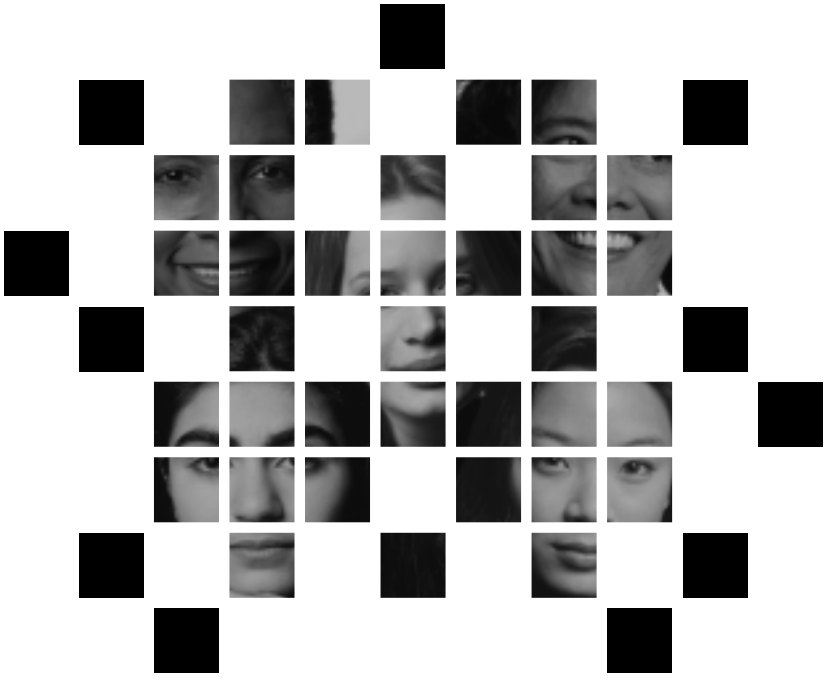


CHAPTER III

DESCRIPTION OF THE REPORT CARD INDICATORS

This chapter contains a description of the status and policy indicators used in the *Report Card*. At the beginning of the chapter, an Index of the *Report Card* Status Indicators and an Index of the *Report Card* Policy Indicators listing each indicator and the page upon which it appears are provided as a guide to the descriptions that follow. Chapter IX on Technical Notes on Indicators gives more detailed information on the data underlying each indicator and the grading and ranking of the states and the nation.

Index of *Report Card* Status Indicators

Index of *Report Card* Policy Indicators

Indicator

Women's Access to Health Care Services

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

Eligibility and Outreach for Publicly Funded Health Insurance

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

Status Indicator: What percentage of women do not have health insurance?
Without health insurance, most women cannot obtain appropriate health care, and the percentage of women in the nation who do not have insurance has increased in the past decade and continues to rise.[1] The *Report Card's* benchmark is insurance coverage for 100 percent of women in a state (because the Healthy People 2010 benchmark is 100 percent coverage for all people).[2] No state has met this goal, and only eight states (Connecticut, Delaware, Hawaii, Massachusetts, Minnesota, Nebraska, Rhode Island and Wisconsin) received a "U" because they were within ten percent of the benchmark. The remaining 42 states and the District of Columbia received an "F" because they missed the benchmark by more than ten percent. The nation also received an "F."

Reducing the Number of Uninsured: Washington State's innovative Basic Health Plan provides comprehensive health insurance benefits to all state residents not covered by other insurance, covering 131,250 enrollees in 2000. The plan is fully state funded, and premiums vary by ability to pay.[A]

Policy Indicator: Has the state taken strong steps to expand Medicaid income eligibility?
Medicaid is a critical source of insurance for women: 15 percent of all women are Medicaid recipients.[3] While federal law requires states to cover specific categories of low-income adults, states may expand the pool of people covered by Medicaid, particularly by raising the income level at which people are eligible.[4] If Medicaid covered all individuals whose incomes are up to 200 percent of the Federal Poverty Level (FPL), it is estimated that the number of uninsured would be halved.[5] The components of this indicator reflect state efforts to increase Medicaid participation by increasing the income eligibility levels for (a) pregnant women, (b) single parents and (c) the aged and disabled. No state has raised its Medicaid eligibility levels to 200 percent of FPL for pregnant women and single parents and to 100 percent of FPL (the highest level at which states can receive federal matching funds) for the aged and disabled.[6] Only 11 states and the District of Columbia have made substantial efforts to reach those income eligibility levels for all three groups. Thirty-three states have not consistently raised the level in each category, and six states (Alabama, Arkansas, Louisiana, Montana, Virginia and Wyoming) have not raised income eligibility levels above the federal minimum at all.

(a) Does the state Medicaid program cover pregnant women with incomes at or above 200 percent of FPL? Expanded Medicaid coverage has contributed to the nationwide increase in women receiving prenatal care in the first trimester.[7] Ten states (Alaska, California, Georgia, Illinois, Maryland, Massachusetts, Minnesota, Rhode Island, Tennessee and Vermont) have raised the qualifying income level for Medicaid to 200 percent of FPL or above. Twenty-seven states and the District of Columbia have raised the eligibility level to 185 percent of FPL (which had been the upper ceiling for federal matching funds).[8] Thirteen states have not raised the Medicaid income eligibility level above the federal minimum of 133 percent of FPL.[9]

(b) Does the state Medicaid program cover single parents with incomes at 200 percent of FPL? Because nearly half of all working poor families are uninsured, with a large percentage headed by women, expanding Medicaid coverage by raising qualifying income levels is critical to ensure that these low-income families have access to health care services.[10] Minnesota and the District of Columbia have expanded their Medicaid income eligibility requirements to cover single parents with incomes at 200 percent of FPL. Eighteen states have expanded the Medicaid eligibility level over 74 percent of FPL but below 200 percent of FPL. Thirty-one states have failed to raise these requirements beyond 74 percent of FPL.[11]

(c) Does the state Medicaid program cover the "aged and disabled" with incomes at or above 100 percent of FPL? Although most women age 65 and over and many disabled women have health insurance through Medicare, Medicaid is a crucial additional source of coverage for six million low-income elderly Medicare beneficiaries and for 6.8 million disabled individuals.[12] Fourteen states and the District of Columbia have expanded income eligibility for the aged and disabled to or above 100 percent of FPL.[13] Fourteen states have increased the

Medicaid income eligibility level above the federal minimum, but to less than 100 percent of FPL. Twenty-one states have failed to increase the Medicaid income eligibility level for the aged and disabled beyond the federal minimum (which in 1998 was the income eligibility level for SSI of 74 percent of FPL).[14] As there is no single standard income eligibility determinant in Illinois, this review does not include Illinois.

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

States can expand the pool of women insured by Medicaid by changing non-income-related eligibility requirements and by investing in efforts to reach out to people eligible for Medicaid who are not currently participating in the program. Expanded outreach is especially important because a recent significant drop in the number of Medicaid enrollees has been attributed to the lack of knowledge by many that they remain eligible for Medicaid despite their ineligibility for cash assistance due to changes in the welfare laws.[15] This policy indicator includes four key options for expanding Medicaid coverage: (a) dropping restrictions for two-parent working families; (b) providing presumptive eligibility for pregnant women; (c) allowing parents to use the same simplified application available to their children and to submit the application by mail; and (d) eliminating the assets test for parents. Only three states (Delaware, Massachusetts and Missouri) and the District of Columbia have adopted all four policies, and only five states (Illinois, Minnesota, Rhode Island, South Carolina and Vermont) have adopted three of the four policies. The majority of states (39) have adopted only one or two of the policies. Three states (Kentucky, North Dakota and West Virginia) have failed to adopt any of the policies.

States' Use of Federal Funds for Health Care Coverage for Low-Income Families: The U.S. Department of Health and Human Services reports that 21 states spent less than ten percent of their share of the $500 million in federal funds set aside for health care coverage for low-income families that lost cash assistance due to welfare reform. State administrators claimed that they did not receive adequate guidance on allowable uses of the funds from the Health Care Financing Administration (HCFA), and HCFA issued a new guidance on January 6, 2000 clarifying that the funds may be used for a broad range of activities. It will be important to evaluate states' use of these federal funds in light of the new guidance.[B]

(a) Has the state dropped a Medicaid 100-hour work disqualifier for two-parent families? The federal government will cover some of the costs that states incur if they drop a "100-hour" rule under which two-parent families are ineligible for coverage if the principal wage earner works more than 100 hours per month.[16] To date, 34 states and the District of Columbia have dropped the 100-hour rule. Sixteen states have not dropped the rule.

(b) Does the state provide presumptive Medicaid eligibility for pregnant women? Given the importance of prenatal care early in pregnancy, states advance women's health when they adopt a policy that makes a pregnant woman "presumptively" eligible for Medicaid once she submits preliminary income information to Medicaid. Presumptive eligibility allows the woman to receive Medicaid coverage as early as possible while her application is being approved.[17] Twenty-seven states and the District of Columbia have adopted presumptive eligibility for pregnant women, and 23 states have not.

(c) Does the state allow parents and children to apply for Medicaid using the same simplified mail-in application? Under current Medicaid laws, states have significant flexibility in designing their Medicaid application/enrollment process and can make it easier for parents to enroll in Medicaid by allowing them to apply jointly with their children, using a simplified mail-in application.[18] Ten states and the District of Columbia have allowed parents and children to use the same simplified application that can be mailed, and 40 states have not.

(d) Has the state dropped the assets test for parents, thereby both facilitating the application process and increasing the pool of eligible people? Welfare reform gave states the option to disregard parents' ownership of basic assets (e.g., a family car, home or savings account) when determining their eligibility for Medicaid.[19] Eliminating this "assets test" simplifies the application process, streamlines and reduces administrative costs, and increases the pool of eligible people.[20] Twelve states and the District of Columbia have dropped the assets test for parents, and 38 states have not dropped the test.

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

States can adopt many policies to help low-income women move out of the ranks of the uninsured, including programs that provide publicly funded health insurance to otherwise uninsured, low-income adults, regardless of their parental status, age or disability. Seven states (Delaware, Massachusetts, Minnesota, New York, Oregon, Vermont and Washington) have provided comprehensive health coverage (with covered services similar to those covered by Medicaid) to otherwise uninsured adults whose incomes are at 100 percent of FPL. Four states (Arizona, California, Hawaii and Tennessee) had similar programs, but have set the income eligibility requirement below 100 percent of FPL, capped enrollment, or only provide the coverage in limited portions of the state. Eight states (Alaska, Connecticut, Kansas, Maryland, Missouri, North Dakota, Utah and Wisconsin) have

programs that either provide insurance coverage to a limited group of adults not otherwise covered by publicly funded health insurance (e.g., disabled individuals who do not otherwise qualify for Medicare or Medicaid) or provide a narrower set of services to individuals at or below a specific income level. The remaining 31 states and the District of Columbia have not enacted any such programs.

Overcoming Barriers to Health Care Beyond Insurance Coverage

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

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

In the United States, nearly one in ten people lives in a "medically underserved area" ("MUA"), with reduced access to primary care physicians.[21] The lack of accessible health care services is particularly acute for poor and low-income people, who do not have the financial resources to travel to find health care.[22] Although state data regarding the percentage of women who live in underserved areas are not available, the state data for men and women overall are a useful proxy to assess women's access to primary care. No benchmark is available for this indicator, so it is ranked, not graded. Maryland ranked first and Louisiana ranked last.

POLICY INDICATOR: Are safety net services for the medically underserved provided?

Although the federal government supports "safety net" providers of medical services designed to help low-income people who might otherwise fall through cracks in the system, current federal efforts only reach about ten percent of the uninsured and less than 25 percent of the underinsured.[23] The components of this composite indicator are policies that (a) help ensure low-income women's access to health care services through state funding of comprehensive primary medical care practice programs, and (b) continue full Medicaid support of Federally Qualified Health Centers (FQHCs). Only three states (Maryland, Michigan and Texas) have adopted both policies, and only nine states (California, Georgia, Massachusetts, New Hampshire, New Jersey, New Mexico, North Carolina, Washington and West Virginia) have funded the operation of primary medical care practices and had a non-binding commitment to fund FQHCs. Twenty-nine states and the District of Columbia have adopted only one of the policies (sometimes in a weak form). Nine states (Alabama, Alaska, Delaware, Kentucky, Nevada, Oklahoma, Oregon, Tennessee and Utah) have had none of these policies.

(a) Does the state fund the operation of comprehensive primary medical care practice programs for the medically underserved? Some states have attempted to provide a safety net by funding the operation of "comprehensive primary medical care practice" programs that provide preventive and diagnostic services and hospital referrals on a 24-hour basis to low-income individuals.[24] A state's financial support for the operation of primary medical care programs reflects its commitment to providing the uninsured and medically underserved with access to health care services. Nineteen states have funded the operation of these programs, and 31 states and the District of Columbia have not.

(b) Has the state continued to reimburse Federally Qualified Health Centers (FQHCs) for 100 percent of the cost of serving Medicaid recipients? Federally Qualified Health Centers (FQHCs) provide comprehensive, primary and preventive health care to patients below the poverty level in underserved communities.[25] While federal law no longer requires states to reimburse FQHCs for the full cost of providing care to Medicaid beneficiaries (i.e., "100 percent cost-based reimbursement"), states can help FQHCs continue to serve the uninsured and to provide a greater range of services by choosing to fully reimburse FQHCs (states who do so will receive federal matching funds for the full amount).[26] Seven states have continued 100 percent reimbursement either through legislative requirements (Colorado, Indiana, Iowa, Maine, Maryland, and Texas) or through binding agreements between the state Medicaid Director and the FQHCs (Michigan). Twenty-five states have continued 100 percent reimbursement through non-binding administrative agreements between the state Medicaid Director and the FQHCs, but without a legal commitment. Two states (Louisiana and Virginia) and the District of Columbia have not yet decided whether to continue the 100 percent reimbursement (although they are currently reimbursing at 100 percent pending the decision). Sixteen states do not provide 100 percent reimbursement of FQHCs.

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

Many women facing a serious health condition of their own or caring for a family member cannot afford to take needed time away from work. Because women disproportionately bear the responsibility for family caregiving, many endanger their own health by struggling to meet both the demands of work and family care. States can help by adopting the policies reflected in (a) the family and medical leave expansions and (b) the paid temporary disability insurance requirements in this composite indicator. Three states (California, Hawaii and Rhode Island) have both expanded family and medical leave and provided paid temporary disability insurance. Sixteen states and the District of Columbia have adopted one of the two policies. Thirty-one states have adopted neither policy.

(a) Does the state have a family and medical leave law that offers protections in addition to those provided by the federal law? Although the federal Family and Medical Leave Act (FMLA) requires larger employers to allow workers to take unpaid leave to recover from their own illnesses or to care for certain family members in certain circumstances, almost half of the private workforce (41 million people) is not covered by the FMLA.[27] States can expand family and medical leave by covering more people and/or by providing more generous family and medical leave benefits than the federal law. Seventeen states and the District of Columbia have enacted laws expanding family and medical leave. The remaining 33 states have not expanded family and medical leave.

(b) Does the state provide temporary disability insurance? Many women cannot afford to take unpaid family or medical leave (as provided by federal and state family and medical leave laws).[28] States can assist these women by providing some payment during family and medical leave periods through temporary disability insurance (TDI) laws (usually provided through expansions of unemployment or disability insurance). Although limited, these laws provide partial wage replacement for employees who are temporarily disabled for non-work related reasons and represent a first step toward making personal medical leave more affordable.[29] Five states (California, Hawaii, New Jersey, New York and Rhode Island) have TDI laws.[30] The remaining 45 states and the District of Columbia did not provide TDI.

