, *Facility Labor and Birth Charges by Site and Mode of Birth, United States, 2003-2005* (2008), http://www.childbirthconnection.org/article.asp?ck=10463.

8 *Births: Preliminary Data for 2006*. National Center for Health Statistics (December 2007), http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_07.pdf.

9 Deborah J. Chollett & Adele M. Kirk, The Henry J. Kaiser Family Foundation, *Understanding Individual Health Insurance Markets* 44 (Mar. 1998); *see also* National Women's Law Center, *Nowhere to Turn: how the Individual Health Insurance Market Fails Women*, (2008), http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf?docID=601.

10 Robert H. Jerry II & Kyle B. Mansfield, *Justifying Unisex Insurance: Another Perspective*, 34 Am. U.L. Rev. 329, 343 (1985).

11 America's Health Insurance Plans, *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* 24-25 (Dec. 2007); America's Health Insurance Plans, *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits* 26-27 (Aug. 2005). *See also* Anne C. Cicero, *Strategies for the Elimination of Sex Discrimination in Private Insurance*, 20 Harv. C.R.-C.L. L. Rev. 211, 215 n.23 (1985) (suggesting that maternity costs may be factored into women's rates even though not covered by their policies).

12 For a detailed discussion of the inadequate maternity coverage offered in the individual market *see Nowhere to Turn*, *supra* note 9.

13 Cicero, *supra* note 11, at 214-15 (citing testimony given by Ralph J. Eckert, Chairman and Chief Executive Officer, Benefit Trust Life Insurance Co. at Fair Insurance Practices Act: Hearings on S. 372 Before the Comm. on Commerce, Science, and Transportation, 98th Cong., 1st Sess. 2-16 (1983)).

14 *See, e.g.*, Colo. Rev. Stat. Ann. § 10-3-1104(1)(f)(III) (West 2008) (defining "unfair discrimination" as "[m]aking or permitting to be made any classification solely on the basis of marital status or sex, unless such classification is for the purpose of insuring family units or is justified by actuarial statistics"); Okl. Admin. Code § 365: 10-I-9(A)(2008) (This section "is not intended to prohibit reasonable and justifiable differences in premium rates based upon sound actuarial principles or actual or reasonably anticipated experience.")

15 Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* 11 (Apr. 2008).

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23 Amy Bernstein, Alpha Center, *Insurance Status and Use of Health Services by Pregnant Women* (March of Dimes 1999), www.marchofdimes.com/bernstein_paper.pdf; Susan Egerter et al., *Timing of Insurance Coverage and Use of Prenatal Care Among Low-Income Women*, Am. J. Public Health 92(3): 423-27 (March 2002).

24 *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (2008).

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26 *How Private Health Coverage Works*, *supra* note 15.

27 *Id.*

28 Chollet & Kirk, *supra* note 9, at 43-44.

29 Families USA, *Issue Brief: Understanding How Health Insurance Premiums Are Regulated* 7 (Sept. 2006).

30 *See Nowhere to Turn*, *supra* note 9 for statutory citations relevant to premium regulations.

31 *See Id.* for statutory citations relevant to guaranteed issue requirements.

32 Dawn M. Gencarelli, Nat'l Health Policy Forum, *Background Paper: Health Insurance Coverage for Small Employers* 3 (Apr. 2005), http://www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.

33 John Holahan & Allison Cook, *The U.S. Economy and Changes in Health Insurance Coverage, 2000-2006*, Health Affairs, Feb. 20, 2008, at w135-w144.

34 Patchias & Waxman, *supra* note 22, at 2.

35 Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey* (2008), http://ehbs.kff.org/.

36 Paul Fronstin & Ruth Helman, Employee Benefit Research Inst., *Issue Brief No. 253, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey* 11 (Jan. 2003), http://www.ebri.org/pdf/briefspdf/0103ib.pdf.

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40 Community Catalyst & Families USA, *supra* note 38.

41 In researching the individual insurance rates for Appendix 1, NWLC found high premiums in New York, where pure community rating is required. One insurance company charged everyone a monthly premium of $425.14, while another insurance company charged $665.88 for coverage, regardless of age, gender, health status, or other factors.

2008

Table 1. Prevalence of Gender Rating and Range in the 'Gender Gap' Among Best-Selling Plans in the Individual Insurance Market

The 'gender gap' reflects the difference between premiums charged to same-aged women and men for best-selling individual insurance market plans offered by the leading online provider in their state's capital city. For instance, all ten of the best-selling plans available to a 40-year-old woman living in Jefferson City, Missouri use gender to set premium rates. Depending on the best-selling plan she selects, this woman is charged at least 15 percent more and up to 140 percent more than a 40-year-old man for the same coverage.

State	Proportion of Best-Selling Plans That Gender Rate[a,b]	Range in Percentage Difference in Premiums Between 40-Year-Old Women and Men, Among Plans that Gender Rate	
		Minimum	*Maximum*
Alabama	All	11%	44%
Alaska	All	10%	24%
Arizona	All	2%	51%
Arkansas	All	13%	63%
California	Some	10%	39%
Colorado	Some	8%	43%
Connecticut	All	4%	41%
Delaware	Some	13%	25%
District of Columbia	Some	11%	24%
Florida	All	14%	44%
Georgia	All	15%	47%
Hawaii	All	23%	23%
Idaho	All	42%	44%
Illinois	All	15%	39%
Indiana	All	20%	48%
Iowa	All	15%	44%
Kansas	All	10%	49%
Kentucky	All	15%	48%
Louisiana	All	13%	38%
Maine[c]	N/A (and gender rating prohibited)		
Maryland	Some	12%	22%
Massachusetts[c]	N/A (and gender rating prohibited)		
Michigan	Some	15%	40%
Minnesota	None	Gender rating prohibited	
Mississippi	All	13%	43%
Missouri	All	15%	140%
Montana	None	Gender rating prohibited	
Nebraska	All	11%	60%
Nevada	All	11%	39%
New Hampshire	None	Gender rating prohibited	
New Jersey[d]	Some	23%	36%
New Mexico	All	19%	21%
New York	None	Gender rating prohibited	
North Carolina	All	11%	43%
North Dakota[e]	All	19%	29%
Ohio	All	15%	48%
Oklahoma	All	11%	40%
Oregon	None	Gender rating prohibited	
Pennsylvania	All	13%	37%
South Carolina	Some	15%	54%
South Dakota	All	20%	25%
Tennessee	All	18%	37%
Texas	All	15%	42%
Utah	Some	8%	37%
Vermont[c]	N/A		
Virginia	All	11%	32%
Washington	None	Gender rating prohibited	
West Virginia	All	13%	34%
Wisconsin	All	14%	45%
Wyoming	All	13%	25%

Notes

a. "Best-selling" status is assigned by eHealthInsurance, based on the number of applications submitted through its website, http://ehealthinsurance.com, and approved by the insurance company during the most recent calendar quarter.

b. Across the nation, a total of 347 best-selling plans (83%) gender rate. The absence or presence of maternity coverage generally cannot explain gender rating. Of the best-selling plans that gender rate, a total of 21 (6%) include maternity coverage in the individual health insurance policy.

c. Individual rate quotes were not available for Maine, Massachusetts, or Vermont through eHealthInsurance.

d. Although gender rating is prohibited in New Jersey, the best-selling plans available through eHealthInsurance include bare-bones basic and essential plans, which are exempted from the state's prohibition on gender rating.

e. Gender rating is prohibited in North Dakota, but the only company offering individual policies through eHealthInsurance does use gender as a rating factor.

Table 1 Methodology

The data in Table 1 were gathered through eHealthInsurance from its website, http://www.ehealthinsurance.com. NWLC submitted information for a hypothetical female applicant and a hypothetical male applicant at age 40 in 50 states and D.C., using a coverage start date of July 15, 2008. Applicants were listed as healthy non-smokers living in the state's capital city, in the same zip code as the governor's office (in D.C. the zip code of the mayor's office was used). For each of the 47 states and D.C. where coverage was offered, NWLC then determined how many of the best-selling individual insurance plans use gender as a rating factor. "Best-selling" status is assigned by eHealthInsurance, and is based on the number of applications submitted through eHealthInsurance's website and approved by the insurance company during the most recent calendar quarter. In the case of North Dakota, because only 12 plans are offered, the website lists all plans rather than only the best-selling plans. For this state, all 12 plans were analyzed. For each plan that gender rates, NWLC calculated the gender gap, or the difference in the premiums charged to a woman versus a similarly-aged man as a percentage of the premium charged to the woman. The Table indicates the minimum and maximum percentage difference in the premiums charged to a man and a woman among the best selling plans that gender rate.

Notably, eHealthInsurance may not represent all insurance companies licensed to sell individual health insurance policies in every state. However, the company bills itself as the leading online source of health insurance for individuals, families, and small businesses, partnering with over 160 health insurance companies in 50 states and D.C. and offering more than 7,000 health insurance products online.

Table2: State Laws Protecting Against the Use of Gender, Age, and Health Status to Set Premiums in the Individual Market

See Table 2 notes for statutory citations.

State	Gender	Age	Health Status
Alabama	✕	✕	✕
Alaska	✕	✕	✕
Arizona	✕	✕	✕
Arkansas	✕	✕	✕
California	✕	✕	✕
Colorado	✕	✕	✕
Connecticut	✕	✕	✕
Delaware	✕	✕	✕
District of Columbia	✕	✕	✕
Florida	✕	✕	✕
Georgia	✕	✕	✕
Hawaii	✕	✕	✕
Idaho	✕	✕	⊖
Illinois	✕	✕	✕
Indiana	✕	✕	✕
Iowa	✕	✕	✕
Kansas	✕	✕	✕
Kentucky	✕	✕	⊖
Louisiana	✕	✕	⊖
Maine (modified community rating)	●	⊖	●
Maryland	✕	✕	✕
Massachusetts (modified community rating)	●	⊖	●
Michigan	✕	✕	✕
Minnesota	●	⊖	⊖
Mississippi	✕	✕	✕
Missouri	✕	✕	✕
Montana	●	✕	✕
Nebraska	✕	✕	✕
Nevada	✕	✕	⊖
New Hampshire	●	⊖	⊖
New Jersey (modified community rating)	●	✕	●
New Mexico	⊖	✕	✕
New York (pure community rating)	●	●	●
North Carolina	✕	✕	✕
North Dakota	●	⊖	✕
Ohio	✕	✕	✕
Oklahoma	✕	✕	✕
Oregon (modified community rating)	●	✕	●
Pennsylvania	✕	✕	✕
Rhode Island	✕	✕	✕
South Carolina	✕	✕	✕
South Dakota	✕	⊖	⊖
Tennessee	✕	✕	✕
Texas	✕	✕	✕
Utah	✕	✕	⊖
Vermont (modified community rating)	⊖	⊖	●
Virginia	✕	✕	✕
Washington (modified community rating)	●	✕	●
West Virginia	✕	✕	✕
Wisconsin	✕	✕	✕
Wyoming	✕	✕	✕

Key

● Protections exist

⊖ Limited protections exist (use limited through rate band)

✕ No protections exist

Notes to Table 2

Alabama: Ala. Admin. Code r. 482-1-074-.03 (2008) (prohibiting only rates based on blindness as unfairly discriminatory). See also Ala. Code §§ 27-19-1 to -39 (2008), Ala. Admin. Code r. 482-1-024-.01 to -.06 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Alaska: Alaska Stat. §§ 21.36.090(b), 21.51.405 (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory between individuals of the same class). See also Alaska Stat. §§ 21.51.010–.500 (2008), Alaska Admin. Code tit. 3, §§ 28.410–.520 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Arizona: Gender: Ariz. Admin. Code § 20-6-607(G) (2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."); see also Ariz. Admin. Code § 20-6-207(C)(2) (2008) (restricting gender discrimination in insurance "except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under A.R.S. Title 20"). Age: Ariz. Admin. Code § 20-6-607(G) (2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."). Health status: Ariz. Rev. Stat. Ann. §§ 20-1341 to -1382 (2008), Ariz. Admin. Code §§ 20-6-101 to -2201 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Arkansas: Gender and age: Ark. Ins. Dep't, Consumer Frequently Asked Questions, *available at* http://www.insurance.arkansas.gov/Consumers/F_A_Q.htm (last visited Sept. 18, 2008) (explaining that the state's unfair discrimination statute, Ark. Code Ann. § 23-66-206(14)(G) (West 2008), does not prohibit an insurer from basing rates on age or gender, if proven to substantially affect underwriting). Health status: Ark. Code Ann. §§ 23-85-101 to -139 (West 2008), Ark. Code R. 18 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

California: Cal. Dep't of Insurance, Consumers: Individual Health Insurance Underwriting/AB 356, *available at* http://www.insurance.ca.gov/0100-consumers/0070-health-issues/ind-health-insurance-underwriting-ab-356.cfm (last visited Sept. 18, 2008) ("When you apply for individual health insurance, the health insurance company uses a process called underwriting to look at your age, sex, and health history to decide whether it will cover you and how much it will cost to provide you coverage.").

Colorado: Gender: Colo. Rev. Stat. § 10-3-1104(1)(f)(III) (2008) (providing that classifications based solely on gender do not constitute unfair discrimination if justified by actuarial statistics). Age: Colo. Rev. Stat. § 10-16-107(1.5) (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory); see also 3 Colo. Code Regs. § 702-4-2-11(8)(E) (2008) (providing that "use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating" is not prohibited); 3 Colo. Code Regs. § 702-4-2-11(6)(P) (2008) (requiring that the actuarial memorandum display "all other rating factors and definitions, including the area factors, age factors, gender factors, etc., and support for each of these factors in a new rate filing"). Health status: Colo. Rev. Stat. § 10-16-107(1.5) (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory); see also Colo. Rev. Stat. §§ 10-16-101 to -220 (2008), 3 Colo. Code Regs. §§ 4-2-1 to -28 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Connecticut: Conn. Gen. Stat. §§ 38a-481(b), 38a-488 (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory between individuals of the same class). See also Conn. Gen. Stat. §§ 38a-480 to -511 (2008), Conn. Agencies Regs. §§ 38a-78-11 to -16, 38a-434-1, 38a-481-1 to -4, 38a-505-1 to -13 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Delaware: Gender and age: 18-1300-1303 Del. Code Regs. § 7.4 (Weil 2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."); see also Del. Code Ann. tit. 18, §§ 2503(a)(2), 2304(13)(b) (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory between individuals of the same class). Health status: Del. Code Ann. tit. 18, §§ 2503(a)(2), 2304(13)(b) (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory between individuals of the same class); see also Del. Code Ann. tit. 18, §§ 3301–3355, 3601–3608 (2008), 18-1300-1301 to -1304 Del. Code Regs. (Weil 2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

District of Columbia: D.C. Code § 31-2231.11(b) (2008) (prohibiting only rates that are unfairly discriminatory between individuals of the same class). See also D.C. Code §§ 31-2801 to -3851.13 (2008), D.C. Code Mun. Regs. tit. 26, §§ 100–8899 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Florida: Fla. Stat. § 627.410(8)(a) (2008) (providing that benefits are deemed to be reasonable in relation to premium rates if filed pursuant to a loss ratio guarantee). See also Fla. Stat. §§ 627.601–.6499 (2008), Fla. Admin. Code Ann. r. 69O-149.002–.024, 69O-154.001–.210 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Georgia: Ga. Code Ann. §§ 33-9-4(1), 33-6-4(8)(A)(iv)(I) (West 2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory because based on race, color, or national or ethnic origin). See also Ga. Code Ann. §§ 33-29-1 to -22, 33-9-1 to -44 (West 2008), Ga. Comp. R. & Regs. 120-2-81-.01 to -.20 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Hawaii: Haw. Ins. Div., A Consumer's Guide to Health Insurance in Hawaii 3, *available at* http://hawaii.gov/dcca/areas/ins/consumer/consumer_information/health/Health_Insurance_Consumers_guide.pdf (last visited Sept. 18, 2008) ("The law does not limit what you can be charged for individual health insurance policy and you can be charged substantially higher premiums because of your health status, age, gender, and other factors.").

Idaho: Gender and age: Idaho Code Ann. § 41-5206(f) (2008) ("The individual carrier shall not use case characteristics, other than age, individual tobacco use, geography as defined by rule of the director, or gender, without prior approval of the director."). Health status: Idaho Code Ann. §§ 41-5206(1)(a) (2008) (providing that rates may not vary by more than 50% of the index rate).

Illinois: Gender: Ill. Admin. Code tit. 50, § 2603.40(a) (2008) (allowing insurance companies to differentiate in rates on the basis of gender if such "differentiation is based upon expected claim costs and expenses derived by applying sound actuarial principles"). Age and health status: 215 Ill. Comp. Stat. § 5/352–5/370e (2008), 50 Ill. Admin. Code tit. 50, § 2001.1–2051.100 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Indiana: Ind. Code §§ 27-8-5-1.5(1), 27-4-1-4(7)(B) (2008) (requiring only that benefits be reasonable in relation to the premium charged and prohibiting only unfairly discriminatory rates between individuals of the same class). See also Ind. Code §§ 27-8-5-1 to -5.7-11 (2008), 760 Ind. Admin. Code 1-8 to 1-9-4 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Iowa: Iowa Code § 513C.5(5)(a) (2008) (requiring insurers to disclose "[t]he extent to which premium rates for a specified individual are established or adjusted based upon rating characteristics"); Iowa Code § 513C.3(16) (2008) (defining "rating characteristics" as "demographic characteristics of individuals which are considered by the carrier in the determination of premium rates for the individuals and which are approved by the commissioner"). Health status: Iowa Code § 513C.5(1)(e) (2008) (only limiting an insurer's use of health status as a rating factor within a single block of business, that is all people insured under the same individual health benefit plan).

Kansas: Kan. Stat. Ann. § 40-2404(7)(b) (2008) (prohibiting only rates that are unfairly discriminatory between individuals of the same class). See also Kan. Stat. Ann. §§ 40-2201 to -2259 (2008), Kan. Admin. Regs. §§ 40-4-1 to -42g (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Kentucky: Gender and age: Ky. Rev. Stat. Ann. § 304.17A-0952(6) (West 2008) (allowing the use of gender and age as rating factors). Health status: Ky. Rev. Stat. Ann. § 304.17A-0952(1) (West 2008) (providing that rates may vary by no more than 35% of the index rate between individuals with "similar case characteristics").

Louisiana: Gender and age: La. Rev. Stat. Ann. § 22:228.6(B)(3) (2008) (expressly allowing individual insurance carriers to use gender and age as rating factors). Health status: La. Rev. Stat. Ann. § 22:228.6(B)(2) (2008) (providing that premiums may not deviate according to medical underwriting and screening or experience and health history rating by more than plus or minus 33%). Some reports suggest that Louisiana's health status rate band is not enforced. See Georgetown Univ. Health Policy Inst., *Summary of Key Consumer Protections in Individual Health Insurance Markets* 5 (Apr. 2004), *available at* http://www.healthinsuranceinfo.net/images/discrimination_limits_front.gif.

Maine: Gender and health status: Me. Rev. Stat. Ann. tit. 24-A, § 2736-C(2)(B) (2008) (prohibiting insurance carriers from varying the community rate due to gender or health status). Age: Me. Rev. Stat. Ann. tit. 24-A, § 2736-C(2)(D)(3) (2008) (imposing a rate band under which insurance carriers may only vary the community rate due to age by plus or minus 20% for policies issued after July 1, 1995).

Maryland: Gender: Md. Code Ann., Ins. § 27-208(b)(2) (West 2008) (prohibiting "a differential in ratings, premium payments, or dividends for a reason based on the sex of an applicant or policyholder unless there is actuarial justification for the differential"). Age and health status: Md. Code Ann., Ins. §§ 15-201 to -226 (West 2008), Md. Code Regs. 31.10.01.01–.35.03 (2008) (no statute or regulation restricts the use of age or health status as rating factors in the individual market).

Massachusetts: Gender and health status: Mass. Gen. Laws ch. 176M, § 1 (2008) (defining "modified community rate" as "a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a guaranteed issue health plan is the same without regard to health status; provided, however, that premiums may vary due to age, geographic area, or benefit level for each rate basis type as permitted by this chapter"). Age: Mass. Gen. Laws ch. 176M, § 4(a)(2) (2008) (imposing a rate band under which the "premium rate adjustment based upon the age of an insured individual" may range from 0.67 to 1.33).

Michigan: Gender and age: Mich. Comp. Laws § 500.2027(c) (2008) (prohibiting as unfair competition the "[c]harging of a different rate for the same coverage based on sex, marital status, age, residence, location of risk, disability, or lawful occupation of the risk unless the rate differential is based on sound actuarial principles"). Health status: Mich. Comp. Laws §§ 500.3400–.3475 (2008), Mich. Admin. Code r. 500.1–501.354, 550.101–.302 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Minnesota: Gender: Minn. Stat. § 62A.65(4) (2008) ("No individual health plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan."). Age: Minn. Stat. § 62A.65(3)(b) (2008) (imposing a rate band under which the "[p]remium rates may vary based upon the ages of covered persons . . . [by] up to plus or minus 50 percent of the index rate"). Health status: Minn. Stat. § 62A.65(3)(a) (2008) (mandating that rates may vary no more than 25% above and 25% below the index rate based on health status, claims experience, and occupation).

Mississippi: Miss. Code Ann. § 83-5-35(g)(2) (West 2008) (prohibiting only unfairly discriminatory rates between individuals of the same class). See also Miss. Code Ann. §§ 83-9-1 to -35 (West 2008), Code Miss. R. 28 000 001–095 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Missouri: Gender: Mo. Rev. Stat. § 375.936(11)(b) (2008) (prohibiting only unfairly discriminatory rates between individuals of the same class); Mo. Rev. Stat. § 375.936(11)(e) (2008) (restricting insurers from limiting the amount of coverage available to an individual based on gender); see also Mo. Rev. Stat. §§ 376.770–.823 (2008), Mo. Code Regs. Ann., tit. 20, §§ 400-2.010–.170 (2008) (no statute or regulation restricts the use of gender as a rating factor in the individual market). Age and health status: Mo. Rev. Stat. §§ 376.770–.823 (2008), Mo. Code Regs. Ann., tit. 20, §§ 400-2.010–.170 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Montana: Gender: Mont. Code Ann. § 49-2-309(1) (2008) ("It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits."). Age and health status: Mont. Code Ann. §§ 33-22-201 to -311 (2008), Mont. Admin. R. 6.6.101–.8512 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Nebraska: Gender: 210 Neb. Admin. Code § 28-005 (2008) (requiring insurers to provide, upon request, justification in writing for rating differentials based on gender, providing that "[a]ll rates shall be based on sound actuarial principles, valid classification systems and must be related to actual experience statistics"). Age and health status: Neb. Rev. Stat. §§ 44-710 to -7,102 (2008), 210 Neb. Admin. Code §§ 2-001–81-004 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Nevada: Gender and age: Nev. Rev. Stat. § 689A.680(2) (2008) (allowing the use of gender and age as rating factors). Health status: Nev. Rev. Stat. § 689A.680(3) (2008) (imposing a rate band in which the highest rating factor associated with health status may not exceed the lowest rating factor by more than 75%).

New Hampshire: Gender: N.H. Rev. Stat. Ann. § 420-G:4(I)(d) (2008) (allowing insurers to base rates in the individual market solely on age, health status, and tobacco use). Age: N.H. Rev. Stat. Ann. § 420-G:4(I)(d)(1) (2008) (imposing a rate band in which the maximum differential based on age is 4 to 1). Health status: N.H. Rev. Stat. Ann. § 420-G:4(I)(d)(2) (2008) (imposing a rate band in which the maximum rating differential due to health status is 1.5 to 1).

New Jersey: 2008 N.J. Sess. Law Serv. Ch. 38, page nos. 12, 15 (Senate 1557) (West) (amending N.J. Stat. Ann. § 17B:27A-2 (West 2008) to define "modified community rating" as "a rating system in which the premium for all persons under a policy or a contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographic location or any other factor or characteristic of covered persons, other than age," and amending N.J. Stat. Ann. § 17B:27A-4 (West 2008) to require individual health benefits plans to "be offered on an open enrollment, modified community rated basis"). New Jersey law excludes bare-bones basic and essential plans from the modified community rating requirement. See N.J. Dept. of Banking & Ins., *N.J. Individual Health Coverage Program Buyer's Guide: How To Select a Health Plan – 2006 Ed.* (2006), http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcbuygd.html.

New Mexico: Gender: N.M. Stat. § 59A-18-13.1(A) (2008) (allowing gender rating); N.M. Stat. § 59A-18-13.1(B) (2008) (providing that "the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than twenty percent of the lower rate"). Age: N.M. Stat. § 59A-18-13.1(A) (2008) (allowing insurers to use age as a rating factor in the individual market). Health status: N.M. Stat. § 59A-18-13.1(C) (2008) (providing that insurers are not precluded from using health status as a rating factor).

New York: N.Y. Ins. Law § 3231(a) (McKinney 2008) (defining community rating as "a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation").

North Carolina: Gender: 11 N.C. Admin. Code 4.0317(a) (2008) (excluding from definition of unfair discrimination gender rating when based on rate or premium differentials not prohibited under the chapter); see also NC Gen. Stat. Ann. §§ 58-3-1 to -4-25, 58-50-1 to -95 (West 2008), 11 NC Admin. Code 12.0101–.1804 (2008) (no statute or regulation restricts the use of gender as a rating factor in the individual market). Age and health status: N.C. Gen. Stat. Ann. §§ 58-3-1 to -4-25, 58-50-1 to -95 (West 2008), 11 N.C. Admin. Code 12.0101–.1804 (2008) (no statute or regulation restricts the use of age as a rating factor in the individual market).

North Dakota: Gender and age: N.D. Cent. Code § 26.1-36.4-06(1) (2008) (imposing a rate band under which age, industry, gender, and duration of coverage may not vary by a ratio of more than 5 to 1, but providing that "[g]ender and duration of coverage may not be used as a rating factor for policies issued after January 1, 1997"). Health status: N.D. Cent. Code § 26.1-36.4-06 (2008) (not explicitly prohibiting the use of health status as a rating factor in the individual market). Association health plans offered in North Dakota are not subject to these rating requirements. See N.D. Cent. Code § 26.1-36.4-02(1) (2008) (the definition of "insurer" does not include an association that offers health insurance coverage).

Ohio: Ohio Rev. Code Ann. § 3923.15 (West 2008) (prohibiting only unfairly discriminatory rates between individuals of substantially the same hazard). See also Ohio Rev. Code Ann. §§ 3923.01–.99 (West 2008), Ohio Admin. Code §§ 3901-1-01 to -7-04 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Oklahoma: Gender: Okla. Admin. Code § 365:10-1-9(d)(1) (2008) ("The amount of benefits payable, or any term, conditions or type of coverage shall not be restricted, modified, excluded, or reduced solely on the basis of the sex or marital status of the insured or prospective insured except to the extent the amount of benefits, term, conditions or type of coverage vary as a result of the application of rate differentials permitted under the Oklahoma Insurance Code."). Age and health status: Okla. Stat. tit. 36, §§ 4401–4411 (2008), Okla. Admin. Code §§ 365:10-1-1 to :10-3-20, 365:10-5-1 to :15-5-2 (2008) (no statute or regulation restricts the use of age as a rating factor in the individual market).

Oregon: Or. Rev. Stat. § 743.767(2) (2008) ("The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age.").

Pennsylvania: Gender: 31 Pa. Code § 145.1 (2008) (excluding from the definition of "unfair discrimination" when insurers "differentiat[e] in premium rates between sexes where there is sound actuarial justification"). Age: 40 Pa. Cons. Stat. § 1171.5(a)(7)(iii) (2008) (prohibiting unfair discrimination with regard to underwriting standards based on age, among other factors, but excluding the promulgation of rates based on age from the definition of unfair discrimination); see also 40 Pa. Cons. Stat. §§ 752–776.7 (2008), 31 Pa. Code §§ 88.1–.195 (2008) (no statute or regulation restricts the use of age as a rating factor in the individual market). Health status: 40 Pa. Cons. Stat. §§ 752–776.7 (2008), 31 Pa. Code §§ 88.1–.195 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Rhode Island: R.I. Gen. Laws § 27-18.5-3(f) (2008) ("nothing in this section shall be construed to create additional restrictions on the amount of premium rates that a carrier may charge an individual for health insurance coverage provided in the individual market"). See also RI Gen. Laws §§ 27-18-1 to -68 (2008), RI Code Ins., R. 23, Pts. VII & XI (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

South Carolina: Gender and age: S.C. Code Ann. § 38-71-325 (2008) ("Nothing contained in this section may be construed to prevent the use of age, sex, area, industry, occupational, and avocational factors or to prevent the use of different rates for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the person and are approved by the director or his designee."). Health status: S.C. Code Ann. §§ 38-71-310 to -680 (2008), S.C. Code Ann. Regs. 69-34 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

South Dakota: Gender: S.D. Codified Laws § 58-17-74(8) (2008) (expressly allowing the use of gender as a rating factor). Age: S.D. Codified Laws § 58-17-74(8) (2008) ("The maximum rating differential based solely on age may not exceed a factor of 5:1."). Health status: S.D. Admin. R 20:06:39:03 (2008) ("The application of rating factors based on health status or weight is limited to a 30 percent deviation from the index rate.").

Tennessee: Gender: Tenn. Comp. R. & Regs. 0780-1-34-.04(1) (2008) ("The amount of benefits payable, or any term, conditions or type of coverage shall not be restricted, modified, excluded, or reduced solely on the basis of the sex or marital status of the insured or prospective insured except to the extent the amount of benefits, term, conditions or type of coverage vary as a result of the application of rate differentials permitted under the Tennessee Insurance Code."). Gender and age: Tenn. Comp. R. & Regs. 0780-1-20-.06(1) (2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."). Health status: Tenn. Code Ann. §§ 56-26-101 to -133 (West 2008), Tenn. Comp. R. & Regs. 0780-1-20-.01 to -.09 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Texas: Gender: 28 Tex. Admin. Code § 21.406 (2008) ("When rates differ by sex or marital status, the insurer may be required to justify that the differential equitably reflects the difference in the risk assumed."). Age and health status: Tex. Ins. Code Ann. §§ 1201.001–1202.052 (Vernon 2008), 28 Tex. Admin. Code §§ 3.1–.128 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Utah: Gender and age: Utah Code Ann. § 31A-30-106(1)(h) (West 2008) (allowing the use of gender and age as rating factors). Health status: Utah Code Ann. § 31A-30-106(1)(b)(i) (West 2008) (providing that premium rates may vary from the index rate by no more than 30% of the index rate for individuals with "similar case characteristics").

Vermont: Vt. Stat. Ann. tit. 8, § 4080b(h)(1) (2008) (prohibiting the use of the following rating factors when establishing the community rate: demographics including age and gender, geographic area, industry, medical underwriting and screening, experience, tier, or duration); Vt. Stat. Ann. tit. 8, § 4080b(h)(1) (2008), 21-020-034 Vt. Code R. § 93-5(11)(G), (13)(B)(6) (2008) (providing that upon approval by the insurance commissioner, insurers may adjust the community rate by a maximum of 20% for demographic rating including age and gender rating, geographic area rating, industry rating, experience rating, tier rating, and durational rating).

Virginia: Gender and age: 14 Va. Admin. Code § 5-130-60(C)(7) (2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."). Health status: Va. Code Ann. §§ 38.2-3430.1–.10, 38.2-3500 to -3520 (West 2008), 14 VA Admin. Code §§ 5-13-10 to -100 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Washington: Wash. Rev. Code § 48.43.005(1) (2008) (defining "adjusted community rate" as "the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities"); Wash. Rev. Code § 48.44.022(1)(a) (2008) (allowing insurers to only vary the adjusted community rate based on geographic area, family size, age, tenure discounts, and wellness activities).

West Virginia: W. Va. Code § 33-15-1b(c) (2008) ("Nothing contained in this section may be construed to prevent the use of age, sex, area, industry, occupational, and avocational factors in setting premium rates or to prevent the use of different rates after approval by the commissioner for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the person.").

Wisconsin: Gender: Wis. Admin. Code Ins. § 6.55(5) (2008) (permitting insurers to differentiate rates on the basis of gender provided that such rates are based "on sound actuarial principles or a valid classification system and actual experience statistics"). Age: Wis. Admin. Code Ins. 3.13(6) (2008) (requiring individual accident and sickness insurers to file a "schedule of rates including policy fees or rate changes at renewal, if any, variations, if any, based upon age, sex, occupation, or other classification"). Health status: Wis. Stat. §§ 632.71–.899 (2008), Wis. Admin. Code Ins. §§ 3.13–.70 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Wyoming: Wyo. Stat. Ann. § 26-13-109(a) (2008) (prohibiting only rates that are unfairly discriminatory between individuals of the same class). See also Wyo. Stat. Ann. §§ 26-18-101 to -137 (2008), Wyo. Admin. Code Ins. Gen. ch. 1, § 1 to ch. 59, § 7 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

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Health Savings Accounts and High-Deductible Health Plans: The Wrong Answer to Women's Health Care Needs

A combination of Health Savings Accounts (HSAs) and High-Deductible Health Plans (HDHPs) have been a primary strategy of the Bush Administration's health care reform agenda, and some states have also begun to promote this approach to health coverage. Unfortunately, this short-sighted remedy fails to address the dual problems of an increasing number of uninsured Americans and spiraling health care costs. Closer examination of HSA/HDHP arrangements proves that they are the wrong answer to the country's health care crisis, and are particularly unacceptable for women.

How Do HSAs and HDHPs Work?

Health Savings Accounts (HSAs) are tax-sheltered accounts for individuals enrolled in high-deductible health plans (HDHPs). An HSA is not a health insurance policy in itself; it is a savings vehicle for HDHP members, who may use tax-free HSA dollars to purchase health care up to their required deductible. HSAs and HDHPs are part of a family of health insurance products that are often referred to as "consumer-directed health care." Supporters of this type of health insurance reason that a higher deductible will encourage individuals to be wiser consumers, since they are responsible for the cost of health care below the deductibles.

An HSA and HDHP Strategy Is the Wrong Solution for Uninsured Women and Families

Proponents of HSAs and HDHPs maintain that they will increase the efficiency of the health care system and reduce the growth of health care costs. Since HDHP premiums are typically lower than those of traditional coverage, supporters also claim that consumer-directed health plans will be more affordable for the uninsured.[1,2] The goals behind this approach may have merit, but in practice HSA/HDHP arrangements do not improve or expand access to health care for uninsured women and families.

HSA and HDHP arrangements require levels of cost-sharing that are not affordable for lower-income women and their families. Women generally have lower incomes than men and they typically need and use more health services.[3] For health coverage to be accessible and usable for women, it must be affordable. Premiums for HDHPs may be lower than those for traditional coverage, but they account for just a fraction of the cost of insurance and are invariably counteracted by higher deductibles and other forms of enrollee cost-sharing.

As its name implies, an HDHP includes a deductible that is higher than those of traditional health insurance plans. To open an HSA in 2008, individuals must be enrolled in an HDHP with an annual deductible of at least $1,100 for an individual or $2,200 for a family, but policies sold in the insurance market tend to have even higher deductibles than the regulations specify.[4] The health plan will not begin to pay insurance claims until plan enrollees have paid out-of-pocket for health care charges up to the deductible amount. Some HDHPs have two separate deductibles depending on whether care is sought from an in-network or out-of-network provider, making overall deductible spending even higher for women who must see a provider who is not in their plan's network. Even after high deductibles are met, HSA-qualified health insurance policies often require additional out-of-pocket spending in

the form of co-payments and coinsurance, up to a maximum of $5,600 for an individual or $11,200 for family coverage (2008 guidelines).

Women—who are more likely than men to have greater-than-average health care needs—are at increased financial risk with an HSA and HDHP. Women are more likely than men to have a chronic condition that requires ongoing treatment, and even healthy women use more health care services than men.[5] If health insurance is to be beneficial for women, it must cover the services that they need without exposing them to significant financial risk.

However, those who need the most health care—including women with disabilities and chronic conditions—are most likely to struggle to meet increased cost-sharing requirements of HDHPs. These individuals often experience higher medical costs and are more likely to spend amounts up to their deductible each year.[6] Healthy people with very low medical expenses, on the other hand, may benefit from an HSA arrangement since their HDHP premiums are lower than those required under traditional insurance plans and they pay trivial out-of-pocket amounts.

HSAs and HDHPs provide an incentive for women to use less cost-effective and preventive care. HSA and HDHP arrangements have implications for women's preventive health service use. Because HDHPs shift more costs to the plan enrollee, they provide an incentive to use less (and therefore spend less on) health care services. HSA guidelines do permit certain preventive services to be exempt from the deductible, but this is voluntary for insurers. For example, prescription drugs—even those that serve a preventive rather than a treatment purpose—are generally not exempt from a deductible.[7]

The majority of American women use a form of contraception that can only be accessed with a prescription. Under most HDHPs, they would be responsible for the full cost of their birth control.[8] This presents an affordability-related barrier to family planning, especially for lower-income women. Participating in an HSA/HDHP could have a negative impact on women's health if they delay or go without necessary care because they cannot afford to meet the high deductible.

