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.

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

Paul Fronstin & Ruth Helman, Employee Benefit Research Institute, *Issue Brief No. 253, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey* 3 (Jan. 2003), http://www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.

References

1 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.

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.).

13 William Pierron & Paul Fronstin, Employee Benefit Research Inst., *Issue Brief No. 314, ERISA Pre-emption: Implications for Health Reform and Coverage* 1 (Feb. 2008), http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.

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.

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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

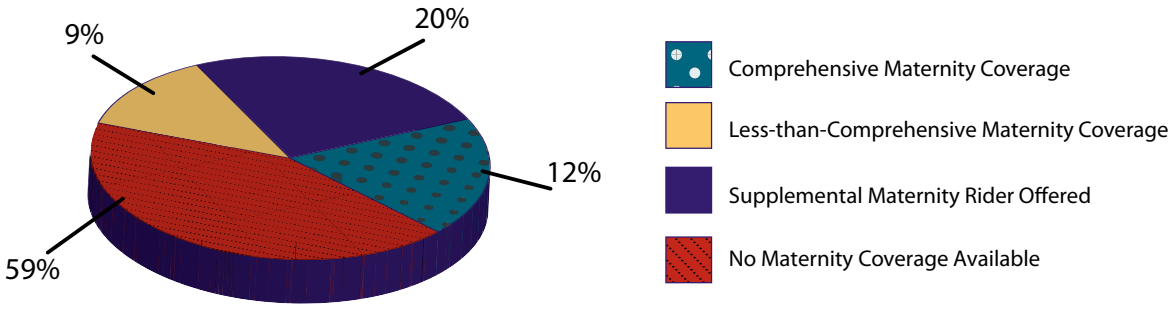
Unless prohibited by state law, when a person applies for coverage directly from an insurance company, the insurer is free to deny coverage if the applicant has prior health insurance claims, health conditions, or a history of health problems. If offered coverage, these applicants are more likely to 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]

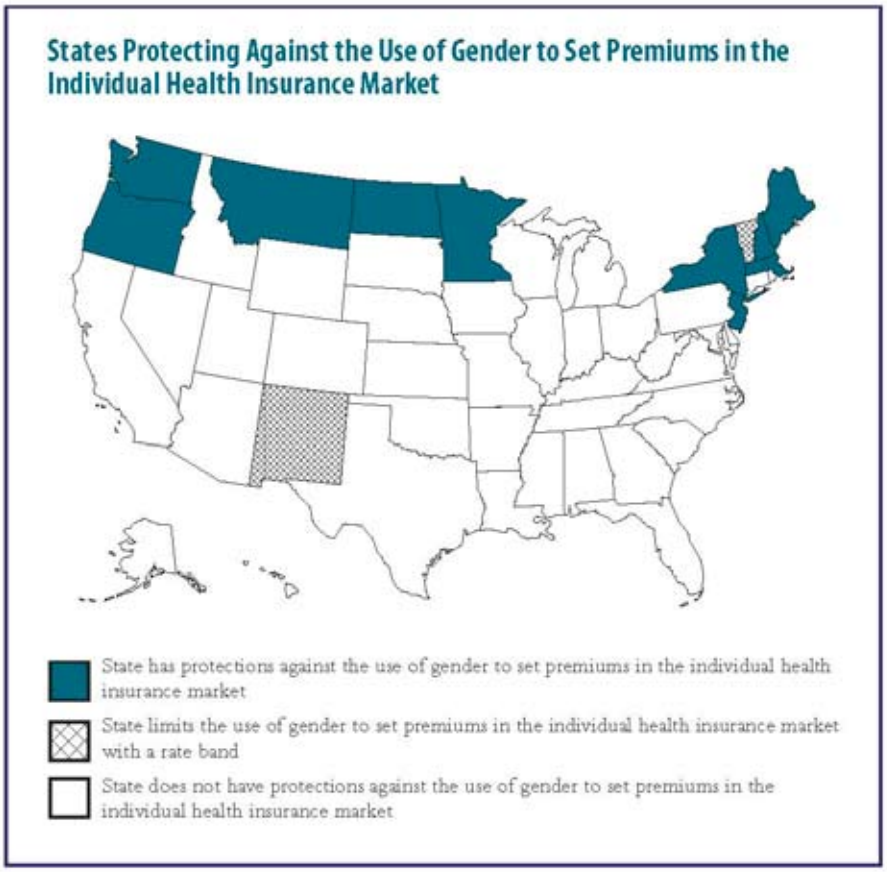
How Have States Used Premium Regulations?[30]

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.