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

The Commonwealth Fund Survey of the Health of American Women found that in 1998, three-quarters of insured women were enrolled in some form of managed care plan.[31] Early information suggests that managed care plans are doing at least as good a job with preventive care for women as fee-for-service plans, and possibly better.[32] Concerns have arisen, however, about managed care practices that may impede access to needed treatment, especially higher cost care, and to fair grievance mechanisms, particularly for low-income and less educated women. Although states have adopted many different protections, this indicator includes four components that reflect policies of particular import to women: (a) direct access to broad obstetrical-gynecological and health maintenance services; (b) "continuity of care" provisions; (c) coverage for participation in clinical trials; and (d) the right to external review of complaints. Virginia is the only state to adopt all four of these policies. Twelve states and the District of Columbia have adopted three of the four policies. Thirty states have either adopted fewer policies or weaker versions of the policies, and seven states (Alaska, Arizona, Kentucky, Massachusetts, Nebraska, North Dakota and Wyoming) have adopted none of these policies.

(a) Does the state require that managed care programs allow women to have direct access to broad reproductive, gynecologic and health maintenance services? Direct access to broad reproductive, gynecologic and health maintenance services allows women, if they choose, to obtain access to reproductive and related health care without having to obtain a referral first. While it is preferable for states to provide direct access to physicians, midwives, nurse practitioners, nurses and other trained providers of these services, most states have focused on women's access to physicians. Thirty-five states and the District of Columbia have these positive, first-step requirements. Fifteen states have failed to adopt these requirements.

(b) Does the state have "continuity of care" provisions? Continuity of care provisions protect patients from disruptions in care because of a change in plan or a change in a provider's network status. These provisions are particularly important for pregnant women, patients with chronic or long-term illnesses and patients with terminal illnesses. Optimally, these provisions require plans to cover continued care from the provider: (a) for at least 60 days; (b) if the patient is pregnant and has begun prenatal care with the provider; and (c) if the patient faces any condition so severe that the treatment is medically necessary. Thirteen states and the District of Columbia have such provisions. Eight states (Colorado, Illinois, Indiana, Iowa, Kansas, Oklahoma, South Dakota and Texas) have continuity of care provisions that provide some protection for patients. Twenty-nine states have no continuity of care provisions.

(c) Does the state require managed care programs to cover clinical trials for adults? Access to clinical trials can be crucial in defining and treating life-threatening illnesses, especially when experimental approaches are the only treatment available. Five states (Illinois, Louisiana, Maryland, Rhode Island and Virginia) have required that managed care plans pay the routine costs associated with these trials for adult patients. Forty-five states and the District of Columbia have no such provisions.

(d) Does the state require managed care programs to provide patients with a right to external review of the managed care company's decisions? A strong grievance and appeals process that includes a right to an external review (i.e., a review by an independent party) allows patients to challenge decisions of managed care companies and to protect their own health needs. Twenty-seven states and the District of Columbia have required managed care companies to have an external review procedure, and 23 states have not.

Policy Indicator: Does the state have comprehensive requirements for the provision of appropriate interpretation and translation services to patients with limited English proficiency?

Language barriers can inhibit a health care provider's ability to diagnose and treat patients with limited English proficiency—a

barrier to health care that affects millions of people who do not have the ability to proficiently speak, read, write and understand the English language.[33] Only four states (California, Illinois, Massachusetts and New York) have adopted a comprehensive legal requirement to address the language needs of those seeking health care. Laws and/or regulations in 23 states and the District of Columbia have made some reference to language barriers, but are limited in their scope. The remaining 23 states' laws and regulations have not addressed the barriers to health care facing individuals with limited English proficiency at all.

Methods to Improve Access to Specific Health Care Services

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

STATUS INDICATOR: What percentage of women receive prenatal care in the first trimester?

Women who have prenatal care beginning in their first trimester of pregnancy (i.e., within the first 12 weeks) tend to stay healthier and have healthier babies.[34] The *Report Card's* benchmark is the Healthy People 2000 goal that at least 90 percent of all pregnant women receive prenatal care in the first trimester of pregnancy.[35] No state met this goal, but 36 states were within ten percent of the benchmark; they received a "U." Fourteen states and the District of Columbia missed the benchmark by more than ten percent; they received an "F." The nation received a "U."

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

The number of abortion providers nationwide has declined by 30 percent since 1982, and the lack of access to abortion providers is particularly severe for women living in rural communities.[36] The absence of health care providers trained and available to provide abortion services can endanger women's lives and health. Nationally, almost one-third of all women reside in a county with no abortion provider.[37] Although several types of providers may perform abortion services, this procedure should be as available to women as access to obstetrical-gynecological services. Therefore, the states are graded based on a comparison between the percentage of women living in a county without an abortion provider and the percentage of women who live in a county without an office-based obstetrician-gynecologist.[38] In Hawaii, Massachusetts and the District of Columbia, the same percentage of women live in a county without an abortion provider as live in a county without an obstetrician-gynecologist; they received an "S." The remaining 48 states were not within ten percent of the benchmark; these states received an "F." The nation also received an "F."

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

The high cost of prescription drugs has become a barrier to health care in the United States, creating financial hardship for many, but particularly for older women.[39] In 1999, spending for prescription drugs accounted for the largest portion of individual out-of-pocket health care spending after premium payments.[40] Medicare does not cover most pharmaceuticals and almost half of Medicare beneficiaries do not have continuous drug coverage from some other source throughout the year.[41] States can help patients afford prescription drugs through the policies included in this indicator: (a) Medicaid coverage for an unlimited number of prescriptions; (b) elimination of Medicaid prescription co-payments; (c) non-Medicaid state pharmacy assistance programs; and (d) high eligibility levels in their AIDS Drug Assistance Program (ADAP) (specifically targeted to people with AIDS/HIV). Only New Jersey has adopted all four of these policies. Nineteen states have adopted at least some combination of the policies that have a significant effect on the coverage available for pharmaceuticals. Thirty states and the District of Columbia have adopted fewer policies or policies so weak that their effect is minimal.

(a) Does the state Medicaid drug benefit cover an unlimited number of prescriptions? The Medicaid prescription drug benefit is the second most frequently used Medicaid benefit (second only to physician services).[42] Although states must comply with federal guidelines to receive matching funds, they have some flexibility in determining the scope of coverage, including whether to limit the number of prescriptions covered during a specific time period.[43] Research has shown that these restrictions significantly limit Medicaid beneficiaries' access to prescription drugs.[44] Thirty-seven states and the District of Columbia do not have such restrictions. The remaining 13 states have restricted such prescription coverage.

Pregnancy Risk Assessment Monitoring System: Only 23 states participate in the Pregnancy Risk Assessment Monitoring System (PRAMS), a surveillance project of the Centers for Disease Control and Prevention and state health departments, collecting state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy. All 50 states and the District of Columbia must participate if vital information gaps on pregnant women and new mothers' health needs are to be filled.[C]

(b) Does the state Medicaid program cover prescriptions without a patient co-payment? Like restrictions on the number of prescriptions that can be filled, co-payment requirements also seriously limit Medicaid patients' access to prescription drugs, because even a minimal out-of-pocket cost may be too expensive for low-income women and may prevent them from buying prescription drugs they need.[45] Nineteen states have required no co-payments. Twenty-six states and the District of Columbia have required co-payments of two dollars or less. Five states (Alabama, Arkansas, Indiana, Louisiana and Maine) have required co-payments of more than two dollars.

(c) Does the state have a broad, non-Medicaid pharmaceutical program? State-sponsored "pharmacy assistance" programs help to ease the financial burden of buying prescription drugs for non-Medicaid-eligible, low-income people.[46] Eligibility varies by state (most plans cover people age 65 and over to help fill the gap in Medicare coverage, but some also cover selected populations, such as people with disabilities), as do the rules governing the scope of prescriptions covered and patient cost-sharing. Two states (New Jersey and Pennsylvania) have adopted higher income eligibility levels than other states, covered most prescription drugs, and adopted only limited co-payments and other cost-sharing requirements. Fourteen states have more limited non-Medicaid pharmaceutical programs. The remaining 34 states and the District of Columbia have not had programs.

(d) Does the state cover pharmaceuticals for individuals with incomes at or above 400 percent of the Federal Poverty Level (FPL) under the AIDS Drug Assistance Program? State AIDS Drug Assistance Programs (ADAP) cover HIV/AIDS pharmaceuticals to low-income, uninsured and under insured people living with HIV/AIDS who otherwise could not afford these drugs to improve the quality and length of their lives.[47] Nine states (California, Hawaii, Illinois, Maryland, Mississippi, Nevada, New Jersey, New York and Rhode Island) have allowed people at 400 percent or higher of FPL to participate in the ADAP program, so that more people can benefit from it. Thirty-five states and the District of Columbia have allowed participation for people with incomes from 200 percent to 400 percent of FPL. Six states (Colorado, Georgia, Montana, North Carolina, North Dakota and Oklahoma) have allowed only individuals with incomes below 200 percent of FPL to participate.

Respite Care: Approximately 12 million women are in-home caregivers to ill or disabled relatives and bear the significant health and financial costs that come with caring for others. "Respite care" programs provide services that temporarily relieve the caregiver from some of those responsibilities. These services include in-home care, adult day care and short-term overnight care for the patients. Comprehensive state-by-state data on respite care programs are not available, but California, New Jersey, New York, Oregon and Pennsylvania have programs with broad eligibility criteria and a wide range of services.[D]

POLICY INDICATOR: Does the state provide for access to quality long-term care services?

Women constitute the majority of long-term care recipients.[48] Approximately three out of four nursing home residents are women, and two out of three home care consumers are women.[49] There are many barriers to quality long-term care services, including cost. Medicare does not cover most long-term care services, and there are serious limitations on the coverage available through private insurance or Medicaid.[50] This composite indicator includes several components that measure state commitment to affordable, quality long-term care: (a) paid ombudsman program staff; (b) "spousal impoverishment" Medicaid eligibility rules; and (c) Medicaid coverage for home and community-based care. Only four states (Alaska, Georgia, Kentucky and Mississippi) and the District of Columbia have had the number of ombudsmen that meets an Institute of Medicine standard and have the highest spousal impoverishment eligibility requirements allowed by the federal government. Twelve states have an acceptable level of ombudsmen and also have moderate spousal impoverishment eligibility requirements. Seventeen states have adopted one of the policies (sometimes in a weaker form). The remaining 17 states have had neither policy. State Medicaid support for home and community-based services also varies substantially. Oregon has had the most service recipients with 11 recipients of such services per 1,000 adults. Tennessee has had the fewest, with only .07 recipients per 1,000 adults.

(a) Does the state's long-term care ombudsman staffing level meet the Institute of Medicine's (IOM) minimum acceptable standards? Residents in long-term care facilities often need an advocate to help them (or their families) address problems. The federal long-term care ombudsman program, administered and partially funded by the states, provides "ombudsmen" who act as advocates to help residents and their families obtain a better quality of life in long-term care settings.[51] In 1994, the IOM issued a landmark report that determined the minimum acceptable ratio of paid ombudsmen per long-term care facility beds to be one to 2,000.[52] In FY 1998, the average national ombudsman-to-bed ratio was one to 2,831, falling short of the IOM minimum standard by about one-third.[53] Twenty states and the District of Columbia have met the IOM standard. The remaining 30 states have not met the standard.

(b) Has the state chosen the largest allowable protection for income and assets of the "community" spouses of nursing home residents under the Medicaid program? To prevent the high cost of long-term care from impoverishing the spouses of nursing home residents, federal law now requires states to protect the assets and income of the non-institutionalized spouse ("community spouse") through a "resource allowance" and "income allowance." In general, the couple's resource level determines whether the nursing home resident is eligible for Medicaid, while the couple's income level determines how much money (if any) the nursing home resident has to pay the nursing home each month.[54] Ten states and the District of Columbia have chosen the highest resource and income allowances allowed by the federal government. Nineteen states have chosen to use neither the highest nor the lowest levels permitted by the federal government. Twenty-one states have chosen not to provide community spouses with any sheltered income or resources above the federal minimum.

(c) How many adults per 1,000 receive Medicaid Home and Community-Based Services (HCBS)? For older and disabled women, home and community-based long-term care can offer greater independence and more familiar surroundings than living in a nursing home. Most state-supported HCBS are funded through various state options in the Medicaid program.[55] Because of limited data on the scope of services offered by states, the *Report Card* measured the number of adults who receive HCBS Medicaid benefits as a proxy. These data were not analyzed by sex, so the total number of men and women served in each state is provided. The states range from 11.09 HCBS recipients per 1,000 adults in Oregon, to .07 HCBS recipients per 1,000 adults in Tennessee. Oregon has more than doubled the number of people who receive long-term care services in a home and/or community-based setting by centralizing responsibilities in one agency, effectively coordinating with local governments, and streamlining the application process. Washington and Colorado also have innovative home and community-based programs.[56] The national average is 3.30 per 1,000.

Nursing Home Staffing: Nursing home staffing level standards can prevent the adverse effect that inadequate staffing can have on nursing home quality. For example, Missouri experienced a 277 percent increase in the number of health and safety violations in nursing homes in the two years after its state legislature abolished its minimum staffing standard in 1997. Minimum staffing level requirements have been recommended by the National Coalition of Nursing Home Reform (NCCNHR) and others.[E]

POLICY INDICATOR: Has the state enacted mental health parity legislation?

Approximately one in five Americans suffers from a mental disorder in any given year, yet many insurers fail to cover mental health services on the same basis as physical health services.[57] In fact, two in three adults with a diagnosed mental disorder do not receive treatment.[58] One important way for states to increase access to mental health care services, in addition to Medicaid coverage, is to enact mental health parity legislation that requires private insurers to cover mental health disorders on the same basis as physical disorders.[59] This indicator is a composite of three mental health parity issues of particular importance to women; First the *Report Card* reviews general mental health parity mandates for private insurers. In the absence of general parity mandates, the *Report Card* reviews eating disorder parity mandates and depression parity mandates for private insurers. Only four states (Connecticut, Maryland, Minnesota and Vermont) have provided comprehensive mental health parity protection that includes both eating disorders and depression. Six states (Arkansas, California, Delaware, Georgia, Indiana and Louisiana) have provided either near-comprehensive parity or limited parity that covers eating disorders and depression. Seventeen states have offered minimal mental health parity protections. Twenty-three states and the District of Columbia have not had any mental health parity protections at all.

(a) Does the state have mental health parity legislation? Although federal legislation passed in 1996 offers some enhanced coverage, it does not require private insurers to provide full parity for mental health care services.[60] Four states (Connecticut, Maryland, Minnesota and Vermont) have addressed this gap by passing comprehensive laws requiring parity for all mental health problems and substance abuse. Two states (Georgia and Indiana) have adopted parity laws with some limitations. Twenty-one states have required parity for only a limited set of mental health problems (e.g., severe mental illness), for a limited population (e.g., state and local employees), or only for specific types of coverage (e.g., spending limits, out-of-pocket expenses). Twenty-three states and the District of Columbia have had no parity requirements.

(b) Does the state require private insurers to cover treatment for eating disorders on the same basis as other health conditions? Eating disorders predominantly affect women (90 percent of cases involve adolescent or young adult women), and have one of the highest death rates of any mental disorder.[61] Ten states (Arkansas, California, Connecticut, Delaware, Georgia, Indiana, Louisiana, Maryland, Minnesota and Vermont) have explicitly required insurers to cover anorexia and bulimia on the same basis as other physical health conditions. Five states (Arizona, Missouri, North Carolina, South Carolina and Tennessee) have required insurers to cover anorexia and bulimia on the same basis as other health conditions, but only in a limited way (i.e., they only require parity in spending limits or only for certain

populations such as state employees). Thirty-five states and the District of Columbia have not had any laws requiring insurers to cover anorexia and bulimia on par with other health conditions.