HDHPs have unique implications for women's health services, particularly maternity care. HSA-qualified health plans have specific consequences for maternity care, one of the most common and costly medical interventions that women of reproductive age will experience. Pregnant women enrolled in an HDHP might be exposed to high out-of-pocket costs, particularly when complications arise. Many HDHP policies available on the individual insurance market exclude coverage for maternity care altogether, so that expenses for these services would not even count towards the deductible.

For plans that do cover maternity care, prenatal visits are typically subject to an HSA-qualified deductible (unlike other preventive services such as well-child care), which might keep some women from obtaining timely prenatal care. Nine-month pregnancies tend to span two insurance plan contract years and so may be subject to two annual deductibles, compounding the affordability issue. A 2007 study demonstrated the range of out-of-pocket maternity care costs that women could face under several different HSA/HDHP options—from a low of $3,000 for an uncomplicated pregnancy with vaginal delivery to a high of $21,194 for a complicated pregnancy with a Cesarean section delivery.[9]

Lower-income women will not benefit from the tax advantages of HSAs. Most lower-income women and families do not face high enough tax liability to benefit in any significant way from the HSA tax advantages. Deposits to an HSA account reduce a participant's taxable income by the amount of the contribution; since tax rates increase as income increases, the deduction is a better deal for the more affluent.

Reports on the income level of HSA account holders support this notion; nonelderly tax filers who reported HSA activity in 2005 had an average adjusted gross income of about $139,000, compared to about $57,000 for other filers.[10] Furthermore, though HSAs were designed to be used as a tax-saving method to accumulate funds for health care expenses, some evidence suggests that these accounts are more often being used as tax shelters by higher-income individuals.[11]

LESSONS FROM THE STATES:

Indiana Experiments with a 'Health Savings Account'-Type Product for Medicaid Enrollees

In late 2007, Indiana received federal approval for a new Medicaid health coverage program called the Healthy Indiana Plan (HIP). The program, which is the first of its kind, provides very low-income uninsured adults—those with incomes between 22 percent and 200 percent of the federal poverty level—with a health insurance product that mimics an HSA/HDHP arrangement. HIP members are required to pay between 2 and 5 percent of their annual income into a savings account. The state makes up the difference so that the total yearly contribution into the account is $1100; this contribution distinguishes HIP from a typical employer-sponsored HSA/HDHP arrangement, as employer HSA contributions are optional.

Insurance coverage does not begin until a HIP member has spent down the account, though some preventive services are covered separately. The target population is a very low-income group and the costs to participate in HIP are high enough to question affordability—someone making about $15,000 a year, for example, would be required to pay around $50 a month for the program. Penalties for nonpayment are steep: members are booted from the program for a full year if they miss a payment by more than 60 days.

By late March 2008, HIP had enrolled just over 3,000 applicants, and roughly two-thirds of these enrollees have been women.[12] While it is still too early to know whether and how HIP has impacted access to health care for Indiana's poorest women, there are several reasons to watch this state experiment closely. Key questions include: Will low-income women be able to afford the required contributions? Will the HSA/HDHP-like arrangement discourage women from seeking necessary and cost-effective medical care? Since enrollment in HIP is capped, what will happen when a pregnant woman (who must transition from HIP to traditional Medicaid for the course of her pregnancy) wants to get back onto the program postpartum? And most importantly, will HIP actually expand quality health insurance to those who need it most?

An HSA and HDHP Strategy Is the Wrong Solution for America's Health Care Crisis

In addition to the problems that HSA arrangements pose for women and families, this strategy is unlikely to deliver on its promise to help solve America's health care crisis.

HSAs and HDHPs will do little to curb the rising costs of health care. Most of America's health care costs are incurred by only a small percentage of very sick or injured individuals, whose treatment costs exceed HDHP deductibles (and are therefore still paid for by the health plans).[13] Simply put, HSA and HDHP arrangements will not contain those high-end expenditures.

Additionally, if consumer-directed plans disproportionately attract healthier and wealthier individuals—as research demonstrates they have done—sicker and poorer Americans will be concentrated in traditional, comprehensive insurance plans.[14] This divides the pool of insured people so that risk (or cost) is no longer spread between those with high and low medical expenditures, and premiums for those in traditional plans will be driven even higher as a result.

An HSA and HDHP strategy is also unlikely to reduce the number of uninsured Americans. In 2006, nearly two-thirds of the nonelderly uninsured were poor or near-poor, with incomes at or below 200 percent of the federal poverty level ($40,000 for a family of four in that year).[15] These lower-income families are unlikely to have the resources to participate in a health plan with high levels of cost-sharing; less than half of all households with at least one uninsured member have sufficient assets to meet the minimum HSA-related deductible.[16]

Moreover, since many lower-income families earn too little to have any tax liability, coverage proposals which rely on tax deductions— such as the HSA initiative—will provide little or no benefit to low-income people who are uninsured. Indeed, recent surveys of HSA-qualified health plan enrollees demonstrate that adults in these plans are no more likely to have been uninsured prior to enrollment than those enrolled in traditional coverage plans.[17]

What Can Advocates Do?

Advocates can demonstrate why HSAs and HDHPs are not the answer to the nation's health care crisis.

Women and their families face greater financial risk with HSAs and HDHPs than they do under traditional insurance plans, and so it is important to understand both the limits of coverage and the financial and other responsibilities placed on enrollees. Financially-concerned HSA enrollees might forgo necessary health care and those with higher-than-average medical expenditures—including women—may take on significant financial risk. Contrary to the claims of its proponents, consumer-directed health care will not lead to reductions in the uninsured or in America's overall health care costs.

For reading information, see:

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Women and Individual Mandates

Health care reform plans may include an "individual mandate," or a requirement that individuals obtain acceptable health insurance.[1] Some policymakers and health economists believe that an individual mandate is necessary to achieve universal coverage, whereby all residents in a state or nation have health insurance.[2] Though various state and federal proposals for health reform have included an individual mandate, to date, only Massachusetts has enacted a health reform plan with this feature.

While proposals that include an individual mandate will increase the number of people with health coverage, women's advocates should approach this type of health reform with some caution. Unless and until an individual mandate policy is combined with reforms that make comprehensive health insurance more available and affordable, a requirement to obtain coverage will do little to benefit—and may even unfairly penalize—some women and their families.

What Is an Individual Mandate?

An individual mandate requires all residents within a state or nation to obtain health insurance coverage at least to the minimum benefit level set by the mandate. Typically, those who fail to buy insurance must pay a penalty unless they have arranged for a special exemption from the requirement.

An individual mandate attempts to correct the problem of "adverse selection" in health insurance markets; that is, if low-risk, healthy individuals choose not to buy insurance, that leaves an insured group of high-risk, sicker individuals with more expensive health care costs. The smaller an insured group, the fewer people among whom to spread the costs. When health insurance is required for all, costs are spread across a larger number of people and low-risk individuals help share the burden of insuring high-risk individuals.

Why Should Women's Advocates Approach an Individual Mandate Policy With Some Caution?

Proponents of individual mandates reason that obtaining coverage must be a requirement because otherwise, some (healthy) people will forgo purchasing insurance until they are sick enough to need it, making coverage more unaffordable for everyone. But opponents of this type of reform counter that individual mandates—and their associated penalties—will harm residents who cannot find or afford health coverage that fits their needs. At a minimum, individual mandate policies must adhere to principles of affordability, adequacy, and availability.

An individual mandate should not require women to spend more than they can afford on health insurance. Many cost-related barriers exist in the current health care system—especially for women. Compared to men, women have more trouble affording health care since they are generally poorer and they need and use more health services.[3] Health reform plans must establish mechanisms to ensure the affordability of health insurance before imposing any requirement to purchase coverage under an individual mandate. These mechanisms include tax credits for the purchase of health insurance,[4] annual limits on the amount an individual spends on healthcare costs (including premiums and all other forms

of out-of-pocket spending), and government subsidies for those whose healthcare spending exceeds the established limits.

An individual mandate reform should include exemptions for people who cannot find affordable coverage, and the exemptions themselves should be easy to apply for and obtain. However, while exemptions are necessary to avoid unfairly penalizing some individuals, they offer no solution to the underlying problems of affordability or uninsurance, since exempt residents will remain uninsured even after the reform has been implemented.

An individual mandate should not require women to purchase insurance that does not adequately meet their needs. To hold down costs, some women (especially those living in financially-strained households) might purchase policies for catastrophic health insurance coverage only, or obtain other types of coverage that do not adequately protect their health. While these kinds of policies may be less expensive, they do not cover many of the health services that women need on a regular basis, such as preventive care and immunizations, maternity care, chronic disease management, and family planning services. It is important that, as part of any mandate policy, an adequate standardized minimum benefit set is established. Individuals should only be required to buy coverage that will meet their needs and will not leave them "underinsured" (i.e. insured under a plan with unaffordable deductibles or very limited benefits that leaves women vulnerable to financial risk and unmet health needs). Moreover, public dollars should not be used to subsidize inadequate private insurance products.

An individual mandate should be combined with health reforms that will increase the availability of coverage for all women. Some women cannot obtain health insurance simply because there are no coverage options available to them. Women who are not eligible for public or employer-sponsored health insurance, for example, must look for coverage in the individual insurance market, where—in an overwhelming majority of states—it is legal for insurers to deny coverage to a woman with a pre-existing health condition or to sell her a policy that explicitly excludes coverage for the condition. Individual market insurers are also usually allowed to charge more for health premiums depending on a person's gender, age, health status, or occupation. Women seeking coverage in the individual market may not be able to find an insurer who is willing to offer them coverage, or they may be offered coverage that is cost-prohibitive. In many states, ensuring that virtually all residents can obtain adequate health insurance will likely require changes within the individual insurance market—such as adoption of guaranteed issue policies—to make sure that insurance companies are not allowed to deny coverage based on someone's health status or other factors.[5]

Reform plans can also establish new insurance options for people who are not eligible for public or employer-sponsored health coverage. This includes those who work part-time and are not offered employer fringe benefits—in 2005, nearly a quarter of all uninsured women worked part-time.[6] To create new coverage options for women, states may propose to merge the small group insurance market (where small businesses purchase coverage for their workers) with the individual insurance market, which spreads health care risks and costs among more people. Some states, such as Massachusetts, have also established new "Connector" entities to serve as a type of marketplace that makes it easier for individuals and small businesses to compare and purchase insurance policies.

From the Experts: Which Consumer Protections Are Necessary Under an Individual Mandate?

Policy analysts at Community Catalyst, a national health advocacy organization that has closely monitored the implementation of the Massachusetts individual mandate, released a report in early 2008 which details "Ten Ways to Make Individual Mandates Work for Consumers":

1. Establish a right to purchase insurance ("guaranteed issue").
2. Prohibit insurers from charging people different premiums based on factors such as health status ("community rating").
3. Encourage efficiency in health insurance.
4. Establish an affordability scale.
5. Create adequate subsidies to help people afford insurance.
6. Set minimum benefit standards to guard against underinsurance.
7. Protect lower income populations from harsh penalties.
8. Create a robust and easy-to-use waiver and appeals process.
9. Encourage equal responsibility by all stakeholders.
10. Consider a phased-in approach.

For more information about this set of recommendations, the report titled *A Guide to Protecting Consumers under an Individual Mandate* (March 2008, authored by Christine Barber and Michael Miller), is available on the Community Catalyst website at: www.communitycatalyst.org.

What Is "Shared Responsibility," and What Does an Individual Mandate Have to Do With It?

Reform proposals often include both an individual and an employer mandate[7] (a requirement that employers contribute to the cost of workers' health care) along with efforts to expand publicly-sponsored insurance options funded by the government. The term "shared responsibility" refers to these types of policy combinations, since employers, individuals, and the government all share the duty of providing or obtaining health coverage; each plays a significant role in increasing the number of people with health insurance.

If implemented together with sufficient safeguards, employer and individual mandates can result in a major reduction in the number of uninsured people. Alone, however, each type of mandate presents a problem in achieving universal coverage:

- An individual mandate places responsibility for obtaining coverage on an individual. It does not address whether health insurance is available to that individual or whether the coverage is affordable. If employer participation in the health insurance marketplace is not also mandatory and the cost of coverage continues to grow, employers will continue to shift the burden of cost increases to their workers or could decide to forgo offering employee health benefits altogether. This would make it more difficult for individuals to meet the mandatory insurance coverage requirement, since fewer workers would be able to obtain affordable coverage through their jobs and more individuals would bear the entire cost of their coverage.
- Without additional reforms, an employer mandate has the potential to leave many individuals uninsured, such as non-workers, workers who are eligible for employer plans but choose not to enroll, workers who do not fulfill the minimum "full-time" requirements, and employees at small or low-revenue firms that may be exempt from

the mandate. This point is particularly relevant for women, since they are more likely to be among those potentially "left-out" of an employer mandate; when compared to men, women are more likely to be non-workers or to work part-time (i.e. fewer than 35 hours per week),[8] and they also hold the majority of low-wage jobs.[9]

Moreover, while an employer mandate may exempt small and low-revenue businesses from compliance, it does not address the challenges these firms face in finding affordable health coverage for their workers; in 2007 nearly three-quarters of small firms that did not offer employee health benefits cited high premiums as a "very important" reason for not doing so.[10]

Additionally, for individual and employer mandate reforms to be successful, they must be appropriately enforced. Governments must set up efficient systems for determining whether individuals and employers are in compliance with the mandate and there must be appropriate penalties for those who do not comply. The goals of shared responsibility will never be met if mandates are not properly enforced.

Lessons from the States:

Massachusetts Adopts an Individual Mandate as Part of a Comprehensive Health Reform Plan

Massachusetts enacted health reform in April 2006 which included shared responsibility between the Massachusetts government, employers, and individuals. In addition to expansions of public programs and premium subsidies for low-income families, the state adopted an individual mandate that required all adults in the state to purchase a minimum level of health insurance by the end of 2007. Residents may be exempt if they can demonstrate that they cannot afford coverage. Those who failed to obtain health insurance by the deadline lost their personal income tax exemption (about $217 for an individual or $437 for a family in 2007[11]).

The verdict is not in on how the 2006 Massachusetts health reforms are impacting women and their families. Although health insurance coverage rates are increasing (as of March 2008, over 350,000 of the estimated 450,000 uninsured had obtained health care coverage[12]), over 60,000 people have received exemptions from the individual mandate.[13] These individuals remain uninsured and are presumably not getting the health care that they need. An additional 86,000 uninsured residents were deemed "able to afford" coverage but elected to pay the penalty (i.e. forgo their personal tax exemption) instead—it is not clear whether those people had problems accessing health insurance due to affordability or whether they will be any more willing to purchase insurance in subsequent years. During the reform plan's first year, it was widely acknowledged that paying the penalty cost less than purchasing health coverage; state officials have raised the penalty for 2008, which may prompt more people to purchase coverage.

What Can Women's Advocates Do to Ensure That Individual Mandates Work for Women?

Women's advocates can make certain that before any individual mandate is adopted, there are adequate consumer protections in place to ensure affordability, availability, and adequacy of health coverage.

The individual mandate policy alone does not address whether health insurance is available to women or whether the coverage is affordable. To truly improve women's access to health care, individual mandate policies must adhere to principles of affordability, adequacy, and availability.

Women's advocates can insist that an individual mandate policy include a simplified process for obtaining an exemption from the mandate when appropriate.
An individual mandate reform should include exemptions for people who cannot find affordable coverage. Exemptions are necessary to avoid unfairly penalizing some individuals.

Women's advocates can promote concepts of "Shared Responsibility" between government, employers, and individuals.
Health reform plans that require these three entities to share the duty of providing or obtaining health coverage build on the existing system of health financing.

For further reading, see:

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4 See: "Women, Tax Policy, and Health Reform" section of the *Reform Matters Toolkit* for further discussion on tax credits.

5 See: "Women and the Individual Health Insurance Market" section of the *Reform Matters Toolkit* for further discussion.

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Women and Employer Mandates

Some health care reform proposals include an "employer mandate," which typically requires an employer of a certain size and/or with certain annual business revenue to contribute towards the health care of its employees.[1] Several states are currently considering health reform plans with an employer mandate and a number of federal proposals have also included this type of reform, but so far just three states—Hawaii, Massachusetts, and Vermont—and the city of San Francisco have enacted a policy requiring employers to pay for a portion of workers' health care costs.

What Is an Employer Mandate?

An employer mandate is a requirement that employers contribute to the cost of health insurance coverage for their employees. Employer mandates usually follow a "Pay or Play" design, which requires employers to either directly offer insurance to employees (Play) or contribute to a public fund to help cover the uninsured (Pay).[2] Employer-sponsored health insurance (ESI) is the leading source of coverage for non-elderly Americans, but the percentage of employers offering ESI to their workers is in decline; in 2000, 69 percent of employers offered health benefits, but in 2007, the portion had dropped to 60 percent.[3] Employer mandates also ensure that employers who provide health insurance for their workers do not suffer a competitive disadvantage for doing so.

What Challenges Are Associated with an Employer Mandate?

Employer mandates may generate strong opposition from businesses. It is likely that employers will organize to oppose employer mandates, since this type of reform will involve new expenses for firms that do not currently contribute anything towards the cost of their worker's health care. Indeed, business groups have presented major obstacles in states that have unsuccessfully considered "Pay or Play" policies in the past (such as California and Maryland) and some employer groups were strongly opposed to the failed national reform effort (which incorporated an employer mandate) of the early 1990's. Notably, Massachusetts legislators were able to pass a comprehensive health reform plan with the employer mandate intact and with the support of business groups. Many believe, however, that this support hinged on a relatively low (and inadequate) employer contribution requirement, since the annual employer assessment of $295 per uninsured employee is far lower than the annual costs of a worker's health coverage.

Employer mandates may unfairly penalize small businesses. Compared to large firms, small businesses are increasingly less likely to provide health benefits for their employees, largely due to cost.[4] This is particularly relevant for women, as small businesses that do not offer health benefits are more likely to have a larger proportion of female workers.[5] Most small businesses lack the purchasing power of larger employers. Reforms are necessary to ensure that small business owners have the ability to purchase quality, affordable coverage for their employees and that lower-revenue firms (which often employ low-wage workers) receive subsidies that make health insurance more affordable. In the absence of these changes, however, employer mandate policies must provide exemptions for these types of businesses so they are not unfairly penalized.

Employee Retirement Income Security Act (ERISA) may cause problems for employer mandates. A federal law known as the Employee Retirement Income Security Act of 1974 (ERISA) was enacted to make it easier for multi-state employers to administer employee benefits uniformly across states, but the legislation can also restrict states' abilities to establish "Pay or Play" employer mandates. Court challenges continue to define ERISA's limits for states pursuing health reform plans that include an employer mandate (see text box).

The *Healthy San Francisco* Program: Employer Mandates and the Employee Retirement Income Security Act (ERISA)

In 2006, San Francisco created the *Healthy San Francisco* program with the goal of providing health care services to all uninsured residents. The program is not a health insurance program; it connects uninsured adults to a medical home that provides them with basic medical care, with an emphasis on preventive care and the management of chronic conditions. The program also imposes an employer mandate by requiring that certain employers in the city spend a minimum amount on healthcare per worker per hour (in 2008, this is between $1.17 and $1.76). Employers can comply with the requirement by directly paying for health care services, providing health insurance, funding health savings accounts, or by paying a fee to the city to help fund the *Healthy San Francisco* program.

The employer mandate was challenged by a group of employers in 2006 on the premise that it violated the federal ERISA law, which effectively limits a state's ability to regulate the benefits that employers offer to workers. In September 2008, however, a three-judge panel of the Ninth Circuit Court of Appeals upheld the *Healthy San Francisco* employer mandate. In its ruling, the Ninth Circuit distinguished its decision from a 2006 ruling by the Fourth Circuit Court of Appeals. In that case, the Fourth Circuit struck down the "Maryland Fair Share Health Care" law, which would have required certain large employers to either contribute to employee health benefits or pay directly into the state's health program for the poor, ruling that the law violated ERISA. Given the likelihood of an appeal to the 2008 *Healthy San Francisco* decision, the United States Supreme Court may ultimately decide the question of what state or local governments can and cannot do with regard to requiring employers to contribute to their workers' health care.

What Is "Shared Responsibility" and What Does an Employer Mandate Have to Do with It?

Reform proposals often include both an employer and an individual mandate[6] (a requirement that individuals obtain acceptable health insurance) along with efforts to expand publicly-sponsored insurance options funded by the government. The term "shared responsibility" refers to these types of policy combinations, since employers, individuals, and the government all share the duty of providing or obtaining health coverage; each plays a significant role in increasing the number of people with health insurance.

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- An individual mandate places responsibility for obtaining coverage on an individual. It does not address whether health insurance is available to that individual or whether the coverage is affordable. If employer participation in the health insurance marketplace

is not also mandatory and the costs of coverage continues to grow, employers will continue to shift the burden of cost increases to their workers or could decide to forgo offering employee health benefits altogether. This would make it more difficult for individuals to meet the mandatory insurance coverage requirement, since fewer workers would be able to obtain affordable coverage through their jobs and more individuals would bear the entire cost of their coverage.

- An employer mandate alone has the potential to leave many individuals uninsured, such as non-workers, workers who are eligible for employer plans but choose not to enroll, workers who do not fulfill the minimum "full-time" requirements, and employees at small or low-revenue firms that may be exempt from the mandate. This point is particularly relevant for women, since they are more likely to be among those potentially "left-out" of an employer mandate; when compared to men, women are more likely to be non-workers or to work part-time (i.e. fewer than 35 hours per week),[7] and they also hold the majority of low-wage jobs.[8] Moreover, while an employer mandate may exempt small and low-revenue firms from compliance, it does not address the challenges these firms face in finding affordable health coverage for their workers; in 2007 nearly three-quarters of small firms that did not offer employee health benefits cited high premiums as a "very important" reason for not doing so.[9]

Lessons from the States:

Massachusetts Adopts an Employer Mandate as Part of a Comprehensive Health Reform Plan

Massachusetts enacted health reform in April 2006 which included shared responsibility between the Massachusetts government, employers, and individuals. In addition to expansions of public programs and premium subsidies for low-income families, the state adopted a "Pay-or-Play"-style employer mandate. The policy requires employers with 11 or more employees who do not contribute a "fair and reasonable" amount towards employee health benefits to pay the state a "Fair Share Contribution" of $295 per year for each full-time worker. For 2008, "fair and reasonable" is defined as having 25 percent of full-time employees enrolled in an employer-sponsored insurance plan, or contributing at least 33 percent towards employee premiums. Employers with 10 or fewer workers are exempt.

It is unclear whether the employer mandate has had any significant impact on expanding coverage in Massachusetts. Although health insurance coverage rates are increasing (as of March 2008, over 350,000 of the estimated 450,000 uninsured had obtained health care coverage[10]), over 60,000 people have received exemptions from the individual mandate.[11] These individuals remain uninsured and are presumably not getting the health care that they need. If the state had more money, it could provide higher subsidies to help these exempt (and currently uninsured) people better afford coverage.

The current required employer contribution of $295 per employee per year is viewed by many as inadequate because it is considerably less than the cost of employee health benefits; a more substantial employer contribution would mean increased revenue to finance reform efforts, and may even prompt more firms to offer coverage to their workers directly. In 2007, Massachusetts spent $636 million to provide health care coverage to employees of large companies that did not offer health benefits.[12]

Additionally, for individual and employer mandate reforms to be successful, governments must establish systems for assessing whether the target group is in compliance with the mandate and institute appropriate penalties for those who do not comply. Neither type of mandate will achieve its goal if it is not appropriately enforced.

What Can Women's Advocates Do to Ensure That Employer Mandates Work for Women?

Women's advocates can promote concepts of "Shared Responsibility" between government, employers, and individuals.
Health reform plans that require these three entitities to share the duty of providing or obtaining health coverage build on the existing system of health financing.

Women's advocates can promote policies that improve access to affordable and comprehensive coverage for small and low-revenue businesses.
Small businesses lack the purchasing power of their larger counterparts and health insurance is often prohibitively expensive. Advocates should promote policies that would help businesses with a very small number of workers, those with low revenue, and those that employ a large percentage of low-wage workers purchase high-quality and affordable health insurance for their employees.

Women's advocates can insist that an employer mandate policy include a simplified process for obtaining an exemption from the mandate when appropriate.
In the absence of changes to ensure that small business owners have the ability to purchase quality, affordable coverage, employer mandate policies must not require small and low-revenue businesses to offer health insurance that they cannot afford.

Women's advocates can support employer contributions that are adequate.
Significant funding may be required for health reform initiatives that extend coverage to previously uninsured people or that improve the quality and efficiency of health care. Employer contributions generate funding for these initiatives and play an important role in making (and keeping) a health reform plan financially sustainable; inadequate contribution requirements can threaten the viability of health reform plans.

For further reading, see:

Patricia A. Butler, California HealthCare Foundation, *Fact Sheet: ERISA Implications for State "Pay or Play" Laws* (July 2007), http://calhealthreform.org/pdf/ERISAfactsheetButlerP.pdf.

Kaiser Family Foundation, *Fact Sheet: Healthy San Francisco* (March 2008), http://www.kff.org/uninsured/upload/7760.pdf.

Community Catalyst and Families USA, *The Consumer Guide to State Health Reform: Pay-or-Play Worksheet*, http://www.communitycatalyst.org/projects/schap/links?id=0049 (last visited Jul. 16, 2008).

References

1 Mandate is a commonly-used word in the debate about health care reform. It is important to note the difference between a mandate to purchase or offer health insurance (the individual and employer mandates) and a mandate that requires health insurers to provide specific benefits to policyholders ("mandated benefits"). See: "Mandated Insurance Benefits: Important Health Protections for Women and Their Families" section of the *Reform Matters Toolkit* for detailed information on mandated benefits.

2 Reform plans might also require that, at a minimum, employers offer their workers the option to establish a Section 125 plan (also known as a "cafeteria plan") to purchase health insurance with pre-tax dollars.

3 The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Summary of Findings* (2007), http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf.

4 The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey* (2007), http://www.kff.org/insurance/7672/upload/76723.pdf.

5 Paul Fronstin et al., Employee Benefit Research Institute, *Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey* (Jan. 2003), http://www.ebri.org/pdf/briefspdf/0103ib.pdf.

6 See: "Mandated Insurance Benefits: Important Health Protections for Women and Their Families" section of the *Reform Matters Toolkit* for detailed information on mandated benefits.

7 In 2006, about 25 percent of employed women were part-time workers, compared with 11 percent of employed men. See: US Department of Labor, Bureau of Labor Statistics, *Charting the US Labor Market in 2006* (Sep. 28, 2007), http://www.bls.gov/cps/labor2006/.

8 Marlene Kim, *Women Paid Low Wages: Who They Are and Where They Work*, Monthly Labor Review Online, 123 (9): (Sept. 2000), http://www.bls.gov/opub/mlr/2000/09/art3exc.htm.

9 *Employee Health Benefits*, *supra* note 4.

10 The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *States Moving Toward Comprehensive Health Care Reform* (Apr. 3, 2008), http://www.kff.org/uninsured/statehealthreform/ma.cfm.

11 Massachusetts Department of Revenue, *Preliminary Data on the Individual Mandate, Tax Year 2007* (as of June 2, 2008), http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/HC_Data_Report_FINAL.pdf.

12 Executive Office of Health and Human Services, Division of Health Care Finance and Policy, *Employers Who Had Fifty or More Employees Using MassHealth, Commonwealth Care, or the Uncompensated Care Pool in State FY07* (May 2008), http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/50_plus_employees_05-08.pdf.

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April 2007

Issue Brief

Women and Health Coverage: The Affordability Gap

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ABSTRACT: Although men and women have some similar challenges with regard to health insurance, women face unique barriers to becoming insured. More significantly, women have greater difficulty affording health care services even once they are insured. On average, women have lower incomes than men and therefore have greater difficulty paying premiums. Women also are less likely than men to have coverage through their own employer and more likely to obtain coverage through their spouses; are more likely than men to have higher out-of-pocket health care expenses; and use more health care services than men and consequently are in greater need of comprehensive coverage. Proposals for improving health policy need to address these disparities.

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Introduction

While lack of insurance is a major barrier to health care, having just any insurance does not guarantee access to affordable and comprehensive health care. In addition to the 44.8 million Americans without health coverage, there are an estimated 16 million more adults who, because of high out-of-pocket costs relative to their income, can be considered "underinsured."[1] Although men and women are at similar risk of not having health insurance, women—whether insured or uninsured—are more likely to report cost-related access problems. These problems can be attributed directly to women's lower average incomes compared with men and to their greater need for, and use of, health care services.

This issue brief examines the unique difficulties women encounter in obtaining and paying for health care. The data cited come primarily

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from three surveys: the Annual Social and Economic Supplement to the Current Population Survey (CPS), 2005; the Medical Expenditure Panel Survey (MEPS), 2004; and the Commonwealth Fund Biennial Health Insurance Survey, 2005 (see Study Methods box on page 10). In a companion report available from the National Women's Law Center, *Women and Health Coverage: A Framework for Moving Forward*,[2] the authors analyze various policy approaches to determine those that will best serve women's needs.

Insurance Coverage Patterns

Currently, health insurance coverage patterns are similar for adult men and women (ages 19–64) in a number of ways, though important differences do exist. About two-thirds of nonelderly adults, or some 113 million people, are covered by employer-sponsored insurance. Another 10.3 million people (among whom women slightly outnumber men) purchase their health coverage through the individual insurance market; and 8.3 million men and women are insured through Medicare, military health coverage, or other sources. Medicaid insures nearly twice as many women as it does men (6.1 million vs. 3.5 million).[3]

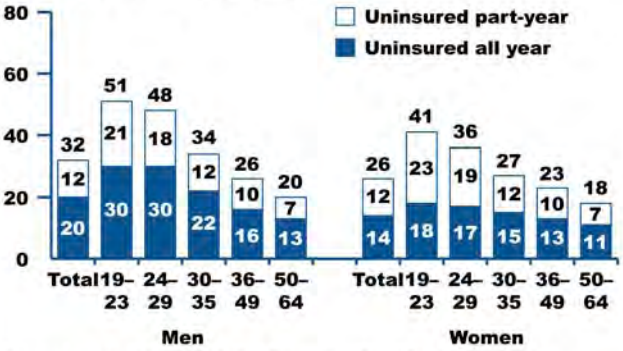
Although health insurance coverage is vital for timely and meaningful access to health care, 44.8 million Americans, including children, currently lack such coverage. Uninsured men and women are more likely to be younger, be single, have a low-income, work in small businesses, and belong to a racial or ethnic minority than those who are insured (Table 1, p. 8).

In order to investigate the extent to which insured and uninsured women are accessing needed health care, it is important to tease out their patterns of health coverage.

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 millions more people are uninsured for months at a time. When examined over a two-year period, the data reveal that a total of about 80 million people are uninsured for all or part of that time.[4] For women, being uninsured part of the year is almost as common as being uninsured all year: 12 percent of women are uninsured for part of the year, while 14 percent of women are uninsured all year (Figure 1). Younger women and men are the most likely to be uninsured for part of the year.

Figure 1. Younger Women Are Most Likely to Be Uninsured Part-Year



Source: Analysis of the 2004 Medical Expenditure Panel Survey by S. Glied and B. Mahato for The Commonwealth Fund.

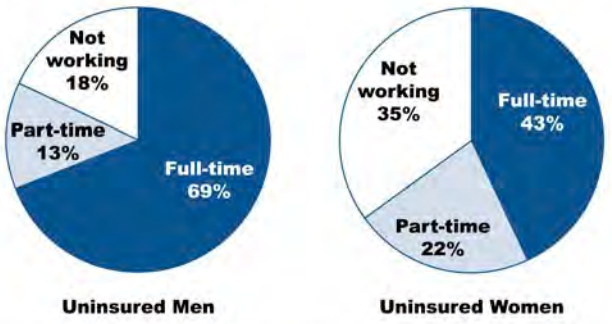
Women have less access to employer-sponsored insurance because they are less likely to be employed and more likely to work part-time.

Individuals who are not employed or who work part-time are more likely to be uninsured; the uninsurance rate for those who are not working is 26 percent, while it is 18 percent for full-time workers (Table 1, p. 8). The employment status of uninsured women differs from that of men. Thirty-five percent of uninsured women do not work, compared with only 18 percent of uninsured men (Figure 2). When uninsured women do

work, they are more likely to work part-time than are uninsured men. While all part-time workers are less likely to be insured, only 13 percent of uninsured men work part-time while 22 percent of uninsured women work part-time.

Figure 2. Uninsured Women Are Less Likely to Work Full-Time Than Uninsured Men

Distribution of uninsured adults ages 19–64 by work status



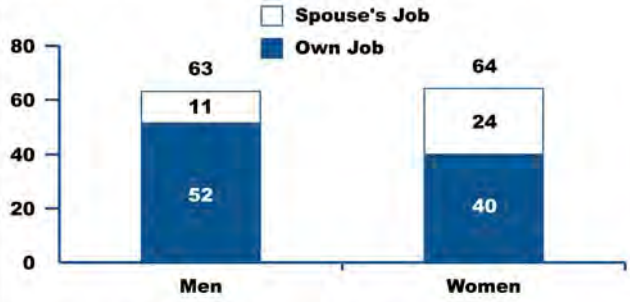
Source: Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

Women are more likely to depend on their spouses for insurance and therefore face more instability in their coverage.

Women are more than twice as likely as men to get employer-sponsored insurance through their spouses. Twenty-four percent of women are insured through their spouse's job, compared with only 11 percent of men (Figure 3). Though it is beneficial that women have the option to get coverage through their spouses, such insurance (known as dependent coverage) is a less stable form of coverage. A dependent must rely not only on her spouse staying in the job but also on the continuation of the marriage and the employer's willingness to cover dependents. Recently, in an effort to contain their health care costs, employers have actually

Figure 3. Women Are More Likely to Have Employer-Sponsored Insurance Through Their Spouses

Percent of adults ages 19–64 by insurance source



Source: Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

been cutting back on dependent coverage. In fact, between 2001 and 2005, employers dropping such coverage accounted for 11 percent of the decline in employer-sponsored insurance overall.[5]

Older adults are particularly at risk. Among adults ages 50 to 64, there are 3.5 million uninsured women and 3.1 million uninsured men (Table 1, p. 8). Women are more likely to be married to an older spouse, which places them at risk of losing dependent coverage when their spouse becomes eligible for Medicare.[6] Women without coverage through their own employers who lose their spouse's coverage may be forced to turn to the individual market for their insurance, which is especially costly for those with health issues—not uncommon among women in the 50-to-64 age group.[7]

A small percentage of women purchase individual health insurance, which is more expensive to secure.

Only about 10.3 million adults, or 6 percent of nonelderly adults (ages 19–64), get insurance through the individual market.[8] According to one survey, roughly 58 million adults over a three-year period considered buying coverage in the individual market, yet close to 90 percent of them never purchased a plan.[9]

Slightly more women than men (5.4 million vs. 4.9 million) purchase insurance in the individual market.[10] Women with individual coverage have higher incomes (76% of women purchasing individual coverage are at 200 percent of the federal poverty level or higher), and are older (55% are ages 45–65).[11] More than one-third (35%) are unemployed.[12]

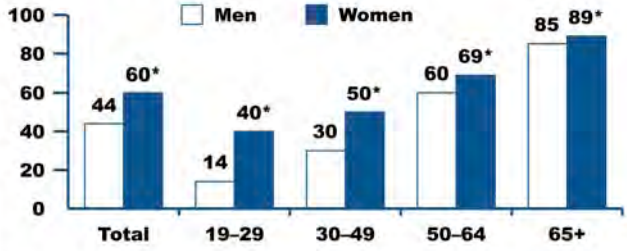
Women covered by individual health insurance are also relatively healthy: 88 percent report excellent, very good, or good health, while only 12 percent report they are in fair or poor health.[13] These findings suggest that women who have a greater need for health insurance face barriers in purchasing individual insurance coverage because they can be denied coverage altogether—for example, because of a preexisting condition—or charged unaffordably high rates.