References

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).

16 Best-selling plans identified by www.ehealthinsurance.com. *See Nowhere to Turn, supra* note 9 at Appendix 2, pg. 28.

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22 Alina Salganicoff et al., Kaiser Family Foundation, *Women and Health Care: A National Profile* (Jul.2005), http://www.kff.org/womenshealth/7336.cfm.

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

27 *Id.*

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

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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/.

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37 Insure Montana, *Tax Credit*, www.insuremontana.org/taxcredit.asp (last visited Sept. 17, 2008).

38 Community Catalyst & Families USA, *Additional Strategies for Increasing Access to Private Insurance, in A Consumer Guide to State Health Reform*, www.communitycatalyst.org/projects/schap/links?id=0020 (last visited Sept. 17, 2008).

39 Sara R. Collins et al., Commonwealth Fund, *A Roadmap to Health Insurance to All: Principles for Reform* 42 (Oct. 2007), http://www.commonwealthfund.org/usr_doc/Collins_roadmaphltinsforall_1066.pdf?section=4039.

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.

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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:

Karen Pollitz, et al., Henry J. Kaiser Family Foundation, *Maternity Care and Consumer-Driven Health Plans* (June 2007), http://www.kff.org/womenshealth/upload/7636.pdf.

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2 U.S. Department of Treasury, *Health Savings Accounts* (January 2008), http://www.ustreas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-07.pdf.

3 Elizabeth Patchias and Judy Waxman, The Commonwealth Fund, *Women and Health Coverage: The Affordability Gap* (2007), http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf.

4 In 2006-2007, over 60 percent of all individual market single-coverage plans that qualified for an HSA or Medical Savings Account (MSA) had an annual deductible of $2,500 or higher. Likewise, over 60 percent of all family-coverage HSA or MSA-qualified plans had an annual deductible of $5,000 or higher. See: America's Health Insurance Plans (AHIP), *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (December 2007), http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.

5 *Women and Health Coverage*, *supra* note 3.

6 A Harvard Medical School analysis of 2003 Medical Expenditure Panel Survey (MEPS) data found that women's median health expenditures are $997 higher than men's. While only one third of insured men under 45 spent $1,050 or more each year in medical costs, over half of insured women reached this figure. See: Steffie Woolhandler and David U. Himmelstein, *Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise*, Society of General Internal Medicine, 22(6): 879-881 (June 2007), http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2071952.

7 A survey of insurers offering consumer-driven health plans found that less than 6 percent of these plans included coverage for prescription drugs as a preventive, exempt benefit. See: America's Health Insurance Plans (AHIP), *A Survey of Preventive Benefits in Health Savings Account (HSA) Plans* (July 2007), http://www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf.

8 William D. Mosher, et al., Advance Data From Vital & Health Statistics, *Use of Contraception and Use of Family Planning Services in the United States: 1982-2002*, 350:15 (December 10, 2004), http://origin.cdc.gov/nchs/data/ad/ad350.pdf.

9 Karen Pollitz et al., Henry J Kaiser Family Foundation, *Maternity Care and Consumer-Driven Health Plans* (June 2007), http://www.kff.org/womenshealth/upload/7636.pdf.

10 U.S. Government Accountability Office, *Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes* (April 1, 2008), http://www.gao.gov/new.items/d08474r.pdf.

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15 Henry J. Kaiser Family Foundation, *Distribution of the Nonelderly Uninsured by Federal Poverty Level, States (2005—2006), US (2006),* http://www.statehealthfacts.org/comparebar.jsp?ind=136&cat=3 (last visited July 7, 2008).

16 Paul D. Jacobs and Gary Claxton, Health Affairs: The Policy Journal of the Health Sphere, *Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans* (April 15, 2008), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.3.w214.

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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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2 Linda Blumberg and John Holahan, The Urban Institute, *Do Individual Mandates Matter?* (Jan. 28, 2008), http://www.urban.org/url.cfm?ID=411603.

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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.

6 Elizabeth M. Patchias and Judy Waxman, National Women's Law Center and The Commonwealth Fund, *Women and Health Coverage: The Affordability Gap* (Apr. 2007), http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf.

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

8 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* (Sept. 28, 2007), http://www.bls.gov/cps/labor2006/.

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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.

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 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.

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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.

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