(c) Does the state require private insurers to cover treatment for depression on the same basis as other health conditions? Major depression affects twice as many women as men.[62] Twenty states have required insurers to cover depression on the same basis as other physical health conditions. Five states (Arizona, Missouri, North Carolina, South Carolina and Tennessee) have required insurers to cover depression on the same basis as other health conditions, but only in a limited way (i.e., they only require parity in spending limits or only for certain populations such as state employees). Twenty-five states and the District of Columbia have not had any laws requiring insurers to cover depression on par with other health conditions.

Mental Health Community Treatment: The Program for Assertive Community Treatment (PACT) is a comprehensive, multi-disciplinary mental health service delivery model that addresses the traditionally unmet needs of the severely mentally ill. Despite PACT's effectiveness in reducing the most severe outcomes of untreated mental illness, only six states (Delaware, Idaho, Michigan, Rhode Island, Texas and Wisconsin) have statewide programs.[F]

POLICY INDICATOR: Does the state require private insurance plans to cover diabetes supplies and education?

Over five percent of women in the United States suffer from diabetes, a condition requiring self-managed treatment. Patients need access to medical supplies (including test strips, insulin and meters) and training to use these supplies and to manage their condition. Currently, 35 states have required private insurance plans to include diabetes supplies and education as part of general coverage. Three states (Georgia, Mississippi and Missouri) have required insurers to offer to sell diabetes supplies and education coverage to customers, but have not required that it actually be included in insurance plans. Twelve states and the District of Columbia have not required this coverage at all.

POLICY INDICATOR: Does the state have policies to improve health care services related to mastectomy?

In 1996, approximately 108,000 women had mastectomies.[63] Many women face barriers to receiving needed health care services associated with this procedure. The policies addressing these barriers that are included in this composite are: (a) private insurance coverage for reconstructive surgery and (b) private insurance coverage for post–mastectomy hospital stays. Eight states (California, Florida, Illinois, Maine, Montana, New York, North Carolina and Pennsylvania) have adopted both of these policies. Nine states (Arkansas, Connecticut, Maryland, New Jersey, Oklahoma, Rhode Island, South Carolina, Texas and Virginia) have adopted both policies, but with at least one of the policies in a weaker form. Sixteen states have adopted one of the policies (sometimes in a weaker form) and 17 states and the District of Columbia have no policies addressing mastectomy-related services.

(a) Does the state require private insurers to cover reconstructive breast surgery? Some insurance plans exclude coverage of breast reconstruction after a mastectomy, deeming it "cosmetic" surgery that is not medically necessary.[64] Although a federal law was passed in 1998[65] to combat this practice, state laws add the strength of state enforcement mechanisms. Twenty-eight states have passed laws requiring private insurers to cover reconstructive breast surgery. Two states (Michigan and South Carolina) have required coverage, but only if the surgery is deemed medically necessary by the patient's physician. One state (Kentucky) has required that private insurers offer to sell coverage of reconstructive breast surgery to customers, but has not required that it actually be included in insurance plans. Nineteen states and the District of Columbia have not had any laws regarding coverage for reconstruction.

(b) Does the state require private insurers to cover hospital stays following a mastectomy? Federal law requires that insurance companies allow physicians, in consultation with their patients, to determine how long a woman stays in the hospital following a mastectomy, based on the patient's individual needs and circumstances.[66] The law was enacted because, to the detriment of patients' health, insurance companies have denied coverage beyond a pre-determined length of stay. Nine states (California, Florida, Georgia, Illinois, Maine, Montana, New York, North Carolina and Pennsylvania) had the same standard as the federal government, and required insurance companies to pay for the length of hospital stays determined by physicians (in consultation with their patients). Ten states (Arkansas, Connecticut, Maryland, New Jersey, New Mexico, Oklahoma, Rhode Island, South Carolina, Texas and Virginia) have required private insurers to cover hospital stays following a mastectomy, but only set a minimum length of stay that must be covered (usually 48 hours). Thirty-one states and the District of Columbia have not enacted any protections for patients who have had mastectomies.

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

Family planning services (contraceptive drugs, devices and related services) provide numerous essential health benefits—including better spacing of pregnancies leading to healthier outcomes, and fewer unintended pregnancies, abortions and sexually transmitted diseases. In fact, reducing negative health outcomes through the consistent use of effective family planning methods is one goal of Healthy People 2010.[67] Despite the importance of family planning services for women, private health insurance does not provide adequate coverage of contraceptive drugs and related services.[68] Contraceptives can be expensive, and without

insurance coverage, many women are forced to either forgo using contraceptives completely or to use less effective methods. The two policies included in this indicator are: (a) required private insurance coverage for contraceptives and (b) expanded Medicaid coverage for family planning services and supplies. Only two states (California and Maryland) have both passed comprehensive contraceptive coverage laws and have applied for or received a Medicaid waiver to expand family planning coverage. One state (Kentucky) has passed a limited contraceptive coverage law and has applied for a Medicaid waiver to expand family planning coverage. Twenty-six states have adopted only one of these policies. Twenty-one states and the District of Columbia have adopted neither policy.

(a) Does the state require private insurers that cover prescription drugs to cover all forms of Food and Drug Administration (FDA)-approved prescription contraceptive drugs and devices? Eleven states have required that private insurance companies that cover prescription drugs also cover all five FDA-approved forms of contraception.[69] Six states (Colorado, Idaho, Kentucky, Minnesota, New Jersey and Texas) have required that private insurance companies that cover prescription drugs also provide limited coverage for prescription contraceptives. The remaining 33 states and the District of Columbia have no laws requiring contraceptive coverage.

(b) Has the state applied for and/or received a Medicaid waiver to expand coverage for family planning services? Medicaid—the largest public provider of family planning services for low-income women—is unavailable to more than half the low-income women who need these services.[70] States can expand the pool of low-income women eligible for Medicaid coverage of family planning services by securing a federal Medicaid waiver to broaden the eligibility requirements. These expansion efforts have dramatically increased the number of low-income women served by Medicaid family planning programs.[71] Fifteen states have applied for this waiver. The remaining 35 states and the District of Columbia have not applied for the waiver.

Emergency Contraception: Although emergency contraception (the "morning-after pill") is highly effective at preventing pregnancy when taken promptly, many women do not have access to it. Twenty-two states have enacted laws that, once the necessary protocols are established, will permit pharmacists to dispense specific medications directly without a prescription. Only Washington State has actually put these protocols in place so that women can secure emergency contraception with greater ease.[G]

POLICY INDICATOR: Does the state provide for access to infertility services and adequate maternity hospital stays?
More than six million couples nationwide have trouble conceiving children after one year of trying.[72] Many private insurance companies do not cover the costs of infertility treatments, placing these treatments out of financial reach for many families.[73] In many managed care settings, pregnant women are being denied coverage after childbirth for hospital stays longer than 24 hours.[74] Although being discharged soon after birth can be beneficial for many patients, other mothers and their infants can suffer negative health consequences from an early discharge. Medical experts agree that the determination about the length of a woman's hospital stay after childbirth—however short or long—should be made not by insurance companies, but by the health care provider[75] in consultation with the patient. This composite measures policies that ensure that women get the services they need both (a) while they are trying to get pregnant (requiring insurance companies to cover infertility services) and (b) after they have given birth (requiring insurance companies to cover physician-determined hospital stays after childbirth). No state has adopted both of these policies, and only nine states (Arkansas, Illinois, Maryland, Massachusetts, Montana, New York, Ohio, Rhode Island and West Virginia) have adopted both laws but with coverage limits. Thirty-four states and the District of Columbia have either one of the policies or both policies but with weaker coverage. Seven states (Delaware, Michigan, Mississippi, Nebraska, Utah, Wisconsin and Wyoming) have adopted neither of these policies.

(a) Does the state require that private insurance companies cover physician-determined maternity stays after childbirth? Six states (Florida, Indiana, Maine, Vermont, Virginia and Washington) have required insurance companies to pay for physician-determined length of stays after birth.[76] Thirty-six states and the District of Columbia have adopted laws requiring that insurance companies cover at least a minimum length of stay at the hospital following childbirth (usually 48 hours for vaginal deliveries and 96 hours for cesareans). Eight states (Delaware, Hawaii, Michigan, Mississippi, Nebraska, Utah, Wisconsin and Wyoming) have no such protections.

(b) Does the state require private insurance companies to provide coverage for the diagnosis and treatment of infertility? Five states (Hawaii, Illinois, Massachusetts, New York and Rhode Island) have required insurance companies to cover infertility diagnosis and treatments. Five states (Arkansas, Maryland, Montana, Ohio and West Virginia) have required limited coverage. Three states (California, Connecticut and Texas) have required insurance companies to offer to sell coverage of infertility treatment to customers, but have not required that it actually be included in insurance plans. Thirty-seven states and the District of Columbia have no laws regarding infertility coverage.

POLICY INDICATOR: Does the state provide for access to abortion services?
Reproductive health care, including abortion, is a basic component of women's health care. While women in the United States have had a constitutionally protected right to abortion

since the 1973 *Roe v. Wade* decision, actual access to abortion services is diminishing.[77] States have enacted policies that either restrict or protect women's access to abortion, and the following components of the policy indicator reflect key policies adopted by states: (a) enacting clinic access laws; (b) allowing all medically accepted abortion procedures; (c) allowing minors to obtain abortions without parental consent or notification requirements; (d) allowing abortions without waiting periods; and (e) providing state funding for abortions for low-income women. Only one state (Washington) has adopted all five policies. Only 12 states and the District of Columbia have made a substantial effort to protect access to abortion services by adopting substantial aspects of these policies. Twenty-eight states have had minimal protections. Nine states (Indiana, Louisiana, Mississippi, Nebraska, North Dakota, Ohio, South Carolina, South Dakota and Utah) had none of these protections.

(a) Has the state passed "clinic access" legislation to protect women and providers from violence and harassment at reproductive health centers? Threats and violent attacks on reproductive health centers, including murders of health care providers, have had an extremely negative impact on women's ability to obtain reproductive health services.[78] These attacks have frightened patients away from clinics, disrupted the functioning of the clinics, and discouraged physicians and other health care professionals from providing reproductive health services.[79] In 1994, Congress passed the Freedom of Access to Clinic Entrances Act (FACE), which was immediately followed by a decline in such incidents.[80] Several states have also passed laws to ban clinic violence, providing concurrent state police and prosecutorial authority. Washington is the only state that has adopted comprehensive provisions similar to FACE that protect clinic access. Fourteen other states and the District of Columbia have laws that contain limited protections. Thirty-five states have no laws addressing clinic access.

(b) Has the state allowed the availability of all medically accepted abortion procedures? Over the past five years, 30 states have enacted bans on medically accepted abortion procedures, often referred to as bans on "partial birth" abortion procedures.[81] On June 28, 2000, the U.S. Supreme Court struck down the Nebraska ban as unconstitutional, because it could ban the most common abortion procedure used in the second trimester, and because, even had only one procedure been banned, there was no safeguard to allow the procedure when needed to protect a woman's health.[82] States' enactment of these bans reflect their willingness to erect barriers to women's access to medically necessary abortion services. Twenty states and the District of Columbia have not enacted an abortion procedure ban, in contrast to the 30 that have.

Strong Protections in the Legal System for Victims of Sexual Assault: In California, sexual assault victims may have "advocates" present during all their contacts with law enforcement and defense or district attorneys (all of whom are required to inform victims of this right). In Illinois, the state Sex Crimes Investigation Manual includes a statewide protocol for testing victims for date rape drugs. The state also has a Sex Offender Management Board (that includes victim advocates as members) that addresses issues regarding sex offender punishment and treatment.[H]

(c) Does the state allow minors to obtain abortions without requiring parental consent or notification? Parental consent and notification laws require that minors, usually those under age 18, involve one or both parents in their decision to terminate a pregnancy.[83] These requirements can endanger the health of young women—some young women may delay the procedure, and others may travel alone to another state to secure the abortion.[84] Eighteen states and the District of Columbia have not had laws forcing parental involvement in a minor's decision. Two states (Maine and Maryland) have parental involvement laws, but allow health care providers (and in Maine other counselors) to waive the requirement where appropriate. The remaining 30 states have adopted parental consent/notification laws.

(d) Does the state allow women to receive abortions without a mandatory waiting period? Some states require a waiting period, typically 24 hours, between the time when a woman receives state-mandated "counseling" and the abortion. These waiting periods are a serious barrier to women seeking abortions, making it difficult to schedule appointments, and causing delays (thereby enhancing the risk of complications). They also force many women to incur greater financial costs, or to face additional harassment at clinics and from abusive partners and spouses.[85] These problems are exacerbated for the almost one-third of all women who live in counties with no abortion providers.[86] Thirty-six states and the District of Columbia have not had laws requiring waiting periods, and 14 states have such laws.

(e) Does the state provide funding for abortion as it does for other medically necessary procedures? Women who cannot afford to pay for abortions are often unable to obtain them. Federal law prohibits the use of federal Medicaid funds to cover abortion except in cases where the pregnancy is the result of rape or incest, or the life of the woman is endangered (this law is commonly known as the "Hyde Amendment").[87] States can, however, pay for abortion services with their own funds. Fifteen states have provided funding for abortions as they do other medically necessary procedures. Five states (Idaho, Illinois, Iowa, Virginia and Wisconsin) have provided limited funding for abortions beyond the federal requirement. Thirty states and (pursuant to Congressional mandate) the District of Columbia have not covered the cost of abortions for low-income women beyond those allowed under federal law.

Policy Indicator: Does the state have laws to address the health needs of women subjected to violence? Violence against women presents a serious health problem in need of major attention. States have attempted to reduce both domestic violence and sexual assault by increasing victims' access to health care through: (a) requiring health care protocols,

training and screening for domestic violence; (b) prohibiting insurance discrimination against domestic violence victims; and (c) requiring protocols concerning sexual assault victims. Only one state (California) has adopted all three policies, and only three states (Alaska, New York and Pennsylvania) have adopted both domestic violence policies and a weaker version of the sexual assault policy. Thirty-four states have had minimal policies. Twelve states and the District of Columbia have had none of these policies.

(a) Does the state require domestic violence protocols for, training for and screening by health care providers? Early detection and intervention by health care providers can help domestic violence victims escape abusive relationships. Health care providers need training not only to appropriately treat women who exhibit signs of domestic violence injuries, but also to screen for and recognize abuse in a patient who does not exhibit recent injuries.[88] There are national efforts to promote protocols to help practitioners identify victims of domestic violence and perform interventions, but there is evidence that the protocols are not being routinely followed.[89] Three states (California, New York and Pennsylvania) have had laws that help domestic violence victims get treatment by requiring: written protocols describing how health care providers should identify and treat domestic violence victims; routine screening for domestic abuse; and training to help health care providers assist domestic violence victims. Three states (Alaska, Maryland and Ohio) have had two out of three of these requirements. Six states have had only one component (Florida, Iowa, Kentucky, Oklahoma, Texas and Washington). Thirty-eight states and the District of Columbia have not had any of these requirements.