Women Face Difficulty in Affording Health Services

Women are more likely to have lower incomes than men. Women are somewhat more likely to be poor. Seventeen percent of women ages 19 to 64 are below 100 percent of the federal poverty level, compared with 13 percent of men in that age group; poverty rates for younger women are even greater.[14] In terms of earnings, in 2004 the median earnings of female workers age 15 and over were $22,224, compared with $32,486 for men. Among full-time workers, women earn only 76.5 cents for every dollar that men earn.[15]

On average, women use more health care services. Women are more likely than men to need health care throughout their lifetimes. Women's reproductive health needs require them to get regular check-ups, whether or not they have children, and women of all ages are more likely than men—60 percent versus 44 percent—to take prescription medications on a regular basis (Figure 4). For younger women, this difference is even greater; women ages 19 to 29 use prescription drugs at almost three times the rate of men in that age group. Further, women are more likely than men to have a chronic condition requiring ongoing treatment (38% vs. 30%).[16] Finally, certain mental health problems, including anxiety and depression, affect twice as many women as men.[17]

Figure 4. Women Under Age 65 Are More Likely Than Men to Take Prescription Medicines on a Regular Basis

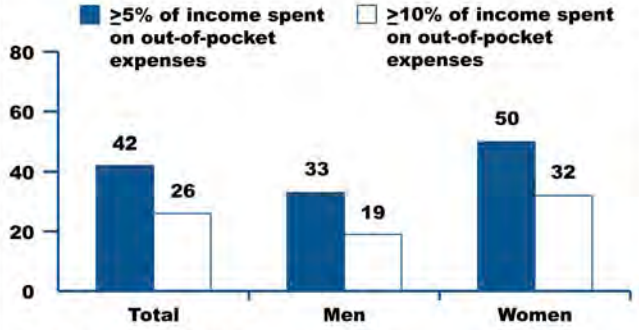


* Difference between men and women is significant at $p \leq 0.05$ or better.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Women have higher out-of-pocket costs than men as a share of their income. About 12 percent of all insured individuals ages 19 to 64 are considered underinsured because they have high out-of-pocket costs relative to their income.[18] Because women's greater health care needs and rates of use, combined with their lower incomes, lead them to have higher out-of-pocket costs, more women than men are underinsured (16% vs. 9%). Women insured through employer-sponsored insurance or with an individual policy are more likely than men to spend more than 10 percent of their income on out-of-pocket costs and premiums (Figure 5).

Figure 5. Percent of Income Spent on Family Out-of-Pocket Costs and Premiums

Percent of adults ages 19–64 who are privately insured^



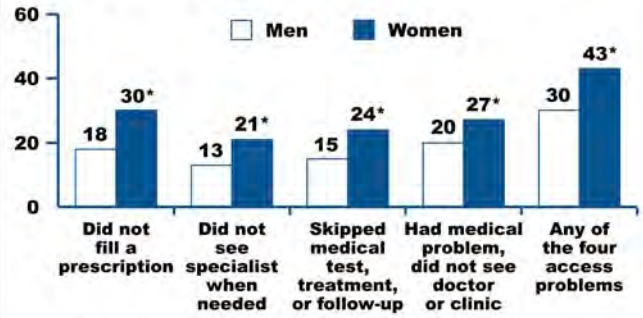
^ Employer-sponsored or individual insurance.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

higher rates with every problem as compared with men (Figure 7). Though women are more likely to face cost-related access barriers regardless of their age, the barriers are particularly dramatic for young women (ages 19–29) when compared with young men—50 percent versus 33 percent (data not shown). Ironically, even though young adult women are more likely to have insurance than young adult men, half of these women reported problems accessing health care because of cost in the past year.

Figure 7. Women Are More Likely Than Men to Have Access Problems in Past Year Because of Cost

Percent of adults ages 19–64 reporting the following problems in past year because of cost



* Difference between men and women is significant at $p \leq 0.05$ or better.

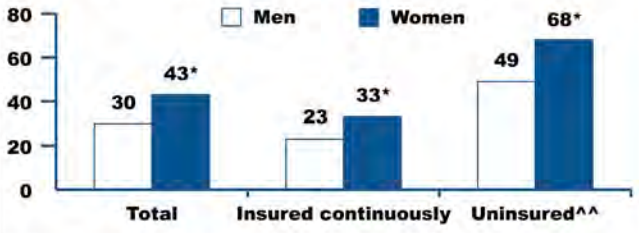
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

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%) (Figure 6). When asked which, if any, of four access problems were encountered in the past year, women reported

Figure 6. Women Are More Likely Than Men to Have Cost-Related Access Barriers

Percent of adults ages 19–64 who have difficulty accessing health care^



* Difference between men and women is significant at $p \leq 0.05$ or better.

^ Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.

^^ Uninsured combines currently uninsured and currently insured but had a time uninsured in the past 12 months.

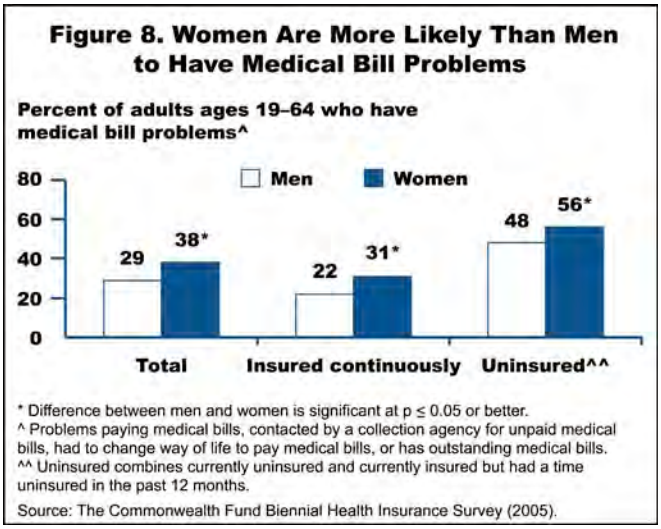
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Women are more likely to have medical bill and debt problems.

Whether they are insured or uninsured, women are also somewhat more likely than men to have problems paying for their care.Nearly two of five women (38%) report medical bill problems, compared with 29 percent of men (Figure 8).[19] Among the uninsured, 56 percent of women report difficulty paying bills. About one-quarter (26%) of women said they were not able to pay

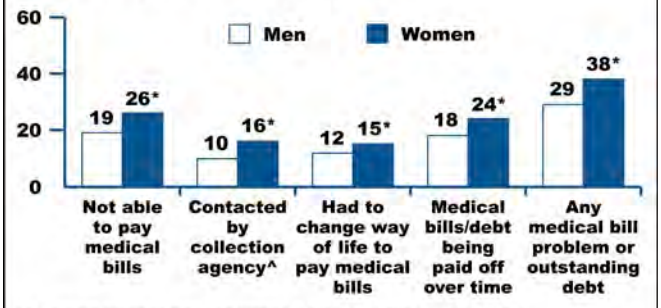
their medical bills (Figure 9). Adult women under age 50 have the greatest difficulty paying for care, possibly reflecting their responsibility both for their own medical care and that of their children (data not shown).

Figure 8. Women Are More Likely Than Men to Have Medical Bill Problems



* Difference between men and women is significant at p ≤ 0.05 or better.
^ Problems paying medical bills, contacted by a collection agency for unpaid medical bills, had to change way of life to pay medical bills, or has outstanding medical bills.
^^ Uninsured combines currently uninsured and currently insured but had a time uninsured in the past 12 months.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Figure 9. Medical Bill Problems in Past Year



* Difference between men and women is significant at p ≤ 0.05 or better.
^ Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Conclusion

Though the data suggest that men and women have some similar challenges with regard to health insurance, women face unique barriers to becoming insured. In particular, women are less likely to have coverage through their own employer and more likely to obtain coverage through their spouses as dependents. More significantly, women have greater difficulty affording health care services even once they are insured. Women are more likely to have lower incomes than men and therefore have greater difficulty paying premiums. They are more likely to use more health care and to have higher out-of-pocket health care expenses. The combination of lower incomes and higher out-of-pocket spending means that many women are more likely to spend greater than 10 percent of their income on health care expenditures and premiums. Given these factors, policy proposals that provide comprehensive benefits at affordable cost would help more women obtain meaningful coverage. Conversely, reforms that result in higher out-of-pocket expenses and limited benefits will not significantly improve the health and financial security of women.[20]

Notes

[1] C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302.

[2] E. M. Patchias and J. G. Waxman, *Women and Health Coverage: A Framework for Moving Forward* (Washington, D.C.: National Women's Law Center, Apr. 2007).

[3] Analysis of the March 2005 Current Population Survey, by S. Glied and B. Mahato, for The Commonwealth Fund.

[4] ERIU Research Highlight, Economic Research Initiative, available at http://www.umich.edu/~eriu/qa-fastfacts.html.

[5] Ibid.

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

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[10] Analysis of the March 2005 Current Population Survey, by S. Glied and B. Mahato, for The Commonwealth Fund.

[11] A. Salganicoff, U. R. Rangi, and R. Wyn, *Women and Health Care: A National Profile* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, July 2005).

[12] Ibid.

[13] Salganicoff et al., *Women and Health Care,* 2005.

[14] NWLC calculations from the Current Population Survey 2005 Annual Social and Economic Supplement, Table POV34.

[15] Current Population Survey 2004 Poverty Tables, http://pubdb3.census.gov/macro/032005/pov/toc.htm.

[16] Salganicoff et al., *Women and Health Care,* 2005.

[17] National Women's Law Center and Oregon Health and Science University, *Making the Grade on Women's Health: A National and State-by-State Report Card* (Washington, D.C.: NWLC, 2004).

[18] Specifically, "underinsured" is defined either as having medical expenses (excluding premiums) that represent 10 percent or more of income; medical expenses (excluding premiums) for low income (defined as being below 200 percent of the federal poverty level) that represent 5 percent or more of income; or a deductible that represents 5 percent or more of income. Schoen et al., "Insured But Not Protected," 2005.

[20] Medical-bill problems include difficulty paying medical bills, has been contacted by a collection agency for unpaid medical bills, has had to change his or her way of life to pay medical bills, or has outstanding medical bills.

[19] Patchias and Waxman, *Women and Health Coverage,* 2007.

Table 1. Comparison of Men and Women Ages 19–64, 2004

	Total				Men				Women			
	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)
Total in millions	178.1	36.5	36.5	36.5	87.8	19.7	19.7	19.7	90.3	16.7	16.7	16.7
Percent distribution	100%		20%	100%	100%		23%	100%	100%		19%	100%
Income (as a percent of poverty)												
<100%	15%	12.2	46%	33%	13%	6.0	53%	30%	17%	6.2	40%	37%
100%–199%	16%	10.0	35%	28%	16%	5.5	40%	28%	17%	4.6	30%	27%
200%+	69%	14.3	12%	39%	72%	8.3	13%	42%	66%	6.0	10%	36%
Race/Ethnicity												
White	68%	18.3	15%	50%	68%	9.8	16%	50%	68%	8.5	14%	51%
Black	12%	5.3	25%	15%	11%	2.7	28%	13%	13%	2.7	23%	16%
Hispanic	14%	10.3	42%	28%	15%	5.9	46%	30%	13%	4.4	37%	26%
Other	7%	2.6	22%	7%	6%	1.4	24%	7%	7%	1.2	20%	7%
Age												
19–23	11%	6.5	33%	18%	11%	3.6	36%	18%	11%	2.8	29%	17%
24–29	13%	7.2	30%	20%	14%	4.2	35%	21%	13%	3.0	26%	18%
30–35	14%	5.5	23%	15%	14%	3.1	26%	16%	13%	2.4	20%	14%
36–49	34%	10.7	18%	29%	34%	5.7	19%	29%	34%	5.0	16%	30%
50–64	28%	6.6	13%	18%	27%	3.1	13%	16%	28%	3.5	14%	21%
Family status												
Married with children	31%	7.5	14%	21%	30%	3.6	14%	18%	32%	3.8	13%	23%
Married w/o children	27%	7.2	15%	20%	27%	3.5	15%	18%	26%	3.6	15%	22%
Single with children	7%	3.1	24%	8%	4%	1.0	28%	5%	10%	2.1	23%	12%
Single w/o children	35%	18.7	30%	51%	39%	11.5	34%	58%	32%	7.2	25%	43%

Table 1. Comparison of Men and Women Ages 19–64, 2004 (continued)

	Total				Men				Women			
	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)
Total in millions	178.1	36.5	36.5	36.5	87.8	19.7	19.7	19.7	90.3	16.7	16.7	16.7
Percent distribution	100%		20%	100%	100%		23%	100%	100%		19%	100%
Work status												
Full-time	66%	20.9	18%	57%	78%	13.7	20%	69%	55%	7.2	14%	43%
Part-time	13%	6.1	26%	17%	8%	2.5	35%	13%	18%	3.6	22%	22%
Not working	20%	9.5	26%	26%	14%	3.6	29%	18%	26%	5.9	25%	35%
Firm size												
<25	24%	13.4	31%	37%	28%	8.7	35%	44%	20%	4.7	26%	28%
25–99	10%	3.5	20%	10%	11%	2.2	22%	11%	9%	1.4	17%	8%
100–499	10%	2.8	15%	8%	11%	1.6	17%	8%	10%	1.1	13%	7%
500+	35%	7.3	12%	20%	35%	3.6	12%	18%	35%	3.7	12%	22%
Not working	20%	9.5	26%	26%	14%	3.6	29%	18%	26%	5.9	25%	35%
Health status												
Excellent	30%	9.4	17%	26%	31%	5.3	19%	27%	30%	4.1	15%	25%
Very good	34%	12.0	20%	33%	34%	6.6	22%	33%	34%	5.4	18%	32%
Good	25%	11.1	25%	30%	24%	5.9	27%	30%	25%	5.2	23%	31%
Fair	8%	3.1	23%	8%	7%	1.6	25%	8%	8%	1.5	21%	9%
Poor	3%	0.9	16%	2%	3%	0.4	17%	2%	3%	0.5	16%	3%

Note: Subgroup numbers and percents may not sum to totals because of rounding.

Source: Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

Study Methods

Most data in this issue brief are from three surveys: the Annual Social and Economic Supplement to the Current Population Survey (CPS), 2005; the Medical Expenditure Panel Survey (MEPS), 2004; and the Commonwealth Fund Biennial Health Insurance Survey, 2005. Sherry Glied and Bisundev Mahato of Columbia University's Mailman School of Public Health provided analysis of the CPS and MEPS.

The CPS and MEPS are federal surveys sponsored by the Census Bureau and the Agency for Healthcare Research and Quality, respectively. The CPS, which is the primary source of information on U.S. labor-force characteristics, is conducted monthly on a sample of some 57,000 households representing approximately 140,000 people. The Annual Social and Economic Supplement to the CPS is conducted in March of each year with a sample of about 99,000 households. The MEPS uses an overlapping-panel design in which data are collected in a series of five interviews over a 30-month period, with a new panel started each year. The sample size in 2004 was about 13,000 families, representing approximately 33,000 people.

The 2005 Commonwealth Fund Biennial Health Insurance Survey was conducted by Princeton Survey Research Associates International from August 18, 2005, through January 5, 2006. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 4,350 adults age 19 and older living in the continental United States. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental U.S. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the nation's approximately 212 million adults age 19 and older.

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Women, Tax Policy, and Health Reform

Our national tax system already plays a major role in the way Americans get their health insurance, and some health reform plans propose to modify the federal tax code in ways that would change employers' incentives to offer—and individuals' incentives to purchase—health coverage. These proposals, which would rely on the tax code as a tool to expand private health insurance to more individuals, have unique implications for women.

What Role Does the Tax System Currently Play in the Way Women Get Health Coverage?

The tax treatment of health insurance depends on where you get it; tax treatment varies by whether coverage is provided by an employer or purchased in the individual insurance market, and whether or not it is purchased by a self-employed individual.

- **Employer-sponsored health insurance** (ESI) is treated as a nontaxable fringe benefit, so it is not counted as part of the total compensation that is subject to income tax for employees, nor is it subject to the payroll tax that employers pay.[1] Employers get an additional tax benefit because they can deduct 100 percent of their spending on employee health premiums as an ordinary business expense. In part because of this favorable tax treatment, most nonelderly Americans get their health insurance at work. In 2007, nearly two-thirds of adult women were covered through ESI, either in their own name or as a spouse or dependent.[2]

- **Insurance purchased in the individual market** (or directly from an insurance company), in contrast, does not generally get any favorable tax treatment. Individual market insurance costs are not typically excluded from taxable income; a woman can deduct the cost of this type of insurance policy only if the coverage costs (along with all other out-of-pocket medical expenses) exceed 7.5 percent of her income.

- A woman who is **self-employed** can deduct the full cost of an individual market insurance policy from her income tax, provided that she does not have access to ESI through her own or a spouse's employer. Her health benefits, however, are still subject to a payroll tax.

- Individuals and their employers also receive tax breaks on funds contributed to certain types of savings accounts that can be established to pay for health care, such as **Flexible Spending Accounts (FSAs)** which allow workers to set aside a fixed amount of their annual salary on a tax-free basis, or **Health Savings Accounts (HSAs)**, tax-free accounts for individuals enrolled in high-deductible health plans.[3]

How Would Health Reform Proposals Change the Tax Code in Ways That Encourage More Women to Purchase Coverage?

In their health care reform plans, several 2008 presidential candidates proposed new tax credits for individuals and families to purchase health insurance from an employer-sponsored plan or through the individual insurance market. One proposal, for example, would have provided a flat tax credit of $2,500 for individuals or $5,000 for a family. Another plan would have incorporated a tax credit for low- and moderate-income families, with credit amounts determined by an income-based sliding scale.

Other proposals offer different ways to equalize the tax treatment of health coverage among people that get ESI and those who purchase insurance from the individual market. These reforms might limit or completely eliminate the current tax break that workers and employers receive on job-based health insurance by including the value of ESI benefits as taxable income and establishing a new standard tax deduction or tax credit in place of the current tax break. For instance:

- The Bush Administration has proposed to eliminate the existing tax exclusion for employer-based coverage and replace it with a standard tax deduction ($7,500 for individuals and $15,000 for a family) that would be available to anyone who purchases private health insurance, whether from their employer or the individual insurance market.
- The Tax Equity and Affordability Act of 2007 (S. 397), sponsored by Senators Martinez (FL) and Coburn (OK), would cap the current tax exclusion for employer-sponsored health benefits at $5,000 for individual or $11,500 for family coverage.

Alternatively, proposals could leave the current ESI tax breaks intact and create a new tax deduction for coverage purchased through the individual market, such as:

- The Health Care Equity Act (S. 2835), sponsored by Senators DeMint (SC) and Kyl (AZ), which would allow those purchasing coverage through the individual insurance market to deduct their health premiums from income taxes.

What Limitations Are Associated with Tax-Based Health Reform Proposals?

For various reasons, health reforms that would change the federal tax code are limited in their ability to improve women's access to high-quality, affordable health coverage.

Many health reform tax proposals would encourage women to buy their coverage through the individual (non-group) insurance market, which has many flaws. Health reform proposals that eliminate the tax advantages associated with employer-based coverage and provide new tax incentives for women to purchase coverage on their own will encourage more women, in effect, to buy coverage directly from insurers through the individual insurance market. Yet this market presents many challenges for women and their families. Consider the following facts:

- In most states, individual market insurers are permitted to charge people more for health premiums based on factors such as age, gender, or health status. Women with even a minor health condition may have difficulty obtaining an affordable insurance policy in the individual insurance market, or insurers may deny coverage altogether for women with health problems.[6]
- Individual insurance policies generally require a greater level of out-of-pocket spending. They may involve high deductibles, coinsurance, and copayments at the point of service (in addition to the required monthly premiums), or they may offer a limited benefit package so that women are required to pay out-of-pocket for the costs of care that is not covered. In 2004, people with individual insurance coverage paid an average of 55.3 percent of total health expenditures out-of-pocket, compared to 31.9 percent for people with group coverage.[7]

What Is the Difference Between a Tax Credit and a Tax Deduction?

Over half of all uninsured people are not eligible for public coverage programs, yet they still cannot afford to purchase private health insurance.[4] Tax credits and tax deductions are government subsidies that are used to offset the costs of health insurance and encourage more individuals to buy private coverage. These two mechanisms function differently:

- A **tax credit** reduces the amount of taxes paid, so that for every $1 a woman receives in tax credits, the amount of taxes she owes is reduced by $1. Tax credits can be structured to include three important features:
  - A refundable tax credit is available even to very low-income women with limited or no tax liability; regardless of whether she owes taxes, she will get full cash value of the tax credit through a refund.
  - An advanceable tax credit is "forward funded," or made available to a woman at the beginning of a year so that she can use it whenever her health insurance premium is due.
  - An assignable tax credit is directly and automatically paid to the health insurance company.

  These three features are particularly important to include in tax credit proposals because they will enable low-income recipients with limited cash resources to purchase health insurance policies.
- A **tax deduction** reduces a woman's gross income, lowering her overall taxable income and thus lowering the amount of taxes she owes. Rather than a dollar-for-dollar reduction in taxes owed, the value of a deduction depends on the woman's income tax rate. For example, for each $1 deducted, a woman in the 35 percent tax bracket would save $0.35 and a woman in the 10 percent tax bracket would save $0.10.

What refundable tax credits and tax deductions have in common is that they are both contingent on an individual's income. But millions of Americans, especially single mothers and elderly women, have incomes too low to owe any federal income taxes.[5] In the most general sense, proposals that rely on the tax system have limited ability to reach the low-income uninsured. Tax deductions, in particular, hold little benefit for those women who already owe little or no taxes; what advantage will they gain by further lowering their gross income, since they owe minimal or no taxes to begin with? Moreover, tax deductions require a woman to pay up-front for health benefits during the year and then deduct that spending later, when taxes are filed; this may be difficult or even impossible for lower-income families to manage.

In contrast, refundable, advanceable, and assignable tax credits are more likely than tax deductions to benefit individuals in lower- and middle-income brackets, but credits would need to be large enough to cover premiums and out-of-pocket health care spending to effectively increase health care coverage for poor women. It is also critical that any health insurance premium subsidy—whether a tax credit or a deduction—continues to increase over time in order to keep up with the growth in health care costs.

- Individual health policies often do not include the comprehensive benefits that women need. Limitations on certain benefits such as prescription drugs or mental health services are common, and maternity care is usually not covered at all. Individual market insurers frequently sell pregnancy-related benefits under a separate "rider" at additional cost, but this coverage is often limited in scope or may only be used after a significant waiting period.[8]

Unless tax proposals are combined with individual insurance market reforms or options to buy into group insurance, they are unlikely to help low-income uninsured women purchase meaningful coverage.

Health reforms that change the federal tax code could threaten the security of employer-based health insurance. If the tax benefit for job-based coverage did not exist, some employers would likely elect to stop offering coverage altogether. Analyses of proposals that would replace the tax exclusion for employer-based coverage with a new standardized tax-based health subsidy estimate that this type of reform could result in the loss of job-based coverage for between 12 million and 20 million workers (depending on proposal details); this loss would be concentrated among medium and small-sized firms.[9, 10]

New tax incentives might also encourage some workers currently covered by employer-sponsored insurance to seek health insurance outside of the workplace. If the value of a tax incentive is greater than the subsidy available through an employer, healthier workers may leave job-based coverage to enroll in an individual market plan. This shift would break up the group of people covered under ESI, since sicker workers—who, by nature of their health status would have fewer or no options in the individual market compared to their healthier counterparts—would remain in job-based coverage. If ESI plans lack a healthier, lower-risk population to help spread the costs of higher-risk enrollees, premiums for those plans could become unaffordable.

Tax-based subsidies may be inadequate for the purchase of high-quality, comprehensive health insurance coverage with affordable cost-sharing requirements. Many tax credit proposals fall far short of the actual total cost of health insurance. In 2005, the average premiums for a non-group health insurance policy were $3,664 for an individual and $5,568 for a family.[11] These averages do not represent the *total* health spending required of enrollees—since health insurance policies sold in this market typically require significant out-of-pocket costs such as deductibles, coinsurance, and copayments in addition to premiums—nor do they account for the great variation in the benefit levels of the policies. In addition, these estimates do not reflect the fact that most insurance companies are allowed to charge individuals more for a policy based on factors like health status, gender, and age.

Consider the results of a 2004 study to determine the average premium cost for a "standard" health insurance plan (similar to plans offered to federal workers through the Federal Employees Health Benefits Plan). The study reported an annual premium of $5,780 for a healthy, non-smoking 55 year-old woman; $3,536 for a 40 year-old woman; and $2,403 for a 25 year-old woman.[12] A tax credit of $2,500 may be sufficient for a 25 year-old woman to purchase a standard health insurance plan, but the same credit would barely cover half the cost of a standard health insurance plan for her 55 year-old counterpart.

Low-income people are not likely to be able to make up the difference between the credit amount and the cost of an adequate insurance policy. When tax credits fall short, poor women

may be forced to choose between purchasing a health plan that fits the credit amount and redirecting a portion of her limited household resources to supplement a plan that actually fits her needs. If women obtain insurance that is inadequate, such as a plan that requires unaffordable deductibles or a bare-bones plan with very limited benefits, a situation of underinsurance results, leaving women vulnerable to financial risk and unmet health needs.

Tax proposals may do little to reduce the number of uninsured women. Poor or near-poor women are particularly at risk for being uninsured.[13] But tax deductions, which reduce a woman's taxable income, are unlikely to benefit low-income women because they have little or no tax liability in the first place. Tax deductions, therefore, are not likely to significantly reduce uninsurance rates; an analysis of the Bush Administration's tax deduction proposal estimated that it would only reduce the ranks of the uninsured by about one-fifth.[14]

While a refundable, assignable, and advanceable tax credit is more likely than a tax deduction to help low-income uninsured women obtain health coverage, health policy experts question whether even this type of reform would be successful in expanding health coverage in any meaningful way.[15] The credit would benefit those people who are already purchasing health insurance on their own, but there is no evidence that such a policy would actually encourage currently uninsured people to obtain health coverage. For instance, how would a tax credit help improve access to care for a woman who is otherwise "uninsurable" because of her health status? The credit itself will do little good if insurance companies will not offer her an affordable policy, or if they will only issue a policy that excludes coverage for her pre-existing health conditions.

Lessons from the Health Care Tax Credit Program

The U.S. has little experience with using tax credits to cover the uninsured, and so there is limited evidence of their effectiveness in increasing coverage. The Health Care Tax Credit (HCTC) program—enacted as part of the Trade Assistance Adjustment Reform Act of 2002—provides a single example of an existing health insurance tax credit policy. The program provides a refundable tax credit (covering just 65 percent of the cost of premiums for health coverage) to a limited number of individuals, including workers who lost their jobs due to the North American Free Trade Agreement (NAFTA).

Only 15 percent of eligible individuals participate in the HCTC. Low participation rates are related to the program's complex enrollment processes, eligible individuals' inability to find a "HCTC-qualified" benefit plan that cover their needs, or—even when a qualified plan is available—their inability to afford the remaining 35 percent of insurance premiums. In addition to these issues, extremely high administrative costs (accounting for over a third of the total program costs) make the HCTC a bad deal.[16]

What Can Women's Advocates Do?

Women's advocates can support proposals that use mechanisms other than the federal tax code to expand health care coverage.
In general, health reforms involving changes to the federal tax code are limited in their ability to increase coverage among low-income people (who account for a majority of uninsured

Americans). Unless tax incentives are structured in ways that would allow poor women and their families to purchase health coverage, and unless they are combined with reforms to the individual insurance market, they are unlikely to solve America's health care crisis.

However, if women's advocates must work with a reform proposal that relies on a tax mechanism to expand coverage, there are certain actions that they can take to make tax-based health reforms more acceptable. They can:

- **Promote tax credits over tax deductions, and ensure that tax credit proposals include features that would enable low-income uninsured women to purchase health coverage.** Tax deductions lower an individual's taxable income and provide greater benefits to higher-income people. Tax credits are generally more advantageous for lower-income women and their families. In addition, certain features—such as mechanisms to make tax credits refundable, advanceable, and assignable—make it more likely that low-income people with little or no tax liability will be able to use the credits to purchase health coverage for themselves and their family members.

- **Promote health reforms that would make individual market health insurance more accessible for all women, including those who are older or who have a pre-existing medical condition.** These reforms include but are not limited to: mergers of the individual and small-group insurance markets (which spread medical costs among a larger group of insured people), community rating, or limiting how long individual market health insurers can exclude coverage for a pre-existing condition.[17]

- **Promote health reforms that would ensure that women have access to an adequate package of health benefits.** Reforms that impose a minimum standard for health benefits or that require health insurers to offer at least one standardized minimum benefit plan may make it easier for women to purchase health coverage that meets their needs. These reforms should be combined with adequate subsidies so that comprehensive coverage is more affordable for low-income women.

For further reading, see:

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1 Health benefits for employees and qualified spouses and dependents are not taxed as income by federal and state governments. However, health benefits for employee's domestic partners are taxed as income by the federal government and in a majority of states. See the "Domestic Partner Health Insurance Benefits and Tax Policy" section of the *Reform Matters Toolkit* for a more detailed discussion of this issue.

2 National Women's Law Center analysis of 2007 data on health coverage from the 2008 Current Population Survey's Annual Social and Economic Supplement , using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.

3 See the "Health Savings Accounts and High-Deductible Health Plans: The Wrong Answer to Women's Health Care Needs" in the *Reform Matters Toolkit* for a more detailed discussion of HSAs.

4 Lisa Dubay et al., *The Uninsured And The Affordability Of Health Insurance Coverage*, Health Affairs, 26(1):22-30 (Nov. 30, 2006).

5 Gerald Prante, The Tax Foundation, *Fiscal Facts: President to Propose Large Tax Deduction to Spur Health Insurance Purchases* (Jan. 2007), http://www.taxfoundation.org/publications/show/2162.html.

6 See the "The Individual Insurance Market: A Hostile Environment for Women" in the *Reform Matters Toolkit* for a more detailed discussion of premium rating in the individual market.

7 Jessica S. Banthin et al., *Financial Burden of Health Care, 2001-2004,* Health Affairs, Volume 27(1); 1-8 (Jan./Feb. 2008).

8 National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (2008), http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf?docID=601

9 John Sheils and Randy Haught, The Lewin Group, *President Bush's Health Care Tax Deduction Propoal: Coverage, Cost and Distributional Impacts* (2007), http://www.lewin.com/content/publications/BushHealthCarePlanAnalysisRev.pdf.

10 Len Burman, et al. *An Updated Analysis of the 2008 Presidential Candidates' Tax Plans* (Jul 2008), http://www.taxpolicycenter.org/UploadedPDF/411741_updated_candidates.pdf

11 Didem Bernard, PhD and Jessica Banthin, PhD, Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey (MEPS) Statistical Brief # 202: Premiums in the Individual Health Insurance Market for Policyholders under Age 65: 2002 and 2005* (Apr. 2008), http://www.meps.ahrq.gov/mepsweb/data_files/publications/st202/stat202.pdf.

12 Families USA, *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured, 2004 Update* (Nov. 2004), http://www.familiesusa.org/assets/pdfs/10_Foot_Rope_update_2004804d.pdf.A "standard" plan was defined as one that enables a consumer to receive adequate health care with a reasonable level of cost-sharing. Standard plans had to meet certain requirements for cost-sharing, such as not having a deductible higher than $250, or coinsurance rates for inpatient and outpatient services that were higher than 20 percent.

13 Kaiser Family Foundation, *Women's Health Insurance Coverage* (Oct. 2008), http://www.kff.org/womenshealth/6000.cfm.

14 *President Bush's Health Care Tax Deduction Proposal*, *supra* note 9.

15 Ellen Meara et al., Employment Policies Institute, *Comparing the Effects of Health Insurance Reform Proposals: Employer Mandates, Medicaid Expansions, and Tax Credits* (Feb. 2007), http://www.epionline.org/study_detail.cfm?sid=104.

16 Stan Dorn, The Urban Institute, *Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons* (Feb. 2008), http://www.urban.org/UploadedPDF/411608_health_coverage_tax.pdf.

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Domestic Partner Health Benefits and Tax Policy

Nearly 6 million Americans live together as unmarried partners.[1] Currently, the federal tax code treats health benefits for unmarried and married partners differently, contributing to higher rates of uninsurance among those couples who are unmarried.[2] Comprehensive health reform must include efforts to revise federal and state policies that unfairly tax health benefits for unmarried partners.

Health Insurance for Domestic Partners: Same Benefits, Different Tax Treatment

Most nonelderly women, and most Americans in general, get their health care coverage tax-free from an employer. In the United States, most women with health insurance are covered through an employer-sponsored health plan. In 2007, 39 percent of nonelderly women were covered through their own employer's plan and another 25 percent were covered as spouses or dependents under a family member's employer-sponsored plan. [6]

The majority of employers who offer health insurance to their employees also offer health insurance for the employees' spouse and children. Like the job-based coverage an employee receives, coverage for a spouse or dependent child is not taxed because it is not considered employee income by the state or federal government. This means that employees receive a double benefit – health insurance for the people they care about, on a tax-free basis.

But workers with unmarried domestic partners are unlikely to receive an employer offer of health coverage for their partner; those who can get

What Is a Domestic Partnership?

A domestic partnership is a legal or personal relationship between two individuals who live together and share a common domestic life but are not joined by a traditional, government-sanctioned marriage. The federal government does not currently recognize domestic partnerships, but as of June 2008, 9 states—California, Connecticut, Hawaii, Maine, New Hampshire, New Jersey, Oregon, Vermont, and Washington—and the District of Columbia provided relationship-recognition structures for domestic partners, typically through laws that allow civil unions or that establish domestic partner registries.[3,4]

The majority of the above states have instituted these structures as a way to recognize same-sex unions, though some states' laws apply to both same-sex and opposite-sex couples. Additionally, Massachusetts and Connecticut[5] offer same-sex couples all of the state-level rights and benefits of marriage, and New York recognizes marriages by same-sex couples legally entered into in another jurisdiction.

Regardless of whether their state formally recognizes such relationships, employers may choose to offer health benefits to workers' domestic partners. Employers themselves can determine the criteria for a domestic partnership, including whether same-sex couples and/or opposite-sex couples qualify. For example, an employer may determine eligibility for domestic partner benefits by requiring employees to sign an "Affidavit of Domestic Partnership" and show proof of their partnership, such as evidence of joint purchase and ownership of a home.

benefits for their partners do not receive the same federal tax benefits as their married coworkers. In contrast to their married coworkers, employees with unmarried domestic partners do not receive the aforementioned "double benefit." An overwhelming majority of American employers—roughly three out of four—do not offer health benefits to the domestic partners of their workers; employees of small businesses are especially unlikely to get an offer of domestic partner health benefits.[7]

Even if a worker is able to get health benefits for her domestic partner through her employer, her partner's coverage does not receive the same favorable tax treatment as coverage for spouses and children. Domestic partner health benefits are treated like income by the federal government and most states, and are taxed as if the employee received a raise in salary for the value of the health coverage.

Because of this unequal tax treatment, workers who get job-based health insurance for their domestic partners pay an average of $1,069 more per year in federal taxes than their married counterparts who get the same coverage for spouses or children. Collectively, unmarried partners spend roughly $178 million per year in additional federal income taxes.

This unequal tax treatment also provides a disincentive for employers to offer coverage for domestic partners. Because partner coverage counts as employee income and raises the firm's total payroll, employers pay more in payroll taxes when they cover partners versus other family members. U.S. employers pay an estimated $57 million per year in additional payroll taxes because of this situation.[8]

State Tax Laws and Domestic Partner Benefits

The majority of states generally follow the federal lead on tax policy, but a handful of states have adopted tax laws that give domestic partner health insurance benefits the same favorable tax treatment as other job-based dependent coverage. For example, some of the state relationship-recognition laws referenced on the previous page influence how domestic partner health benefits are taxed. In those states where domestic partner health benefits are treated differently by federal and state tax systems, employers and employees must calculate income in several different forms based on state guidelines and then based on federal guidelines.[9]

Federal Proposals Related to Domestic Partner Health Benefits

Though the federal government has not yet taken any actions that would improve circumstances for workers with domestic partners, two notable health reform proposals have been introduced in Congress that would benefit couples in domestic partnership arrangements:

- The Tax Equity for Domestic Partner and Health Plan Beneficiaries Act (S. 1556), sponsored by Senator Gordon Smith (OR), would eliminate the unequal tax treatment of domestic partner benefits so that the value of these benefits would be excluded from their federal income tax.
- The Domestic Partnership Benefits and Obligations Act (H.R. 3848), sponsored by Representative Tammy Baldwin (WI), would provide domestic partnership benefits (including retirement, life insurance, and health benefits) to all federal civilian employees on the same basis as spousal benefits. The legislation would allow domestic partners of eligible federal employees to get coverage through the Federal Employees Health Benefits Plan (FEHBP), which is the largest employer-sponsored health insurance program in the country. The FEHBP currently covers about 8 million federal employees, retirees, and their dependents through contracts with private insurance plans.[10]

What Can Women's Advocates Do?

The current tax treatment of domestic partner health benefits is unjust and makes it more difficult for domestic partners to obtain job-based health coverage. Individuals living as unmarried couples are two to three times more likely to have no health coverage than their married counterparts.[11] As the nation considers proposals to expand coverage to the swelling ranks of the uninsured, flawed policies that make it more difficult and more expensive for millions of hardworking Americans to get employer health benefits for their partners will only make the situation worse.

Women's advocates can support federal and state legislation that would treat domestic partner health benefits the same as spouse and family coverage.
Such legislation will prevent families headed by domestic partners from paying more in taxes than their married counterparts. It will also eliminate a financial disincentive for employers to offer health coverage to domestic partners, and therefore could increase the number of employers offering this coverage.