(b) Does the state have a statute prohibiting discrimination against domestic violence victims in all types of private insurance? Victims of domestic violence experience discrimination in all "lines" of insurance: health, life, disability and property/casualty.[90] Insurance companies have used a history of abuse to deny coverage or to increase premiums, and have refused to cover abuse-related medical conditions and claims.[91] These practices can discourage victims from seeking help for fear of losing their insurance coverage if the abuse is discovered. Although federal law offers some protection against these practices,[92] several states have offered more comprehensive protection by enacting laws that prohibit discrimination against domestic violence victims. Fifteen states have prohibited discrimination in all four lines of insurance. Seven states (Arizona, Illinois, Indiana, Kansas, Maine, Utah and West Virginia) have barred discrimination in three lines of insurance. Fourteen states have barred discrimination in one or two lines of insurance. Fourteen states and the District of Columbia have not enacted laws protecting domestic violence victims from insurance discrimination.

(c) Does the state have laws that require training for health care providers, police and prosecutors in handling sexual assault cases? Victims of sexual assault are often subject to inadequate or inappropriate responses from health care providers, police and prosecutors. For example, health care providers may not be adequately trained in how to care for victims during evidence collection (or even how to perform the collection) and police and prosecutors may not be sufficiently sensitive to the special traumas sexual assault victims face. Four states (Alaska, California, Connecticut and Illinois) have enacted laws requiring both that health care providers be trained in sexual assault evidence collection, and that police and prosecutors be trained in dealing with sexual assault victims. Eleven states have required one of the two training programs. The remaining 35 states and the District of Columbia have had neither training requirement.

Addressing Wellness and Prevention

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

Ovarian Cancer: Approximately one in 55 women nationwide is diagnosed with ovarian cancer and half of these women die within five years. Early diagnosis increases the five-year survival rate for ovarian cancer to 95 percent, but the medical community has not yet developed a simple screening mechanism for the disease.[1]

Screening

The *Report Card* examines screening for cervical cancer, chlamydia, breast cancer, colorectal cancer and osteoporosis. These tests (intended to be given even when women do not have symptoms) were selected because the diseases for which they screen can effectively be treated with early interventions. Furthermore, these screening tests are often the first step for women gaining access to general health care services. Both Medicaid and Medicare provide certain preventive screenings (for example, states are required to cover Pap smears and mammograms under Medicaid, and Medicare covers both of those screenings as well).[93] However, states can supplement what is provided under publicly funded health insurance programs by requiring private insurers to cover important screenings for women. The policy indicators below focus on these private insurance requirements regarding Pap smears, chlamydia screening, mammograms, bone density screening and colorectal cancer screening.

Status Indicator: What percentage of women age 18 and over have had a Pap test within the past three years?

Papanicolaou (Pap) smears remain the primary screening test to help prevent cervical cancer. Nevertheless, many women have not received a Pap smear in the past three years. This is especially true for older women, uninsured women and women in some minority groups.[94] In 24 states and the District of Columbia, at least 85 percent of women age 18 and over had received a Pap smear in the past three years (the target set by Healthy People 2000); they received an "S."[95] The remaining 26 states received a "U" because they came within ten percent of the Healthy People 2000 benchmark. The nation also received a "U."

Policy Indicator: Does the state require private insurers to cover annual Pap smears and cervical cancer screening?

Although the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program covers the cost of Pap smears for certain categories of underserved women,[96] many women who need these screenings would not receive them if states did not take additional steps to provide coverage. Twenty-two states and the District of Columbia have enacted laws that require private insurers to cover annual Pap smears. One state (Ohio) has required insurers to offer to sell coverage for Pap smears and cervical cancer screenings to customers, but has not required that it be included in insurance plans. The remaining 27 states have not required insurers to cover cervical cancer screenings.

Policy Indicator: Does the state require private insurers to cover testing for chlamydia?

Chlamydia is the most common bacterial sexually transmitted disease and is most prevalent among young women age 15 to 25.[97] Screening for chlamydia is recommended for young women and for all women in high-risk categories, including those who have had a sexually transmitted disease, have a new partner or multiple partners, or inconsistently use barrier contraceptives.[98] Only three states (Georgia, Maryland and Tennessee) have required insurers to cover the recommended screening for chlamydia. The remaining 47 states and the District of Columbia have not required coverage for chlamydia screening.

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

Mammograms help detect breast cancer in its early stages; it is critical that women have access to them. Although the overall number of women who get mammograms is increasing, a number of women—particularly those who are uninsured, older and members of certain racial and ethnic minority groups—do not get mammograms at the same rate.[99] In all 50 states and the District of Columbia, at least 60 percent of women age 50 and over received a mammogram within the past one to two years, thereby meeting the Healthy People 2000 goal.[100] Therefore, the 50 states, the District of Columbia and the nation received an "S." However, Healthy People 2010 has recently set the new goal of mammograms within two years for women 40 and over.[101] Future analyses will determine whether states meet this new benchmark, and whether there is improvement among groups of women who currently tend not to get mammograms.

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

Although the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program covers mammograms for certain categories of underserved women,[102] many women who need these screenings still would not receive them if states did not take additional steps to provide coverage.[103] Fourteen states and the District of Columbia have enacted laws that require private insurers to cover annual mammograms for women age 40 years and over.[104] Twenty-eight states have enacted laws that require private insurers to cover annual mammograms for a narrower category of women (the majority of these states cover annual mammograms for women age 50 years and over). Four states (Arkansas, Michigan, Mississippi and Ohio) have only required that insurance companies offer to sell coverage of mammograms to customers, but have not actually required that it be included in insurance plans. Four states (Minnesota, Utah, Washington and Wyoming) have had no requirements regarding insurance coverage for mammograms.

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

Bone density testing (also known as bone mass measurement) can predict a woman's risk for bone fractures (one of the most common and debilitating consequences of osteoporosis).[105] Although Medicare covers bone density testing for five high-risk groups, states can help cover more women who need the test by requiring private insurers to cover high-risk people not covered by Medicare.[106] Five states (Florida, Maryland, North Carolina, Oklahoma and Texas) have required private insurers to cover bone density screening for people in all five high-risk categories. One state (Louisiana) has required private insurers to cover bone density screening for three of the five categories. Two states (Georgia and Kentucky) have required insurers to offer to sell coverage for bone density testing to consumers, but do not actually require that insurance plans include it. The remaining 42 states and the District of Columbia have had no requirements regarding coverage of bone density testing.

Pap Smear Programs: The Vietnamese Community Health Promotion Project in San Francisco has successfully increased the number of Vietnamese women receiving Pap smears through a coordinated outreach and education effort led by indigenous lay health workers. This program is particularly important because of the high rates of cervical cancer among Vietnamese women (the highest cervical cancer incidence rate of any ethnic group in the United States). Over three years, these outreach efforts have increased the percentage of Vietnamese women receiving Pap smears from 46 percent to 66 percent.[J]

STATUS INDICATOR: What percentage of women age 50 and over have ever had a sigmoidoscopy?

Colorectal cancer is the third leading cause of cancer-related deaths among women after lung and breast cancer.[107] Colorectal cancer is most common in people age 50 and over and the risk increases with age.[108] Regular screening examinations can reduce a person's risk of developing colorectal cancer and are recommended for people age 50 and over.[109] One commonly recommended screening procedure is a sigmoidoscopy.[110] In 19 states and the District of Columbia, at least 40 percent of women age 50 and over had a sigmoidoscopy at some point in their lives (meeting the Healthy People 2000 goal of 40 percent of all people 50 and over having had sigmoidoscopy); they received an "S."[111] Thirteen states came within ten percent of this goal; they received a "U." Eighteen states missed the goal by more than ten percent; they received an "F." The nation received a "U."

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

Early detection and treatment can greatly reduce the risks associated with colorectal cancer.[112] Only two states (Illinois and Missouri) have required private insurers to cover colorectal cancer screening; the other 48 states and the District of Columbia have not.

Prevention

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

STATUS INDICATOR: What percentage of women did not engage in any leisure-time physical activity in the past month?

Regular exercise is critical to maintaining good health and preventing severe illness, yet almost one-third of women report no leisure time physical activity. All 50 states and the District of Columbia missed the Healthy People 2000 goal (when the goal was applied to women) of reducing to no more than 15 percent the proportion of people who engage in no leisure-time physical activity; and received an "F." [113] The nation also received an "F."

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

Currently, half of teenagers nationwide report that they do not engage in regular vigorous physical activity, and girls are far more likely than boys to report being inactive.[114] Promoting physical activity in school is crucial to encouraging girls to reap the health benefits of regular exercise and to develop lifelong good exercise habits.[115] Only one state (New Jersey) has required students in grades nine through 12 to take four years of Physical Education (P.E.) in order to graduate. Thirty-six states and the District of Columbia have required students to take less than four years of P.E. to graduate. Thirteen states either have had no P.E. graduation requirement or have specified that the local district will determine the amount.[116]

STATUS INDICATOR: What percentage of women are overweight?

No state met the Healthy People 2000 goal of reducing the percentage of overweight persons (age 20 and over) to 20 percent or less when the goal was applied to women.[117] This failure has serious implications for women's health since overweight is associated with a greater risk of diseases such as cardiovascular disease and diabetes, and of exacerbating existing conditions such as arthritis.[118] Only Arizona was within ten percent of the benchmark; it received a "U." The remaining 49 states and the District of Columbia missed the benchmark by more than ten percent; they received an "F." The nation also received an "F."

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

One of the best ways to assess a healthy diet is to count the number of servings of fruits and vegetables an individual eats in a day.[119] Poor nutrition increases both the prevalence and the severity of many conditions (including obesity, high blood pressure, osteoporosis and arthritis) and illnesses (including cardiovascular diseases, diabetes and certain cancers).[120] The Healthy People 2000 goal was to increase to at least 50 percent the proportion of people who eat five or more servings of fruit and vegetables a

Exercise Programs: *Be Active North Carolina* is a state program designed to increase the physical activity levels of North Carolina's teenagers and elderly, and to reduce the disparity in physical activity levels between African Americans and whites. The program uses such diverse strategies as conducting outreach through religious centers; redesigning commercial zoning projects to include walkways, bike paths, and open areas; and getting public recreation facilities to offer free membership or sliding scale membership fees.[K]

Preventing Heart Disease: Georgia's Stroke and Heart Attack Prevention Program (funded by both the Georgia state government and the Centers for Disease Control and Prevention) provides education about the risk factors for heart attack and stroke and subsidizes screening, physician referrals, diagnosis and treatment through the county health departments. Screenings are provided at local health departments; at meetings of industrial, civic and other groups; and at public sites such as health fairs.[L]

day.[121] No state came within ten percent of the goal when the goal was applied to women; all 50 states and the District of Columbia received an "F." The nation also received an "F."

POLICY INDICATOR: Does the state have nutrition outreach and education programs?

One of the greatest barriers to good nutrition for many low-income women is lack of information—both about the services available and about healthy eating. Two programs that states can adopt to counteract this problem are (a) outreach programs to women eligible for Food Stamps, and (b) the Food Stamp Nutrition Education Program to teach safe and healthy eating. Nine states (Arizona, Connecticut, Kentucky, Massachusetts, New Hampshire, New York, Tennessee, Vermont and Washington) have participated in both programs, 39 states have participated in one or the other, and two states (Delaware and Maryland) and the District of Columbia have participated in neither program.

Nutrition: The Expanded Food Nutrition Education Program, a 50-state federally funded education program, teaches low-income individuals (more than 90 percent of whom are women) how to choose more nutritious foods, handle food safely, and stretch their food budgets. The 30-year-old program has a high success rate, but because of limited funding reaches relatively few women.[M]

(a) Is the state using federal matching funds to conduct outreach to ensure that all eligible individuals are enrolled in the Food Stamp Program? The Food Stamp Program helps eligible low-income people (the majority of whom are women) buy nutritious food, and outreach efforts are critical to ensuring that these eligible people participate.[122] Since the enactment of welfare reform, Food Stamp enrollment has declined, possibly because some people who were no longer eligible for some types of public assistance mistakenly believed that they also were not eligible for Food Stamps.[123] By using federal matching funds to inform people that they are still eligible for Food Stamps, states can ensure that these low-income people get enough food. Only nine states (Arizona, Connecticut, Kentucky, Massachusetts, New Hampshire, New York, Tennessee, Vermont and Washington) have conducted outreach with these federal funds. Forty-one states and the District of Columbia have not conducted federally funded outreach.

(b) Does the state have a Food Stamp Nutrition Education Program? States that participate in the Food Stamp Nutrition Education Program (FSNEP) can receive federal matching funds if they demonstrate that their programs educate Food Stamp recipients about healthy eating, handling food safely, and managing a food budget. Forty-eight states have had FSNEPs, and Delaware, Maryland and the District of Columbia have not.

STATUS INDICATOR: What percentage of women smoke?

Nationally, approximately one in four adult women smoke. Cigarette smoking is the leading preventable cause of death among women and leads to an increased risk of many ailments, including cancer, heart disease, stroke, reproductive health problems and pulmonary conditions.[124] Only one state (Utah) met the Healthy People 2000 goal of reducing the percentage of people 18 and over who smoke cigarettes to 15 percent or less, when the goal is applied to women; it received an "S."[125] Minnesota was within ten percent of the benchmark; it received a "U." The remaining 48 states and the District of Columbia missed the benchmark by more than ten percent; they received an "F." The nation also received an "F."

POLICY INDICATOR: How strong are the state's anti-smoking policies?

State anti-smoking efforts are critical to ensuring both that non-smokers do not start smoking and that smokers stop. Thus, the *Report Card* examines: (a) state Medicaid smoking cessation coverage; (b) the state's rate of tobacco sales to minors; (c) laws banning indoor smoking; and (d) excise taxes on cigarettes. No state has adopted strong forms of all four of these policies, and only four states (California, Maine, Maryland and New Hampshire) have made substantial efforts to reduce smoking by adopting all of these policies with most of them in a moderately strong form. Forty-six states and the District of Columbia have adopted fewer or weaker versions of these policies.

(a) How comprehensive is the state's private insurance and Medicaid smoking cessation treatment coverage? The numerous major health problems associated with smoking make smoking cessation efforts a critical component to improving overall health. A smoker who quits before age 50 cuts in half her risk of dying in the next 15 years.[126] Currently, no state has enacted laws requiring private insurers to fully cover smoking cessation treatments. Only six states (California, Florida, Maine, Minnesota, New Mexico and Oregon) have had Medicaid programs that cover all three forms of smoking cessation treatment (over-the-counter treatments, prescription treatments, and smoking cessation counseling).[127] The Medicaid programs in 12 states have covered two of the three categories of treatment. Medicaid programs in six states (Arizona, Kansas, Montana, New Jersey, North Carolina and Oklahoma) and the District of Columbia have covered only one category of treatment. Twenty-five states have not covered any of the three categories of treatment. Virginia did not respond to the survey from which this data are drawn .

(b) What is the state's sales rate of tobacco products to minors? Women who start smoking as adolescents are more likely to be heavy adult smokers.[128] A good way to prevent adult women from smoking is to ensure that they never start as children. Currently, more than 40 percent of high school students report using tobacco and are already on their way to assuming the health risks associated with smoking.[129] All states ban the sale of tobacco products to minors. A state's effectiveness in enforcing its ban is measured by a "tobacco sales rate" that reflects the annual

percentage of merchants who break the law by selling tobacco products to minors.[130] Three states (Florida, Maine and Vermont) had a FY 1999 sales rate to minors below ten percent (the target set by health experts).[131] In addition, Florida has a particularly effective anti-smoking public education campaign targeted at youth.[132] Eighteen states had sales rates above ten and up to and including 20 percent (the target set by the federal government).[133] The remaining 29 states and the District of Columbia had sales rates over 20 percent.

(c) Does the state have laws restricting indoor smoking and how restrictive are those laws? The U.S. Environmental Protection Agency (EPA) has classified environmental tobacco smoke (ETS, also called "second-hand smoke") as a Group A carcinogen.[134] Like cigarette smoking, ETS can lead to lung cancer, heart disease and many other life-threatening conditions for smokers and also for non-smokers, making it a major public health hazard.[135] States can help prevent exposure to ETS by completely prohibiting smoking in indoor sites, including government and private worksites, schools, day care centers, health care facilities and places of public access (e.g., elevators, public transit, shopping centers or restaurants). Only four states (California, Maryland, Utah and Vermont) have imposed comprehensive ETS restrictions (e.g., barring smoking in almost all indoor government, public and private sites). Eight states (Hawaii, Maine, Michigan, Minnesota, New Hampshire, New York, Washington and Wisconsin) have imposed extensive restrictions (e.g., barring smoking in most indoor government, public and private sites). Twenty-five states and the District of Columbia have adopted moderate restrictions (e.g., barring smoking in some indoor government, public and private sites). Thirteen states have had either no laws or minimal laws.

(d) Does the state have an excise tax on cigarettes of one dollar or more per pack? Increasing the excise tax on cigarettes is one of the most effective ways to reduce smoking, especially among youth. Current research shows that a ten percent increase in the price of cigarettes leads to a seven percent reduction in teenage smoking and a six percent reduction in overall smoking.[136] Moreover, when excise taxes support a comprehensive tobacco control program, decreases in consumption will continue even if tobacco prices are lowered to pre-excise-tax values.[137] Currently, New York has adopted the highest excise tax of $1.11 per pack, and only two other states (Alaska and Hawaii) have imposed a tax rate of one dollar or more. Fifteen states and the District of Columbia have adopted a tax rate between $0.50 and $0.99 per pack. Thirty-two states have adopted a tax rate between $0 and $0.49 per pack.

Smoking – Tobacco Settlements: Forty-six states participated in the multi-state settlement of the lawsuits against the tobacco companies, and, to date, 38 have finalized their plans for the settlement funds. Many of these states are planning to commit only a small portion of the funds – or no money at all – to tobacco prevention efforts. Only 12 states (Colorado, Hawaii, Indiana, Maine, Maryland, Massachusetts, Minnesota, Ohio, Nebraska, Vermont, Washington and Wisconsin) have committed a substantial portion of their settlement funds for tobacco prevention efforts.[N]

STATUS INDICATOR: What percentage of women have had five or more drinks on at least one occasion during the past month? Excessive alcohol use is dangerous to a woman's health. While chronic alcohol use is a known health problem, binge drinking (having five or more drinks on at least one occasion) is an especially hazardous form of alcohol abuse.[138] Eighteen states have met the Healthy People 2010 target (to reduce to six percent or less the percentage of adults who engage in binge drinking) when that goal was applied to women; they received an "S."[139] Six states (Florida, Indiana, New Jersey, New Mexico, Virginia and Washington) came within ten percent of this benchmark and received a "U." Twenty-six states and the District of Columbia failed to come within ten percent of the Healthy People 2010 goal; they received an "F." The nation received an "F."

POLICY INDICATOR: Does the state have a Comprehensive Capacity Diabetes Control Program that it supplements with state funds? The high rate of diabetes (particularly among women) has led the Centers for Disease Control and Prevention to fund State Diabetes Control Programs to: improve public understanding of diabetes; develop prevention and control strategies and opportunities; and increase access to care.[140] States that demonstrate a strong commitment to preventing and controlling diabetes receive the Centers for Disease Control and Prevention's highest funding level ("comprehensive" funding) that averages $800,000 per state annually. Six states (Illinois, Michigan, Minnesota, New York, North Carolina and Texas) have received comprehensive funding and supplemented it with state funds. Ten states (California, Massachusetts, Montana, Ohio, Oregon, Rhode Island, Utah, Washington, West Virginia and Wisconsin) have received comprehensive funding, but have not supplemented the budget with state funds. The remaining 34 states and the District of Columbia have not demonstrated a strong enough commitment to warrant receiving more than the "core" CDC funding (an average of $232,000 per state annually).

POLICY INDICATOR: Does the state receive federal funds to create an enhanced Community Based Arthritis Program? A large number of women in the United States, particularly women of color, suffer from arthritis. A state's participation in the federally funded Community Based Arthritis Program is critical to increasing awareness of arthritis as a public health problem and creating education, intervention and treatment strategies for people living with arthritis. The Centers for Disease Control and Prevention provide two levels of funding for the

Community Based Arthritis Programs. Level Two grants provide each state with $300,000 annually, based on the state's demonstrated commitment to addressing arthritis. Level One grants provide $60,000 to each state annually. Eight states (Alabama, California, Florida, Georgia, Illinois, Minnesota, Missouri and Utah) have received Level Two funding from the Centers for Disease Control and Prevention. Thirty states have received Level One funding. Seven states (Arkansas, Indiana, Louisiana, New York, Pennsylvania, Texas and Wisconsin) and the District of Columbia applied for, but did not receive federal funds. Five states (Delaware, Montana, Nevada, South Dakota and West Virginia) have not had any arthritis programs and did not apply for funds.

Arthritis Control Program: Missouri has a unique network of arthritis centers that provide arthritis screening, treatment and education (including both preventive education and self-management classes) to patients, their families, the general public and health professionals.[O]

POLICY INDICATOR: Does the state fund an osteoporosis public education program?

Osteoporosis public education programs help to prevent the disease and improve treatment outcomes by increasing public awareness and understanding of osteoporosis and by helping health care professionals learn how to prevent, diagnose and treat it.[141] Twenty-six states have had state-funded osteoporosis public education programs (funding levels for these programs range from $2,500 to $750,000). Twenty-four states and the District of Columbia have not had a state-funded osteoporosis public education program.

Osteoporosis: North Carolina and Massachusetts have developed comprehensive public education programs about the prevention and treatment of osteoporosis among all age groups, especially the elderly. North Carolina conducts outreach through diverse partners, including the Girl Scouts, churches, senior centers and cosmetology groups. Massachusetts utilizes interactive curricula, plays, and school tours to involve younger children in osteoporosis education, and has a traveling model home that illustrates how the elderly can "fall-proof" their homes.[P]

POLICY INDICATOR: Does the state require an effective sexuality and STD/HIV education program in public schools?

Healthy People 2010 seeks to increase both the number of young adults receiving school-based education on contraception and abstinence and the number of young adults receiving school-based education on sexually transmitted diseases (STDs) and HIV prevention.[142] Sexuality and STD/HIV education is one of the best ways to reduce and prevent unintended pregnancy and the spread of sexually transmitted diseases, including HIV/AIDS. Only five states (Delaware, New Jersey, Rhode Island, Vermont and West Virginia) have adopted both policies, and only eight states (Alabama, California, Kentucky, Michigan, New Mexico, Oklahoma, Oregon and Pennsylvania) have adopted one. The remaining 37 states and the District of Columbia have adopted neither policy.

(a) Does the state require that sexuality education be taught and that it include information about both contraception and abstinence? States can promote sexuality education by requiring school-based sexuality education and enacting comprehensive content requirements for these programs (including both contraception and abstinence).[143] Five states (Delaware, New Jersey, Rhode Island, Vermont and West Virginia) have had required sexuality education programs and have a content requirement that includes both contraception and abstinence. The remaining 45 states and the District of Columbia have not had state-required sex education program requirements.

(b) Does the state require that STD/HIV education be taught and that it include abstinence and other methods of prevention? States can effectively promote STD and HIV/AIDS education in public schools by requiring schools to offer STD/HIV education and by enacting comprehensive content requirements for these programs (i.e., cover both abstinence and other methods of prevention that include contraception and the role of drug use in the transmission of the disease).[144] Thirteen states have required school-based STD/HIV education programs that include both contraception and abstinence. The remaining 37 states and the District of Columbia have not had state-required STD/HIV education requirements.

Key Health Conditions, Diseases and Causes of Death for Women

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

Index Of Policies Addressing Risk Factors For Key Health Conditions

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

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

Lung Cancer
- Smoking

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

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

Arthritis
- Arthritis Program
- Exercise
- Nutrition

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

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

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

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

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

Key Causes of Death

STATUS INDICATOR: How many women die from heart disease?

Heart disease is the leading cause of death for women in the United States, accounting for one-half of all women's deaths.[145] Women who have heart attacks are more likely to die from them within a year than are men.[146] Thirty states reduced the number of women dying from heart disease to no more than 100 per 100,000 women (the Healthy People 2000 goal being 100 per 100,000 people); they received an "S."[147] Ten states (Alaska, Delaware, Illinois, Indiana, Michigan, Missouri, Nevada, North Carolina, Ohio and Pennsylvania) came within ten percent of this goal and received a "U." Ten states (Alabama, Georgia, Kentucky, Louisiana, Mississippi, New York, Oklahoma, South Carolina, Tennessee and West Virginia) and the District of Columbia missed this goal by more than ten percent; they received an "F." The nation received an "S." The *Report Card* examines policies that encourage preventive behaviors (for example, exercising, eating well, not smoking and reducing stress) because prevention is crucial to reducing women's deaths due to heart disease.

STATUS INDICATOR: How many women die from strokes?

Strokes are the third leading cause of death among women in the United States. An average of 24.5 women per 100,000 die from strokes each year.[148] Four states (Connecticut, Massachusetts, New York and Rhode Island) have reduced stroke deaths to no more than 20 per 100,000 women (the Healthy People 2000 goal being 20 per 100,000 people) and received an "S."[149] Five states (Arizona, Delaware, Florida, Maine and New Jersey) came within ten percent of the goal; they received a "U." Forty-one states and the District of Columbia failed to come within ten percent of the benchmark; they received an "F." The nation also received an "F."

STATUS INDICATOR: How many women die from lung cancer?

Nationally, lung cancer is the leading cause of cancer death for women and the second most common cause of death for women overall.[150] The incidence of lung cancer among women has increased 600 percent over the past 50 years.[151] Twenty-five states and the District of Columbia have reduced the lung cancer death rate among women to less than 27 per 100,000 (the Healthy People 2000 goal); they received an "S." [152] Thirteen states have reduced the number of deaths to within ten percent of the Healthy People 2000 goal; they received a "U." Twelve states missed the benchmark by more than ten percent; they received an "F." The nation received an "S." Since cigarette smoking is the primary risk factor for lung cancer, the *Report Card* includes policies that help women stop smoking, prevent them from starting or limit their exposure to second-hand smoke.

Leading Causes of Death For All Women Nationally by Age

Per 100,000 Women

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

Source: NCHS (See Chapter IX Technical Notes for more information)

STATUS INDICATOR: How many women die from breast cancer?

Breast cancer is the most common type of cancer for women in the United States, and the second leading cause of cancer death for women (following lung cancer).[153] It is the leading cause of cancer death for women age 25 to 54, and will account for about 15 percent of cancer deaths among women nationwide in 2000.[154] Thirty-six states reduced the number of women who died of breast cancer to 20.6 or less per 100,000 (the Healthy People 2000 goal); they received an "S."[155] Fourteen states were within ten percent of the goal; they received a "U." The District of Columbia missed the benchmark by more than ten percent and received an "F." The nation received an "S." The Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program[156] provides mammograms and Pap smears to poor, older and minority uninsured women in each of the 50 states and the District of Columbia. The Program does not, however, fund treatment, so women diagnosed with breast and/or cervical cancer under the program may not have access to treatment. Legislation currently before Congress would establish a Medicaid option to allow states to cover treatment for these women. If it becomes available, it will become relevant to review which states take this Medicaid option. Because early detection greatly improves a woman's likelihood of surviving breast cancer, the *Report Card* includes policies that provide access to mammography and other screening mechanisms, as well as policies that ensure women's access to treatment options.

Medicaid Access for Women With HIV: Maine is the only state taking advantage of a new Medicaid option that allows states to expand Medicaid coverage to individuals with HIV who are not yet disabled by AIDS. This coverage allows low-income HIV positive women to have access to the drugs and medical care that can enhance both the quality and the length of their lives.[Q]

Chronic Conditions

STATUS INDICATOR: What percentage of women have high blood pressure?

Controlling high blood pressure helps decrease the risk of developing heart disease and stroke. No state has met the Healthy People 2010 goal of reducing the percentage of people with high blood pressure to no more than 16 percent when that goal was applied to women.[157] Arizona came within ten percent of the benchmark; it received a "U." The remaining 49 states and the District of Columbia missed the benchmark by more than ten percent; they received an "F." The nation also received an "F." (Policies affecting high blood pressure are similar to those affecting heart disease, discussed above).

STATUS INDICATOR: What percentage of women suffer from diabetes?

Approximately five percent of women in the United States suffer from diabetes.[158] No state has met the Healthy People 2000 goal of reducing the prevalence of diabetes cases to no more than 25 per 1000 people, when that goal was applied to women.[159] Only one state (Alaska) came within ten percent of this goal; it received a "U." The remaining 49 states and the District of Columbia missed the benchmark by more than ten percent; they received an "F." The nation also received an "F." Risk factors for diabetes include obesity, physical inactivity, poor nutrition, smoking and poor prenatal care. The *Report Card* includes policies addressing these issues.[160]

STATUS INDICATOR: How many women are reported to have been diagnosed with AIDS?

In just over a decade, the percentage of all AIDS cases that are adult and adolescent women has more than tripled, from seven percent of all AIDS cases in 1985 to 23 percent of all AIDS cases in 1998.[161] The incidence of AIDS has increased most dramatically among women of color. In the United States, African American and Hispanic women account for more than three quarters of AIDS cases in women reported to date, even though they represent less than a quarter of all women.[162] Forty-three states have an AIDS incidence rate of no more than 13 per 100,000 women (the Healthy People 2000 goal); they received an "S."[163] Two states (Connecticut and South Carolina) came within ten percent of this goal; they received a "U." Five states (Delaware, Florida, Maryland, New Jersey and New York) and the District of Columbia missed the benchmark by more than ten percent; they received an "F." The nation received an "S." The *Report Card* includes policies that both help to prevent the spread of HIV/AIDS, including family planning programs and programs that educate young people about HIV prevention, and that treat the disease by providing pharmaceutical assistance to people with HIV/AIDS.

STATUS INDICATOR: How many women have arthritis?

Arthritis is the leading cause of disability in the United States, and 22.7 percent of women suffer from it.[164] Women are more likely than men to get arthritis, and it is the leading cause of limited activity among women age 40 and over.[165] Unfortunately, data collection on the prevalence of arthritis is sporadic and research did not reveal any consistent measure across the states as a benchmark. Therefore, the *Report Card* only includes national information about this disease, and does not grade on this indicator. Because of the positive impact that exercise and nutrition have on the pain and disability caused by arthritis, the *Report Card* includes policies that focus on these issues.

STATUS INDICATOR: How many women age 50 and over have osteoporosis?

Nationally, 20 percent of women have osteoporosis. Osteoporosis can cause many health problems, particularly for older women, and it is a major risk factor for hip fracture.[166] Research did not reveal any reliable data on the prevalence of osteoporosis by state.

Therefore, the *Report Card* only includes national information about this disease, and does not grade the states on this indicator. The nation failed to meet the Healthy People 2010 goal of reducing the number of osteoporosis cases to eight percent of adults age 50 and over, when that goal was applied to women. Because the nation missed this benchmark by substantially more than ten percent, it received an "F."[167] There is currently no cure for osteoporosis, making prevention an important priority. The *Report Card* includes policies encouraging preventive behavior (e.g., good nutrition, exercise, and not smoking) and public education, as well as policies that improve access to bone density screening.