For further reading, see:

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Addressing Health Care Costs: An Essential Part of Health Reform

It is impossible to have a serious discussion about health reform without considering the growing cost of health care. Health-related spending grows on an annual basis, often outpacing spending on the other goods and services that make up the United States economy. Those responsible for paying for health care—the government, employers, and families alike—increasingly feel the financial squeeze of uncontrolled health care inflation. Confronted with rising health care costs, a growing number of employers may find that they cannot afford to provide health insurance for their workforce, and more and more families may not be able to afford to purchase coverage. Simply put, any attempt at expanding coverage for all will be short-lived if health care costs are not controlled.

Women's advocates encounter both challenges and opportunities when considering how cost control fits into progressive health reform. Some health reform plans that aim to control costs may only shift more of the burden of health care costs to health plan enrollees, making it more difficult for families to afford health care when they need it. Or, federal and state government attempts to control the costs of publicly-funded health coverage programs may result in the loss of basic health benefits for the nation's most vulnerable populations. Advocates must work to ensure that cost containment does not come at the expense of access to high-quality and affordable health care for women and their families. Cost control initiatives, however, also present an opportunity for health system improvements that can result in the delivery of more efficient and higher-quality care. If implemented carefully, health reforms that address growing health care costs can ensure that health system improvements are sustained in the future.

Why Must We Consider Health Care Costs?

Health care costs are skyrocketing, and their growth far outpaces that of workers' wages. Health care costs continue to increase faster than incomes, and families spend more out-of-pocket each year for their health insurance premiums and for health care services.[2] Health insurance premiums, for instance, grew by 78 percent between 2001 and 2007, compared to wage growth of just 19 percent.[3] Rising health care costs place a growing burden on families. In 2007, about 57 million Americans lived in families that reported problems paying medical bills, an increase of more than 14 million since 2003. Most of those people had insurance coverage. They reported challenges with paying for other basic necessities such as food, housing, and clothing, and they also reported much higher levels of unmet medical need than families without medical bill problems.[4]

Who Pays for Growing Health Care Costs?

While Americans may believe that their employers feel the greatest squeeze from increasing health care costs, economists generally agree that the growing cost of health care is coming out of employee wages in a cost-wage trade-off. In other words, the rising cost of health insurance coverage has led to smaller wage increases. Over the last 30 years, while health insurance premiums have grown by 300 percent, after-tax corporate profits have grown by 200 percent and average hourly wages for employees have actually *decreased* by 4 percent.[1]

Addressing costs is essential for a sustainable health system, and for the solvency of publicly-funded health programs.
In 2005, health care accounted for 16 percent of the nation's gross domestic product (or GDP, a common measure of national economic activity). By the year 2016, health spending is projected to account for nearly 20 percent of the GDP.[5] If health care costs continue to grow rapidly, more and more employers and individuals will find themselves priced out of the health insurance market, and unable to afford coverage at all. Moreover, the state and federal governments that pay for nearly half of all health care spending will not be able to sustain the public coverage programs they administer—including Medicare, Medicaid, and the State Children's Health Insurance Program—if costs are not contained. Or, if the costs of public coverage programs continue to consume ever larger shares of state and federal budgets, other areas of government spending, such as education or transportation, will suffer from reduced resources. Policymakers may propose cuts to public program eligibility levels (so that fewer people qualify for and enroll in the programs) as a way to address the problem of rising health care costs, but these types of cost containment measures are not acceptable health reform since they will result in greater numbers of low-income women and families without access to the health care they need.

Addressing costs can lead to a less wasteful and more efficient health care system.
Spending more on health care does not guarantee better care. Indeed, though Americans spend more almost twice as much per capita (over $6,500 per person in 2005) on health care as citizens of other developed countries, their health is no better and in many cases is worse in comparison to these countries. As much as 30 percent of health care spending, or roughly $700 billion, is considered wasteful because it has no value to the patient and does not improve health outcomes. Indeed, at a July 2008 Congressional hearing on getting better value out of health care, the Director of the Congressional Budget Office (CBO) declared that "health care is the least efficient sector of our economy."[6]

Cost control is inextricably linked to health care access and health care quality.
The savings that result from thoughtfully-implemented cost containment initiatives can be diverted to expanding access to health care for greater numbers of uninsured people, financing new coverage programs, or making improvements to the health infrastructure. Moreover, the savings from cost containment can lead to improved quality because—as detailed below—reform initiatives that control costs are also those that result in the delivery of more efficient health care.

Why Are Health Care Costs Increasing?

Health care costs are increasing for a number of interrelated reasons, including, but not limited to:

- **Growth in health care technologies.** Most health economists and analysts point to major advances in medical science as the primary factor contributing to the growth of health care spending in recent decades. The emergence, adoption, and widespread diffusion of costly new drugs, medical equipment, and skills have increased health care spending overall.[7]

- **Increasing life expectancy and incidence of chronic diseases.** Since average medical spending typically increases with a person's age, as the United States population ages and average life expectancy increases, health spending rises. Spending projections, however, indicate that an aging population will have only a modest effect on national

health care spending.[8] The burden of chronic disease also affects health care costs, since people with chronic conditions such as diabetes, asthma, and heart disease are likely to have significantly higher average healthcare costs than people without them. As the incidence of certain chronic conditions increases, so do overall health care costs.

- **The current health care financing structure.** In the current U.S. health care system, health care providers are generally paid according to the volume and intensity of the services they deliver, rather than whether or not they keep patients healthy. This approach may not benefit health consumers, providers, or the system overall, since it provides an incentive for unnecessary care and costs.

- **Growth in health care insurance industry profits.** Between 2000 and 2005, the insurance industry's administrative expenses (i.e. costs of marketing, medical underwriting, claims processing) and profits increased by 12 percent per year. This is considerably faster than the growth rate for overall health spending during that time period. The consolidation and concentration of market power in the insurance industry over the past several years—in addition to major increases in the market share of the biggest health insurers and higher profit margins—have contributed to the steady growth of health care costs.[9]

What Are Some Ways That Health Reform Plans Can Contain Costs?

- **Health reform plans can incorporate initiatives that will improve health care quality.** High-quality health care is, simply put, the right care, at the right time, for the right reason. Health reform provisions that improve the quality of health care that women and their families receive also have the potential to reduce health care costs. These include health reforms that promote chronic disease management, and reforms that revise health care payment systems so that providers are encouraged to manage care more effectively for better health outcomes. For instance, a "pay-for-performance" pilot program administered by the Centers for Medicare and Medicaid Services (CMS) pays physicians participating in the Medicare program based on the quality and efficiency of the care they provide. The program has reported promising results, showing gains in quality of care to patients with congestive heart failure, coronary artery disease, and diabetes. Importantly, the program also reduced CMS spending.[10] The "Ensuring Quality Health Care in Health Reform" section of the *Reform Matters Toolkit* explores initiatives to improve health care quality in greater detail.

- **Health reform plans can emphasize preventive and primary care.** By accessing timely preventive health services—such as immunizations, cancer screening services, or annual physical examinations—women and their families can avoid the development of more complicated and costlier health problems in the future. To encourage patients to seek the appropriate care at the appropriate time, health reform plans might incorporate "value-driven" health benefit designs that better align patient and provider incentives, by eliminating or reducing copayments for preventive and essential medical services and medications, while requiring higher copayments for specialized services that are subject to overuse.[11]

- **Health reform plans can include initiatives that promote the widespread use of health information technology (HIT).** HIT, or the use of computers and other electronic devices to manage health information, can reduce medical errors and improve coordination of health care among providers, thereby enhancing not only the

Emphasizing Preventive Care to Improve Health and Save Costs.
In their 2007 report *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*, the Partnership for Prevention highlights the fact that effective preventive care is significantly underutilized in the United States, which results in lost lives, poor health, and inefficient use of health care dollars. The report ranks several clinical preventive health services according to their cost effectiveness, measured as the health service's return on investment (the cost of a service compared to its health benefits). The most cost-effective preventive services include:

- Childhood immunizations
- Advising at-risk adults for daily aspirin use
- Smoking cessation advice and help to quit for adults
- Alcohol screening and brief counseling for adults
- Colorectal cancer screening for adults age 50 and over
- Influenza immunization for adults age 50 and over
- Vision screening for adults age 65 and over

By increasing use of just five of the preventive services examined in the report, the Partnership for Prevention estimates that 100,000 lives could be saved. More widespread preventive care would also result in the more effective use of national health resources since the country would get more value—in terms of premature death and illness avoided—for the money it spends on health care.[12]

quality but the effectiveness of care. Some analysts believe, however, that while incorporating HIT into the health care system will save costs and improve efficiency, HIT initiatives alone will only result in modest cost savings.[13] These types of reforms must be coupled with other efforts to slow the growth of health care costs. The "Health Information Technology: A Key Component of Health Reform" section of the *Reform Matters Toolkit* explores HIT in greater detail.

- **Health reform plans can support the role of public coverage programs as a way to expand access to health insurance, including the creation of a public health plan option for individuals and employers.** One recent study indicates that total medical spending is much lower when coverage is provided by public health insurance programs such as Medicaid or SCHIP than when it is provided by private insurance. The study authors conclude that "efforts to expand coverage for low-income populations, whether conducted at the national or state level, would be less costly to society and much less costly to financially strapped beneficiaries if the expansions were based on public insurance like Medicaid and SCHIP."[14] Moreover, a publicly-sponsored health program that competes on a level playing field with private health insurance companies for enrollees may result in lower administrative costs, reduced health care industry profits, and greater choice and competition among plans.[15]

Why Must Women's Advocates Approach Cost Containment with Caution?

To ensure that health reform plans do not harm access to health care, reforms to control cost must be considered carefully. Some health proposals that seek to control costs may diminish important health consumer protections or simply shift more costs onto women and their families. These include proposals that allow insurance companies in the individual and small group markets to sell bare-bones health plans (i.e. plans that are exempt from critical

mandated health insurance benefits) offering limited health coverage, as well as so-called "consumer-directed health care" plans, which combine high-deductible health plans with tax-free health savings accounts (HSAs).[16]

Lessons from the States:

Opportunities and Challenges Posed by Rhode Island's Cost Control Reforms.

In 2008, Rhode Island Lieutenant Governor Elizabeth Roberts introduced a comprehensive health reform package, the Healthy Rhode Island Reform Act of 2008. Though the reform package includes some provisions to establish a universal coverage system similar to that of neighboring Massachusetts, early news reports on the Rhode Island plan distinguished the state's efforts as stressing costs as much as coverage, stating that the "plan acknowledges that Rhode Island cannot afford, financially or politically, to insure all its residents unless it can deliver healthcare more efficiently and raise money through a tax on businesses that do not provide coverage."[17] One component of the reform legislation that has already been enacted, for example, involves a statewide Chronic Care Management Program, which aims to identify eligible patients, ensure that each chronic care patient has a designated primary care provider, coordinate care among health providers, and monitor performance by establishing process and outcome measures for program participants.[18]

But with the same aim to control costs, Rhode Island has also applied for federal permission to transform its state Medicaid program into a block grant, whereby the state would receive an annual fixed amount for Medicaid with no additional federal funding to address unanticipated health care cost increases or enrollment.[19] In exchange for accepting the block grant, Rhode Island seeks unprecedented flexibility to manage the costs of Medicaid. If approved, the state's proposal would eliminate a number of federal protections for Medicaid beneficiaries, allowing the state to make significant changes to its program without federal oversight. Many of Rhode Island's most vulnerable families would be at risk of losing coverage and services.[20]

These two different cost containment approaches in Rhode Island demonstrate both the opportunities and challenges that women's advocates encounter when considering reforms that address health care costs.

What Can Women's Advocates Do?

Women's advocates can understand the role of costs in health reform, and ensure that reform plans address growing health care costs without harming women's access to high-quality health care.

Addressing health care costs presents a significant challenge for health reformers, as potential interventions may require new approaches to health care delivery and the establishment of new information systems. Advocates are further challenged to ensure that cost control does not harm access to health care for women and their families. Ultimately, however, health care reform that is realistic and sustainable **must** include provisions to control the growth of health care costs. In the absence of these provisions, the nation's foundation of employer-sponsored insurance will continue to erode, and women and their families will continue to struggle to afford high-quality health coverage.

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Reproductive Health Care and Health Reform

Women's reproductive health is too often segregated from women's health care in general, and women's reproductive needs have come to be seen as a secondary set of concerns rather than an integral part of their health and wellbeing. Yet, reproductive health is a key determinant of overall women's health. To be truly comprehensive, health care must include women's reproductive health needs.

Advocates have an important role to play in ensuring that reproductive health is not marginalized in health reform. It is essential they are armed with facts about the importance of reproductive health to women's health, how reproductive health services are covered in the current health care system, and how different health reform proposals might affect that coverage. It is also essential to secure a seat at the health reform table early in the discussions to make sure women's advocates' voices are heard. This piece is designed to assist advocates in taking those steps. It provides general information about the significance of reproductive health, as well as the kinds of services that should be included in health reform proposals. It then focuses on three reproductive health services—abortion, contraception, and maternity care—offering advocates an assessment of current coverage, an examination of how health care reform may affect coverage, and concrete steps to take.

Facts about Women's Reproductive Health Care

Comprehensive, affordable health care that includes reproductive health care is essential for women's well-being. Consider these facts:

- Access to family planning services is critical to preventing unintended pregnancies and enabling women to control the timing and spacing of their pregnancies, which in turn reduces the incidence of maternal death, low birth weight infants, and infant mortality.[1]
- Women rely on prescription contraceptives for a range of medical purposes in addition to birth control, such as regulation of cycles and endometriosis. Hormonal contraceptives can also provide other health benefits, such as decreasing the risk of ovarian and endometrial cancer, protecting against ectopic pregnancy, and preventing bone density loss.[2]
- Birth control enables women to engage in preventive behaviors and ensures that they are visiting doctors' offices, which can contribute to the early detection of diseases through regular health screenings.
- Nearly half of all women have faced an unintended pregnancy, and one in three will have an abortion at some point in her life.[3]
- Unintended pregnancy is associated with an increased risk of morbidity for women and adverse effects for infants.[4]
- Inadequate prenatal care can increase risks of low infant birth weight, premature births, neonatal mortality, infant mortality, and maternal mortality.[5]
- In 2003, the most common procedures performed in U.S. hospitals were related to childbirth, with approximately 4 million births in US hospitals that year.[6]

- The maternal mortality ratio in the United States is 13.1 deaths per 100,000 live births, with black women facing a much higher risk than white women of dying from pregnancy-related conditions.[7]
- Women are more likely than men to contract genital herpes, chlamydia, or gonorrhea.[8] Women suffer more serious complications from sexually transmitted infections, including pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain, and cervical cancer from the Human Papillomavirus (HPV).[9]
- Approximately 600,000 hysterectomies are performed each year in the US. Hysterectomy is the second most frequent major surgical procedure among reproductive-aged women.[10]
- Between 1995 and 2002, 7.3 million women in the US reported utilizing infertility services.[11] Treating infertility can cost from $200 to almost $13,000 per cycle, depending on the cause of the fertility problem and the therapy used to treat it.[12] However, private insurance companies do not always cover the costs of treatments, placing them out of financial reach for many families.[13]

As these facts demonstrate, reproductive health is inextricably linked to broader women's health care. It must be part of any health reform effort.

Which Reproductive Health Services Should Be Included in Comprehensive Health Reform Packages?

The debate about which services must be included as part of comprehensive benefits can occur at any stage of the health reform process. It could be a precursor to drafting legislative language that will include reference to certain services. Alternatively, the legislature may pass a bill that broadly addresses the principles of health care reform but leave the details of any proposed plan's benefits package to be worked out at a later time by a separate entity. No matter the stage at which benefits are considered, it is critically important that women's health advocates be involved and engaged in the full health reform debate and that they make the case not only for which benefits to cover but also for their affordability. Comprehensive benefits mean little if coverage is unaffordable. Advocates must work to ensure that health care reform guarantees coverage of reproductive health services, and that women are able to truly secure access to those services, without losing the protections and quality care upon which they have come to rely.

Lessons from the States:

Massachusetts Health Reform Legislation Was Silent on Benefits, Leaving Determinations to a Separate Entity

In Massachusetts, the health care reform legislation passed in 2006 did not specify which benefits would be included. Instead, the law required individuals to obtain "minimum creditable coverage" and created an entity to handle implementation.[14] The entity—the Commonwealth Health Insurance Connector Authority—decided which services must be included in the Commonwealth Choice program, which provides private coverage to individuals, families, and small businesses.[15]

Health reform packages must provide the full range of reproductive health services. This includes, but is not limited, to:

- Routine gynecological care
- Maternity (e.g. prenatal, birth, and postpartum) care
- Family planning services
- Abortion
- Testing and treatment for sexually transmitted infections
- Screening for cervical and other cancers
- Sterilization
- Infertility treatment

It is important to note that even if a decision is made to include certain services as part of a benefit package, they still might not be explicitly mentioned in health reform legislation. Instead, they could be encompassed by a broader term, such as "services for pregnant women," "reproductive health services," or even "medically-necessary services." If the exact benefits are not specifically mentioned, then attempts could be made later to exclude certain services, like abortion. For example, advocates could fight for "pregnancy-related services" to be included in legislation, only to find that the entity in charge of defining the covered services in detail did not include abortion in the definition. If broad language is used, advocates must remain vigilant to ensure that key services are not excluded. Getting a seat on the board or entity making determinations, making sure those who get on the board support women's reproductive health care, and constantly monitoring the board's work, are all important.

What Other Aspects of Women's Reproductive Health Should Health Care Reform Address?

In addition to the specific services that should be covered, there are other considerations to take into account when planning for women's reproductive health care needs. Women need autonomy and privacy when securing their reproductive health care. Providing a choice of provider and confidentiality are essential to guarantee this and must be a part of health reform proposals.

> Getting reproductive health services covered is essential, but it is not enough! Advocates must ensure that choice of provider and confidentiality are part of health reform proposals.

Choice of Provider

Choice of provider provisions (also known as "freedom of choice") protect health plan enrollees by giving them the authority and responsibility for choosing the health care provider best equipped to care for them. In other words, enrollees with freedom of choice are permitted to seek services from providers who are not part of their health plan's network, without having to get a referral. For example, Medicaid managed care enrollees who are seeking family planning services are guaranteed freedom of choice.[16] This protection recognizes that choice of provider provisions are critical in the context of reproductive health care. This is true because:

- The nature of reproductive health services is sensitive. Requirements for referrals or prior approval may cause women to delay or avoid important care.

- In some cases, patients may prefer to receive reproductive care from a particular physician or other type of health provider.
- Patients may need to look out of their network to find a provider with whom they are comfortable enough to see regularly, and whose advice on preventive care they will heed.
- It is an unfortunate and well-documented reality that some providers will refuse women access to basic reproductive health services.[17] Choice of provider provisions help women avoid these distressing and often humiliating encounters, and make sure that they have a trusted alternative should they be refused reproductive care.

When Considering a "Medical Home" Initiative, Think about Choice of Provider!
A "medical home" (sometimes called a "health care home") generally refers to a centralized location for health care, with one personal health care provider who coordinates an individual's care. This personal provider is responsible for all of a patient's health care needs, including appropriately arranging care with other health professionals. Public and private health insurers have implemented medical home initiatives as strategies to improve health care quality and safety, but a medical home system could conflict with an individual's desire to see a particular provider or clinic for reproductive health care services. When a health reform plan incorporates a medical home initiative, women's advocates must ensure that choice of provider for reproductive health is a key component of the medical home guidelines and that the women participating in the initiative understand that they are permitted to seek family planning services from a provider that is not affiliated with their medical home. Alabama's Patient 1st program provides Medicaid enrollees with a medical home, for example, and the *Patient 1st Rights and Duties* statement notifies program participants of their right "To go to any doctor or clinic for birth control without getting approval from your personal doctor. You do not have to use your personal doctor for birth control or any family planning services."[18]

Confidentiality
Confidentiality is crucial when it comes to reproductive health services. Patients who fear that their use of services will not be kept private may delay or forgo important services central to their and their family's health.

Confidentiality is particularly important for young women. Although a significant body of state and federal law explicitly guarantees confidential access to services for teens or does so by implication,[19] some reform plans could change that. For example, plans that propose to extend the age for dependent care coverage would extend coverage to more young women under their parents' plans. Several states have already done this. While extending the age for dependent coverage can provide certain young adults with more options for health insurance, this kind of coverage may compromise confidentiality since parents would be informed about the services their dependent child secures through Explanation of Benefit statements. Research indicates that lack of confidential services can discourage young women from seeking needed reproductive health care services, and is potentially harmful to teens' health and wellbeing.[20]

Federal Health Care Reform

Health care reform at the national level must also include provisions that will preserve and expand access to reproductive health care services. Federal health care reform has important implications for state-level coverage of reproductive health care. Women's advocates should take the following questions into account when considering federal health care reform and its potential impact:

- Will the federal health care reform plan affect state laws related to reproductive health services, including abortion and contraception? For instance, does the federal health care reform plan set a floor or a ceiling in terms of what states must or can offer?
- How are health care services and procedures defined? For example, if a bill uses the term "medically necessary," what does that mean? Or, if a bill refers to "pregnancy-related services," what is included?
- Who would determine the health services that must be included in newly-created health insurance plans or products? Would it be Congress or an independent entity?
- What are the important technicalities underlying the way that health care is delivered and financed? For example, what is the source of funding for services?
- Are there "refusal clauses" that allow providers or institutions to refuse to provide care? Will they injure patients seeking care? How do these provisions interact with state laws ensuring access to care?

State-level women's advocates have a critical role to play in federal health care reform. They need to understand what is happening on the federal level so that they can translate what federal reform would mean for coverage of reproductive health services in their state. By engaging state officials and state policymakers early in the federal reform process, women's advocates can also ensure that their voices are heard when federal reforms that would affect state coverage are considered.

In conclusion, comprehensive health care reform holds the promise of sustaining access to the reproductive services—as well as other key health care services—that women sorely need. For some, it continues care they already rely upon. For others, it offers an opportunity for coverage and access to reproductive health care that they are currently lacking. No one should lose services or benefits because of a health care reform plan that does not take into account women's reproductive health care needs.

The reforms pursued now will affect women's ability to secure access to quality care for decades to come. Access to the full range of reproductive health services must be part of the comprehensive benefits guaranteed to individuals.

What Can Women's Advocates Do to Ensure That Health Reform Preserves and Expands Access to Reproductive Health Care Services?

Women's advocates can support comprehensive health reform at the state and national levels. Educate policymakers about the kind of health reform that meets women's needs, and why. If the state is moving forward with health care reform, make sure an advocate or a person friendly to reproductive issues is at the table when benefits are discussed.

Women's advocates can learn more about the reproductive health services that should be included in a benefits package.
The attached case studies go into depth on three of those services—abortion, contraception, and maternity care. The case studies will explore how each reproductive health service is currently covered, the potential impact of health care reform on coverage, and next steps for ensuring coverage for these particular services.

Women's advocates can learn how federal health care reform proposals could affect coverage of reproductive health services in their state.
The case studies that accompany this section of the *Reform Matters Toolkit* describe the various ways that women's advocates can gather information about the current status of coverage and access to reproductive health services in their state. (See the "What can women's advocates do…" sections of each case study.) If advocates need more assistance in identifying the specific ways that federal health reform might affect reproductive health service coverage and access in their state, they can contact the *Reform Matters* project team at reformmatters@nwlc.org.

Women's advocates can raise awareness of the effects that a federal reform proposal may have on state coverage and access to reproductive health services.
Once women's advocates have an understanding of how a particular federal health care reform proposal can affect access to and coverage of reproductive health services in their state, they can work with state officials and policymakers to weigh in at the federal level on whether it is a good or bad proposal.

Women's advocates can become part of the health care reform movement and conversation.
Learn about the important issues in health care reform, find out who the key players are at the state level, stay updated on federal reform plans as they develop, and figure out how to join the conversation about health care reform.

- For a list of groups working on health reform in each state, go to www.uhcan.org and click on "State Connections."
- For national groups and campaigns working on health reform, go to www.uhcan.org and click on "National Connections" or visit www.healthcareforamericanow.org.
- By visiting the National Women's Law Center *Reform Matters* project website, www.nwlc.org/reformmatters/, advocates can sign up to receive NWLC alerts and updates on health reform, and to participate in monthly conference calls hosted by the project team.

For further reading, see:

Wendy Chavkin, et al., Columbia University Mailman School of Public Health, *Women's Health and Health Care Reform: The Key Role of Comprehensive Reproductive Health Care* (Oct. 2008), http://www.jiwh.org/attachments/Women%20and%20Health%20Care%20Reform.pdf

Adam Sonfield, *Toward Universal Insurance Coverage: A Primer for Sexual and Reproductive Health Advocates*, (2008) Guttmacher Policy Review 11(1): 12-16 (2008), http://guttmacher.org/pubs/gpr/11/1/gpr110111.pdf

Case Study

CASE STUDY: ABORTION COVERAGE AND HEALTH CARE REFORM

Facts about Insurance Coverage of Abortion

Currently, women's access to insurance coverage for abortion depends on the source of funding. Abortion is generally covered in private insurance plans. Low-income women who qualify for Medicaid, on the other hand, generally receive coverage for abortion only in certain limited circumstances.

For those women who have abortion coverage, it is critical that any health care reform efforts preserve that coverage. But preserving coverage is not enough. Health care reform is also an opportunity to provide abortion coverage to women in need.

How is Abortion Currently Covered?

Public Insurance Coverage

Medicaid, the primary health care program for low-income people, is run jointly by the federal and state governments. Each state administers its own Medicaid program under federal guidelines, and the federal government contributes more than half of the program's costs.[21]

- **Federal Medicaid Funding for Abortion.** The federal Medicaid program covers abortion for women enrollees whose pregnancy is the result of rape or incest or whose life is in danger.[22] Yet, many women on Medicaid—low-income women whose health is at risk or who seek an abortion for other reasons—are left without coverage. Today, by restricting coverage to cases of rape, incest, or life endangerment only, Medicaid pays for less than 1 percent of all abortions.[23] For the women on Medicaid who do not meet the narrow exceptions, lack of coverage can mean serious hardship. These women may be forced to divert money essential to meet other basic necessities, continue the pregnancy to term, or seek unsafe, illegal abortions.[24]

- **State Medicaid Funding for Abortion.** The federal restrictions on Medicaid funding for abortion affect only federal funds. States are free to use their own funds to cover additional abortion services. Seventeen states use their own funds to cover medically necessary abortions for Medicaid beneficiaries.[25] While four of these states do so voluntarily, thirteen do so because a court held that such funding was required under the state constitution.[26]

Private Insurance Coverage

- **Private Group Insurance Coverage.** Because private group insurance (i.e. the employer-provided health insurance that a majority of Americans depend on for coverage) follows medical standards and considers abortion a medical procedure, it is generally covered. Federal law requires some coverage by employers. The Pregnancy Discrimination Act of 1978, which amended Title VII of the Civil Rights Act of 1964,

State Bans on Public Funding of Abortion

Some states have laws, regulations, or constitutional provisions broadly restricting public funding of abortion. These provisions generally only allow public funding for abortion when the woman's life is at risk. Courts have blocked such laws to the extent that they conflict with federal Medicaid requirements that also require funding for abortions due to rape or incest. Courts in some states have gone even further, blocking the laws and ordering the state to fund all medically necessary abortions.[27] Depending on the type of health care reform being pursued in the state, these laws may come into play.

Case Study

State Bans on Private Insurance Coverage of Abortion

Five states (ID, KY, MO, ND, and OK) prohibit private insurance plans from covering abortions except in certain circumstances.[30] Four of the states (KY, MO, ND, and OK) apply the prohibition to all insurance policies issued in the state.[31] In Idaho, Kentucky, Missouri and North Dakota, coverage is prohibited except where a woman's life is endangered. Oklahoma includes rape and incest along with its life endangerment exception. Abortion coverage in each of the five states is allowed only through purchase of an additional rider and payment of an additional premium. Also, three states (MN, MS, and WA) permit insurers to refuse to provide abortion coverage.[32] These restrictions mean that even women with private insurance in those states can face particular hardship trying to secure access to abortion coverage.

requires employers with 15 or more employees to pay for health insurance benefits for abortions when the life of the mother is endangered. It also requires employers to cover medical complications arising from an abortion.[28]

- **Private Individual Insurance Coverage.** No published data on abortion coverage in the private individual insurance market—where individuals and families purchase coverage directly from insurers—has been found. As with private group insurance coverage, abortion should typically be covered in the individual insurance market as "surgery" or any other medical procedure. However, it can be very difficult for women to obtain insurance at all in the individual market; those who do have access to this type of insurance often face expensive premiums or limited coverage.[29]

State Employee Insurance Coverage

Some state employees face restrictions on abortion coverage. Certain states, like Kentucky, have laws that specifically prohibit state employee health insurance policies from covering abortion.[33] Other states with more general laws banning public funding for abortion may apply those restrictions to state employees or other groups whose health insurance coverage is funded (at least in some part) by the state. For example, the Colorado state constitution prohibits public funding for abortion. The Colorado Attorney General issued an opinion applying the constitutional prohibition to the state employee health insurance plan.[34]

Federal Employee Insurance Coverage

The federal government is one of the largest employers in the nation, with 1.2 million women of childbearing age enrolled in its health benefits program.[35] Congress restricts abortion coverage in the Federal Employee Health Benefits Plan (FEHBP). It is available only when a woman's life is in danger or when the pregnancy is the result of rape or incest.[36]

How Will State Health Care Reform Proposals Affect Abortion Coverage?

The outcome of specific state health care reform efforts on abortion coverage is impossible to predict, since it depends on the particular health care reform proposal as well as the state's existing laws regarding abortion coverage under public and private insurance plans. This section describes lessons from two states that have implemented, or are thinking about implementing, a comprehensive health reform plan. They serve as examples of the different factors that can have an impact on abortion coverage under state health reform.

Case Study

Lesson from the States:

How Abortion Became a Covered Service in the Massachusetts Public/Private Plans

Massachusetts adopted a health care reform approach that blends public funding and private insurance coverage. Though the reform legislation did not specify which services would be covered in health insurance benefit packages, abortion became a covered service under the state's new and expanded public and private health insurance plans. A number of factors contributed to this outcome:

- Massachusetts is one of the 17 states that funds medically necessary abortions for Medicaid recipients in the state. This coverage is based on the state constitution, which a court interpreted to require the state to fund medically-necessary abortions for women enrolled in public programs.[37]
- Abortion is already covered by private insurance, thereby resulting in its inclusion as a benefit in the state's new private health insurance products as simply maintaining the status quo.
- Members of the Commonwealth Connector board—the entity responsible for implementing many parts of the state's health reform plan—understood the importance of covering a comprehensive set of women's reproductive health services.
- There is a long tradition of health care advocates working together in the state, including those who focus on women's health in particular and those who work on access to health care more generally.
- The presence of religious health care providers was limited. For example, there are no sectarian health plans in Massachusetts and only a small number of hospitals in the state are Catholic.

Although the combination of these particular factors may not be present in many other states,[38] its experience can inform efforts by women's advocates in other states pursuing health reform.

Lesson from the States:

How a Single Payer Plan Could Have Restricted Women's Access to Abortion in Colorado

Legislation enacted in Colorado in 2006 established the Blue Ribbon Commission for Healthcare Reform "to study and establish health care reform models to expand coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents."[39] The Commission evaluated five distinct health care reform proposals, including a single-payer plan.[40, 41] Adoption of a single-payer health plan in Colorado could have resulted in women losing access to abortion coverage, since this state has a constitutional provision prohibiting public funding for abortion. A single payer health plan's funding source—taxes collected from individuals and employers—would

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arguably be subject to the constitutional provision. Consequently, women in Colorado who now have access to abortion coverage through private insurance could lose this covered benefit if the state adopted a single payer model. NARAL Pro-Choice Colorado submitted comments to the Commission, highlighting concerns about the constitutional provision's impact and the need to ensure women's right to safe, legal abortion in the state.[42]

Ultimately, the Commission did not recommend a single-payer plan, but this example illustrates the critical role that advocacy groups can play in identifying and highlighting problems and areas of concern.

What Can Women's Advocates Do to Figure Out the Impact of Potential Health Reform Proposals in Their State?

In order to ensure that advocates are prepared to make the case for inclusion of abortion in any state health care reform, it is essential to understand the state's current laws on abortion coverage.

Research whether the state prohibits public funding of abortion.
If so, are there any exceptions? Does it apply across-the-board or only to certain groups or programs? Or is the state one of the 17 that funds medically-necessary abortions for women in the state Medicaid program?

Review and understand the state's legal and regulatory landscape.
Key sources include the state constitution, state laws and regulations, court cases interpreting the state constitution, laws, and regulations. Key information is available on NARAL Pro-Choice America's website, http://www.naral.org/choice-action-center/in_your_state/. Select the state and look under "Restrictions on Low-Income Women's Access to Abortion."

Research whether the state prohibits insurance companies from offering abortion coverage.
Look under "Insurance Prohibition for Abortion" for the state on NARAL's website.

Find out whether the state permits insurers to decline to pay for abortions or offer coverage.
Look under "Refusal to Provide Medical Services" for the state on NARAL's website.

Contact the National Women's Law Center at the email address: reformmatters@nwlc.org.
The Center is available for assistance in figuring out how a health reform proposal can affect abortion coverage in a state.

Case Study

CASE STUDY: CONTRACEPTIVE COVERAGE AND HEALTH REFORM

Facts about Insurance Coverage of Contraception

For the most part, insurance coverage of contraception has become widespread. However, any health care reform efforts must ensure that contraceptive coverage is not restricted, and that availability is improved. Women who still lack contraceptive coverage must either pay out-of-pocket for prescription contraception, use over-the-counter methods that may not be as effective, or not use contraception at all.[43] Additionally, plans may not cover the full range of FDA-approved contraceptive methods, leaving women unable to choose the method best suited to their needs. Health care reform presents an opportunity to ensure insurance coverage of contraception for those who need it.

How is Contraception Currently Covered?

Public Insurance Coverage

- **Medicaid**. Medicaid provides vital contraceptive coverage to the millions of low-income women of reproductive age who depend on the program for their health care. Family planning services and supplies are specified as a "mandatory benefit" under Medicaid, so states must include them among the services provided to beneficiaries. However, Medicaid law does not explicitly define "family planning" and each state is permitted to decide (within certain guidelines) which services and supplies to cover. States are most likely to classify medical procedures directly related to contraception, prescription and over-the-counter contraceptive supplies, and sterilizations as family planning. For instance, coverage of prescription contraception is nearly universal among state Medicaid programs, and two-thirds of the states also cover over-the-counter contraceptive methods such as condoms.[44]

- **Title X.** Title X is a federal program devoted to providing family planning services and information. While it is not a health insurance program, per se, Title X does provide public funding to cover contraception and other family planning services for 5 million low-income women and men each year in 4,400 health centers across the country. For the most part, clients of Title X programs are low-income, uninsured, and do not qualify for Medicaid.[45] Fees for services are based on the client's income.

Private Group Insurance Coverage

The majority of employer sponsored insurance plans provide coverage for prescription contraception. According to data from 2003, 88 percent of all firms covered oral contraceptives, while 72 percent of all firms covered all five FDA-approved reversible contraceptives. Yet, in the same year, 99 percent of all firms offered some level of prescription drug benefits.[46] Clearly, there are some employers that exclude prescription contraceptives from otherwise comprehensive plans.

State Employee Insurance Coverage

Inclusion of contraception in state employee health insurance plans is almost universal among states.[47]

Federal Employee Insurance Coverage

Congress enacted legislation in 1999 requiring all health insurance plans available to federal employees to include coverage of prescription contraceptives if other prescription drugs are covered.[48]

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What Does the Law Require?

Contraceptive coverage not only makes good policy sense, it is required by law in many places. Federal law requires employers to provide coverage of contraception when they have an otherwise comprehensive prescription benefit plan. In addition, some states require insurers to do the same. Studies have shown that the combination of these laws played a clear role in the sharp increase in contraceptive coverage in the private insurance market between 1993 and 2002.[49]

Employer-Sponsored Insurance

- **Federal Law.** Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act of 1978, prohibits sex discrimination, including pregnancy discrimination, by employers with 15 or more employees, including in the health insurance benefits these employers provide to their employees.[50] Employers that provide health insurance that covers prescription drugs and devices but excludes prescription contraceptives are in violation of Title VII's prohibition against sex discrimination. In December 2000, the Equal Employment Opportunity Commission (EEOC), which enforces Title VII, issued a ruling confirming that such exclusion of contraceptive coverage is a Title VII violation.[51]

- **State Law.** Almost every state has a law against sex discrimination in employment along the same lines as Title VII. Michigan, Montana, and Wisconsin have explicitly interpreted their laws like Title VII's contraceptive coverage requirements.[52]

All Private Insurance Policies Issued in a State

Twenty-four states have enacted legislation specifically requiring that health insurance policies issued in the state that provide coverage for prescription drugs generally must provide coverage for any prescription contraceptive drug or device (often referred to as "contraceptive equity"). The states are: Arizona, Arkansas, California, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Vermont, Washington, and West Virginia.[53] Some of these state laws include religious refusal clauses—exceptions to the contraceptive equity mandate for religious employers or insurers whose religious tenets prohibit the use of contraceptives.

Additionally, there are several states that mandate coverage of "family planning services" by HMOs, but do not appear to have interpreted these laws to require coverage of contraceptive drugs and devices. These states are: Minnesota, North Dakota, Ohio, Oklahoma, and Wyoming.[54]

Some states have mandated "offer" laws, but not coverage. For example, Texas and Virginia require insurers to offer contraceptive coverage as an employer option, but do not require employers to purchase this coverage.[55] Similarly, Colorado, Idaho, and Kentucky require small-group and/or individual market carriers to offer standardized plans that include coverage of contraceptives, but do not require employers to select these plans.[56] It is important to note that Title VII trumps state laws when it provides greater protections.

Gaps Remain

Although the combination of anti-discrimination laws and state contraceptive coverage laws ensure contraceptive equity for numerous women, gaps remain:

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- Title VII applies only to employer-sponsored plans. An estimated 10.3 million Americans obtain health insurance from private insurance other than employer-provided plans.[57] This includes people who are: self-employed; employed by employers who offer no health insurance; part-time, temporary, and contract workers; early retirees too young for Medicare; and unemployed or disabled but not eligible for public insurance. Women are disproportionately represented in several of these categories, such as part-time, temporary, and contract workers.
- Title VII also applies only to employers with 15 or more employees. Less than a fifth of all U.S. employers have 15 or more employees and some 14 million workers are employed by entities that fall beneath this threshold.[58]
- Twenty-six states do not have a contraceptive coverage law for private insurance companies.
- State contraceptive coverage laws do not apply to self-insured health plans. Many large employers do not use private insurance companies to provide health insurance to their employees. Rather, they "self-insure" and use insurance companies only to administer benefits while paying employee claims directly. Many large businesses self-insure, and more than half of all workers with job-based coverage are covered by a self-insured health plan.[59] The coverage that these workers receive is not subject to state insurance company contraceptive coverage laws.
- Religious employer exceptions in some state contraceptive coverage laws can leave employees without coverage for contraception.
- Some states have laws permitting certain health care professionals or institutions to refuse to provide contraceptive services.[60] Women who face these refusals may have a hard time finding someone else to help them, especially if their insurance plan only covers certain providers.

How Will Health Care Reform Proposals Affect Contraceptive Coverage?

Most insurers and employers recognize the benefits of contraceptive coverage. However, some issues might arise in efforts to secure coverage in health care reform proposals:

- The free market approach seeks to eliminate insurance mandates altogether,[61] thereby threatening legal mandates for contraceptive coverage.
- Moves away from employer-sponsored coverage would make Title VII contraceptive coverage requirements inapplicable.

> Advocates need to ensure that all current mandated benefits, like contraceptive coverage, are protected in health reform proposals.

What Can Women's Advocates Do to Figure Out the Impact of Potential Health Reforms in Their State?

In order to be prepared to advocate for contraceptive coverage in health care reform, women's advocates need to understand a state's current laws on the topic.

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Research whether the state has a contraceptive equity law or another law governing insurance coverage of contraceptives.
Detailed explanations about each state's contraceptive coverage law, including any religious employer exemptions, are available from the National Women's Law Center in the report ***Contraceptive Equity Laws In Your State: Know Your Rights—Use Your Rights***, available at http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf.

Find out whether the state allows certain providers or institutions to refuse to provide contraception.
Does a contraceptive equity law have an exemption for religious employers? Go to Guttmacher's State Center at http://www.guttmacher.org/statecenter/ and look for State Policies in Brief. Find the one entitled "Refusing to Provide Health Services" for details on which individuals and entities are allowed to refuse contraception services.

Contact the National Women's Law Center at the email address: reformmatters@nwlc.org.
The Center can provide assistance in figuring out how a health reform proposal can affect contraceptive coverage in a state.

Case Study

CASE STUDY: MATERNITY COVERAGE AND HEALTH REFORM

Facts about Insurance Coverage of Maternity Care

Three-quarters of American women become mothers during their lifetimes.[62] Maternity care—the health care that a woman receives during pregnancy, childbirth, and postpartum—is one of the most common types of medical care that women of reproductive age will receive. Maternity care is also expensive. In 2006, the average cost of an uncomplicated hospital-based vaginal birth was $7,488; an uncomplicated birth by Cesarean section cost an average of $13,194.[63] Notably, these are just the costs related to the birth itself—they do not include expenses for prenatal visits, vitamins and other pregnancy-related medications, or postpartum care.

Despite this need, insurance benefits for maternity care can be exceedingly difficult—if not impossible—for some women to obtain. A woman's access to maternity benefits may depend on factors such as:

- Whether she has access to employer-sponsored health insurance (ESI) through either her own job or that of her spouse. A federal law—the Pregnancy Discrimination Act of 1978—requires employers with 15 or more workers to provide the same level of coverage for pregnancy as is provided for other medical conditions. Correspondingly, the fair employment laws in almost all states consider discrimination based on pregnancy to be sex discrimination, and the majority of these laws apply to employers that are smaller than those covered by Title VII.[64] As a result of state and federal anti-discrimination protections, most women with job-based health insurance receive maternity benefits.

- Her income level. Low-income women who do not have job-based health coverage may qualify for maternity benefits through their state's Medicaid or State Children's Health Insurance (SCHIP) program.[65] States have used these programs to extend health coverage to pregnant women at income levels typically much higher than the eligibility levels for other adults. Federal law requires states to cover pregnant women in families with incomes of up to 133 percent of the federal poverty level (FPL), but most have expanded eligibility beyond that minimum level. For example, the District of Columbia—which has the highest upper income limit for pregnant women under Medicaid, covers pregnant women in families with incomes up to 300 percent of the FPL (for 2008, this is $52,800 for a family of three).[66]

Maternity Coverage in the Individual Insurance Market

If a woman does not have access to employer-sponsored coverage and does not qualify for health insurance through a public program like Medicaid or SCHIP, she may attempt to purchase coverage directly from an insurance company in the individual insurance market. Most individual market health insurance policies, however, do not cover maternity care at all. Consider these facts about maternity care and the individual insurance market:

- An uninsured woman who wants to purchase individual market coverage after she is already pregnant will probably not receive any offers of maternity coverage at all—in most states, individual market insurers are allowed to deny coverage to a pregnant applicant. Even if they are required to issue a policy, insurers are generally allowed to consider the pregnancy as a "pre-existing condition" and will exclude coverage for maternity services.[67]

Case Study

- Even if a woman is not currently pregnant, it is very unlikely that an insurer will provide or even offer maternity benefits as part of her regular insurance policy. While a handful of states have enacted laws requiring all individual market insurers to cover maternity care,[68] research conducted by the National Women's Law Center (NWLC)—and available in the report ***Nowhere to Turn: How the Individual Insurance Market Fails Women***—indicates that the vast majority of individual market health insurance policies do not include coverage for maternity care. After reviewing over 3,500 policies available to a 30-year-old healthy woman in state capitals across the nation,[69] NWLC found that just 12 percent included comprehensive maternity coverage (i.e. coverage for pre- and post-natal visits as well as labor and delivery, for both routine pregnancies and in case of complications) within the insurance policy. Another 9 percent of the policies examined included some level of maternity coverage that was not comprehensive.[70] The NWLC findings are in agreement with the results of an earlier study of 25 cities across the country, which reported that most available insurance plans did not include maternity benefits—even plans with the highest premium costs—and the few plans that did provide these benefits had waiting periods or high levels of out-of-pocket spending for the services.[71]

- If maternity benefits are not included in her insurance policy, a woman may be able purchase optional maternity coverage (called a "rider") for an additional premium. Even when a maternity rider is available, however, the additional cost can be prohibitively expensive. In the aforementioned ***Nowhere to Turn*** report, for instance, NWLC identifies maternity riders that cost over $1000 per month, and these costs are in addition to a woman's regular insurance premium.

Maternity Care and "Consumer-Directed Health Care"

A certain type of health insurance arrangement that proponents call "Consumer-Directed Health Care" has specific consequences for maternity care. This arrangement—which combines a high-deductible health plan (HDHP) with a tax-sheltered health savings account (HSA)—is becoming more common in both the employer-sponsored health insurance and individual insurance markets. Pregnant women enrolled in such plans might be exposed to high out-of-pocket costs, particularly when complications arise.

HDHPs, as their name implies, have a deductible (i.e. a specified amount that health plan enrollees must pay out-of-pocket for health care charges before the insurer will begin to pay) that is higher than that of traditional plans. While HSA guidelines permit certain preventive services to be exempt from a deductible, this is a voluntary option for health plans.[76] And unlike other preventive services such as well-child care, prenatal care is typically subject to a HSA-qualified deductible. This significant cost-sharing might keep some women from obtaining prenatal care services. Nine-month pregnancies tend to span two insurance plan contract years and so may be subject to two annual deductibles, compounding the issue. A 2007 study demonstrated the range in out-of-pocket maternity care costs that women could face under several different plan options—from a low of $3,000 for an uncomplicated pregnancy with vaginal delivery to a high of $21,194 for a complicated pregnancy with a Cesarean section delivery.[77, 78]

Case Study

- Riders may also involve a waiting period (one or two years, for example) during which a woman pays the monthly rider premium but cannot use the maternity benefits.[72] Maternity riders are also often limited in scope. In ***Nowhere to Turn***, NWLC reports that it is quite common for a rider to limit the total maximum benefit to amounts such as $3,000 (available only after a 10-month waiting period for a rider option identified in the District of Columbia) or $5,000 (available only after a 12-month waiting period for an Arkansas rider option).[73]

- A woman's age has an impact on whether maternity benefits are available and at what cost—a 25-year-old woman is likely to have significantly more options, at a more affordable price, for maternity benefits than her 35-year-old counterpart.[74]

- Past maternity care experiences can also have an impact; women who have given birth by Cesarean section (C-section) may encounter additional barriers when trying to purchase coverage through the individual market. An insurance company may charge a woman who underwent a previous C-section a higher premium, impose an exclusionary period during which it refuses to cover another C-section, or reject her for coverage altogether unless she has been sterilized or is beyond childbearing age.[75]

How Can Health Reform Improve Access to Maternity Coverage?

There are a number of ways that state-level health reforms can improve access to maternity coverage. States can raise eligibility levels or simplify enrollment processes for public health insurance programs so that more women can obtain coverage during pregnancy. They can also prohibit insurers from treating pregnancy as a pre-existing condition, or establish new insurance benefit mandate laws that require insurers who sell policies in the state to cover maternity care.[79] Consider the experiences of these two states:

- In **California**, several bills to reform the private insurance market were considered during the 2007-2008 legislative session, in the wake of a failed bipartisan plan for more comprehensive health reform. Among these bills was A.B. 1962, sponsored by Assemblymember Hector De La Torre, which intended to ensure fair, affordable access to maternity coverage in health care benefits, regardless of the type of insurance plan offered. The legislation, which was ultimately vetoed by Governor Schwarzenegger, would have required nearly all individual and group health insurance policies that cover hospital, medical, or surgical expenses to also cover maternity services for women in California. The law included a comprehensive definition of maternity services, including prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care.[80] Importantly, this was the second time that the Governor vetoed such a measure; his veto messages in both instances claim that because of their cost implications, mandate laws are unsound until the passage of comprehensive health reform addressing access to affordable health coverage.[81]

- **Vermont** passed a comprehensive health reform plan in 2006, which included the creation of Catamount Health, a state-subsidized health insurance plan open to all uninsured residents. Catamount Health offers a standard insurance plan, with benefits similar to the typical private plan in the state, through two private insurers. When enrollment in Catamount Health began in October 2007, these insurers were permitted to treat pregnancy as a pre-existing condition and thus excluded coverage for maternity

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care in the health insurance policies they offered to pregnant women.[82] In response to public outcry, state officials moved quickly to address this access barrier, and in June 2008 enacted a new package of health reforms that removed pregnancy from the list of pre-existing conditions for which insurers are able to deny coverage.[83]

What Can Women's Advocates Do?

Advocates can take the following steps to ensure that maternity care is covered as part of health care reform.

Find out whether the state already has laws that prohibit insurers from treating pregnancy as a pre-existing condition, or laws that require insurers or health plans to cover maternity benefits.
Consider which insurers or health plans are subject to any requirements (i.e. Does the law only affect Health Maintenance Organization (HMO) plans?) and also whether the scope of maternity benefits is defined by the law (i.e. Are prenatal or post-partum visits included as part of the required maternity coverage?). This information is available by reviewing state laws and regulations firsthand, by contacting the National Women's Law Center at reformmatters@nwlc.org, or by contacting the state office of insurance. For help with the latter suggestion, the National Association of Insurance Commissioners (NAIC) has an interactive website with links to each state's insurance department: http://www.naic.org/state_web_map.htm.

Support efforts to expand eligibility for public health insurance programs so that more lower-income pregnant women can get coverage.
Public insurance program eligibility levels for pregnant women are already higher than levels for other, non-pregnant adults. However, there is still room for improvement, especially in those states that cover pregnant women only at or near the federally-mandated minimum level.[84] Advocates can determine a state's current Medicaid/SCHIP eligibility level for pregnant women by visiting The Kaiser Family Foundation tool "State Health Facts Online" at: http://www.statehealthfacts.org/comparetable.jsp?ind=206&cat=4.

Promote efforts to recognize maternity coverage—including prenatal, birth, and postpartum care—as a basic health benefit, including "benefit mandates" that require insurers to include coverage for maternity care in all health insurance policies.
The importance of adequate maternity care—especially prenatal care—cannot be overestimated. If a woman visits a healthcare provider early and regularly during her pregnancy, birth defects and other complications can be prevented or appropriately managed. But a precursor to timely care is having the finances or insurance coverage to pay for it; when pregnant women are uninsured, they are considerably less likely to get proper prenatal care.[85] Adequate and affordable maternity coverage is essential for the health of mothers and their children—it should not be a luxury to which only some women have access.

Support efforts around federal health reform that will guarantee access to affordable maternity coverage.
It is especially critical that health reform plans at the federal level include maternity care as part of a comprehensive health benefit package, since only federal action will guarantee that women across the nation have access to the maternity care they deserve. Until this type of federal solution becomes reality, however, women's advocates must work to ensure that maternity care is included as a basic and affordable health benefit in all health insurance policies sold in their state.

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29 See: "Women and the Individual Health Insurance Market" section of the *Reform Matters Toolkit* for further discussion.

30 Idaho Code §§ 41-2142, 2210A, 3439 (Enacted 1983); Idaho Code § 41-3924 (Enacted 1983; Last Amended 1997); Ky. Rev. Stat. Ann. § 304.5-160 (Enacted 1978); Mo. Ann. Stat. § 376.805 (Enacted 1983); S.B. 139, 51st Leg., 2007 1st Sess. (Okla. 2007) (Enacted 2007) (to be codified at Okla. Stat. Ann. tit. 63, § 1-741.2); N.D. Cent. Code § 14-02.3-03 (Enacted 1979).

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Mandated Insurance Benefit Laws: Important Health Protections for Women and Their Families

What Are Mandated Insurance Benefits, and Why Do They Exist?

Mandated insurance benefits are benefits that, by law, must be included in a health insurance policy or contract. Federal and state governments mandate specific health benefits to prevent insurance companies from excluding coverage for certain conditions and from placing stringent limits on covered services. Many laws that mandate health benefits are inspired by real-life instances of insurance company practices driving health care decisions. For example, in the mid-1990's—after learning of women who were sent home from the hospital too soon after giving birth—federal and state policymakers alike responded to the disturbing trend of 'drive-by deliveries' by making new laws that established a minimum postpartum stay for mothers and newborns.[1]

Most insurers complain bitterly about mandated benefits and argue that they increase the cost of insurance, and some health reform proposals seek to limit or eliminate state mandated benefits. However, mandated insurance benefit laws are important: they improve the value of insurance to women because they guarantee that the insurance policies women purchase will include vital health services and procedures. Attempts to limit these laws as part of reform should be rejected.

How Do Mandated Insurance Benefit Laws Work?

Mandated benefits generally fall into three categories: (1) types of health care services or treatments that must be covered; (2) health care providers that are entitled to reimbursement; and (3) coverage eligibility requirements for dependents or other related individuals.[2] Tables 1 and 2 display a selected group of mandate laws enacted by each state, for the first two categories.

Mandate laws can be enacted at either the federal or state level, and they can apply to coverage offered in either the group insurance market (where small or large employers purchase insurance to offer to their workers), the individual insurance market (where individual people and families purchase insurance directly from insurers), or both. In some instances, a benefit is regulated by both the federal and a state government.

Do Mandated Benefits Increase the Cost of Health Insurance Premiums?

The most common argument against the establishment of mandated health benefit laws is that they increase the cost of private health insurance premiums, thereby discouraging employers and individuals from offering or purchasing health coverage. Over the past two decades, many studies have explored the cost and coverage impacts of mandated health insurance benefits, using different methodologies and reporting wide-ranging results.[3] There is a general consensus that mandated health benefit laws do increase premium costs but only to a limited degree.

The U.S. Congressional Budget Office (CBO), for example, has reported that the additional costs of mandated insurance benefits are modest. The CBO estimated that the marginal costs (i.e. the total costs of compliance for those health plans that did not previously offer the

benefit) for five of the most expensive mandated health benefits—including requirements to cover mental health and substance abuse treatment—would increase premiums anywhere from 0.28 to 1.15 percent.[4] Additionally, when considering the establishment of new mandated health benefit laws—as well as the preservation of existing laws—advocates should be aware of the cost savings that can result when women and their families have access to the health services that they need. If a woman forgoes necessary health care because it is not covered by her insurance policy, her health problems are likely to become more complex and more costly in the future. In contrast, when coverage of a health service is mandated by law and is thus included in a woman's health policy, she is more likely to seek the appropriate care in a timely manner, saving costs in addition to improving her health and well-being.

Federal Mandates

There are currently just a few federally mandated health benefit laws:

- The Pregnancy Discrimination Act of 1978 requires employers with 15 or more workers who offer health benefits to provide the same level of coverage for pregnancy as is provided for other medical conditions;
- The Newborns' and Mothers' Health Protection Act of 1996 requires health plans that offer maternity coverage to cover a minimum number of days in hospital following childbirth;
- The Mental Health Parity Act of 1996 requires the same annual or lifetime dollar limits for mental health benefits as is provided for other physical health

A New Federally-Mandated Benefit? : The Breast Cancer Patient Protection Act

The 110th Congress is considering The Breast Cancer Patient Protection Act (H.R. 758, sponsored by Representative Rosa DeLauro) which would ensure that insurance companies cannot restrict a hospital stay in connection with a mastectomy to less than 48 hours. Importantly, the proposal does not mandate that every patient stay in a hospital for that length of time, but for those patients whose physicians recommend a 48-hour stay, the mandate would ensure that insurance companies cannot deny coverage.

The legislation addresses the phenomenon of 'drive-through mastectomies,' whereby healthcare providers—limited by health insurance coverage—send a patient home too soon after their surgeries, while they are still weak, fatigued, and in pain. During a Congressional hearing on the bill in May 2008, a woman who had a drive-through mastectomy shared her harrowing experience, which highlights the need for mandate laws that will protect women's health:

> *I was in shock—my God, my entire breast had just been removed! I felt like a butchered animal. And though my family really wanted to be there for me, they really couldn't understand all of the feelings I was going through. I just wished that I had been in the hospital, so I could have shared my fears with a doctor or a nurse…The worst part was emptying the drainage tubes…We had to empty the drains and then measure and record the bloody fluid…I ended up getting a staph infection and had to seek medical help and in the end, I was six weeks late starting my chemotherapy…It's not right for an insurance company to dictate how a physician must treat a patient. I pay for health insurance to protect myself, in case the worst happens. And when it did happen to me, I found out just how little coverage I really had.*[5]

In September 2008, the U.S. House of Representatives voted to pass the Breast Cancer Patient Protection Act by a wide margin. The U.S. Senate has yet to take up the bill.

benefits when offered by group health plans and insurers; The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (enacted as part of the Emergency Economic Stabilization Act) goes further and requires the same deductibles, co-payments and out-of-pocket expenses, and treatment limitations for mental health and physical health benefits; and,

- The Women's Health and Cancer Rights Act of 1997 requires coverage for breast reconstruction following a health plan-covered mastectomy or lumpectomy, as well as prostheses and treatment of physical complications in all stages of mastectomy.

State Mandates

States have generally gone much further than the federal government in mandating benefits to protect their residents' health care needs. Today, all 50 states and the District of Columbia have enacted various mandate laws that protect patients with dozens of different health care needs. Just two benefits are mandated in all 51 jurisdictions: newborn and maternal lengths of stay and breast reconstruction after mastectomy or lumpectomy. Other benefits, such as diabetic supplies and education, or mammography screening, have been mandated by a large majority of the states. Importantly, a mandate law only applies to the health insurance plans sold in the particular state that has passed the law.

While states play a primary role in regulating health insurance companies, they have limited ability to regulate health benefits when an employer is self-insured. Many large businesses self-insure, and more than half of all workers with job-based coverage are covered by a self-insured health plan.[6] Instead of paying premiums to an insurance company for coverage, a self-insured employer assumes risk itself and pays medical claims for employee plan enrollees as they arise.

Federal law exempts self-insured health plans from state regulation.[7,8] However, federal insurance mandates do apply to self-insured plans; thus, even self-insured employer plans must adhere to the few federal insurance mandates, including those that require coverage for pregnancy-related care, minimum hospital stays after birth, mental health parity, and reconstructive breast surgery after covered mastectomies.

How Do Mandate Laws Protect Women and Their Families?

Some mandated insurance benefit laws guarantee that health insurance policies cover the types of care that women need to stay healthy. Many of the health insurance mandates that states have adopted (and continue to adopt) relate to health care services that women need to lead healthy and productive lives. As Table 1 demonstrates, state mandates include requirements to cover important preventive health care benefits like mammography and cervical cancer screenings, as well as services that help women manage chronic physical and mental illnesses, such as diabetes education and supplies or mental health parity.[9] Mandated benefit laws also guarantee that women have access to the safe and reliable contraception that is an essential component of their reproductive health care—over half of all states require insurers to cover contraceptive prescriptions at the same level as other covered prescription drugs.[10]

It is important to note that though a mandate law may address coverage for a certain important health service, it could still fall short of providing women with full coverage for the care they need. For example, a mandate law may require that health plans cover mental health services, but still allow the plans to impose unrealistically-low annual limits on that

Lessons from the States:
Oregon Enhances Access to Contraceptive Services

In May 2007, Oregon Governor Ted Kulongoski signed the Access to Birth Control Act, making Oregon the 24th state to require insurers to provide equitable coverage of prescription contraceptives (additional states mandate insurers to *offer* equitable coverage of contraceptives or have interpreted state anti-discrimination laws as requiring contraceptive equity). The measure, which applies to employer-sponsored group health plans, requires health insurance plans to provide the same level of coverage for birth control as they do for other prescription drugs. In addition to contraceptive equity, the Act requires hospital emergency rooms in Oregon to offer women who have been victims of sexual assault, or that they believe have been a victim of sexual assault, information about and access to emergency contraception.

coverage. Or, a law may mandate a specific level of coverage for a service only if a plan offers the service in the first place. For example: a mandate for maternity coverage may state that if a plan covers maternity care then it must cover a certain type of prenatal screening test as part of that care.

Some mandated insurance benefit laws require insurers to reimburse certain non-medical or non-physician providers. State insurance mandates also include requirements that insurance policies reimburse non-medical providers such as social workers, and non-physician providers such as nurse-midwives and nurse-practitioners. These laws help ensure that women and their families, when possible, have a choice in health care providers; for example, some women of childbearing age prefer to receive their gynecological or obstetric care from a certified nurse-midwife rather than an obstetrician. In areas where physician providers are in short supply, laws that require insurance policies to reimburse health care services provided by non-physician and non-medical providers can also improve access to timely health care.

In addition, most states have mandate laws that make it easier for women enrolled in managed care plans to get health care from an obstetrician or gynecologist. While managed care arrangements typically require enrollees to access specialists through a referral from a primary care provider, these mandates—commonly called 'Direct Access to OB/GYN' mandates—allow women to seek health care from an obstetrician or gynecologist directly, without first obtaining a referral.

Some mandated insurance benefit laws also require insurers to extend health benefits to dependent family members. Mandated insurance benefit laws do more than guarantee important health services for women—these laws also provide protections for families by requiring health insurance policies to cover certain types of dependents. For example, over three-quarters of the states mandate that health insurance policies cover adopted children on the same terms and conditions as biological children, and the majority of states require insurers to continue coverage for dependent children with disabilities, even after the child has reached maturity.

Mandated benefit laws that require insurers to merely offer a health benefit may not be very beneficial to women and their families. Mandated insurance benefit laws can be classified according to whether they require the insurer or plan to provide coverage in all policies (meaning that the benefit must be included in the policy) or merely offer one or more policies with the specific coverage to potential enrollees (meaning that the benefit

must be offered to the prospective buyer in one of more policies made available by the insurer). A mandate to offer coverage simply makes the coverage available—usually with an additional or higher premium, and perhaps at a high and unaffordable cost for those who need the benefit. Why would an employer who is purchasing coverage for a group of workers include a benefit within a plan just because an insurer must offer it? Hence, an offer law is a compromise that precludes a full coverage law and, from a consumer's perspective, may be the same as having no mandate at all.[11]

Even when a health benefit is mandated by state law, insurers may not be in compliance with state regulations. There is some evidence that health insurance companies do not always comply with a state's mandated health benefit laws. For example, a 1995 study of state mandates for mental health services across the states reported a non-compliance rate of 10 to 15 percent.[12] The laws must be enforced for mandated benefit laws to truly protect women and their families from financial risk and unmet health needs.

The Wrong Direction for Health Reform: Proposals That Would Eliminate Mandated Health Benefits

Some types of health reform plans, if implemented, would limit or eliminate laws that mandate health benefits and other important consumer health protections, such as regulations that limit premium rates or that prohibit insurers from taking pre-existing conditions into account. These proposals are based on the premise that 1) mandate laws and other insurance regulations increase the cost of health insurance and are unnecessary for certain populations and 2) policies that are exempt from many mandates will be more affordable, encouraging more people who cannot find a more comprehensive health plan to buy the plans. These proposals might allow:

- Buying and Selling Insurance 'Across State Lines': Currently, state residents can purchase health insurance sold only within their own state. Federal and state policymakers alike, however, have proposed health reforms that would essentially allow individuals to purchase health insurance products licensed in any state, regardless of the consumer protections that the individual's home state government has adopted. A proposed federal bill called the Health Care Choice Act of 2007 (H.R. 4460, introduced by Representative John Shadegg of Arizona), for example, would allow an insurance company to declare a 'home state' (likely to be the state with the fewest mandate and consumer protection laws) and offer insurance plans approved in that state to people across the country.

- Association Health Plans: Another health reform proposal considered at the federal level would create purchasing coalitions known as Association Health Plans (AHPs). AHPs could buy coverage from insurance companies or become insurance providers themselves by paying claims from their own funds. Since AHPs would be created at the federal level, they would be exempt from state benefit mandates and consumer protection laws and would be subject only to very minimal federal regulations.

- 'Mandate-Lite' Health Insurance: Some states have passed laws that permit health insurers to offer products commonly referred to as 'mandate-lite,' 'minimum (or limited) benefit,' or 'affordable' plans. These products are exempt from many of a state's benefit mandate laws, allowing insurers to sell less expensive policies—with leaner benefit packages—to certain populations. Mandate-lite policies are typically designed for small businesses, since they often face challenges in securing affordable coverage for their

workers, or for previously uninsured individuals. In some cases, a state may even provide publicly-funded subsidies for small businesses or individuals to purchase a mandate-lite plan, essentially undermining its protections for those who can least afford to pay for more comprehensive coverage.

Insurance plans that are exempt from state regulations may be less expensive than more comprehensive insurance products, but they also provide less value to consumers and—by limiting or excluding coverage for certain conditions—expose policyholders to greater levels of financial risk. Proposals that eliminate mandate laws might raise the number of insured people, but they would also reduce the number of people insured against chronic or expensive conditions like diabetes, depression, or breast cancer.

The number of underinsured Americans (i.e. those with insufficient coverage that leaves them vulnerable to financial risk and unmet health needs) is increasing rapidly—a disturbing trend given that underinsured adults are almost as likely as the uninsured to go without needed medical care and incur medical debt—and these proposals will only add to this growing problem.[13] So-called "reforms" that permit insurers to sell health insurance products that are exempt from state mandate and consumer protection laws will undermine states' efforts to meet the needs of their residents and will put women's health at risk. Without strong national standards for comprehensive health coverage, we will continue to need mandated insurance benefit laws.

What Can Women's Advocates Do to Establish or Preserve Important Health Insurance Protections?

Women's advocates can find out which health insurance benefits are mandated in their state, and ensure that their community members understand the protections that do or do not exist under their current state law.
Tables 1 and 2 of this toolkit piece will help women's advocates determine whether their state has a law in place that mandates (selected) health benefits or providers. To fully understand the scope or limitations of a mandate law, however, it may be necessary for advocates to dig deeper with regards to their state insurance laws and regulations (e.g. to determine whether the law applies to the group insurance market, the individual insurance market, or both). Contact the National Women's Law Center at reformmatters@nwlc.org for technical assistance in accessing or interpreting laws related to a state's mandated insurance benefits.

Women's advocates can support benefit mandate legislation that increases women's access to vital health services, providers, and insurance coverage for dependent family members.
As new mandated benefit laws are introduced at the federal and state level, advocates should support those legislative efforts. Specifically, advocates should promote mandate laws that require the actual provision of benefits versus the mere offering of benefits.

Women's advocates can oppose legislation that would limit or eliminate important benefit mandate laws and other consumer health protections.
Such legislation might include proposals to allow insurers to sell health insurance across state lines, proposals to establish Association Health Plans, and legislation that would allow insurers to sell 'mandate-lite' policies. These health reforms would undermine states' efforts and limit their abilities to meet the needs of their residents, and will not further the goal of protecting and improving the health of all Americans. Providing less comprehensive insurance exposes families to health and financial risks; this is no solution to the health care crisis.

For further reading, see:

Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans* (Blue Cross and Blue Shield Association, Dec. 2007).

National Women's Law Center, *Contraceptive Equity Laws in Your State: Know Your Rights-Use Your Rights, A Consumer Guide* (Aug. 2007), http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf.

National Conference of State Legislatures, *NCSL 50-State Legislative Tracking Web Resources: Health Insurance Mandates* (updated June 2008), http://www.ncsl.org/programs/lis/lrl/50statetracking.htm#Insurance

Henry J. Kaiser Family Foundation, *Managed Care & Health Insurance*, http://www.statehealthfacts.org/comparecat.jsp?cat=7 (last visited Aug. 2008).

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2 Greg Scandlen, Employee Benefit Research Institute, *The Changing Environment of Mandated Benefits*, Government Mandating of Employee Benefits, 177-183 (1987).

3 New Jersey Department of Human Services, *Mandated Health Insurance Benefits: A Critical Review of the Literature* (Jan. 2007), http://www.cshp.rutgers.edu/DOWNLOADS/7130.PDF.

4 Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts* (Jan, 2000), http://www.cbo.gov/ftpdocs/18xx/doc1815/healthins.pdf. The benefits included in these CBO estimates are: alcoholism treatment, drug abuse treatment, mental health treatment, chiropractor services, and continuation of coverage.

5 Alva Williams, U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health, Hearing on the Breast Cancer Patient Protection Act of 2007, *Testimony: A Breast Cancer Survivor from North Carolina Speaks Out Against "Drive-Through" Mastectomies* (May 21, 2008), http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.052108.Williams-testimony.pdf.

6 William Pierron and Paul Fronstin, Employee Benefit Research Institute, *Issue Brief No. 314, ERISA Pre-emption: Implications for Health Reform and Coverage* (Feb. 2008), http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.

7 The federal ERISA law makes it easier for multi-state employers to administer employee benefits uniformly across states, but the legislation can also restrict states' abilities to enact substantial health reforms.

8 National Conference of State Legislatures, *Managed Care State Laws and Regulations, Including Consumer and Provider Protections* (update Mar. 2008), http://www.ncsl.org/programs/health/hmolaws.htm.

9 A law that mandates health plans to cover mental health services is generally known as a mental health mandate, and is distinct from a mental health parity mandate. A parity mandate typically requires that if a health plan provides mental health coverage, then that coverage must be equivalent to the coverage that the plan provides for physical health care.

10 National Women's Law Center, *Contraceptive Equity Laws in Your State: Know Your Rights-Use Your Rights, A Consumer Guide* (Aug. 2007), http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf.

11 Miriam J. Laugesen et al., *A Comparative Analysis of Mandated Benefit Laws*, Health Services Research, 41(3p2): 1081-1103 (June 2006).

12 Gail A. Jensen et al., *Mental Health Insurance in the 1990s: Are Employers Offering Less to More?* Health Affairs 17(3): 203 (May/June 1998). Cited by: John R. Graham, Pacific Research Institute, *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance* (July 2008), http://www.pacificresearch.org/docLib/20080630_Heart_to_Hair.pdf.

13 Specifically, "underinsured" is defined either as having medical expenses (excluding premiums) that represent 10 percent or more of income; medical expenses (excluding premiums) for low income people (defined as being below 200 percent of the federal poverty level) that represent 5 percent or more of income; or a deductible that represents 5 percent or more of income. Cathy Schoen et al., The Commonwealth Fund, *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, Health Affairs Web Exclusive, 102:298-309 (June 10, 2008), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=688615.

Table 1: State Mandates for Selected Women's Health Benefits

While this table provides an overview of mandate activity in and across the states, it does not reflect the specific details of each state's mandate law. The sources used do not generally distinguish between the many types of mandate laws, nor the types of insurers who are subject to the law. Depending on how a mandate law is written, it may do little to benefit health consumers. Some of the laws address coverage for a certain health service, but fall short of actually requiring all insurance companies to provide comprehensive coverage for the service. For instance, a mandate law may require that insurers merely offer one or more policies with the specific coverage to potential enrollees, rather than include the coverage in each policy that it sells. Other mandate laws require a specific level of coverage for a service only if a plan offers the service in the first place (i.e. A law requires coverage for a type of prenatal screening test, but it is only relevant for those health plans that choose to cover maternity care.)

Women's advocates can contact the National Women's Law Center at reformmatters@nwlc.org for technical assistance in reviewing the specific details of their state's mandated benefit laws.