Reproductive Health

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

Status Indicator: What percentage of women have chlamydia?

Chlamydia is the most common bacterial sexually transmitted disease and is most prevalent among young women age 15 to 25.[168] Chlamydia is particularly dangerous, because it is often asymptomatic in women and can only be identified through screening.[169] Chlamydia infections can often lead to pelvic inflammatory disease (PID), which in turn can cause infertility, ectopic pregnancy and chronic pelvic pain.[170] Twenty-one states reported chlamydia prevalence of five percent or less among women age 15-24 tested at family planning clinics (the Healthy People 2000 goal) and received an "S."[171] Five states (Arizona, Colorado, Connecticut, Ohio and Wisconsin) and the District of Columbia came within ten percent of the benchmark and received a "U." Twenty-four states missed the benchmark by more than ten percent; they received an "F." The nation received a "U."

Status Indicator: What percentage of pregnancies are unintended pregnancies?

In 1994, almost half of all pregnancies were unintended.[172] The Healthy People 2000 goal was to reduce unintended pregnancies to 30 percent or less of all pregnancies and, because the nation failed to meet this goal by more than ten percent, it received an "F." [173] The proportion of unintended pregnancies varies greatly with women's age. The greatest number of unintended pregnancies occur among teens under 18 (over 80 percent of pregnancies) and women age 40 and over (51 percent of pregnancies).[174] States do not uniformly collect data about unintended pregnancies, so the *Report Card* only includes national information about unintended pregnancies, and does not grade the states on this indicator.

Status Indicator: What is the maternal mortality ratio?

Maternal mortality is a key indicator of health worldwide and reflects the ability of women to secure not only maternal health care services but other health care services as well.[175] The World Health Organization estimates that 20 countries have reduced their maternal mortality levels to below the United States' level of 7.7 deaths per 100,000 live births.[176] African American women face a much higher risk than white women of dying from pregnancy-related conditions.[177] Only three states (New Hampshire, Massachusetts and Washington) have reduced the maternal mortality ratio to no more than 3.3 per 100,000 live births (the Healthy People 2000 goal); they received an "S."[178] Three states (Alaska, Nebraska and Montana) reduced maternal mortality to within ten percent of the goal; they received a "U." The remaining 44 states and the District of Columbia failed to come within ten percent of the benchmark; they received an "F." The nation received an "F."

Human Papillomavirus: Regular Pap smears are critical to addressing human papillomavirus ("HPV"), the most common viral sexually transmitted disease in the United States. HPV is probably the sexually transmitted disease that women know the least about, which is particularly problematic given the high number of infected people (an estimated 20 million people) and the fact that some strains of HPV can lead to cervical cancer. Regular Pap smears are particularly important in addressing HPV, because—although condom use can reduce the likelihood of transmission—it does not completely prevent the transmission of the disease.[R]

Mental Health

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

One of the main themes in the first Surgeon General's report on mental health, issued in 1999, is that mental and physical health have a marked impact on each other and the two cannot be viewed separately.[179] Because good mental health is difficult to define (even though specific mental conditions may be identifiable) the indicator used in the *Report Card* reflects women's own sense of mental well-being by tracking their reporting of the average number of days during the past 30 that their mental health was "not good." Women in Arizona had on average the lowest number of days when their mental health was "not good" (1.2 days), and women in Kentucky had on average the highest number of such days (5.5 days). For the nation, the comparable figure was 3.5 days. Research did not uncover a standard benchmark for the acceptable number of "not good" mental health days, so the states are ranked and not graded on this indicator. The *Report Card* includes state policies addressing "mental health parity" that require private insurers to cover mental health conditions on the same basis as they cover physical health conditions.

Violence Against Women

Status Indicator: What percentage of women are victims of violence?

Nationally, 55 percent of all women report having been raped and/or physically assaulted in their lifetime, affecting both their physical and mental health.[180] Due to the serious lack of consistent and reliable data collected at the state level, the *Report Card* did not grade states on this indicator. The *Report Card* includes a number of policies addressing violence against women, including: health care provider protocols, training and screening on domestic violence; prohibitions on insurance discrimination against domestic violence victims; and sexual assault training for health care providers, police and prosecutors.

Workplace Protections for Domestic Violence Victims: Several states have enacted laws to protect the employment rights of battered women. Four states (California, Maine, New York and Rhode Island) prohibit employers from discharging or discriminating against an employee for taking time off work to obtain a protection order. Several states have also passed laws making battered women eligible for unemployment benefits if they leave their jobs for reasons related to domestic violence.[S]

Living in a Healthy Community

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

Overall Health

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

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

Life expectancy is a key indicator of health status worldwide. Women in Japan have the highest life expectancy (82.9 years), and the *Report Card* uses this benchmark to grade the states and the nation.[181] The United States missed this benchmark by four years (78.9 years), and has only the 19th highest life expectancy for women worldwide.[182] No individual state met this benchmark. All 50 states were within ten percent of the benchmark (with a range of 81.3 years in Hawaii to 76.9 in Louisiana) and received a "U." The District of Columbia missed the benchmark by more than ten percent (74.2 years); it received an "F." The nation received a "U."

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

Illness affects all aspects of women's lives, including their ability to work, to care for their family, to participate in the community and to engage in daily activities. Research did not reveal any benchmark for the number of days out of 30 during which women have to limit activity, so the *Report Card* ranks, but does not grade, the states on this indicator. The average number of days out of the past 30 that women reported having to limit their usual activities due to poor physical or mental health ranged from a low of 2.6 days in Alaska to a high of 6.7 days in Kentucky. For the nation as a whole, the comparable figure was 3.6 days.

Status Indicator: What is the infant mortality rate?

Infant mortality (i.e., infant deaths that occur within the first year of life) is a key indicator of health worldwide, reflecting not only the health of infants, but of the entire population.[183] Infant mortality is also an indicator of pregnant women's access to high quality primary care.[184] Eighteen states met the Healthy People 2000 goal of no more than seven infant deaths per 1,000 live births; they received an "S."[185] Twelve states have infant mortality rates within ten percent of the benchmark; they received a "U." Twenty states and the District of Columbia missed the benchmark by more than ten percent; they received an "F." The nation received a "U."

Economic Security and Education

A woman's inability to afford health care services, health insurance, safe housing, nutritious food, and other basic necessities seriously compromises her health and well-being. Graduating from high school and college also significantly improves a woman's health and well-being, both by opening the door to greater economic security, and by providing the literacy skills necessary to navigate the health care system. The *Report Card* considers three critical measures of women's economic

security and educational attainment: the number of women living in poverty, the wage gap between men and women, and the percentage of women graduating from high school. The *Report Card* reviews the following set of policies to measure the degree to which a state is addressing women's economic security: child support "pass-through"; child support collection rates; Supplemental Security Income; tax policies affecting poor families; and the minimum wage. Other state policies under the Temporary Assistance to Needy Families program vary so widely that they could not be compared.[186]

Status Indicator: What percentage of women age 18 and over live in poverty?
On average, more than 13 percent of women live in poverty in the United States. In many states, nearly a quarter of women live in households below the Federal Poverty Level.[187] No state has eradicated poverty (the *Report Card* benchmark for the states) and therefore no state received an "S." Twelve states came within ten percent of the benchmark; they received a "U." The remaining 38 states and the District of Columbia failed to come within ten percent of the benchmark; they received an "F." The nation received an "F."

Status Indicator: What is the "wage gap" between male and female wage earners in the state?
The wage gap (the difference between men's wages and women's wages) is an important indicator of women's economic security, reflecting the particular economic hurdles women face that endanger their health and well-being. The average wage gap in the United States for 1998 is more than 25 percent, with women earning 72.3 percent of what men earn.[188] The *Report Card* uses a benchmark of women earning 100 percent of what men earn. Since no state was within ten percent of the benchmark, all 50 states and the District of Columbia received an "F." The nation received an "F." The wage gap was smallest in the District of Columbia, where women earn 87.5 percent of what their male counterparts earn, and largest in Alabama and Oklahoma, where women earn less than 66 percent of what men earn.

Status Indicator: What percentage of women in the state graduate from high school?
Women without a high school degree have lower earnings, more difficulty in securing health care, and are more likely to engage in substance abuse, experience unintended pregnancy and suffer other adverse health consequences.[189] The *Report Card* uses the Healthy People 2010 goal of 90 percent high school completion. When this goal is applied to women, only four states (Alaska, Utah, Washington and Wyoming) had 90 percent or more women graduate from high school; they received an "S."[190] Thirty-five states and the District of Columbia were within ten percent of the benchmark; they received a "U." Eleven states did not come within ten percent of the benchmark; they received an "F." The nation received a "U."

Housing and Homelessness: The National Resource Center on Homelessness and Mental Illness and the Better Homes Fund suggest that an increasing number of the homeless are women and families with children. A study published in the *Journal of Psychiatry* reports that women head almost all homeless families. Domestic violence and discrimination are two of the leading reasons women become homeless. Other contributing factors are poverty, substance abuse, mental illness, disability, unemployment, and lack of health insurance. Accurate estimates of the population of homeless women are not available for each state, and more data are needed.[T]

Policy Indicator: Does the state have effective policies to increase women's economic security?
The *Report Card* reviews the following measures which lend themselves to comparisons across states of policies and programs to improve women's economic security: (a) receipt of state-collected child support payments by families; (b) child support collection rates; (c) Supplemental Security Income; (d) amount of taxes poor families pay; and (e) the minimum wage. No state has adopted all of the policies, and only 19 states have adopted three or more of these significant economic policies. Thirty-one states and the District of Columbia have had only minimal policies.

(a) Does the state allow families receiving Temporary Assistance to Needy Families (TANF) to keep some amount of the child support payments collected on their behalf? Child support payments can make a substantial difference in the financial well-being of single mothers and their children.[191] Under federal law, families receiving welfare benefits (TANF) must assign their rights to child support payments to the state.[192] When a state collects child support on behalf of a TANF recipient, the state is permitted to keep the money to reimburse itself and the federal government for TANF assistance. States, however, have the option of allowing some of the child support payment to be "passed-through" to the parent and child. Additionally, this amount of child support, usually $50, is "disregarded" in calculating the amount of TANF assistance the family receives, so the state does not count it as additional income to the family and reduce the amount of assistance by the amount of child support given to the family.[193] By providing this additional income, the "pass-through" allows low-income mothers and their children to better meet their daily needs, and also provides a greater incentive for noncustodial parents to pay child support since some of their child support payments will go to the child, rather than to the state. Twenty-three states have had a child support "pass-through" policy. The remaining 27 states and the District of Columbia have not.

(b) What is the state's child support collection rate? Low-income families are most likely to rely on the state for help in collecting child support.[194] Five states (Maine, Minnesota, New Hampshire,

Vermont and Washington) collected child support in at least 40 percent of the state's child support caseload. Forty-one states' collection rates were below 40 percent and above 15 percent. Four states (Illinois, Indiana, Michigan, and New Mexico) and the District of Columbia collected child support in 15 percent or less of their cases.

(c) Does the state provide its own Supplemental Security Income to the elderly, blind and people with disabilities? Women account for nearly 60 percent of the recipients of Supplemental Security Income (SSI).[195] States can supplement these payments to help these individuals meet their basic needs.[196] Forty-one states and the District of Columbia have provided additional supplemental security income and nine states (Arkansas, Delaware, Georgia, Kansas, Mississippi, Montana, Tennessee, Texas and West Virginia) have not.

(d) What percentage of their income do the poorest 20 percent of families pay in state and local taxes? States can structure their tax laws to alleviate low-income families' financial burdens. The *Report Card* examines the percentage of income the poorest 20 percent of families pay in state and local taxes, taking into account such mechanisms as state level earned income tax credits.[197] States with lower tax burdens allow low-income families to use more of their incomes for necessities, including health care. The percentage of income that states required low-income families to pay in taxes ranged from 6.3 percent (Delaware) to 17.1 percent (Washington).

Welfare and Domestic Violence: Although more than half of the states have selected the "Family Violence Option" (FVO) in their welfare plans (which allows victims of domestic violence to be temporarily excused from work requirements and time limits), many states have not done an adequate job of informing welfare recipients of this provision. Eight states (Rhode Island, Alaska, Oregon, Arkansas, Nevada, New York, Washington and Minnesota) have developed notice forms that clearly explain the eligibility requirements of the FVO. However, a recent study in New York City revealed that having a readable notice form, in and of itself, does not ensure that welfare applicants and recipients actually are informed about the FVO. Rhode Island, Hawaii and Nevada have taken additional steps to ensure that women get this important information by requiring that the notice be signed by the recipient and placed in her case file, which helps ensure that notice was actually given.[U]

(e) Does the state have a minimum wage that allows a family of three to reach the poverty level? Women constitute approximately 60 percent of low wage earners nationwide and an increase in the minimum wage would give a significant number of these women a wage increase.[198] States can improve the economic security of low wage earners by enacting laws that raise the minimum wage for workers in their states above the federal level ($5.15 per hour). The *Report Card* has set a benchmark of a minimum wage of $6.39, which allows a family of three supported by a full-time, year-round, minimum wage earner to reach the poverty level.[199] Both Oregon and Washington have had a minimum wage above $6.39. Eight states (Alaska, California, Connecticut, Delaware, Hawaii, Massachusetts, Rhode Island and Vermont) and the District of Columbia have set minimum wage rates above the federal level but below $6.39. Thirty-three states have set the minimum wage at or below the federal level. Seven states (Alabama, Arizona, Florida, Louisiana, Mississippi, South Carolina and Tennessee) have had no minimum wage laws.[200]

Discrimination

Policy Indicator: Does the state have comprehensive anti-discrimination laws? Discriminatory practices can affect women's health by creating barriers to health care services and health insurance, by creating stress that contributes to physical and mental health problems and by creating barriers to financial and educational achievement. This indicator examines state responses to two discriminatory practices where new legal protections are especially important: (a) employment discrimination based on sexual orientation and (b) genetic discrimination. Only eight states (California, Connecticut, Nevada, New Hampshire, New Jersey, Rhode Island, Vermont and Wisconsin) have adopted policies outlawing both kinds of discrimination. Ten states (Colorado, Hawaii, Illinois, Iowa, Maryland, Michigan, Minnesota, New Mexico, New York and Washington) have adopted policies addressing both kinds of discrimination but at least one is in a weaker form. Twenty-two states and the District of Columbia have adopted policies to address only one form of discrimination. Ten states (Alaska, Arkansas, Idaho, Mississippi, Missouri, North Dakota, South Dakota, Utah, West Virginia and Wyoming) have not adopted policies prohibiting these two types of discrimination.

(a) Does the state prohibit employment discrimination based on sexual orientation? Employment discrimination affects women's health and well-being, not only because access to employment affects women's financial status, but because employment discrimination blocks one of the key avenues to health insurance. The federal government and the vast majority of states prohibit employment discrimination based on sex, race, religion, ethnicity, age and disability.[201] The federal government and most states do not, however, prohibit employment discrimination based on sexual orientation. Eleven states and the District of Columbia have adopted policies prohibiting employment discrimination based on sexual orientation. Nine states (Colorado, Illinois, Iowa, Maryland, Michigan, New Mexico, New York, Pennsylvania and Washington) have prohibited discrimination against public employees only. The remaining 30 states have adopted no laws regarding such discrimination.