	Preventive Health Services				*Behavioral Health Services*		TOTAL
	Breast Cancer Screening[1]	Cervical Cancer Screening[1]	Ovarian Cancer Screening[1]	Osteoporosis Screening[1]	Eating Disorder Parity[2,3]	Mental Health Parity[2,3]	
Alabama	●						1
Alaska	●	●					2
Arizona	●				●	●	3
Arkansas	●				●	●	3
California	●	●		●	●	●	5
Colorado	●					●	2
Connecticut	●				●	●	3
District of Columbia	●	●					2
Delaware	●	●	●		●	●	5
Florida	●			●			2
Georgia	●	●	●	●			4
Hawaii	●					●	2
Idaho	●					●	2
Illinois	●	●		●		●	4
Indiana	●					●	2
Iowa	●					●	2
Kansas	●	●		●			3
Kentucky	●			●	●	●	4
Louisiana	●	●		●		●	4
Maine	●	●			●	●	4
Maryland	●			●	●	●	4
Massachusetts	●	●			●	●	4
Michigan	●						1
Minnesota	●	●	●		●	●	5
Mississippi	●						1
Missouri	●	●		●	●	●	5
Montana	●					●	2
Nebraska	●				●	●	3
Nevada	●	●				●	3
New Hampshire	●				●	●	3
New Jersey	●	●			●	●	4
New Mexico	●	●			●	●	4
New York	●	●		●	●	●	5
North Carolina	●	●	●	●	●	●	6
North Dakota	●						1
Ohio	●	●				●	3
Oklahoma	●	●		●		●	4
Oregon	●	●			●	●	4
Pennsylvania	●	●					2
Rhode Island	●	●			●	●	4
South Carolina	●	●				●	3
South Dakota	●					●	2
Tennessee	●	●		●	●	●	5
Texas	●	●		●		●	4
Utah					●	●	2
Vermont	●				●	●	3
Virginia	●	●				●	3
Washington	●				●	●	3
West Virginia	●	●			●	●	4
Wisconsin	●	●					2
Wyoming	●	●					2
TOTAL	50	29	4	14	24	39	

see page 10 for notes

Table 1, Continued

	Reproductive Health Services				*Mastectomy Services*		TOTAL
	Contraceptive Equity[4,5]	Infertility Diagnosis and Treatment[1]	Maternity Care[8]	Minimum Maternity Stay[9]	Minimum Inpatient Mastectomy Stay[1]	Reconstructive Surgery after Mastectomy[1]	
Alabama				●			1
Alaska				●		●	2
Arizona	●			●		●	3
Arkansas	●	●		●	●	●	5
California	●	●	●	●	●	●	6
Colorado	●		●	●			3
Connecticut	●			●	●	●	4
District of Columbia				●		●	2
Delaware	●			●		●	3
Florida				●	●	●	3
Georgia	●		●	●	●		4
Hawaii	●	●	●	●			4
Idaho	●		●	●			3
Illinois	●	●	●	●	●	●	6
Indiana				●		●	2
Iowa	●			●			2
Kansas				●		●	2
Kentucky	●			●	●	●	4
Louisiana		●		●		●	3
Maine	●		●	●	●	●	5
Maryland	●	●	●	●	●	●	6
Massachusetts	●		●	●			3
Michigan	●[6]		●	●		●	4
Minnesota	[7]		●	●		●	3
Mississippi				●			1
Missouri	●			●		●	3
Montana	●[6]		●	●	●	●	5
Nebraska				●		●	2
Nevada	●			●		●	3
New Hampshire	●		●	●		●	4
New Jersey	●	●	●	●		●	5
New Mexico	●		●	●	●		4
New York	●	●	●	●	●	●	6
North Carolina	●		●	●	●	●	5
North Dakota	[7]			●		●	2
Ohio	[7]			●			1
Oklahoma	[7]			●	●	●	3
Oregon	●		●	●	●	●	5
Pennsylvania				●	●	●	3
Rhode Island	●			●	●	●	4
South Carolina				●	●	●	3
South Dakota				●			1
Tennessee				●			1
Texas	●	●		●	●	●	5
Utah				●		●	2
Vermont	●		●	●			3
Virginia	●		●	●	●	●	5
Washington	●		●	●			3
West Virginia	●			●		●	3
Wisconsin	●[6]			●		●	3
Wyoming	[7]			●			1

see page 10 for notes

Notes and Sources:

1 Source: Kaiser Family Foundation, *State Health Facts Online*, http://statehealthfacts.org. All data is for 2008. Mandates listed apply only to managed care organizations (MCOs), though source does not specify whether the law applies to individual insurance policies, group insurance policies, or both.

2 Source: National Women's Law Center, *Making the Grade on Women's Health: A National and State-by-State Report Card* (2007), http://hrc.nwlc.org. Data is for 2007. Mandate may apply only to managed care organizations (MCOs), and may apply to individual insurance policies, group insurance policies, or both.

3 A parity mandate law is a specific type of mandate which typically requires that if a health plan provides coverage for a certain service, then that coverage must be equivalent to the coverage that the plan provides for physical health care.

4 Source: National Women's Law Center, *Contraceptive Equity Laws in Your State: Know Your Rights-Use Your Rights, A Consumer Guide,* (Aug, 2007), http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf. Data is for 2007. Mandate may apply to individual insurance policies, group insurance policies, or both.

5 Contraceptive equity mandate laws generally require that if a health insurance policy issued in the state provides coverage for prescription drugs generally, it must also provide coverage for any prescription drug or device that has been approved by the United States Food and Drug Administration (FDA) for use as a contraceptive. Most also require that if an insurance policy provides coverage for outpatient health care services, it must provide coverage for outpatient contraceptive services, such as consultations, examinations, procedures, and other medical services.

6 Coverage requirement is a product of litigation based on state anti-discrimination laws, rather than an insurance regulation or law mandating contraceptive equity.

7 The state has a law that mandates HMOs to cover "family planning services." Unlike other states' contraceptive equity mandate laws, the law in this state does not explicitly refer to coverage for contraceptive drugs or devices as part of family planning services; as such, the state may not interpret the law as a specific requirement to cover these services.

8 Sources: The National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (Sept. 2008), http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf?docID=601; Ed Neuschler, Institute for Health Policy Solutions, *Policy Brief on Tax Credits for the Uninsured and Maternity Care* (2004), http://www.marchofdimes.com/TaxCreditsJan2004.pdf. Mandate may apply only to managed care organizations (MCOs), and may apply to individual insurance policies, group insurance policies, or both.

9 Source: Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans* (Dec. 2007). Data is for 2007. Mandate may apply only to managed care organizations (MCOs), and may apply to individual insurance policies, group insurance policies, or both.

Table 2: State Mandates Requiring Reimbursement or Referral for Selected Health Providers

While this table provides an overview of mandate activity in and across the states, it does not reflect the specific details of each state's mandate law. The sources used do not generally distinguish between the many types of mandate laws, nor the types of insurers who are subject to the law. Depending on how a mandate law is written, it may do little to benefit health consumers. Some of the laws address coverage for a certain health service, but fall short of actually requiring all insurance companies to provide comprehensive coverage for the service. For instance, a mandate law may require that insurers merely offer one or more policies with the specific coverage to potential enrollees, rather than include the coverage in each policy that it sells.

Women's advocates can contact the National Women's Law Center at reformmatters@nwlc.org for technical assistance in reviewing the specific details of their state's mandated benefit laws.

	Provider								
	Direct Access to OB/GYN[1,2]	Chiropractors[3]	Nurse Midwives[3]	Nurse Anesthetists[3]	Nurse Practitioners[3]	Optometrists[3]	Psychologists[3]	Speech/ Hearing Therapists[3]	TOTAL
Alabama	●	●		●		●	●		5
Alaska	●	●	●		●	●	●	●	6
Arizona	●	●			●	●	●		4
Arkansas		●		●		●	●	●	6
California	●	●	●		●	●	●	●	7
Colorado		●	●	●	●	●	●		7
Connecticut	●	●	●		●	●	●		6
District of Columbia	●							●	2
Delaware	●	●	●		●	●			5
Florida		●	●	●		●	●		6
Georgia		●				●	●		4
Hawaii	●				●	●	●		3
Idaho	●								1
Illinois		●				●	●		4
Indiana	●	●		●		●	●		4
Iowa	●	●			●	●			3
Kansas		●		●	●	●	●		6
Kentucky	●	●				●			3
Louisiana	●	●	●			●	●	●	6
Maine	●	●	●		●	●	●		6
Maryland	●	●	●	●	●	●	●	●	8
Massachusetts		●	●	●	●	●	●	●	8
Michigan		●	●			●	●		5
Minnesota		●	●	●	●	●	●		7
Mississippi	●	●			●	●	●		5
Missouri	●	●			●	●	●	●	6
Montana	●	●	●	●	●		●		6
Nebraska	●	●	●			●	●		4
Nevada		●	●	●	●	●	●	●	8
New Hampshire		●	●		●	●	●		6
New Jersey		●	●			●	●	●	5
New Mexico		●	●	●	●	●	●		6
New York		●	●			●	●	●	6
North Carolina		●	●		●	●	●		6
North Dakota		●	●	●	●		●		5
Ohio		●	●			●	●		5
Oklahoma		●	●			●	●	●	5
Oregon	●				●	●	●		4
Pennsylvania		●	●	●	●	●	●	●	8
Rhode Island		●	●	●	●				5
South Carolina		●				●	●		4
South Dakota		●	●	●	●	●	●		6
Tennessee		●	●		●	●	●	●	6
Texas		●			●	●	●	●	6
Utah	●	●	●		●	●	●	●	7
Vermont		●				●			2
Virginia		●	●			●	●	●	6
Washington		●	●		●	●	●		6
West Virginia	●	●	●		●	●			5
Wisconsin	●	●			●	●	●		5
Wyoming		●		●	●	●	●	●	6
TOTAL	23	47	31	17	32	46	43	18	

see page 12 for notes

Notes and Sources:

1 A "Direct Access to OB/GYN" mandate requires that managed care programs allow women to have direct access to broad reproductive, gynecologic and health maintenance services, without having to obtain a referral. This is particularly an issue for a female enrollee if she does not select the OB/GYN as her primary care provider.

2 Source: Kaiser Family Foundation, *State Health Facts Online*, http://statehealthfacts.org. Data is from 2008. Mandate applies only to managed care organizations (MCOs), though the source does not specify whether the law applies to individual insurance policies, group insurance policies, or both.

3 Source: Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans* (Dec. 2007). Data is from 2007. Mandate may apply only to managed care organizations (MCOs), and may apply to individual insurance policies, group insurance policies, or both.

Bare-Bones Health Plans: Is Something Better than Nothing?

Some states currently allow private insurance companies to sell bare-bones health insurance plans—policies that offer limited benefits and minimal coverage in exchange for less-expensive premiums.[1] While these basic plans do offer individuals some coverage, they also expose plan enrollees to significant levels of health and financial risk. Due to their specific health care needs and patterns of use, women are particularly ill-served by these plans. Health reform that promotes bare-bones health plans as a means of expanding affordable health coverage is a move in the wrong direction and will only increase the number of *underinsured* Americans—individuals who are more likely to go without needed care because of their insurance plan's inadequate coverage.

What Are Bare-Bones Health Plans and How Do They Work?

Bare-bones health insurance plans are intended to appeal to individuals who want some insurance coverage, but who cannot afford or do not wish to pay for higher-priced comprehensive plans.[2] Bare-bones plans typically offer limited coverage that excludes many critical services. Bare-bones policies are generally sold at significantly lower prices than traditional plans with more comprehensive health benefits. But in return for lower premiums, individuals covered under these plans will likely find themselves with:

- **Fewer benefits.** Bare-bones health insurance includes fewer benefits than traditional health insurance plans. For example, these plans may exclude coverage for prescription drugs, mental health or substance abuse treatment, maternity services, or cancer care.

- **More limitations on benefits that are covered.** Bare-bones policies often limit the coverage on the benefits that are provided. While even traditional health plans place some limits on coverage, the restrictions that some bare-bones plans impose on benefits are often more severe. For example, many traditional health insurance plans do not limit the number of days a person can be in the hospital, nor do they impose annual coverage limits. In contrast, bare-bones policies often cap hospital coverage at a certain number of days in a year and usually only cover a certain amount of costs incurred during a hospital stay. Individuals enrolled in these plans are thus left to pay, often in full, any costs incurred for longer hospital stays or for treatment expenses above the annual coverage limit. This can leave families with thousands of dollars in medical bills—even though they technically have health insurance.[3]

- **Higher levels of out-of-pocket spending.** Bare-bones plans often have high deductibles, co-pays, and other cost-sharing requirements. Some bare-bones plans, for example, include deductibles of $1000 or more for an individual, or several thousands of dollars for a family.[4] Because of these high out-of-pocket expenses, individuals may be required to pay large medical bills before their insurance begins to cover costs. Some health plans, often called "high deductible health plans," also have steep out-of-pocket costs and high deductibles.[5] However, these plans typically do not have the skimpy benefit packages and limits on coverage characteristic of bare-bones policies.

Employers may offer bare-bones health plans to their workers as a lower-cost option alongside more traditional coverage plans, or they may provide bare-bones health coverage

as the only option for employees. This type of health plan may be particularly appealing to small businesses since these businesses have the most difficulty obtaining affordable coverage for their workers. Indeed, many states have enacted laws explicitly allowing insurers to market bare-bones health plans to small businesses—these laws are sometimes called "mandate-lite," "limited-benefit," or "mandate-free" laws because the plans are exempt from many of the state's health benefit mandates (i.e. requirements that insurers include coverage for certain important health benefits in the policies that they sell).[6] Women might also purchase a bare-bones health plan directly from an insurer through the individual insurance market.[7] In general, the health plans that are available through the individual insurance market have more limited benefits and require greater levels of cost-sharing than employer-provided health insurance, though not all individual market plans are bare-bones health plans.

Bare-Bones Plans: A Bad Deal for Women and Families

Due to the lack of coverage for many health benefits and the limited coverage on included benefits, bare-bones plans present women and their families with significant health and financial risks.

- **The limited benefits offered under bare-bones plans disproportionately affect women's access to health care, including preventive health care services.**

  Bare-bones health plans may fail to cover basic health care services essential to a woman's health. On average, women have greater health care needs than men.[8] In particular, women have reproductive health needs that require regular medical visits including maternity care and pre- and post-natal care. Additionally, women of all ages are more likely to take prescription drugs on a regular basis, including oral contraceptives. Women also suffer from certain conditions at higher rates than men, including chronic conditions that require regular treatment such as arthritis, asthma, and diabetes.[9]

  Because of the unique health needs women have, they require comprehensive health insurance that can adequately cover these needs. But bare-bones health plans often exclude certain benefits that are a critical part of maintaining women's health, including prescription drug coverage and maternity care. Women may be less likely to access preventive care such as regular primary care visits and annual gynecological exams if these critical preventive services are not covered under bare-bones plans.

- **Limited coverage and caps on existing benefits put women at increased financial risk.**

  Women are more likely than men to have a chronic condition that requires ongoing treatment, and even healthy women use more health care services than men.[10] Women, therefore, need health insurance that covers their health care needs without leaving them with thousands of dollars of unpaid medical bills.

  Bare-bones plans leave women with significant financial risk because these plans may not cover a woman's full health care costs. For example, while many bare-bones plans purchased on the individual market exclude coverage for maternity care altogether, those plans that do offer coverage often impose severe limits.[11] Under these limitations, even routine pregnancies could leave a woman responsible for significant out-of-pocket

costs. More complicated pregnancies could leave a woman with limited resources in serious debt.

Women who have high health care expenses—such as those with disabilities, chronic conditions, and serious illnesses—are most likely to be negatively affected by the limited coverage and caps on benefits. These individuals generally have higher health care costs, which might exceed the low limits of bare-bones plans. For example, a woman who is admitted into the hospital for multiple days as a result of a severe asthma attack may be left with thousands of dollars in medical bills because her bare-bones plan imposes limits (either in days or dollar amounts) on inpatient hospital stays. Additionally, some plans cover only 5 or 6 visits per year for radiation therapy for cancer.[12] Women who suffer from cancers such as breast cancer and need radiation therapy, however, usually require 5 visits per week over the course of numerous weeks.[13]

LESSONS FROM THE STATES:

"Cover Florida" Creates Bare-Bones Plans to Expand Coverage to the Uninsured

With close to 4 million uninsured residents—one of the highest uninsured rates in the country—Florida faces significant challenges in providing residents with affordable, adequate health care coverage. To address this growing problem, Governor Charlie Crist signed a law in May 2008 that allows insurance companies to offer stripped-down plans to state residents between the ages of 19 and 64 who have been uninsured for six months or longer. All insurance carriers who participate in the program must offer one plan with catastrophic and inpatient coverage and one without these benefits. Neither of the plans will cover important benefits such as treatments for cancer or mental illness.[17] By offering a less valuable, limited benefit package, insurance companies can offer policies for approximately $150 a month, a cost considerably lower than the average price of a traditional, comprehensive health policy.[18] However, individuals who want coverage for excluded services would have to purchase supplemental insurance.[19] Participating insurers are expected to introduce Cover Florida plans in early 2009.[20]

The "Cover Florida" plan is not the state's first attempt at introducing bare-bones plans as a solution to its health care problems. In 2002, the state implemented "Health Flex," a program that allowed insurers to offer limited-benefit plans to low-income residents. Today, only 3 of Florida's 67 counties offer Health Flex plans, and the program has had very low enrollment rates, an experience shared by other states who have allowed insurers to sell bare-bones policies.[21] Reports have suggested that individuals may not consider these plans to be worth the money.[22] The vast majority of individuals who have Health Flex plans use subsidies provided by counties. In fact, Health Flex's 2007 annual report acknowledged that the future of the Health Flex Program depended largely on the availability of government or private funding sources to subsidize part of the program's costs.[23] Unlike Health Flex plans, however, Cover Florida plans will not offer enrollees any subsidies to help pay the $150 monthly premium.[24] This lack of subsidies, along with the limited benefits, further decrease the chance that Cover Florida will be an affordable, adequate health care option for Florida residents.

- **High cost-sharing makes bare-bones plans unaffordable for lower-income women and their families.**

  On average, women earn less than men. They also typically need and use more health services.[14] It is not surprising, then, that women report more difficulty paying for health care than men. Because of the challenges women face paying for health care costs, affordability is a key component to whether a woman is able to obtain the health care services she needs. The high cost-sharing requirements of bare-bones plans—including premiums, co-pays, and deductibles—leave women with high out-of-pocket expenses for health care. Especially for low-income women, this may be more than they can afford. While premiums for bare-bones health plans may be lower than those for more comprehensive coverage, the money saved on lower premiums of bare-bones plans is often spent on higher deductibles and other forms of cost-sharing involved in bare-bones plans. These cost-sharing mechanisms, such as co-pays and deductibles, may also lead women to avoid needed health care.[15] One study, for example, found that some women decided to forgo mammograms altogether when required to contribute even a small co-pay of $10 to $20.[16]

Bare-Bones Plans Are Not Good Health Reform

Bare-bones plans are a risky deal for women and their families and fail to offer an effective solution to the growing number of uninsured and underinsured in America.

Pursuing bare-bones health plans as a reform strategy will do little to reduce the number of uninsured Americans. Instead, these plans will increase the number of underinsured Americans. Historically, limited-benefit products have not sold well.[25] Many insurers are reluctant to sell bare-bones policies, and consumers—aware of the many problems with this type of coverage—are uninterested in buying them. Those that do purchase these plans will join the ranks of the 25 million underinsured Americans—individuals who have health coverage that does not adequately protect them from high medical expenses.[26] According to a recent study, more than half of the underinsured go without needed care—including not seeing a doctor when sick, not filling prescriptions, and not following up on recommended tests or treatment.[27]

Bare-bones plans will further segment the health insurance market and will not help control rising health care costs. Bare-bones plans are intended for those individuals in good health who think they won't need comprehensive coverage. Therefore, these plans will lead healthy, low-cost enrollees away from plans with comprehensive coverage and leave sicker and poorer Americans concentrated in traditional, comprehensive insurance plans.[28] This division of the pool of insured people fails to spread medical risk between those with high and low medical expenses. As a result, the premiums for those in traditional plans may significantly increase.

The high out-of-pocket costs that accompany bare-bones plan may compel financially-concerned individuals to delay or forgo preventive care. This may lead to the development or worsening of illnesses, which the health care system will have to address at a later stage. Treatment for these advanced conditions will likely be far more expensive than the cost of preventing the illness in the first place.

What Can Women's Advocates Do?

Women's advocates can spread awareness about the risks and dangers of bare-bones health plans, and explain why these plans will not help solve America's health care problems.
Bare-bones health plans lack coverage for important health benefits and place limits on the benefits that are covered. Consequently, these health plans present women and their families with significant health and financial risks. Promoting bare-bones health plans will not lead to reductions in America's overall health care costs, but will lead to an increase in the number of underinsured Americans.

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Ensuring Quality Health Care in Health Reform

What Is "Quality" Health Care?

Put simply, it's the **right care**, at the **right time**, for the **right reason**. It's the care we all deserve—but, sadly, it's not the care we can count on in the United States today. Even for those of us fortunate enough to have insurance coverage, too often quality health care is elusive or even out of reach.

Health care reform discussions tend to focus on access to care and the skyrocketing cost of care—both important issues. But unfortunately, ***quality*** is a problem, too. Poor quality care causes serious harm, wastes precious resources, drives up costs and increases disparities. When all is said and done, what good is your insurance coverage if the care you receive isn't right for you? Thus, health reform provides an opportunity to ensure not only that people have access to affordable health care—but that health care is also high quality.

Unfortunately, it's hard to know about the quality of care you're getting. Today, a woman can get more information about the toaster oven or TV set she wants to buy than about her local OB/GYN, pediatrician or internist. There is enormous variation from community to community in the kind and amount of health care people get. Operations like tonsillectomies and hysterectomies are much more common in some areas than others—for no medical reason. Even worse, preventable medical errors—the wrong diagnosis, the wrong operation, the wrong medication—kill more than 180,000 Americans each year.[1]

For women and people of color, the quality problems are particularly striking. For example, women who are having heart attacks are 39 percent more likely to be incorrectly diagnosed than men,[2] and African American women are 36 percent more likely to die from breast cancer than white women.[3]

The Costs of Poor Quality Care

Not only does poor quality cause harm, it is also costly. It is estimated that 1/3 of health care spending is wasted due to poor quality care—either overuse, underuse, or misuse of health care services.[4] Overuse is providing health services for which the potential risks outweigh the benefits—prescribing antibiotics for the common cold, for example. Underuse is not getting patients the tests or treatment they need—evidenced by the fact that only 55 percent of female Medicare beneficiaries between the age of 52 and 69 had a biennial mammogram, despite breast cancer screening guidelines that advise women in this age range to undergo annual mammograms.[5,6] Medication errors are the biggest category of misuse—16 percent of consumers report that they or a family member were the victim of a medication error, with over 20 percent resulting in a serious problem.[7]

How Does Quality Care Fit Into Health Reform?

Fortunately, there is a growing emphasis on delivering better quality, more patient-centered care, and giving consumers information and tools to help them make better decisions and manage their

care more effectively. Using the information provided here, women's advocates can understand the "quality lingo" and advocate for *better* quality health care as part of any health reform plan.

Hospitals, doctors, and other health care professionals have talked about "quality" health care for decades—for example, hospitals have maintained Quality Assurance Committees and medical specialty societies and certifying boards seek to hold doctors to the highest standards. The last several years, however, have brought increasing pressure from health plans, health purchasers (big employers and federal health programs), and patients themselves to independently assess health care providers' performance and to hold them accountable for the care they provide. Beginning in October 2008, for example, Medicare will no longer reimburse hospitals for the treatment of certain conditions that could "reasonably have been prevented"—including falls, pressure ulcers, and infections that result from the improper use of catheters, among others—or for the occurrence of three "never events": objects left in the body during surgery, air embolisms and blood incompatibility.[8] Consumer and patient advocates are playing a progressively more important role in this work.

The Kind of Care Every Patient Deserves

In 1999, the influential Institute of Medicine released "To Err is Human," a report which focused on reducing avoidable errors.[9] Its shocking statistics generated extensive press coverage and launched a movement to improve the quality of care and reduce the tragic number of needless deaths and injuries. Today, preventable medical errors—the wrong diagnosis, the wrong operation, the wrong medication (or the right medication, in the wrong dose)—are the eighth leading cause of death in this country.[10] In American hospitals alone, healthcare-associated infections kill 99,000 people a year. Between 25 and 75 percent of those infections could have been prevented.[11] Many more suffer needlessly, are incapacitated or disabled.

Two years after the release of "To Err is Human," the Institute of Medicine (IOM) released "Crossing the Quality Chasm."[12] This report provided principles that have been widely adopted by policymakers, health care leaders, clinicians and consumer groups. Health care reform lingo now includes reference to "the IOM six"—the six aims for improving the healthcare system. Put simply, every patient deserves care that is:

1) Safe

2) Timely

3) Effective

4) Equitable

5) Efficient

6) Patient-centered

There are three key phrases to remember when thinking about health care reform efforts to address quality:

Measure—whether the right care is given in the right amount at the right time

Report—make the measurement scores available to both the providers who deliver the care and the individuals who receive care

Reward the right things—pay doctors, hospitals and health plans for quality care and good outcomes, and reduce pay for bad care and medical mistakes.

Measure

Health reform should ensure development of performance measures. There is a lot of emphasis today on developing "performance measures"—the yardstick against which we can evaluate how a provider, health plan or hospital is doing in providing some aspect of care. Why is this important? Because if you don't know you have a problem, you can't fix it. What gets measured gets improved! For example, in 1996, only about 62 percent of eligible heart attack patients received beta-blockers (a treatment that is universally recognized as appropriate care). Then health plans began to measure beta-blocker use and by 2003, the rate improved to 95 percent.[13]

Many performance measures have been developed that address care related to specific ailments, such as diabetes, heart disease or asthma. However, until now there has been little effort to develop performance measures relating to reproductive health, including maternity care—despite the great need. The National Partnership for Women & Families has begun a project to catalog existing measures of reproductive health quality, identify gaps, and stimulate development of new measures to fill those gaps. Women need better information when they make decisions about their reproductive health care. They deserve information that helps them decide what care to get and where to get it.[14]

Organizations Leading the Charge to Measure the Quality of Health Care

The National Quality Forum (NQF) is a not-for-profit membership organization that brings together consumers, employers, providers and other stakeholders to endorse national consensus standards for measuring the quality of health care. Some of the areas addressed by NQF standards include:

- Patient safety (medication errors and hospital-acquired infections)
- Ability of providers to communicate and organize care
- Immunizations
- Pain management
- Cancer care
- Asthma care
- Diabetes care
- Pregnancy, childbirth, and newborn care

There are many different types of groups and organizations developing measures of health care quality, including the Joint Commission (which accredits hospitals and other facilities), the National Committee for Quality Assurance (which accredits health plans and other organizations), and the American Medical Association, among others.

We know that measuring can improve care. Measuring *plus public reporting* works even better.

Report

Health reform should ensure public reporting of performance. Public reporting is an essential part of quality improvement. It can spur hospitals and other providers to improve the way they deliver care. It can also help families choose nursing homes that provide the best care for their loved ones, help patients select specialists that have the best patient outcomes, and help employees know which health plans provide the best value for their health care dollars. Consumers have a right to know about the quality of care they are getting, and need good comparative information to make wise choices about where to get their care.

Consumer Decision-Making and Consumer-Directed Health Care

All health insurance plans should aim to provide consumers with the right care, at the right time, for the right reason. Women should have as much information as possible about health care so that they can make wise decisions about the care that they (or their family members) receive. Such information availability is often called "transparency" in health care quality or costs.

Increased transparency in health care quality and costs is at the core of specific type of health insurance called Consumer-Directed Health Care, which is a combination of high-deductible health plans (HDHPs) and tax-free Health Savings Accounts (HSAs). Proponents of Consumer-Directed Health Care maintain that HSA/HDHP arrangements will encourage saving for future health care expenses and allow consumers more control over health care choices, presumably increasing the efficiency of the health care system and reducing the growth of health care costs.

Increased transparency, in and of itself, is a worthy goal. But, support for better-informed *Consumer Decision Making* must not be confused with support for *Consumer-Directed Health Care*. The mechanics of Consumer-Directed Health Care shift much of the risk of needing expensive care from employers and insurers to individuals and families. Financially-concerned HDHP/HSA enrollees might forgo necessary health care and those with higher-than-average medical expenditures—including women—may take on significant financial risk. Contrary to the claims of its supporters, Consumer-Directed Health Care is unlikely to result in a reduction in the uninsured or in America's overall health care costs. The "Health Savings Accounts and High-Deductible Health Plans: The Wrong Answer to Women's Health Care Needs" section of the *Reform Matters Toolkit* explores Consumer-Directed Health Care in more depth.

Reward the Right Things

Health reform can ensure that payment systems reward the right care. This is where the link between cost and quality comes in. Right now, our health care payment system often rewards the wrong things. We pay for procedures regardless of whether they are the right care for the patient. We provide more incentives for specialty care than we do for primary and preventive care—even though primary and preventive care can keep patients healthy and identify problems before they become so serious that specialist care is necessary. Think about it. We pay the same amount whether it is good care or bad care. Changing our payment system to reward the right things will not only improve the quality of care, but also help slow the skyrocketing costs. The federal government and some states are taking steps to make these kinds of changes, like refusing to pay for certain medical errors or hospital-acquired infections. These new payment policies are spurring hospitals and other providers to take the necessary steps to prevent such errors.

What Can Women's Advocates Do to Ensure Better Quality Care for Women and Their Families?

- When advocating for health care reform and improved access to care, look for ways to improve *quality* of care as well. Insist that quality measurement and public reporting provisions be included in any reform plan.
- Many states are now developing health care quality score cards. If your state is publishing this kind of information, make sure the consumer voice is part of that process so that the end result is meaningful and accessible to consumers.
- Raise your voice for better care—be active in efforts to encourage providers to measure and report on the quality of health care and reward the right behavior.
- Look for health care quality information when you make decisions about their care, or seek care for loved ones. Everyone should become a more informed health care consumer.

Lessons from the States:

Examples of Quality Improvement Initiatives in Three States

In **Minnesota**, consumer advocacy groups are working to increase public awareness and demand for quality health care information. As a result of that work:

- Advocates recommended measures for inclusion in Minnesota Community Measurement's 2007 Health Care Quality Report. This report provides comparative information on how well health care providers are doing in providing preventive care and treating certain chronic conditions. This is the first time advocacy groups weighed in and made recommendations about which measures would be most meaningful to their members and which measures would increase consumer use of the Quality Report.
- Advocates advised the state Department of Health about ways to make its Adverse Events Report more consumer-friendly. Adverse events include things like surgery on the wrong patient or body part, serious medication errors, and pressure ulcers. The legislatively mandated annual report discloses the number of adverse events that occur in each of Minnesota's hospitals. The first two reports, released in 2005 and 2006, were lengthy and included a great deal of clinical terminology; advocates suggested a number of ways to address these problems. In response, the state Department of Health created a consumer companion guide to the Adverse Events Report. The guide will make Adverse Events information more accessible to consumers who are making decisions about hospital care.

In **Pennsylvania**, hospitals' inpatient mortality rates plummeted from above the national average to well below the national average after implementation of hospital-specific public performance reports. The Pennsylvania Health Care Cost Containment Council (PHC4) has been operating for more than ten years and releases an annual report on hospital performance, including re-admission analyses. The Council estimates that publishing this information has resulted in 19,000 lives saved and $740 million in saved health care costs.

For more than ten years, the **Utah** Health Department has been issuing annual "report cards" on HMOs in its state for residents to use when making health plan decisions during open enrollment seasons. These report cards give the scores of each health plan on a wide range of measures, including preventive screenings, child and adolescent immunization rates, and consumer experience. The state also publishes reports on individual hospital performance on certain kinds of care, including maternity.

For further reading, see:

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Health Information Technology: A Key Component of Health Reform

When Hurricanes Katrina and Rita ravaged the Gulf Coast in August 2005, most patients evacuated without any record of the treatments they had been receiving. After the hurricanes destroyed more than one million paper-based medical records, providers and their patients were left to rely on memory alone to recall complex plans for medical care like chemotherapy treatments, as well as routine needs like birth control pills.

If Health Information Technology (HIT)—or the use of computers and other electronic devices to securely manage information about a person's health—had been in widespread use before disaster struck, untold numbers of Gulf Coast residents and their care providers would have been spared the distress and uncertainty of reconstructing complete medical records from scratch. Computerized medical records would have facilitated safer, more timely and appropriate health care for Gulf Coast evacuees.[1] Indeed, incorporating HIT into the health care delivery system—both in routine settings and as a disaster preparedness measure—can reduce medical errors and improve coordination of care regardless of patient location, thereby enhancing the quality and efficiency of care.

Though health reformers advocated for the adoption of HIT long before Hurricanes Katrina and Rita, these disasters are a compelling demonstration of why HIT is an essential tool for delivering high-value health care and a key component of many health reform plans.

How Can HIT Improve Health Care Delivery?

In order to ensure that a patient receives the right care at the right time, information is required at the point of care from many sources, including patients themselves. Think about how health care delivery, as well as the ease of using the health system, might improve if a woman could:

- Be sure that her labs, x-rays, and other test results are available to each of her health care providers, enabling shared decision-making during an office visit and improved coordination of services between providers, while eliminating the need to repeat medical tests unnecessarily.
- Track her medical test results over time and share this information electronically with her doctor, assuring her and her doctor that they both are aware of the most up-to-date information, while reserving precious office time for more urgent matters.
- Go directly to the pharmacy after her doctor's appointment, where she is able to pick up her prescription without waiting because the doctor sent it electronically.
- Access her child's immunization records from a home computer and send them to school, an after-school program, or a sports program, all without leaving home.
- Access and manage a complete list of her mother's medications, which is also shared with and updated immediately by her primary care doctor and staff at her skilled nursing facility.

These are only a few examples of how integrating HIT into medical practice can improve health

Confidentiality is Key

The movement to adopt HIT will only succeed if people trust that the information contained within these systems will be protected and shared only with authorized parties. When women obtain reproductive health services, for example, it is crucial that their medical records be treated in a confidential manner. Patients who fear that their use of services will not be kept private may delay or forgo important care central to their own or their family's health.

care delivery by reducing medical errors, improving clinical decision-making, improving coordination of health care regardless of patient location, and empowering patients to participate more actively in their own care.

Defining Key Terms in Health Information Technology

There are many ways to talk about HIT, just as there are many ways to implement this type of reform. Understanding the following concepts is an important first step toward recognizing how HIT can improve the way health care is delivered.

Health Information Technology (HIT) is the use of computers and other electronic devices to manage current and historical health information related to a person's physical, emotional, and social well-being. This can an include clinical, medical, and wellness information.[2]

Health Information Exchange (HIE) is the electronic movement of health-related information among organizations according to nationally recognized standards.[3] It facilitates the mobilization of health care information across organizations and disparate information systems within a region or community.[4]

Electronic Medical Record (EMR)—An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.[5]

Electronic Health Record (EHR)—An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.[6]

Personal Health Record (PHR)—An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the patient/consumer.[7]

E-prescribing is an electronic way for health care providers to generate and transmit prescriptions to participating pharmacies. E-prescribing software can also check for errors like drug allergies, provide a patient's prescription history, and show formulary information that specifies a patient's insurance coverage for prescriptions.

E-prescribing is often considered the best starting point for the implementation of HIT because of the benefits it can offer. Nearly 150 million of the prescriptions written by health care providers each year require a follow-up phone call to the provider's office to clarify the order.[8] Worse yet, the Institute of Medicine estimated in 1993 that approximately 7,000 deaths occur due to medication errors. These errors are mostly due to illegible hand writing, wrong dosing, a missed interaction, or a missed drug allergy.

Why Hasn't HIT Been More Widely Adopted?

There are many reasons why our health care system is not connected electronically, and therefore cannot easily take advantage of the benefits of HIT. For instance:

- Electronic systems can be very expensive for physicians to purchase. Costs vary, but some estimates indicate that a practice will

spend $15,000-$20,000 per physician to implement these new technologies.[9] These estimates do not include the costs associated with lost productivity while practices learn to use the new technologies and to incorporate them into their workflows.[10]

- Different electronic systems may or may not be able to communicate with each other. Standards must be developed and used by all so that systems can securely share data when authorized by a patient or provider. Development of these standards is an ongoing process.

- There are no standard rules in place yet that ensure that people will be able to choose who can have access to their information electronically and who cannot. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides some protection, but was not designed for the new electronic environment that health providers and consumers currently face.[11]

- State laws sometimes present barriers to sharing information across state lines.

HIPAA in the Electronic Health Environment

The HIPAA law offers a foundation of protection for using and disclosing personal health information. For "covered entities"—defined in the law as health care providers, insurance companies, and "health care clearinghouses" that process insurance claims—HIPAA puts restrictions on how they can use and disclose information. One problem is that many people feel that these restrictions are not strong enough to protect patients' privacy. Another major problem in an electronic environment is that there are more and more companies that have access to health information that are not covered entities under HIPAA because they are not a provider, insurer, or clearinghouse. Since they are not subject to the law, there is no way to hold these groups accountable if they acquire and misuse personal health information.

Encouraging Health Providers to Adopt HIT

Adoption of electronic systems continues to be a significant problem. While some hospitals are in the process of implementing electronic systems, physician practices have a very low adoption rate (17 percent according to some studies). Of physicians who have implemented HIT, only 4 percent have fully functioning systems for electronic recordkeeping. The government has begun to promote adoption by creating 'carrot and stick' incentives for e-prescribing in the 2008 Medicare bill. Essentially, physicians will receive a bonus payment from Medicare if they use electronic prescribing. Ultimately this bonus will be replaced by financial penalties for physicians who have not adopted e-prescribing.

What Can Women's Advocates Do to Promote HIT?

Women's and consumer advocates, as well as consumers themselves, can take a number of important actions in support of HIT.

Support health reform plans that would accelerate use of HIT while protecting the privacy, security, and confidentiality of health information.

Learn what kinds of activities are happening in your community related to health information exchange.
A partial list of state activities can be found at www.nationalpartnership.org\hit.

Talk to the leaders of your local efforts about being a consumer representative on a workgroup or planning committee that is focusing on HIT development or implementation.
Advocate for functionality and design that meet consumers' needs for accessing their health information, as well as strong privacy and security protections. You can use the Consumer Principles at www.nationalpartnership.org/HIT to guide your efforts.

Educate policymakers about how HIT can improve care and reduce medical errors, as well as about how they can play a role in crafting policies that are protective of women's health information.
Ask your health care provider if he or she uses e-prescribing or other health information technology. If not, ask what plans they have for adopting new technologies.