(b) Does state law prohibit employment and health insurance discrimination based on genetic information? Scientists are now beginning to identify genes that are related to specific diseases. These scientific advances may lead to discriminatory practices by both health insurance companies and employers looking to avoid the costs of potential illness. There is no federal statute prohibiting genetic discrimination, although an Executive Order does bar such discrimination against federal employees.[202] Twenty states have passed laws prohibiting genetic discrimination in both health insurance and employment. Eighteen states have prohibited discrimination in either health insurance or employment. Twelve states and the District of Columbia have not enacted genetic anti-discrimination legislation.

Gun Control

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

Women lose their lives and survivors face serious health problems as a result of violent crimes.[203] In 1996, almost 5,000 women were killed with guns, and many more were injured.[204] States can enact a variety of policies to control guns, including: (a) requiring licensing and waiting periods; (b) requiring safe storage; and (c) prohibiting concealed handguns. No states have adopted all three of these restrictions, although the District of Columbia banned handguns entirely.[205] Nine states (California, Connecticut, Hawaii, Illinois, Iowa, Massachusetts, Minnesota, Missouri and New Jersey) have adopted a strong combination of many of these restrictions. Eighteen states have adopted weaker or fewer gun restrictions. Twenty-three states have not adopted any of these restrictions. In each of the indicators below, because the District of Columbia has enacted a complete ban on handguns, it is deemed to have adopted each of the policies even though it has not explicitly enacted each separate restriction.

(a) Does the state have statutes requiring handgun licensing or permits, and requiring waiting periods? Licensing and waiting periods together reduce unauthorized and illegal access to guns and give local government the authority and time to conduct thorough background checks on potential handgun purchasers. Ten states (Connecticut, Hawaii, Illinois, Iowa, Massachusetts, Minnesota, Missouri, New Jersey, New York and North Carolina) have adopted both licensing laws and mandatory waiting periods. Eight states (Alabama, California, Florida, Maryland, Michigan, Nebraska, Rhode Island and Wisconsin) have adopted only licensing/laws or waiting periods. The remaining 32 states have adopted neither licensing/laws nor waiting periods.

(b) Does the state have statutes requiring "safe storage"? Safe storage laws that require owners to either store guns in a place that is inaccessible to children and/or use a safety lock help protect women and their families from guns kept in homes. Four states (California, Connecticut, Massachusetts and New Jersey) have adopted safe storage laws and require the sale of safety locks. Fourteen states have adopted either storage laws or require safety locks (but not both). The remaining 32 states have not adopted safe storage laws.

(c) Does the state have statutes prohibiting the carrying of concealed weapons? Limiting access to guns, including limits on the ability to carry concealed weapons, can reduce the rate of violent crime.[206] Seven states (Illinois, Kansas, Missouri, Nebraska, New Mexico, Ohio and Wisconsin) have prohibited the carrying of concealed weapons. Fourteen states have limited a resident's ability to carry concealed weapons. Twenty-nine states have adopted no laws prohibiting concealed weapons.

Environmental Justice: The Environmental Protection Agency's (EPA) Office of Environmental Justice addresses the fact that low-income and minority communities (both urban and rural) bear a disproportionate impact of environmental hazards (e.g., more childhood lead poisoning, higher exposure to air pollution, close proximity to more hazardous industries, limited transportation and a dearth of public parks). Aggressive enforcement of environmental protection laws, partnerships with other state and federal agencies, and community input can lessen these harms. For example, the U.S. Departments of Housing and Urban Development, Health and Human Services and Labor (in conjunction with the EPA) trained and hired poor rural and urban residents in the removal of lead paint from public housing units, resulting in lower lead levels in children and higher employment.[v]

Environment

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

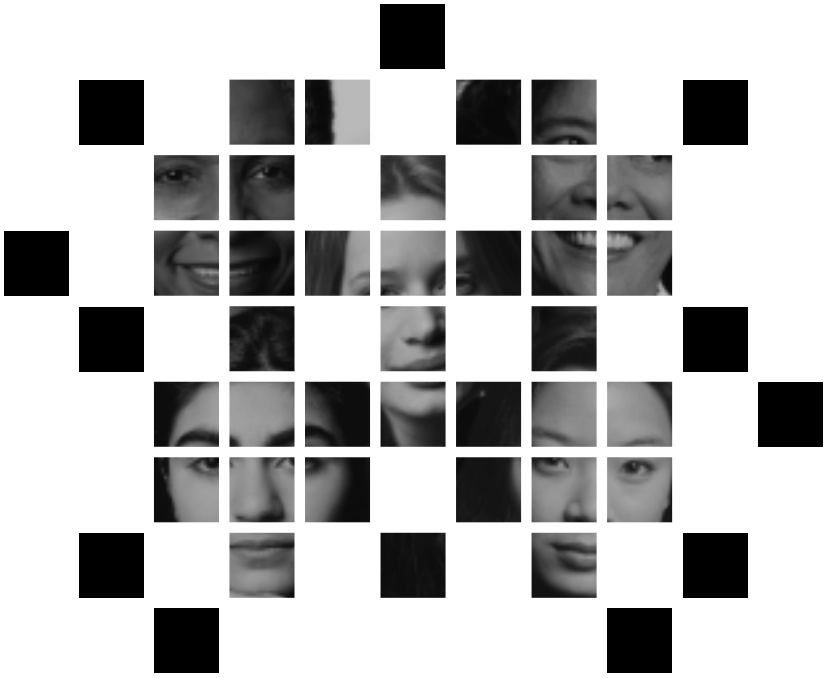
Exposure to hazardous agents in the air, water and soil contribute to illness, disability and death worldwide.[207] Two indicators addressing this issue are: (a) state monitoring of six conditions that can be caused by environmental exposures and (b) per capita spending on public transportation. Four states (Mississippi, Missouri, New Mexico and Wisconsin) have monitored at least five of these conditions. Nine states (Arizona, Connecticut, Hawaii, Iowa, Maryland, Massachusetts, New Jersey, New York and Utah) have monitored three or four of these conditions. Twenty-four states have monitored one or two of these conditions. The remaining 13 states and the District of Columbia have not monitored any of these conditions. Public transportation spending ranged from approximately $675 in New Jersey to less than two dollars per urban resident in Mississippi.

(a) How well does the state monitor diseases or conditions that can be caused by exposures to environmental hazards? Healthy People 2010 has identified 15 significant health conditions caused by environmental factors that states should monitor. These include lead poisoning, mercury poisoning, pesticide poisoning, carbon monoxide poisoning, acute chemical poisoning

and asthma.[208] The *Report Card* selected these six conditions because they may be caused by environmental exposures women may react to or experience differently than do men.[209] Four states (Mississippi, Missouri, New Mexico and Wisconsin) have monitored at least five of these conditions. Nine states (Arizona, Connecticut, Hawaii, Iowa, Maryland, Massachusetts, New Jersey, New York and Utah) have monitored three or four of these conditions. Twenty-four states have monitored one or two of these conditions. The remaining 13 states and the District of Columbia have not monitored any of these conditions.

Toxic Chemical Reduction and Cancer Cluster Studies: California and Massachusetts have especially effective laws aimed at reducing toxic chemicals in the environment. Massachusetts also funds cancer cluster studies (beyond those funded by the federal government) that examine potential environmental influences on cancer, especially breast cancer, in areas with high cancer rates.[W]

(b) How much government money is spent (per urban resident) annually on public transit in the state? A state's transportation policy contributes to a healthy community in important ways.[210] Effective public transit systems make it easier for low-income women to get to their health care providers and their workplaces, and also reduce hazardous air pollution by providing alternatives to automobiles.[211] The *Report Card* evaluates how much money (in federal, state and local funds) states spent annually per urban resident on public transit, averaged over a five-year period. Spending ranged from approximately $675 per urban resident in New Jersey to less than two dollars per urban resident in Mississippi.



CHAPTER IV

FEDERAL POLICY AGENDA ON WOMEN'S HEALTH

The Federal Policy Agenda on Women's Health describes some of the steps that the federal government can take to improve women's health. Through national programs and assistance to the states, the federal government can establish laws addressing private and public health care policies, fund health and ancillary services to individuals, and fund and conduct public education campaigns, research and data collection. The following recommended federal policies would promote women's health and well-being.

Women's Access to Health Care Services

Access to Insurance

To give all women access to health insurance, the federal government should:

- Broaden eligibility requirements for federal publicly funded health insurance programs, including Medicaid, so that low-income women without access to private insurance have coverage for the range of services they need.
- Strengthen and expand federal publicly funded health insurance programs, including Medicare, to ensure that they remain available to older and disabled women, and that they cover the full range of services women need.
- Invest in outreach, public education, and culturally sensitive materials, and remove bureaucratic hurdles, to ensure that women who are eligible for publicly funded health insurance programs are informed of their choices and can participate in these programs.
- Improve access to employer-based health care coverage for workers and their families, and make this coverage affordable.

Access to Health Care Services Beyond Insurance Coverage

To help women overcome many of the barriers that prevent them from receiving health care services, the federal government should:

- Provide a pharmaceutical benefit that gives women access to affordable prescription drugs.
- Remove the barriers to quality health care faced by women of color and of different ethnic backgrounds by supporting culturally competent services including those that address language barriers.
- Remove the barriers to quality health care faced by lesbians by identifying and supporting policies and programs that address their needs, including research into lesbian health and anti-discrimination laws.
- Remove the barriers to quality health care faced by women with disabilities by identifying and supporting policies and programs that allow these women full physical and financial access to services.
- Require that employers provide adequate, flexible family and medical leave benefits so that employees can take time off to take care of their own health needs or those of infants and/or other family members.
- Enact strong patient protections with effective appeals and enforcement provisions in managed care programs to provide access to critical health care services.
- Require private insurers to cover contraceptives when they provide other prescription coverage.
- Provide financial assistance to cover the costs of long-term care services, including home and community-based care, nursing home and respite care, and help ensure quality long-term care by further developing and enforcing appropriate standards.
- Make available and accessible "safety net" health care services for underserved and uninsured women.
- Require that private insurers cover mental health conditions on the same basis that they cover physical health conditions.

Addressing Wellness and Prevention

To help promote good health and prevent disease among women, the federal government should:

- Expand federal programs and increase funding to provide and/or cover preventive screenings like mammograms, Pap smears, and screening for colorectal cancer, osteoporosis, sexually transmitted diseases and domestic violence.
- Increase investment in programs that support physical activity, assist women in getting nutritious food, and educate women about nutrition.
- Expand federal efforts to encourage women not to smoke and allow the FDA to regulate tobacco. Such efforts should include covering smoking prevention and cessation in federal insurance programs, increasing the federal excise tax on cigarettes and enforcing federal laws prohibiting minors from buying cigarettes.
- Increase support for substance abuse programs that address women's needs, including covering treatment in federal insurance programs, providing child care in federally supported programs, and addressing substance abuse by women who are victims of violence or in prison.

Key Conditions, Diseases and Causes of Death for Women

To help address specific health conditions, diseases and causes of death faced by women, the federal government should:

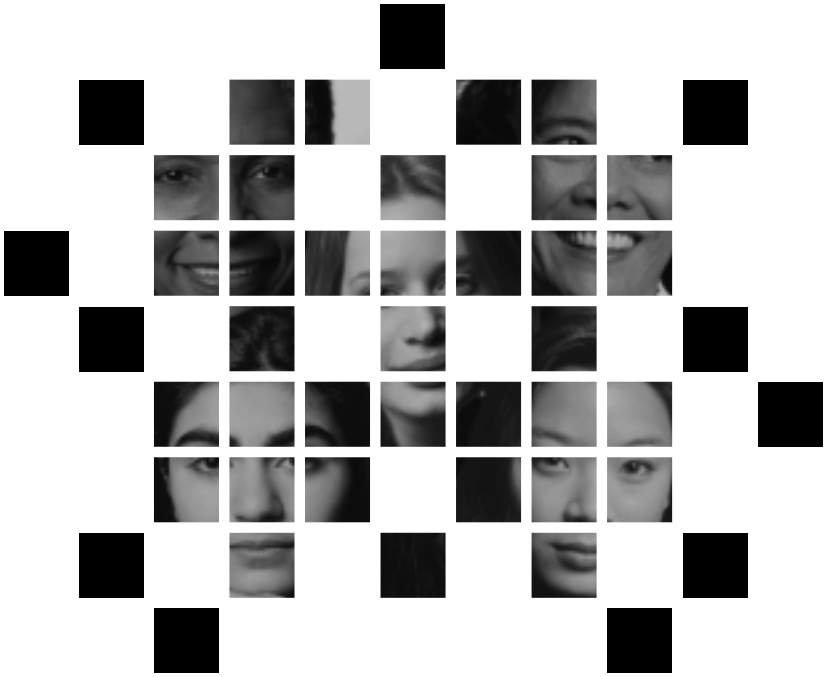
- Increase funding for women's health research, including cardiovascular disease, stroke, lung cancer, breast cancer, diabetes, HIV/AIDS, arthritis, violence against women, sexually transmitted diseases, depression and eating disorders.
- Collect, publish and analyze health data on women in general and on specific populations of women (by race, ethnicity, sexual orientation, disability, socioeconomic status, region and age) and provide the data in a form that allows comparisons across these dimensions.
- Develop and support programs to evaluate and promote effective prevention and health promotion interventions.
- Increase funding for programs to prevent and treat the diseases, causes of death and conditions that constitute key health risks for women, such as heart and other cardiovascular diseases.
- Expand federal programs to cover treatment for breast and cervical cancer and other health conditions for uninsured, low-income women.

- Expand federal programs, including Medicaid, to provide HIV/AIDS pharmaceutical therapies and up-to-date treatments to women with HIV, in addition to women with full-blown AIDS.
- Increase investments in mental health care services, including community-based services for women.
- Expand and invest in federal programs that provide family planning, make infertility treatments more affordable, and increase funding for prenatal and post-partum care.
- Protect and expand women's access to abortion services by removing abortion restrictions on health plan coverage of medically necessary procedures, eliminating restrictions on abortion services provided at federal facilities and enforcing "clinic access" laws that ban interference with reproductive health services.
- Invest in research on effective strategies to combat domestic violence and sexual assault, and support programs that address the health, financial and other needs of victims of these violent crimes.

Living in a Healthy Community

To ensure that all communities promote women's health and well-being, the federal government should:

- Expand programs that provide financial assistance to low-income women and their families, and help the working poor and other low-income women attain economic security.
- Enact new prohibitions against discrimination on the basis of sexual orientation, genetic information and domestic violence, and actively enforce the anti-discrimination laws that are already in place.
- Enact legislation that would end sex discrimination in health care, and provide stronger protection for women from discriminatory pay practices.
- Expand gun control efforts, including regulating the design, manufacture, distribution and sale of firearms and ammunition, and requiring standardized licensing and registration systems.
- Require better monitoring of diseases that may be caused by environmental factors, fund more research to address the relationship between the environment and disease (e.g., cancer and reproductive problems in men and women), and more strictly regulate those toxins and other substances that are related to health problems.
- Actively enforce current federal requirements protecting health in the workplace, expand those protections to require ergonomically correct workplace environments and ensure that occupational health rules adequately protect women.



CHAPTER V

KEY HEALTH DISPARITIES BY RACE, ETHNICITY, SEXUAL ORIENTATION AND DISABILITY

The health of women in the United States varies substantially by race, ethnicity, sexual orientation and disability, and general health statistics for all women fail to reflect significant disparities. Data regarding women's health are severely limited and often it is not possible to break out information by demographic characteristics. Where such data are available for the status indicators, the national and state report cards provide that information. However, the national and state report cards could not address many important disparities because of the data limitations. For example, one such disparity with limited data available is the marked difference in life expectancy among women of different races. The data are only available by state disaggregated by white, black and other than white (and are provided on the national and state report cards) but consistent data by all races and ethnicities are not available.