Tips for Promoting HIT at the Local Level

There are some important things to remember when beginning advocacy work in the HIT arena:

- Community HIT efforts that involve only one patient or consumer advocate fail to appreciate the multiplicity of perspectives that exist within the consumer/patient umbrella, and in so doing exacerbate the power imbalance between consumers and other stakeholders. Consumer advocates must be well-organized and work together to put forth a strong consumer voice.
- There is a tremendous need to make the "value case" for health information technology from the consumer perspective. This means understanding the potential benefits of HIT to the consumer and communicating those benefits in a way that engages and appeals to the public.
- Women's advocates can be crucial participants in these discussions by focusing both on the benefits of HIT and on how to resolve key privacy and security issues. When serving on a workgroup or planning committee that is focusing on HIT development or implementation, women's advocates should consider the following questions:
    - What is being done to ensure the privacy and security of information? If a breach of information does occur, will the individual be told? What remedies will be offered to that person?
    - Are the individuals whose health information is being exchanged able to specify which information they want or do not want to share, or must they agree to share all or none of their information?
    - Are individuals able to access their own information, or are only doctors and other health care providers allowed to access the system?
    - Are individuals able to grant other people (like a son, daughter, or caregiver in the home) access to their health information through the system?
    - Who else will have access to individual health information in the system? For what purposes will they use the information?
    - Are there health care providers in the area that already have a functioning HIT system? How have these providers implemented HIT? (Seeing these technologies at work can help women's advocates understand the value of HIT and facilitate more fruitful conversations about how to mesh privacy and security considerations with the appropriate exchange of information.)

By being active on HIT issues, women's advocates can provide important input for a women's (as well as a consumer's) perspective while strengthening the collective efforts of consumer advocates.

For further reading, see:

National Partnership for Women and Families, *Health Care Quality & Patients Rights: Health Information Technology Project*, www.nationalpartnership.org/HIT (Last visited November 12, 2008)

Alliance for Health Reform, (June 20, 2008), *Health Information Technology and Its Future: More Than the Money* (Briefing Materials), http://www.allhealth.org/briefing_detail.asp?bi=131

Vernon K. Smith, et al., The Commonwealth Fund, (Feb. 2008), *State E-Health Activities in 2007: Findings From a State Survey*, http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=669309

Agency for Healthcare Research and Quality, *Health IT Bibliography*, http://healthit.ahrq.gov/portal/server.pt?open=512&objID=653&&PageID=12790&mode=2&in_hi_userid=3882&cached=true (Last visited October 17, 2008).

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1 Associated Press, *Hurricane Highlights Need for Digital Health Records*, MSNBC (Sept. 13. 2005), http://www.msnbc.com/id/9316246/.

2 National Alliance for Health Information Technology, *Defining Key Health Information Technology Terms* (Apr. 2008), http://www.hhs.gov/healthit/documents/m20080603/10_2_hit_terms.pdf.

3 *Id.*

4 Janet Marchiboda and Jennifer Covich Bordenick, eHealth Initiative Foundation, *Emerging Trends and Issues in Health Information Exchange* (2005), http://www.ehealthinitiative.org/files/eHI2005AnnualSurveyofHealthInformationExchange2.0.pdf.

5 National Alliance, *supra* note 2.

6 *Id.*

7 *Id.*

8 *Id.*

9 Steve Lohr, *Most Doctors Aren't Using Electronic Health Records*, The New York Times (Jun. 19, 2008).

10 Peter R. Orszag, Congressional Budget Office Director's Blog, *Health Information Technology* (May 20, 2008), http://cboblog.cbo.gov/p=106.

11 The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 300gg-41 (2008).

2008

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Forthcoming

In the coming months, the *Reform Matters* project team will prepare brief analyses of health reform efforts in selected states. As they are completed, these pieces of the *Reform Matters Toolkit* will be available on our website: http://www.nwlc.org/reformmatters/toolkit.html

To automatically receive notification when a new toolkit piece becomes available, go to **http://action.nwlc.org/reformmatterstoolkitupdates** to complete a form with your contact information. Keep your copy of the *Reform Matters Toolkit* up-to-date so that you can fully participate in health care reform movements at the state and national levels!

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Dos and Don'ts: Talking About Health Care Reform

Health care ranked among the top three presidential campaign issues for American voters, and more than a dozen states have enacted or proposed plans for comprehensive health reform. While these are hopeful signs that the time is ripe for real change, to fully engage their communities in supporting progressive health reform, women's advocates must be strategic about ***how*** we talk about health care reform.

For women in particular, the state of the nation's health care system is a major concern. To build support for health care reform efforts among this voting group, it is important for advocates to be aware of what women believe and value when it comes to the health care system. In addition, we must understand how to talk with women about health care reform, including which words and concepts to emphasize, and which to avoid.

The following messaging comes from polling conducted by the Herndon Alliance in November 2007.

The Context:

- Health care is very important to voters, and the top issue after the war in Iraq and the economy.
- Rising costs are the top concern for voters, the majority of whom are insured.
- Voters often support reform proposals in principle, but pull away from policy specifics fearing higher costs or lower quality for them personally. They don't want to lose what they have; choice is key.
- The concept of "quality affordable health care" is more appealing than "universal coverage." It connects the needs of the uninsured and underinsured to those of the insured, who are worried about rising costs.
- Health care is a core value for women—linked to the pursuit of the "American Dream," our country's destiny, and each family's well-being and future.
- Female voters talk about health care in moral terms—no American should be denied access to health care. Yet, just calling health care a "moral issue" does not motivate women to be more supportive of health reform.

The Concepts:

Health care reform concepts that resonate with women voters include:

- Health care should be affordable and secure, so that access is not compromised by life transitions such as widowhood, a change in job status, or divorce.
- Women want a choice of health care providers, as well as the ability to maintain a relationship with their current physician;
- Women see a role for government in regulating, rather than providing, health care;
- Small businesses should be protected so that reform efforts do not burden these employers;

- Part-time workers should have access to health insurance; and,
- Women are in favor of eliminating rules that allow health insurers to deny coverage for pre-existing medical conditions.

The Barriers, and How to Overcome Them

Despite their recognition of the many problems within the current health care system, women voters have major concerns about health care reform. Women's advocates must be aware of these concerns; when crafting messages, keep these possible barriers in mind, and focus on messages that will overcome those barriers.

Barriers to Health Reform	Overcoming the Barriers
Cynicism about government & "red tape"	Incorporate an element of personal responsibility
Fear of higher costs, higher taxes	Include options & choices—make sure it's employee choice, not just employer choice
Loss of quality	Use preventive care as a stepping stone
Undocumented immigrants and other 'undeserving' people	Emphasize security, peace of mind, and control
Perceived impact on small businesses	Focus on how reforms will help small business, or small business support for health reform
The ability of powerful interests to block action	Define a role for government as a watchdog and rule-maker

Health Care Reform: Words to Use and Words to Avoid:

The words we use have the ability to affect women who are on the fence about health care reform. Polling data shows that certain words and concepts should be avoided when composing messages about health care reform. Advocates can communicate more effectively by tailoring messages about reform to include words that are familiar to their audience, and that promote positive associations.

Health Care Reform: Words to Use	Health Care Reform: Words to Avoid
Quality affordable health care	Universal coverage
American health care	A system like Social Security; Canadian style health care
A choice of public and private plans	Medicare for All
Sliding scale	Free
Prevention	Wellness
Smart investments; investing in the future	Inexpensive
Choice	Competition
Rules	Regulations
Guaranteed	Required
Giving people control; peace of mind	Government health care for all
Standard package; affordable health plans	Basic health care
Government enforcement/ watchdog	Government health care; public health care

For more detailed information on these health care reform polling results, see the related Powerpoint presentation slides in the "Talking About Health Reform" tab of the ***Reform Matters Toolkit.***

For an online copy of The Herndon Alliance presentation, visit: http://action.nwlc.org/site/DocServer/LakePresentation121207.pdf?docID=381

Herndon Alliance

What Women Want: How to Talk to Women Voters About Health Care

Presentation by Celinda Lake

December 12, 2007

www.lakeresearch.com

1

The Process

- ✓ **Values Mapping**—The Herndon Alliance approach did more than simply identify strong health care messages, it also entailed identifying the beliefs and values of key groups of voters so that bridges can be built between core health care supporters and other constituencies.

- ✓ **Define Constituencies**—The goal is to build a new, values-driven, health justice majority. To do this, we must first identify a health care "Base", and then identify "Constituencies of Opportunity" - those constituencies that hold some but not all of the key values, those who hold progressive values but not as strongly as our base, and those who may not hold the values of the health base but look in other ways much like our base.

2

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The Process – Continued

- ✓ **Workshops developing strategic initiatives**—Workshops consisting of health justice experts and leaders along with researchers from Lake Research Partners and American Environics generated creative new Strategic Initiatives designed to advance a new health care policy agenda that had the potential to bridge the values of base voters and Constituencies of Opportunity.
- ✓ **Focus group testing**—Extensive focus group testing among the Constituencies of Opportunity and health care base voters produced further refinements in the strategic initiatives to ensure they engaged voters on a values level and helped generate support for universal health care. The second round looked at development of Guaranteed Affordable Choice, and testing of attacks and responses.
- ✓ **Survey testing of the strategic initiatives and messages to defined constituencies**—The survey component of the research was designed to test support for initiatives, messages and frames - to experiment with language and test the impact of different health care frames including how well they stand up to opponents' attacks.

3

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The Context

- ✓ **Health care is clearly salient to female voters.** Rising costs and quality are the top concern for women, the vast majority of whom are insured.
- ✓ Voters are concerned it will cost more to insure the uninsured. Cost-shifting is not well-understood.
- ✓ Voters connect to health care as consumers. They feel they are getting less for more, and resent that insurance companies deny coverage to people who need it and to people with pre-existing conditions and hit consumers with increased deductibles and co-pays.
- ✓ Voters often support reform proposals in principle — but pull away from policy specifics fearing higher costs or lower quality *for them personally*. They don't want to lose what they have. Choice is key to reassure them.
- ✓ The concept of "quality affordable health care" is more appealing than "universal coverage." It bridges the uninsured and underinsured to the insured who are worried about rising costs.
- ✓ Voters strongly support Medicare but believe it has problems. Because of those problems, people are wary of using it as a model.

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Core beliefs

- ✓ **Health care is a core value for women**– linked to the pursuit of the American Dream, our country's destiny, and each family's well-being and future.
- ✓ Female voters talk about it in moral terms – no American should be denied access to health care.
- ✓ Yet, just calling this or that health care proposal a "moral issue" is insufficient to move women, or voters in general.
- ✓ Women voters are especially likely to see health care as a necessity. **They see a role for something beyond market forces to ensure affordable access.**
- ✓ Women believe everyone should have access to quality, affordable health care — but they don't want to pay for those they perceive to be "undeserving". Insuring illegal immigrants is a problem.
- ✓ Women voters want an "American" solution. They are skeptical of a "government run" program, but they see a clear role for government as a watchdog.

5

Peace of Mind

People, especially women, want security and peace of mind for themselves and their families. They want affordable health care they can count on. They want affordable health care that mirrors life's transitions: job changes, kids turning 18 or 21, part-time and full-time work, having a major disease, retiring before Medicare kicks in, etc.

And they want affordable health care that mirrors transitions in the economy – outsourcing, mergers, buyouts, reduced hours, profit cycles, etc.

6

"I'm going to be in your situation very soon because, being divorced, I was under my husband's insurance and that's going to run out the first of the year. As an independent contractor, I'm going to have to find insurance." (Atlanta, marginalized middle ager, female)

Overcoming the Barriers

- ✓ Incorporate an element of personal responsibility
- ✓ Include options and choices in proposals – make sure it's employee choice, not just employer choice
- ✓ Use preventive care as a stepping stone
- ✓ Find a uniquely *American* solution, including choice
- ✓ Emphasize security and peace of mind and control, especially with women
- ✓ Focus on our support for small business
- ✓ Propose initiatives that reflect voter values about health care
- ✓ Define a role for government as watchdog and rule maker
- ✓ Animate anger, not fear

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Women Voters

- ✓ 85% of voters say everyone in their household is insured, and 95% of households have coverage for at least some family members. A third (33%) of women voters get their health insurance through their employer.
- ✓ **Women are the real health care issue voters, the keepers of quality, and the drivers of consumer decisions. Men look to women on the issue of health care. It is therefore essential to organize women and address their concerns.**
- ✓ **Small business owners are an important constituency on this issue.** A small business voice on our side is an important signal to persuadable voters. Women-owned businesses and businesses which rank health care for their employees as a top priority can be useful in mobilizing women voters.
- ✓ **Female Proper Patriots are a key swing constituency** (32% of women voters--focused on personal responsibility, everyday ethics and national pride).
- ✓ **Female Marginalized Middle Agers** constitute about 21% of women voters and are looking for help and status.
- ✓ **Female Health Care Base** voters constitute about 26% of women voters and are our core health care reform supporters.

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*SEIU/AHC polling by Lake Research Partners, November 2008.

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Guaranteed Affordable Choice: Focus Group Research

Guaranteed affordable health insurance coverage for every American with a choice of private or public plans that cover all necessary medical services, paid for by payroll taxes on employers and individuals on a sliding scale.

11

Full 2007 Guaranteed Affordable Choice Focus Group Language

- Americans would be guaranteed to have a choice of health plans they can afford, either from a private insurer, or from a public plan offered at a sliding scale cost based on income.
- To maintain quality and allow fair cost comparisons, health insurance companies and the public plan would be required to provide at least a standard, comprehensive package of benefits including preventive care and all needed medical care.
- Employers would be required to offer a choice of the public plan and at least one private plan to all employees, including part-time employees.
- Employers and individuals could choose to keep their current health plans or one that offers more coverage beyond the standard plan, but all plans — private or public—would have to cover at least the standard package of benefits.
- The cost to employers would be 8% of payroll, with discounts for small businesses. Employees would pay 4% of their paycheck through a payroll deduction. This would pay for all of their health care, including their dependents, with no additional premiums and no deductibles.
- No private or public insurer could deny coverage or charge higher premiums to people with pre-existing conditions.
- Illegal immigrants would not be eligible for the plan.
- Costs would be controlled by competition between the plans, and by using a nationwide pool to negotiate lower prices within the public plan.

12

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Women focus group insights on Guaranteed Affordable Choice

- Generally speaking, women like the concept of Guaranteed Affordable Choice—and are generally less skeptical than men. They are upset about the greed of private insurance and pharmaceutical companies and they are ready for an alternative, even as they fear losing what they have.
- Women think the 4% payroll deduction and sliding scale to pay for the plan are fair and reasonable. They want employers to pay more than employees.
- Women are quite concerned about the impact on small business – discounts are important – and some are confused about coverage for multiple family members.
- Women voters tend to perceive a public plan as inferior and need reassurance that they will have a choice and won't be dumped into a public plan. Once they have that reassurance, they like the guarantee that they will always have health coverage, and knowing that all plans have to provide a comprehensive package of benefits.
- Security and peace of mind and control are very important, especially with women. Women want affordable health care they can count on and that mirrors life's transitions: job changes, part-time and full-time work, having a major disease, retiring before Medicare kicks in, etc.
- Women voters like the idea of having the public plan administered by a more independent agency rather than "the government."

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Guaranteed Affordable Choice Survey Research

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Environics

Key Survey Findings— Guaranteed Affordable Choice is Very Popular with Women

- ✓ By wider margins than men, women voters support providing affordable, quality health care for all Americans even if it means raising taxes or a major role for the federal government. In particular, women are less tax-sensitive than men.
- ✓ A strong majority of women voters favor Guaranteed Affordable Choice (GAC), and prefer it to other health care reform alternatives tested like HSAs or a single payer plan.
- ✓ That insurance companies could not deny coverage to people with pre-existing conditions is the strongest-testing component of the plan.
- ✓ Women voters believe their taxes and costs will go up regardless of what is proposed, and 34% of female voters believe their taxes will increase *a lot*. However, they are less tax sensitive than men, and much more comfortable with a very progressive tax structure to pay for GAC.
- ✓ In head-to-head debates on key aspects of GAC, including costs, bureaucracy, and insuring the "undeserving" like illegal immigrants, a plurality side with the opponents' arguments over those defending GAC except on the quality/scarcity and bureaucracy debates, where voters are divided.
- ✓ Despite this, women voters consistently and strongly support GAC—even after they hear tough criticisms of the plan.

15

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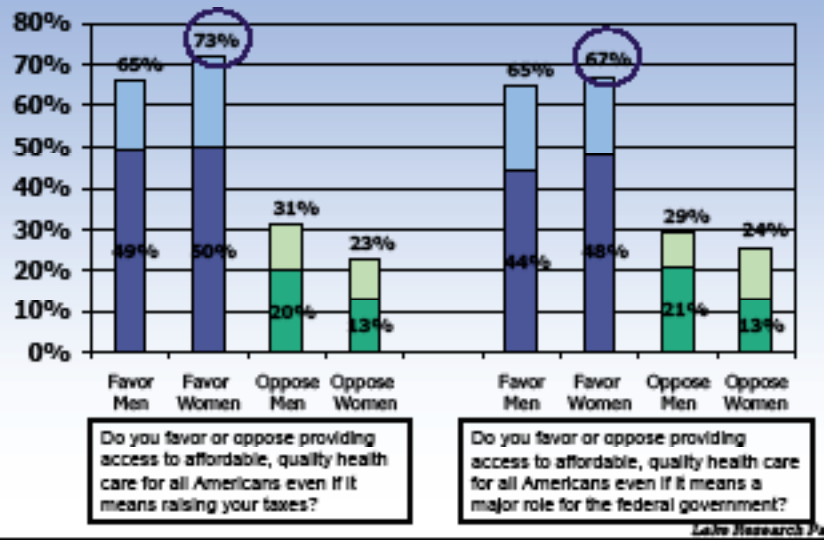
In principle, around two-thirds of all voters favor health care access for all Americans, even if it means higher taxes or a major government role. Women voters are even more supportive, and less tax sensitive in particular.



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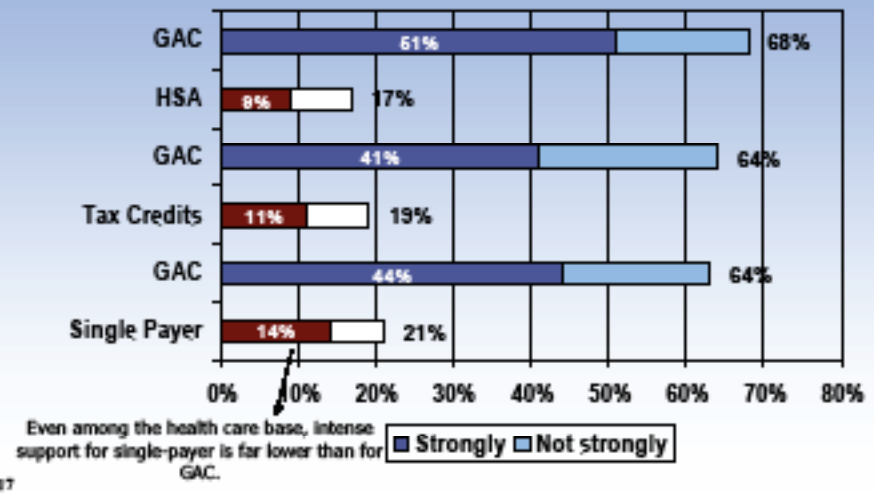
When asked head-to-head, women voters prefer Guaranteed Affordable Choice over health savings accounts, tax credits, or a single payer plan by about three-to-one or more.



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Text of GAC, HSA, Tax Credits, and Single Payer Plan.

Guaranteed Affordable Choice language:

An approach that would guarantee affordable health insurance coverage for every American with a choice of private or public plans that cover all necessary medical services, paid for by employers and individuals on a sliding scale.

Health Savings Account language:

A Health Savings Account program that would provide tax-deductible savings accounts to all Americans if they purchase a private insurance plan with at least a thousand dollar deductible.

Tax Credits language:

An approach that would provide tax credits that will reimburse individuals and families for 25 to 50 percent of the cost of their private health insurance policies.

Single Payer language:

A single government-financed health insurance plan for all Americans financed by tax dollars that would pay private health care providers for a comprehensive set of medical services.

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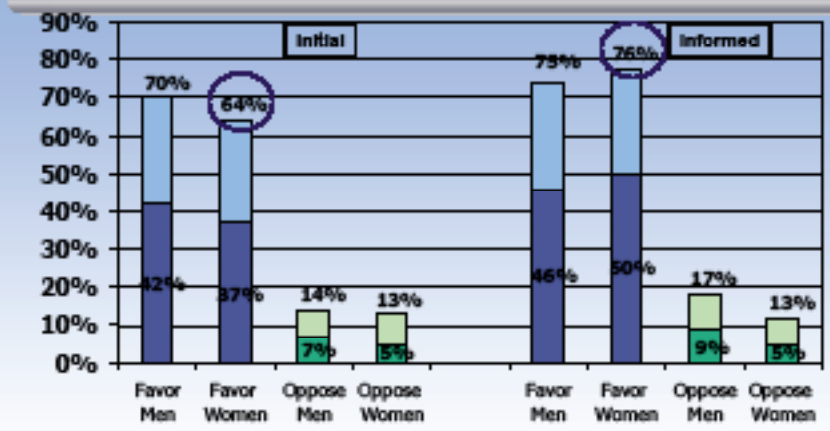
Two-thirds of voters initially favor a short, general description of GAC, with support growing to three-fourths of the voters after they hear more details about the plan. Women voters become even more supportive than voters nationwide once they receive additional information.



Now thinking about this plan by itself, would you favor or oppose a proposal to guarantee affordable health insurance coverage for every American with a choice of private or public plans that cover all necessary medical services, paid for by payroll taxes on employers and individuals on a sliding scale, or are you undecided?

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*Among no demographic group does a majority oppose GAC.

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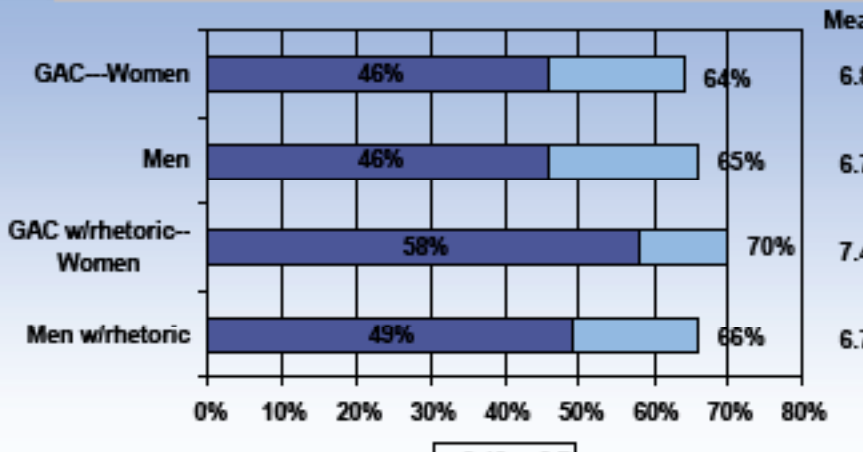
Tapping into key health care values before reading a detailed description of GAC substantially increases the intensity of support among women voters (even more than with men), though the version without the initial rhetoric is also appealing.



Rate how much you favor or oppose it on a scale of zero to ten, with ten meaning you very strongly favor the proposal, zero meaning you very strongly oppose it, and 5 meaning you are neutral.

20

The impact of rhetoric faded quickly over the course of survey, having little lasting impact.

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Description of Guaranteed Affordable Choice—Survey Language

Rhetoric heard in "Values" version:

America can do better. Greedy insurance and drug companies have too much control over our health care system and rising costs are hurting our families. Enough is enough. We need the government to act as a watchdog to protect consumers, get health care costs under control, and make sure everyone has access to quality affordable health care, including a choice of private or public plans and a wide choice of doctor. It's wrong for people who work hard and play by the rules to go without affordable health care.

Description read to all voters:

- Americans would be guaranteed to have a choice of health plans they can afford, either from a private insurer, or from a public plan offered at a sliding scale cost based on income.
- To maintain quality and allow fair cost comparisons, health insurance companies and the public plan would be required to provide at least a standard, comprehensive package of benefits including preventive care and all needed medical care.
- Employers would be required to offer a choice of the public plan and at least one private plan to all employees, including part-time employees.
- Employers and individuals could choose to keep their current health plans or one that offers more coverage beyond the standard plan, but all plans — private or public—would have to cover at least the standard package of benefits.
- Costs would be controlled by competition between the plans, and by using a nationwide pool to negotiate lower prices within the public plan. The public plan would be paid for through a modest tax increase. Small businesses would pay a lower rate.
- No private or public insurer could deny coverage or charge higher premiums to people with pre-existing conditions.

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Among key constituencies of women, invoking key health care values has the greatest impact on support for GAC among Proper Patriots, but no real impact on Marginalized Middle Agers.

RATING OF FULL GAC—WITHOUT & WITH RHETORIC
(mean, % rate 10)

Plan	Total	Proper Patriots	Marginalized Middle Agers	Healthcare Base
GAC without rhetoric	6.8 (22%)	6.3 (13%)	6.8 (24%)	7.7 (32%)
GAC with rhetoric	7.4 (31%)	7.5 (30%)	6.6 (23%)	8.1 (44%)
Difference	+.6 (+9%)	+1.2 (+17%)	-.2 (-1%)	+.4 (+12%)

22

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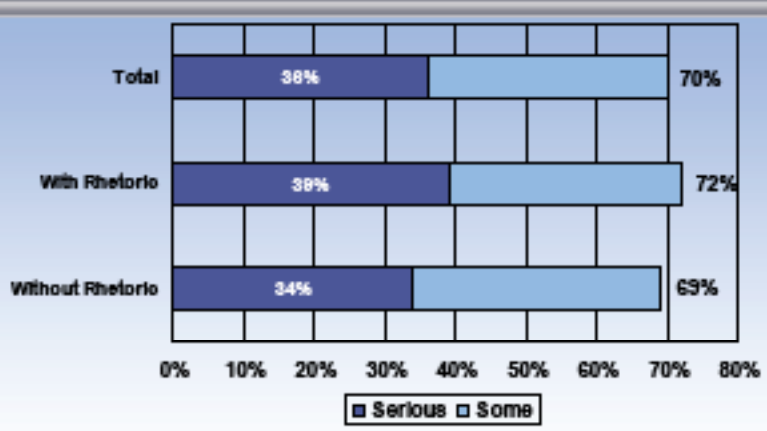
An attack based on higher taxes and scarcity of health care creates significant doubts for over two-thirds of women voters. Having heard the earlier values rhetoric does not help much.



Now let me read you something that some people say about the guaranteed affordable health care plan we have been discussing:

This plan is big government health care that will mean a large tax increase on American middle class families and will lead to more red tape and a shortage of quality care for our families. Does this raise serious doubts, some doubts, minor doubts, or no real doubts in your own mind about the proposal? If you are not sure how you feel about it, please say so.

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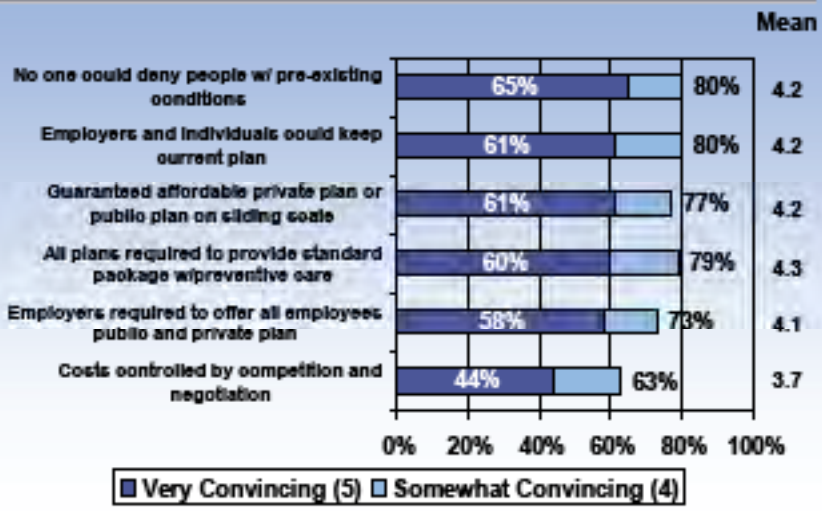
The most compelling aspect of GAC for women voters is that insurers would not be able to deny coverage to people with pre-existing conditions. It is also very important for women voters to hear that they could keep their current plan and that they would have a choice of a private or public plan offered on a sliding scale. Women find all reasons to support GAC slightly more convincing than do men.



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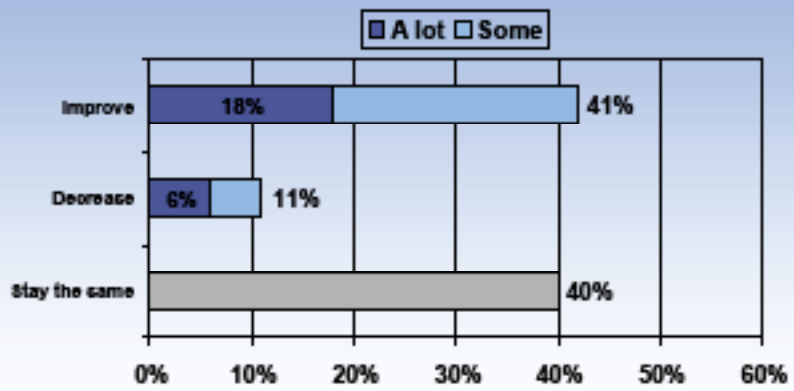
A slim plurality of women voters believe that under GAC the quality of health care would improve to some degree, while very few women voters believe that quality would decline.



Under this plan, do you think the quality of your health care would improve, decrease, or stay the same?

25

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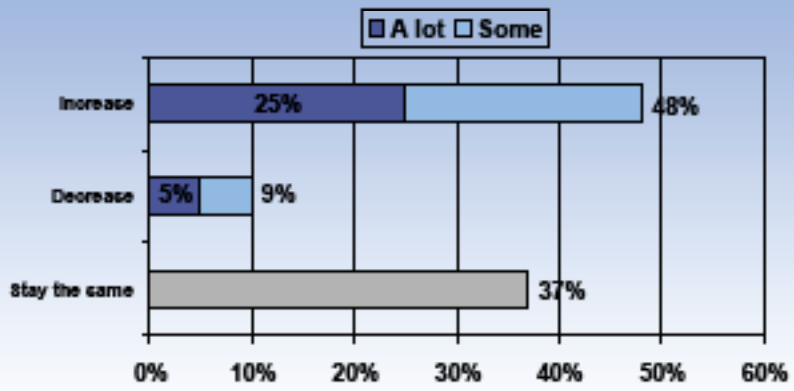
A plurality of women voters believe they will have greater peace of mind about health care under GAC.

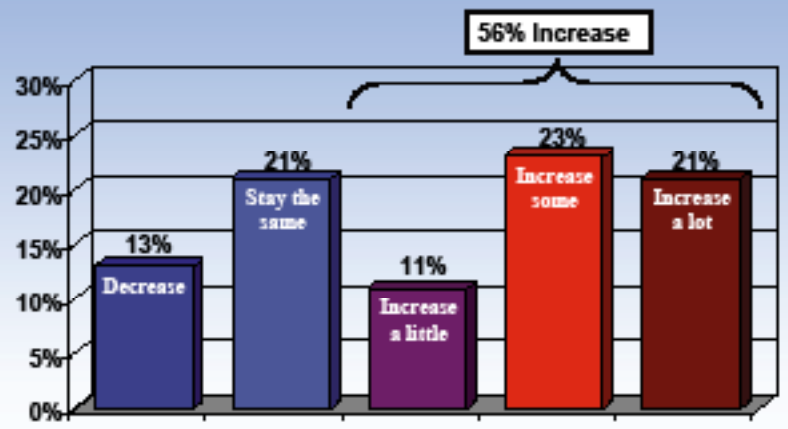


Under this plan, do you think your peace of mind about health care would increase, decrease, or stay the same?

26

Lake Research Partners

However, a solid majority of women voters believe that their costs will increase under GAC, with over 1 in 5 saying they will increase a lot.

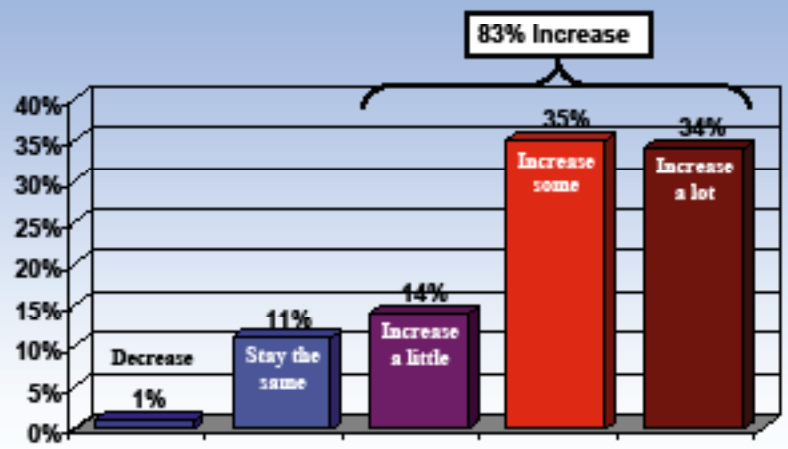


Under this plan, do you think your health care costs would go up, go down, or stay the same?

27

Lake Research Partners

The vast majority of women voters also believe that their taxes will increase to some degree under GAC, and over one third believe they will increase a lot.

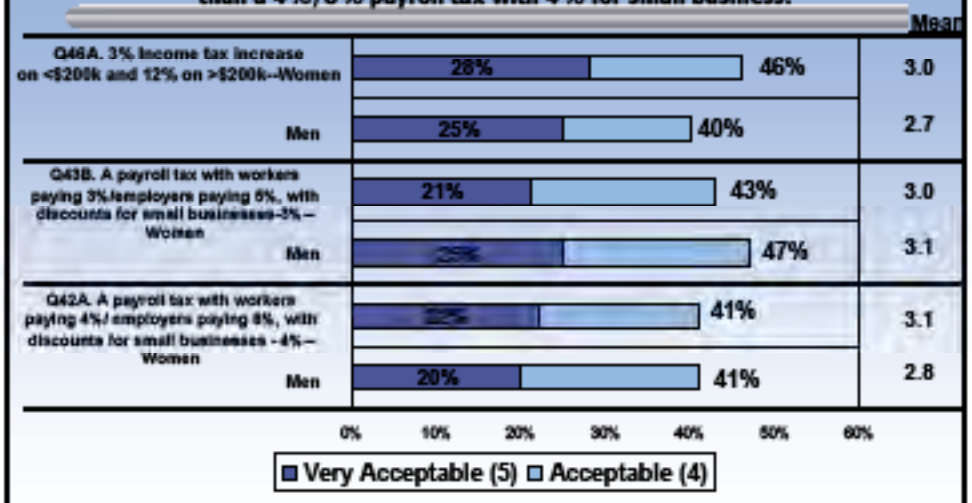


Under this plan, do you think your taxes would go up, go down, or stay the same?

28

Lake Research Partners

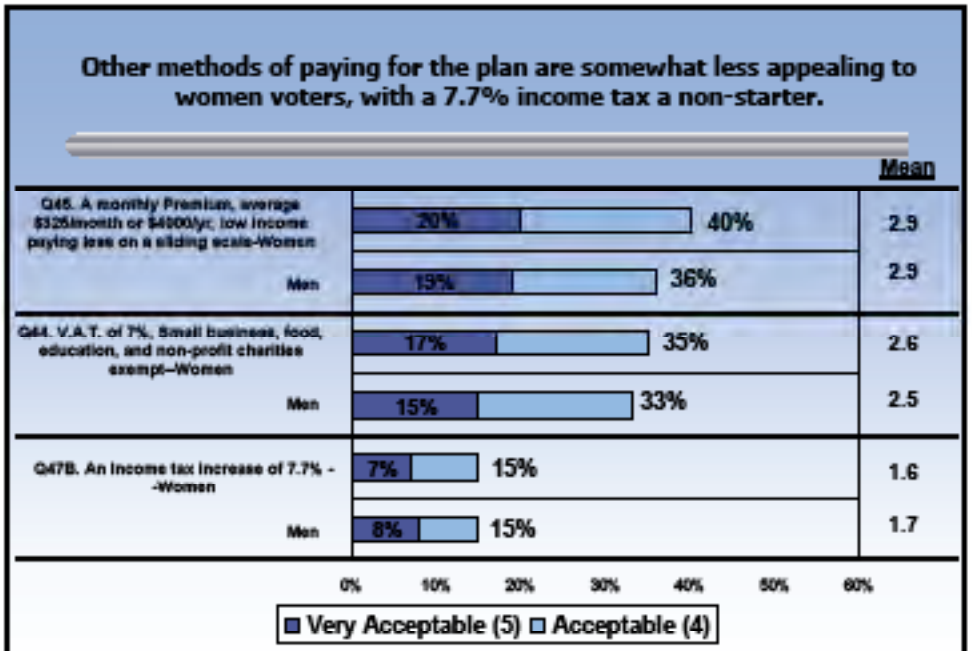
Women see a 3%/12% income tax increase for those earning less or more than $200,000 as the best way to pay for GAC—suggesting women are more populist than men when it comes to paying for GAC. Using a 3%/5% payroll tax to finance the plan with 3% for small business is marginally more acceptable to women voters than a 4%/8% payroll tax with 4% for small business.



29 Please rate how acceptable that revenue source is on a scale of 0 to 5, where 5 means it is a very acceptable source of revenue, and 0 means it is not acceptable at all, and you can use any number from 0 to 5.

Lake Research Partners

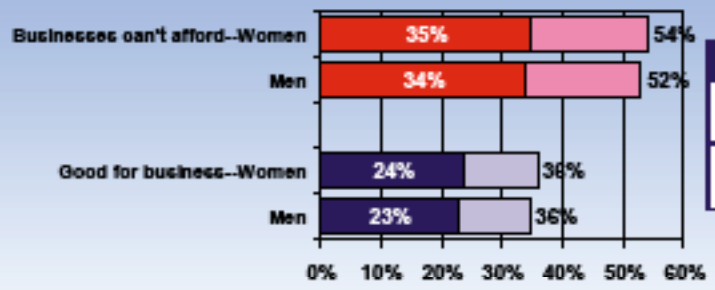
Other methods of paying for the plan are somewhat less appealing to women voters, with a 7.7% income tax a non-starter.



30 Please rate how acceptable that revenue source is on a scale of 0 to 5, where 5 means it is a very acceptable source of revenue, and 0 means it is not acceptable at all, and you can use any number from 0 to 5.

Lake Research Partners

A majority of both men and women voters find the small business attack on GAC similarly compelling.



Total Data	
Businesses can't afford	53% (34%)
Good for business	36% (23%)

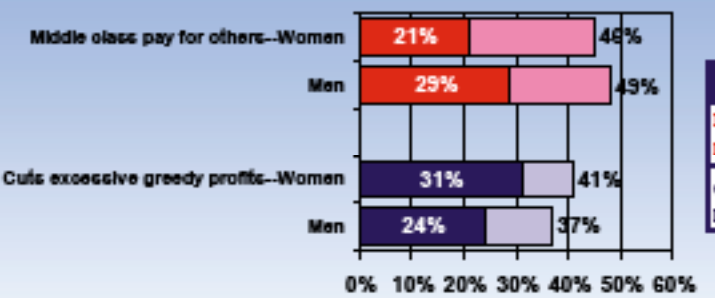
[Businesses can't afford] *Many small businesses just can't afford a mandate to provide insurance to all of their workers. Thousands of small companies all across the country could go out of business as a result, costing millions of jobs. Health care is important, but so is protecting jobs, and supporting the small businesses that are the backbone of our economy.*

[Good for business] *This proposal is a good deal for business. Those that already provide coverage to their employees will, on average, pay less than they do now. Small businesses will pay only half as much as large corporations, and will no longer be charged more because they have a smaller pool of workers, or because they have someone with a pre-existing condition. And they won't have to compete at a disadvantage with companies that don't spend anything on health care.*

31

Lake Research Partners

Defending GAC from charges that the middle class will have to pay for the health care for the uninsured is more effective among women than among men.



Total Data	
Middle class pay for others	47% (25%)
Cut excessive profits	39% (27%)

[Poor have no incentive] *They call this a sliding scale, but immigrants and people on welfare will pay almost nothing and will have no incentive to take care of their health. This program will force middle class families who are already struggling with their health care costs to pay for health care for the uninsured. We can't afford a big tax increase, and that's what this big government health care program really is. When government gets involved, everything just costs more, and taxpayers are left to foot the bill.*

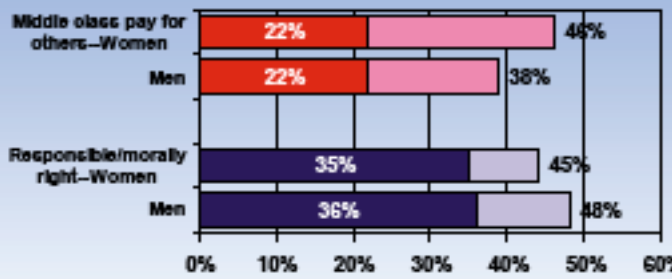
[Cut excessive profits] *Enough is enough. Insurance companies and drug companies are making record profits while spending billions on TV ads and even more on lawyers and bureaucrats to deny people coverage. We're paying more and more every year, but you can't count on coverage when you really need it. This reform will save an estimated 200 billion dollars over 10 years because it cuts excessive profits by insurance companies and reduces the paperwork at hospitals and doctor's offices. For less than we are paying now, we will all have quality, affordable health care that we can count on.*

32

Lake Research Partners

However, defending GAC from the same attack by appealing to the morality of providing affordable health care to those who work hard and play by the rules works better among men than among women.

Middle Class attack



Total Data	
Poor have no incentive	42% (22%)
Responsible/ morally right	46% (36%)

[Poor have no incentive] *They call this a sliding scale, but immigrants and people on welfare will pay almost nothing and will have no incentive to take care of their health. This program will force middle class families who are already struggling with their health care costs to pay for health care for the uninsured. We can't afford a big tax increase, and that's what this big government health care program really is. When government gets involved, everything just costs more, and taxpayers are all to foot the bill.*

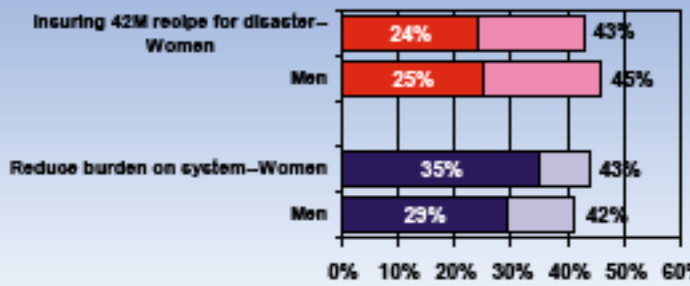
[Responsible/morally right] *It's just wrong for people who work hard and pay taxes to go without affordable, quality health care. Under the current system, many hard-working middle class people are finding it increasingly difficult to afford health care they can count on for themselves and their families. This program is about doing what is morally right by making quality health care coverage affordable for hard-working people who want to be responsible but can't afford it today. It would give millions of hardworking families peace of mind.*

33

Lake Research Partners

Countering charges of scarcity of health care by discussing the improvements to the system under GAC divides women voters roughly evenly between the two sides, but our argument has substantially greater intensity among women.

Quality/Scarcity



Total Data	
Insuring 42M disaster	44% (24%)
Reduce burden	43% (32%)

[Insuring 42M recipe for disaster] *We need to make health care more affordable, but trying to add 42 million uninsured people to the system all at once with a big new government program is a recipe for disaster. The new program will cost billions in taxes, hospitals and doctors will be even more overloaded than they are now, we'll have to wait weeks to get appointments, and quality of care is bound to suffer. This approach punishes families and businesses who are already working hard to pay for health care by adding billions in new taxes and overloading the system.*

[Reduce burden on system] *Doctors and hospitals are overloaded now because they have to fight with insurance companies for every charge, and emergency rooms are overflowing with uninsured people who need care. This proposal will reduce the burden on the health care system by simplifying and standardizing insurance coverage, and making it much easier for people to get the preventive care they need so they don't get sicker and need more expensive treatment. And those with good health coverage now will be able to keep their coverage and keep their doctor.*

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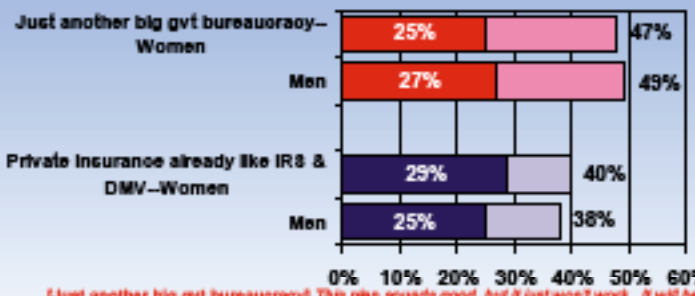
Lake Research Partners

The big government/bureaucracy argument can be neutralized to some extent among women when the tables are turned by pointing out the waste and inefficiency of the current system—but this strategy is slightly less effective among men.

Big government/bureaucracy



Total Data	
Another big bureaucracy	48% (26%)
Insurance like DMV now	39% (27%)

[Just another big gvt bureaucracy] *This plan sounds good, but it just won't work. It will be just another big government bureaucracy like the IRS and the DMV, operating inefficiently and costing taxpayers hundreds of billions of dollars. We will end up paying higher taxes and getting substandard health care with long waits to get treatment and lots of red tape and paperwork. They call this 'Guaranteed Choice' but this is just a big government program to bring socialized medicine to America.*

[Private insurance already like IRS & DMV] *Private insurance is already like the IRS and the DMV, with lots of red tape, limiting your choices, denying people coverage when they need it most and making profits of at least 25 percent off the top. This proposal forces insurance companies to compete on a level playing field—providing a standard package of benefits with prices everyone can understand and afford, and accountability that forces them to deliver what they promise. Government is the watchdog, not the doctor.*

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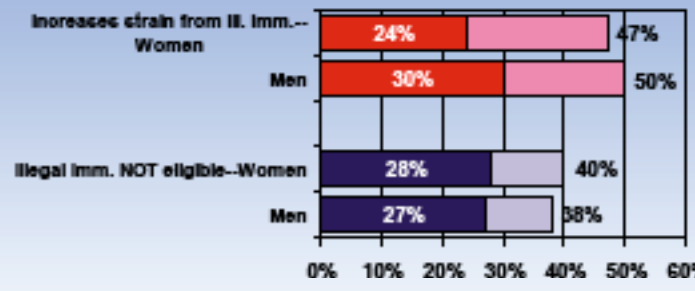
Lake Research Partners

Simply arguing that illegal immigrants would not be covered under GAC is not particularly effective against immigration attacks even if that were the policy position of GAC advocates—which it is not.

Illegal Immigrants-not eligible



Total Data	
Increases ill. imm. strain	48% (27%)
Illegal imm not eligible	39% (27%)

[Increases strain from illegal imm.] *We are already having enough trouble finding ways to get health care coverage for people who are in this country legally, let alone for millions of illegal immigrants who broke the law to get here. By giving health care benefits to all workers, legal or illegal, this proposal would greatly increase the financial strain that illegal immigrants already place on our health care system, and American taxpayers just can't afford to pay for it.*

[Illegal imm. are NOT eligible] *Illegal immigrants are not eligible for health care under the Guaranteed Affordable Choice proposal. Under the current system, many hard-working Americans are finding it increasingly difficult to provide health care they can afford and count on for themselves and their children. This proposal is about making quality health care coverage affordable for millions of hard-working Americans.*

36

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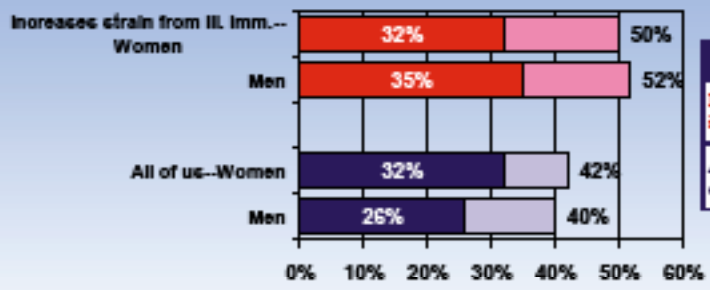
A more pro-immigrant argument that all hardworking people who pay taxes deserve affordable, quality health care is more polarizing, but slightly more effective among women than men.

Illegal Immigrants-traditional



Total Data	
Increases ill. imm. strain	51% (33%)
All of us deserve HC	41% (29%)

[Increases strain from illegal imm.] *We are already having enough trouble finding ways to get health care coverage for people who are in this country legally, let alone for millions of illegal immigrants who broke the law to get here. By giving health care benefits to all workers, legal or illegal, this proposal would greatly increase the financial strain that illegal immigrants already place on our health care system, and American taxpayers just can't afford to pay for it.*

[All of us] *All of us – immigrants and non-immigrants – who are working hard and paying taxes deserve affordable, quality health care, but many hard-working people are finding it increasingly difficult to provide health care they can afford. This program is about doing what is morally right by making quality health care coverage affordable for millions of hard-working people who want to be responsible and who will help pay for this program. It is giving millions of hardworking families peace of mind.*

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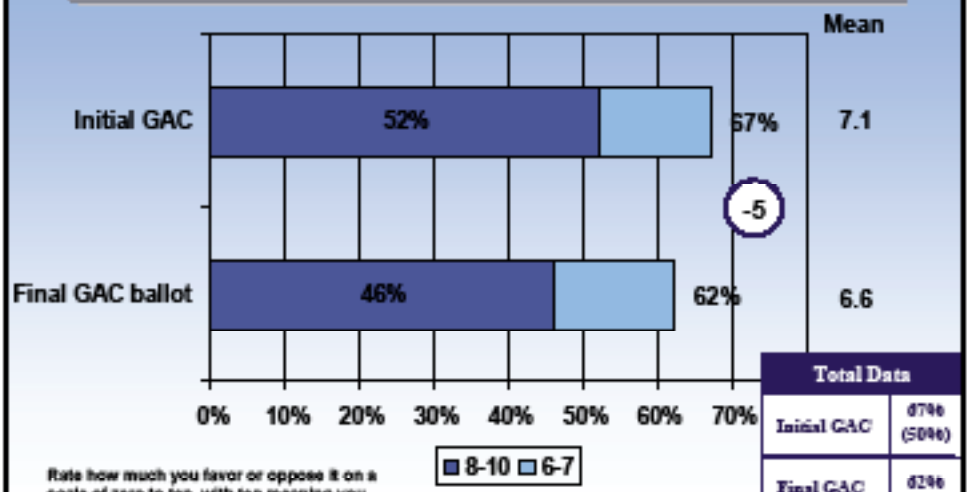
Lake Research Partners

At the end of the survey—after hearing key opponents' attacks, support for GAC among women voters falls somewhat from initial levels.



Total Data	
Initial GAC	67% (50%)
Final GAC	62% (44%)

Rate how much you favor or oppose it on a scale of zero to ten, with ten meaning you very strongly favor the proposal, zero meaning you very strongly oppose it, and 5 meaning you are neutral.

38

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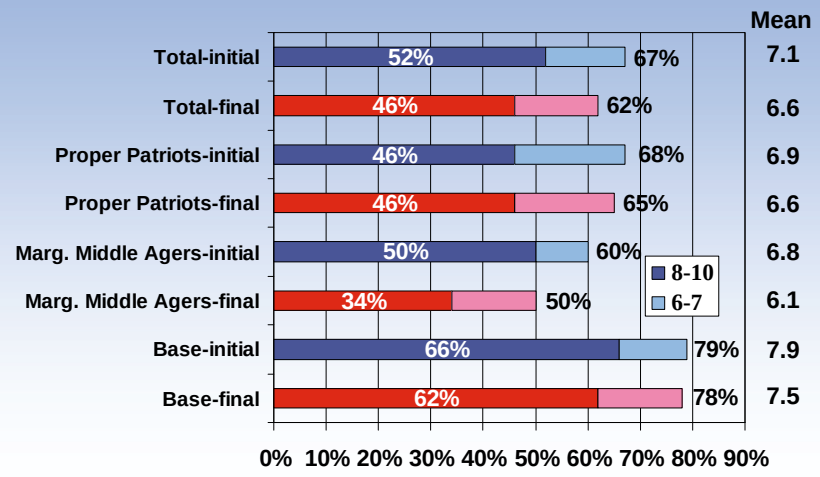
In the final ballot on GAC, health care Base women voters maintain high levels of support while Marginalized-Middle Age women voters show steeper declines in support over the course of the survey.



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Words that Work

Words to Use	Words to Avoid
Quality affordable health care	Universal coverage
American health care	A system like Social Security; Canadian Style Health Care
A choice of public and private plans	Medicare for All
Sliding scale	Free
Prevention	Wellness
Smart investments; investing in the future	Inexpensive
Choice	Competition

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Words that Work

Words to Use	Words to Avoid
Rules	Regulations
Guaranteed	Required
Giving people control; peace of mind	Government health care for all
Standard package; affordable health plans	Basic health care
Government enforcement/watchdog	Government health care; public health care

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LRP conducted focus groups in 7/06 in partnership with AE on behalf of the Herndon Alliance

Lake Research Partners

Tips for Effectively Using the Media

Media can be an important tool and ally when it comes to advocacy work. Media around health care reform has the power to:

- Create an environment of political pressure;
- Convey general information, serving as a public education tool; and
- Counter popular misconceptions.

You can engage the media in health reform through letters to the editor, reaching out to reporters, issuing press releases, or by organizing press events. This will allow your story to reach a wider audience, as well as educate the broader public about health care reform.

The following section provides tips on how women's advocates can engage the media through messaging, pitching your story, media advisories and press releases, letters to the editor and opinion editorials (op-eds), media interviews, and additional resources.

MESSAGING:

When planning a media strategy, it's important to develop a clear and specific message. The message and its three components (**problem, solution, action**) should be featured in every article, interview, and conversation conducted during the course of the campaign.

As you develop your messages, keep in mind:

- Messages take time to create. Don't rush the process.
- The core message should also reflect your organization's central mission and goals.
- Messages should not change frequently. To have impact, they must be repeated over and over again.
- Less is more. Within a single campaign, don't have more than three messages. Multiple messages can confuse the audience and may not be heard.
- Keep it short. Messages should be conveyed in a sentence or two. If it takes a paragraph to get your message across, keep working.
- Make it understandable. Use plain language and avoid specialized vocabulary or acronyms.

A sample message could be: "Our current health care system fails to meet the basic needs of far too many women, and we must act now to get comprehensive, accessible, and affordable health care we all can count on. NWLC has joined a new national effort on health reform—and we hope you'll join, too."

PITCHING YOUR STORY:

Once you establish your message, reach out to reporters and writers at local newspapers to discuss health care reform and its importance to women and families.

Pitch Call

The purpose of a pitch call is to propose a specific story idea, an interview or coverage of an event.

- Begin with reporters you know.
- Make your calls in the morning.
  - Print media deadlines can be as early as 4 pm.
  - For television, pitch two days ahead when possible. Decisions to send crews are made the night before a story appears on air.
- Be succinct and persuasive—pitch your story in one or two minutes.
- Offer a "hook" to your story, such as a compelling human story, an event, a celebrity, or a controversy.
- Find ways to present national information or events with a local angle.
- Stories about real people are ideal. Have community members who have been affected by the current health system (they lost their insurance, they are in debt from a hospital bill, etc.) available and prepared to talk to the press about why health care reform is important to them.
- Follow up with written information, if needed.
- Use pitch calls to build relationships:
  - Get to know journalists who cover your field. Call them with response to breaking news and with good, quotable quotes.
  - Suggest interview "experts" or "real people."
  - Suggest getting together to discuss additional story ideas.

MEDIA ADVISORIES & PRESS RELEASES:

Use media advisories to announce an event (including teleconferences or webinars), and use press releases to announce or respond to breaking news. Templates for media advisories and press releases are available in the "Talking About Health Reform" tab of the *Reform Matters Toolkit* and can also be obtained by contacting the National Women's Law Center at reformmatters@nwlc.org.

Press Release

- A press release announces or reacts to breaking news and is written like a news story.
- If reporters need substantial time to prepare a story, send an embargoed release (indicate this by writing "Embargoed until [date]") ahead of the release date.
- The subject line of your e-mail must grab the reporter—and never send attachments (reporters may be concerned about viruses).

Media Advisory

- A media advisory alerts reporters to an upcoming news event.
- Keep it short (one-page).
- Offer a compelling preview. Don't reveal your news, but provide a reason for them to attend.

- E-mail reporters who cover the issue, editors, news directors, bureau chiefs, TV/radio producers, and daybooks. Remember to put the text in the body of the email, rather than as a link or an attachment.
- Follow up with a phone call (pitch call).

LETTERS TO THE EDITOR & OPINION EDITORIALS (OP-EDs):

Letters to the editor and op-eds provide outlets to present your organization's view and control the message about a particular issue.

Letter to the Editor—A Short Rebuttal to an Article or Commentary

Usually 150-200 words in length.

If you get a story about health care reform placed in the newspaper, or if a newspaper runs a story on health care reform, ask the families or individuals you work with to follow up with letters to the editor about why health care reform matters to them.

- Timing is everything. Coordinate your letter to refute, contribute to, or correct a recently published piece. Identify a story or editorial that needs a response and submit your letter as soon as possible—preferably the same day as publication.
- Be concise and to the point, and know your facts. Focus on making one key point in two or three paragraphs, and use just a couple key facts or statistics (or a brief story) to support your argument.
- Write in good times and in bad. If a publication positively covers your issue, write a letter praising or thanking for the coverage or support.

Opinion Editorials—A Column or Guest Essay

Typically 700 words in length (check the newspaper's web site for specific guidelines).

Opinion Editorials (Op-Eds) are short guest pieces printed in the editorial section of a newspaper, and are a key way to influence the debate.

When writing your op-ed:

- Present three steps: problem, solution, and action.
- Tailor the requested action to your target audience.
- Use short, simple sentences and avoid jargon.
- Personalize the op-ed with an anecdote or story.
- Link the op-ed to a current news story but keep the focus local.
- Provide insight and understanding: educate your reader without being preachy.

Try the following outline for your op-ed:

- 1st paragraph: Begin with a personal anecdote or human story.
- 2nd paragraph: Make your main point.
- Following paragraphs: Begin to elaborate 2 or 3 supporting points. Keep your paragraphs short, with one point per paragraph.Use facts, statistics, and studies. Avoid being overly legal or formal.
- Conclusion paragraph: Draw the piece together and link to your opening anecdote.

MEDIA INTERVIEWS:

Once you have successfully garnered media attention, you or your spokesperson will likely be asked to do telephone or in person interviews with reporters. You can prepare for the interview by knowing all sides of the issue and thinking in advance about what kinds of questions the reporter will ask. Keep track of which reporters you work with so that you can build relationships with them, pitch them further stories, and send them follow-up information and press releases.

Preparing for a Media Interview

- Remember the audience—readers, listeners, and viewers—not the reporter.
- What questions will the reporter likely ask?
- Have your message points and sound bites ready. Practice them before the interview.
- Know your opponents' viewpoints and have counterpoints ready.

The Interview

- Stick to your message.
- In the presence of the media, you are always "on." Don't say anything you wouldn't want to see in print.
- Use concise, conversational, and catchy language. Don't use jargon or acronyms.
- If you don't know the answer, it's okay to say you'll get back to the reporter with additional information.
- Be yourself. Be friendly, calm, and use complete sentences.
- Don't make things up and never lie.
- Give examples that involve real people.
- When asked a question you feel uncomfortable about, use "bridge phrases" or "flag words" to bring the answer to your main message. E.g.:
  - The best way to answer that is to look at the broader issue…
  - What's really at issue here…
  - That's a good question. But first let me go back to an earlier point…
- Keep in mind the three C's: Concise, Conversational, and Catchy.

For further reading, see:

Fenton Communications, "Now Hear This: The Nine Laws of Successful Advocacy Communications," www.fenton.org

Spin Project Tutorials, www.spinproject.org

ImPRESSive Media Tip Sheets, http://familiesusa.org/resources/tools-for-advocates/tips/impressive.html

2008

Media Advisory Template

Use media advisories to announce an event (including teleconferences or webinars).

Your advisory should include the following

[Your organization's logo]

FOR IMMEDIATE RELEASE
Today's Date (prior to the event)

Contact:
Your Name, Phone Number, Email

News Advisory for Date, Time
ATTENTION GRABBING HEADLINE
Newsworthy subhead

Include a few sentences making the case for a reporter to attend the event. Convey why this is news and why they should turn up (the "WHY" of the event).

WHAT:	The event's name and brief description of what the event entails.
WHO:	Mention here who the key players will be. Highlight if you're expecting a local policy maker or celebrity. Provide titles of the people involved.
WHERE:	Location of event, with directions if necessary.
WHEN:	Date and Time

[Your organization's brief mission statement.]

[Your organization's web address or other contact information]

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Press Release Template

Use press releases to announce or respond to breaking news.

Your release should include the following:

[Your organization's logo]

FOR IMMEDIATE RELEASE
Today's Date (prior to the event)

Contact:
Your Name, Phone Number, Email

ATTENTION GRABBING HEADLINE
Subhead

(Your City)—The first paragraph is the "lede"—two or three sentences that convey the main news. It should be catchy and concise.

The second paragraph is everything important that could not be included in the first paragraph. Why is this news right now? Include any additional news hooks that the media will find interesting.

The third paragraph is a compelling quote from your executive director or spokesperson. Ideally, it will state your problem and include a solution or action.

In the next two paragraphs, you can do any of the following: provide a larger context or history to the issue; correct misinformation from the opposition; or, include stand-out facts and findings. These paragraphs will provide reporters with the information they need to write their story.

If space permits, you may follow up with an additional quote. This will be necessary if you're working in a partnership or coalition and need to include other voices.

Ideally a release is one page, but it may be two pages if you absolutely need the space to fully convey your issue.

###

[Your organization's brief mission statement and contact information]

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SAMPLE OP-ED

In November, Women Will Vote With Health Care in Mind

By Judy Waxman, The National Women's Law Center
Posted on August 27, 2008, Printed on August 29, 2008
http://www.alternet.org/story/96365/

Women vote for health care, and with good reason.

Today, women across the country are being forced to make impossible choices in the name of health care; sacrificing life and limb so that they can get coverage for ... a broken limb, or prenatal care. They resign themselves to unhappy marriages in order to keep their husbands' health insurance, reports the *New York Times*. They step out of line at the pharmacy when they realize that they can't afford to pay the cost or even the co-pay on their prescriptions and fill up the tank. Indeed, in 2004, according to the Kaiser Women's Health Survey, one in five women did not fill a prescription because of the cost.

The nation's health care system is in crisis, and women are bearing the brunt of its failures. Throughout their lives, women have greater health care needs and responsibilities than men. Reproductive health needs require them to get regular check-ups, whether or not they have children, and women are more likely than men to suffer from a chronic condition or disability. Meanwhile, eight in ten mothers are primarily responsible for taking their child to doctors' appointments and organizing follow-up care.

In other words, health care is a woman's issue.

Yet 18 percent of all U.S. women are uninsured. Latina, African American, and Native American women are dramatically more likely than white women to be among these 17 million who lack coverage. And while women have greater health care needs than men, they also, on average, have lower incomes and are more likely than men to be *under*insured: forced to spend more than 10 percent of their income on out-of-pocket health care costs. Women also face significant difficulties paying for their care, whether they have insurance or not. Nearly 40 percent of women report medical bill problems.

Women who do not have access to employer sponsored health insurance or are ineligible for public coverage like Medicaid or Medicare are left with no option other than to try to buy health insurance directly from insurers, known as the individual market. But women face unique challenges in this arena. They may be denied coverage based on a (so-called) pre-existing condition—such as ever having had a Caesarean section, as reported recently in the *New York Times*. When women are offered insurance, they are often forced to pay higher premiums than men, as it is legal in 40 states and the District of Columbia to consider gender when setting insurance premiums. Furthermore, the benefit package a woman receives may be woefully inadequate; even something as fundamental as maternity care is often excluded from the basic plans available in the individual market.

The upcoming elections are providing a platform for policy makers and candidates alike

to discuss their proposed solutions for the health care crisis. At the National Women's Law Center (NWLC), we have developed a list of questions to ask when looking at health reform proposals—whether at the state or federal levels—to determine whether the proposals help ensure that all women have access to health care that meets their needs, including:

1. ***Does the plan expand access to ensure that health coverage is available to all?*** Access should not depend on income, age, gender, family status, disability, immigration status, or employment status.
2. ***Does the plan provide care that is affordable?*** The cost of care (including premiums and out-of-pocket costs) should be affordable relative to income.
3. ***Does the plan ensure comprehensive health coverage?*** Covered services must include preventive care, treatment for chronic conditions, and the full range of reproductive health services.

Findings from a new poll by NWLC and Peter D. Hart Research Associates show that 84 percent of women say it is extremely or very important for Congress and the next administration to guarantee access to quality, affordable, comprehensive health care. As the debate over health care reform continues to take shape, it is critical that women's advocates ready themselves to be active and vocal participants in the fight.

A Note on Sources: Unless otherwise indicated, the data in this article come from the U.S. Census Bureau and these NWLC reports: *Women and Health Coverage: The Affordability Gap*; *Making the Grade on Women's Health: A National State-by-State Report Card, 2007*.

Judy Waxman is the vice president and director of health and reproductive rights at the National Women's Law Center.

SAMPLE LETTER TO THE EDITOR

April 3, 2006

Editorial Page Editor
Readers' Alley
P.O. Box 4249
Helena, MT 59604

To the Editor:

We applaud Attorney General Mike McGrath for ruling that Montana law requires health insurance plans to cover prescription contraceptives if they cover other prescription drugs, and urge Blue Cross Blue Shield of Montana to implement the necessary change in its policies immediately. At the same time, we must challenge Blue Cross's blanket assertion that covering contraceptives adds to health insurance costs ("Blue Cross won't challenge AG's ruling on contraceptive coverage," March 30).

After the federal government added contraceptive benefits for its employees in 1998, the U.S. Office of Personnel Management found that adding the coverage did not increase premium costs. Moreover, a number of studies demonstrate -- as common sense suggests -- that it is far less expensive to prevent unwanted pregnancies than to cover all of their attendant costs. For example, the National Business Group on Health (NBGH), representing 160 national and multinational employers, estimated that failing to cover contraceptives could cost an employer 15-17% more than covering them.

All health insurance companies and employers should realize that contraceptive coverage is a win-win proposition: it guarantees that women receive the preventive health care they need, and can actually save money.

Sincerely,

Judith C. Appelbaum
Vice President and Legal Director
National Women's Law Center
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SAMPLE PRESS RELEASE

For Immediate Release: Tuesday, July 8, 2008
Contact: Ranit Schmelzer or Adrienne Ammerman, 202-588-5180

EXPANDING CHOICES

NWLC Joins Nation-Wide Coalition for Health Care Reform

(Washington, DC) The National Women's Law Center is proud to announce today that it has joined the steering committee of an unprecedented national effort on health reform, Health Care for America Now.

Our current health care system fails to meet the basic needs of far too many women – and low-income women and women of color are especially at risk. Overall, 18 percent of women are uninsured. Almost a quarter of African American women lack health insurance. More than one-third of Latinas are uninsured.

For those who have health insurance, women are more likely than men to have health coverage which has too many gaps, including large co-pays, life-time limits, and the exclusion of needed services altogether – including some essential reproductive and other health services for women. Their health insurance also leaves them at great financial risk: 1 in 4 women says that she is unable to pay her medical bills. The high cost of care means women are more likely than men to delay or go without needed health care. Women who have to buy insurance directly from health insurers are often charged more than men.

"These facts are distressing, to say the least," said Marcia D. Greenberger, Co-President of the National Women's Law Center. "And yet they cannot possibly begin to convey the personal stories of the many women who are forced to make impossible choices: between buying their prescription drugs or putting food on their family's table, between staying with an abusive spouse or losing health insurance, between losing their home or losing their battle with cancer. No one should have to make such choices. And for those who thank their lucky stars that they have good coverage today, they live in fear that they will lose it tomorrow."

Health Care for America Now is working toward a bold new solution that gives women real choice and a guarantee of quality coverage they can afford: keeping their current private insurance plan, picking a new private insurance plan, or joining a public health insurance plan. As a member of Health Care for America Now's steering committee, the National Women's Law Center is bringing women's voices to this exciting national movement.

The National Women's Law Center also works towards this goal through our new health care reform initiative, Reform Matters: Making Real Progress for Women and Health Care. Reform Matters empowers women to be active and vocal advocates in the fight for progressive health care reform by providing them the tools to do so.

The project includes:

- Technical advice and informational assistance, including analysis of policy proposals, research and answers to specific questions, written testimony, and more.

- A monthly conference call series which provides an ongoing forum for women's advocates to discuss health care reform, share experiences and questions, and connect with national health policy experts.
- A forthcoming toolkit for advocates, outlining the basics of health care reform and exploring reform issues and their impact on women's access to health care.

Marcia Greenberger's full statement is available here. To learn more about NWLC's Reform Matters project visit www.nwlc.org/reformmatters. To schedule an interview with Marcia Greenberger, contact Adrienne Ammerman at 202-588-5180 or aammerman@nwlc.org.

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The National Women's Law Center is a non-profit 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 economic security, education, employment and health, with special attention given to the concerns of low-income women.

For more information on the Center, visit: www.nwlc.org.

SAMPLE PRESS RELEASE

For Immediate Release: Wednesday, May 14, 2008
Contact: Ranit Schmelzer, 202-588-5180

THE WRONG ANSWER TO WOMEN'S HEALTH CARE NEEDS
Health Savings Accounts Flawed When it Comes to Care

(Washington, DC) Judy Waxman, Vice President for Health and Reproductive Rights at the National Women's Law Center (NWLC), will testify today at the House Ways and Means Subcommittee on Health hearing on Health Savings Accounts.

The hearing will take place at 10:30 a.m. today, Wednesday, May 14, 2008, in room 1100 the Longworth House Office Building.

"Comprehensive, affordable health care is vital to women's well-being. Yet far too many women face serious obstacles in receiving the health care they need," said Waxman. "In fact, 18 percent of women in the U.S. don't have health insurance, and one in four women says that she is unable to pay her medical bills."

"Health Savings Accounts are a short-sighted remedy that fail to address the real obstacles to health care for Americans, especially lower-income women," added Waxman.

Health Savings Accounts (HSAs) are tax-sheltered accounts for individuals enrolled in high-deductible health plans (HDHPs). An HSA is funded by an employer and/or employee, and employers may offer HSAs/HDHPs as the only coverage option for employees or as an alternative to more comprehensive health plans.

While proponents of HSAs state that they encourage saving for future health care expenses and allow consumers more control over health care choices, NWLC maintains that HSAs are the wrong solution for uninsured women and families.

Key reasons include:

- *High-deductible health plans require greater out-of-pocket spending, which will have the most impact on women.* Under a typical HDHP, the health plan does not begin to pay insurance claims until an individual's out-of-pocket spending reaches the deductible, which is at least $1,100 for an individual or $2,200 for a family, but is often much higher. Even after the deductible is met, enrollees can still face additional out-of-pocket costs through co-payments and co-insurance. Women are more likely to have lower incomes than men, and use health care services more throughout their lives—resulting in spending more out-of-pocket on health care than men. Thus, women HDHP enrollees will pay more for their health care.
- *HSAs impact women's health services, particularly maternity care.* A 2007 study showed that, under HDHPs, women could expect to pay out-of-pocket costs ranging from $3,000 for an uncomplicated pregnancy to a high of $21,194 for a complicated pregnancy.

- *HSAs provide an incentive to spend less on cost-effective and preventive care.* Women are more likely than men to avoid needed health care because of cost; participating in an HSA/HDHP could result in delayed or even skipped necessary care because they cannot afford to meet the high deductible.
- *Unhealthy and low-income Americans have the most to lose from HSAs.* People with disabilities and chronic conditions often experience higher medical costs and are more likely to spend amounts up to their deductible each year. Since women are more likely than men to suffer from a chronic condition, they're also more likely to lose out when it comes to possible savings under HSAs. And since women are disproportionately represented among America's low-income population, they are also less likely to benefit from any possible tax breaks or savings through HSAs.

In addition to being the wrong solution for uninsured women and families, HSAs are the wrong solution for America's health care crisis. HSAs do little to curb the rising costs of health care, reduce the number of uninsured Americans, or allow consumers to make informed choices about health care.

The National Women's Law Center is at the forefront of the fight for progressive health care reform that addresses barriers to women's health care access. *Reform Matters: Making Real Progress for Women and Health Care* is a new project aimed at encouraging women to be active and vocal advocates in the fight for progressive health care reform and provides them the tools to do so.

The project includes:

- A toolkit for advocates, outlining the basics of health care reform and exploring reform issues and their impact on women's access to health care.
- A monthly conference call series which provides an ongoing forum for women's advocates to discuss health care reform, share experiences and questions, and connect with national health policy experts.
- Technical advice and informational assistance, including analysis of policy proposals, research and answers to specific questions, written testimony, and more.

Judy Waxman's full testimony is available here. To learn more about NWLC's Reform Matters project visit www.nwlc.org/reformmatters. To schedule an interview with Judy Waxman, contact Ranit Schmelzer at 202-588-5180 or rschmelzer@nwlc.org.

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The National Women's Law Center is a non-profit 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 economic security, education, employment and health, with special attention given to the concerns of low-income women. For more information on the Center, visit: www.nwlc.org.