This section supplements the *Report Card* data with information from other, albeit sometimes inconsistent, sources. By highlighting some additional health information for women by race, ethnicity, age, sexual orientation and disability, the *Report Card* can provide a better look—although not a complete look—at the significant health disparities faced by American women today.

The nation is becoming increasingly diverse, with whites projected to make up barely 50 percent of the population by the middle of this century.[212] The U.S. Bureau of the Census aggregates information by four major race groups (American Indian or Alaskan Native, black or African American, white, and Asian or Pacific Islander) and Hispanic origin.[213] Nationally, data are not always reported for each of the major groups, often because the sample size is too small to be statistically valid.[214] Although multiracial individuals are an increasing segment of the population, the Census Bureau projects that fewer than three percent of Americans will identify themselves as having more than one race in the 2000 Census.[215]

How each group identified by the Census is defined is the source of much debate.[216] Each of these minority groups is actually composed of many different groups of people, who often do not share traditions, attitudes on gender roles, foods, communication styles, child rearing practices, acceptance of American "culture," and attitudes towards "traditional" health care.[217] Generally, minority populations tend to be younger than the general population, reflecting differences in death rates, fertility, immigration patterns and the age of immigrants.[218] How

members of racial and ethnic groups are identified can bias statistics about critical health conditions. For example, the results from several studies show mortality data by race often underestimate the number of deaths and death rates for races other than white and black due to misclassification (e.g., a person who self-reported as Native American or Asian American on Census or survey forms was sometimes reported as white on a death certificate). In addition, undercoverage of minority groups in the Census and resultant population estimates introduces biases into death rates by race.[219]

Poverty, segregation and discrimination affect the well-being of all the groups of women discussed in this chapter. The link between socioeconomic status and race, and its impact on health is increasingly being studied, especially in the nation's effort to eliminate health disparities.[220] There are increasing disparities in socioeconomic status within minority groups, with recent immigrants faring much worse in health outcomes than more established groups who have greater financial resources.[221] White women have the highest economic status of all women, but even they are substantially poorer than white men.[222] Residential segregation by racial and ethnic group affects access to resources, including health care.[223] Linguistic isolation poses unique problems for Hispanic and Asian populations.[224] Such isolation and segregation contributes to the well-documented undercounting of minority groups on the Census, and affects the distribution of federal resources.[225]

Data referred to in the text regarding causes of death (measured in deaths per 100,000), wellness and prevention, poverty and educational attainment are highlighted in the national report card on page 12 and on the charts that follow, and, unless otherwise cited, are from those sources. Data for the leading causes of death for white women are provided on page 157 for ease of comparison with the race and ethnicity groups that are described in this chapter. Data on leading causes of death for all women can be found in Chapter III.

Race/Ethnicity Data for Selected Indicators

	White	Black	Asian/ Pacific Islander	American Indian/ Alaskan Native	Hispanic
Percent of Women Who Had a Pap Smear	84.4	87.8	70.9	83.5	78.1
Percent of Women Who Had a Mammogram	67.1	66.7	69.5	65.6	62.2
Percent of Women Who Had a Colorectal Screening Within the Past Two Years	21.0	21.2	20.3	19.8	18.1
Percent of Women Who Are Overweight	22.7	39.7	9.6	35.5	26.5
Percent of Women Who Do Eat Five Fruits and Vegetables a Day	28.5	22.3	27.1	28	27.7
Percent of Women Who Smoke	21.7	20.2	10.3	30.7	14.3
Percent of Women With Diabetes	4.7	8.2	4.6	9.6	6.3

Source: BRFSS 1992-1994 (See Chapter IX Technical Notes for more information)

African American Women

African American women make up 13.1 percent of all women in the United States, and are the largest group of women of color.[226] Black women are primarily "African American," the term commonly used to describe the descendants of Africans brought to the United States as slaves.[227] There is, however, increasing diversity among blacks, with foreign-born blacks accounting for six percent of all blacks in the United States.[228] Most other blacks in America are of Caribbean descent, coming from island nations including the Dominican Republic, Haiti, Jamaica, and Trinidad and Tobago.[229] Recent immigrants from African countries account for less than four percent of all U.S. immigrants between 1981 and 1998, but there is some indication that these numbers are increasing.[230] Sources used both the terms "African American" and "black" to describe all descendents of Africans living in the United States regardless of country of origin or immigrant status. Therefore, throughout the *Report Card*, the terms "African American" and "black" are used interchangably to describe all black women.

African American women face many barriers to quality health care services, including stereotyping and discrimination on the basis of race.[231] Although access to health care for African American women has improved in recent years, continued efforts are necessary to ensure that health services are of high quality and are culturally appropriate, as well as to address discrimination and stereotyping.

Women's Access to Health Care Services. African American women are less likely than white women to have health insurance coverage. They are more likely than other groups of women to have publicly funded health insurance through Medicaid and Medicare.[232] Even when African American women have health insurance, they often lack access to preventive care because of financial barriers, lack of information about disease symptoms and when to seek care, lack of neighborhood health care facilities and race discrimination they encounter when seeking care.[233]

As with other data not provided by all four race groups and Hispanic origin, data on access to prenatal care disaggregated by race are very limited. However, this limited data show that a smaller percentage of African American women receive prenatal care in the first trimester (71.4 percent) than white women (84.0 percent) or Hispanic women (72.2 percent).

Wellness and Prevention. African American women are the most likely group to have had a Pap smear in the past three years, and compare favorably with other groups of women in securing mammograms and colorectal cancer screening. But they are also the most likely to be overweight (a major factor in African American women having the second highest rate of diabetes), and to not have eaten the recommended servings of fruits or vegetables. Although obesity rates are alarmingly high among black girls, studies have shown that they tend to have healthier body images, and higher self-esteem and confidence.[234] Fewer African American women smoke (20.2 percent) than white or Native American women.

Key Health Conditions, Diseases and Causes of Death. African American women have higher mortality rates than any other population group for nearly every major cause of death. The top three age-adjusted causes of death are heart disease, stroke and diabetes. These leading causes of death for African American women differ from the leading causes of death for white women. The disparity is especially dramatic for these four causes of death: heart disease (152.4 for African American women compared to 92.7 per 100,000 for white women); stroke (38.9 for African American women as compared to 22.9 per 100,000 for white women); deaths related to HIV (19.1 for African American women as compared to 1.8 per 100,000 for white women);[235] and deaths due to diabetes (28.7 for African American women as compared to 10.7 per 100,000 for white women). African American women have the highest death rate due to HIV of any racial/ethnic group of women. While the full explanation for these differences is not known, inadequate health care, delayed diagnosis, and high poverty rates contribute to the disparities.

Causes of death for African American women also vary by age. HIV is the leading cause of death for African American women between the ages of 25 and 44, in contrast to accidents for white women. Notably, homicide is the fourth leading cause of death for African American women in this age group. The leading cause of death for African American women in all age groups 45 and over is the same as for white women, heart disease. For both African American and white women age 45 to 54, the second leading cause of death is breast cancer. For African American women age 55 to 64, the second leading cause of death is lung cancer, while for white women it is the second leading cause of death for women age 55 to 74. Stroke is the second leading cause of death for African American women age 65 and over, and for white women age 75 and over.

Leading Causes of Death for White Women by Age

Per 100,000 Women

All Ages	Diseases of the Heart	92.7
	Lung Cancer	27.4
	Cerebrovascular Disease	22.9
	Breast Cancer	19.7
	Chronic Obstructive Pulmonary Diseases	18.2
	Accidents and Adverse Effects	17.5
	Diabetes	10.7
	Pneumonia and Influenza	10.2
	Colorectal Cancer	9.9
	Ovarian Cancer	6.3
25 to 44	Accidents and Adverse Effects	15.6
	Diseases of the Heart	8.9
	Breast Cancer	8.1
	Suicide	6.4
	HIV	4.3
	Homicide	3.4
	Cerebrovascular Disease	3.0
	Lung Cancer	2.9
	Cirrhosis, Chronic Liver Disease	2.6
	Cervical Cancer	2.4
45 to 54	Diseases of the Heart	46.0
	Breast Cancer	37.5
	Lung Cancer	28.2
	Accidents and Adverse Effects	15.3
	Cerebrovascular Disease	12.4
	Ovarian Cancer	9.1
	Colorectal Cancer	9.0
	Diabetes	8.8
	Chronic Obstructive Pulmonary Diseases	8.1
	Suicide	7.7
	Cirrhosis, Chronic Liver Disease	7.7
55 to 64	Diseases of the Heart	168.9
	Lung Cancer	103.3
	Breast Cancer	66.5
	Chronic Obstructive Pulmonary Diseases	44.7
	Cerebrovascular Disease	33.2
	Diabetes	29.4
	Colorectal Cancer	28.1
	Ovarian Cancer	22.1
	Accidents and Adverse Effects	19.3
	Cirrhosis, Chronic Liver Disease	14.1
65 to 74	Diseases of the Heart	514.5
	Lung Cancer	209.2
	Chronic Obstructive Pulmonary Diseases	143.3
	Cerebrovascular Disease	111.4
	Breast Cancer	99.1
	Diabetes	70.9
	Colorectal Cancer	63.9
	Pneumonia and Influenza	41.6
	Ovarian Cancer	38.9
	Accidents and Adverse Effects	32.5
75 to 84	Diseases of the Heart	1648.0
	Cerebrovascular Disease	445.1
	Chronic Obstructive Pulmonary Diseases	294.8
	Lung Cancer	252.7
	Pneumonia and Influenza	188.5
	Diabetes	141.5
	Breast Cancer	138.7
	Colorectal Cancer	132.1
	Mental Disorders	100.0
	Accidents and Adverse Effects	81.3
85 and Over	Diseases of the Heart	6221.9
	Cerebrovascular Disease	1671.3
	Pneumonia and Influenza	953.5
	Mental Disorders	620.0
	Chronic Obstructive Pulmonary Diseases	423.8
	Alzheimer's Disease	314.5
	Diabetes	262.9
	Colorectal Cancer	258.8
	Atheroschlerosis	250.3
	Accidents and Adverse Effects	244.6

Source: NCHS (See Chapter IX Technical Notes for more information)

Leading Causes of Death for African American Women by Age

Per 100,000 Women

All Ages	Diseases of the Heart	152.4
	Cerebrovascular Disease	38.9
	Diabetes	28.7
	Lung Cancer	26.9
	Breast Cancer	26.9
	Accidents and Adverse Effects	20.4
	HIV	19.1
	Colorectal Cancer	14.5
	Pneumonia and Influenza	13.1
	Chronic Obstructive Pulmonary Diseases	12.8
25 to 44	HIV	43.3
	Diseases of the Heart	29.4
	Accidents and Adverse Effects	20.3
	Homicide	15.8
	Breast Cancer	14.4
	Cerebrovascular Disease	10.4
	Diabetes	4.8
	Pneumonia and Influenza	4.3
	Cirrhosis, Chronic Liver Disease	4.3
	Cervical Cancer	4.2
	Arthropathies and Related Disorders	4.2
45 to 54	Diseases of the Heart	140.7
	Breast Cancer	59.3
	Cerebrovascular Disease	37.9
	Lung Cancer	33.8
	HIV	29.7
	Diabetes	28.0
	Accidents and Adverse Effects	22.6
	Colorectal Cancer	15.8
	Cirrhosis, Chronic Liver Disease	13.9
	Chronic Obstructive Pulmonary Diseases	12.8
55 to 64	Diseases of the Heart	380.9
	Lung Cancer	102.9
	Diabetes	93.1
	Breast Cancer	87.0
	Cerebrovascular Disease	84.5
	Colorectal Cancer	43.5
	Chronic Obstructive Pulmonary Diseases	35.2
	Accidents and Adverse Effects	25.0
	Pneumonia and Influenza	22.2
	Nephritis, Nephrotic Syndrome and Nephrosis	21.0
65 to 74	Diseases of the Heart	898.9
	Cerebrovascular Disease	214.2
	Lung Cancer	197.2
	Diabetes	193.8
	Breast Cancer	115.0
	Colorectal Cancer	94.5
	Chronic Obstructive Pulmonary Diseases	81.3
	Pneumonia and Influenza	58.5
	Nephritis, Nephrotic Syndrome and Nephrosis	51.5
	Septicemia	43.5
75 to 84	Diseases of the Heart	2097.9
	Cerebrovascular Disease	570.1
	Diabetes	326.5
	Lung Cancer	206.3
	Pneumonia and Influenza	192.9
	Colorectal Cancer	173.5
	Breast Cancer	152.9
	Chronic Obstructive Pulmonary Diseases	137.1
	Nephritis, Nephrotic Syndrome and Nephrosis	126.0
	Septicemia	109.3
85 and Over	Diseases of the Heart	5512.2
	Cerebrovascular Disease	1471.0
	Pneumonia and Influenza	695.9
	Diabetes	493.4
	Colorectal Cancer	288.6
	Chronic Obstructive Pulmonary Diseases	215.2
	Breast Cancer	204.3
	Septicemia	301.5
	Nephritis, Nephrotic Syndrome and Nephrosis	297.8
	Mental Disorders	381.5

Source: NCHS (See Chapter IX Technical Notes for more information)

The limited data available for several conditions addressed in the *Report Card,* although not provided by all four race groups and Hispanic origin, suggest a number of important findings. First, African American women fare worse than women in other racial and ethnic groups for several conditions, including arthritis (second highest rate), unintended pregnancy (highest rate), and maternal mortality (the highest rate, which is almost four times higher than white women). However, African American women fare the best in the prevalence of osteoporosis (ten percent compared to 21 percent for white women and 16 percent for Mexican American women, the only group of Hispanic women for whom data were available). In addition, a smaller percentage of African American women have experienced violent crimes in their lifetimes (55.1 percent) than Native American women (64.8 percent) and women of mixed race (61.2 percent).

Living in a Healthy Community. The limited data available for life expectancy and infant mortality, although not provided by all four race groups and Hispanic origin, suggest several important findings. The data that are available suggest that African American women have shorter life expectancies than white women (73.7 years as compared to 79.5 years). In addition, African American women have the highest infant mortality rate of any racial or ethnic group.

African American women have significantly higher rates of poverty than white American women.[236] On average, nearly 26.1 percent of black women in the United States live in poverty. Nationally, 28.2 percent of younger African American women (age 18 to 44), 19.4 percent of middle-aged African American women (age 45 to 64), and 29.3 percent of older African American women (age 65 and over) live in poverty. For white women, 10.3 percent age 18 to 44, 7.1 percent age 45 to 64, and 10.9 percent of age 65 and over live in poverty.[237] Nationally, 77.4 percent of African American women over age 21 have 12 or more years of education, compared to 87 percent of white women.[238] Nationally, 14.4 percent of African American women over age 21 have 16 or more years of education, compared to 23.9 percent of white women.[239] Race discrimination contributes to stress-related health problems, such as hypertension and diabetes, as well as overeating that leads to obesity.[240]

Hispanic Women

Hispanic women are the second largest minority group of women (10.8 percent of all women in the United States) and are expected to surpass African American women in total numbers by 2005.[241] The Hispanic population in the United States is highly diverse and aggregated measures of health status for "Hispanics" can mask important differences. Most Hispanics in the United States are of (in descending order of population size) Mexican, Puerto Rican, Cuban, Central American or South American descent.[242] In addition, cultural differences can exist between Hispanic women born in the United States and Hispanic women born abroad. Hispanic women can be of any race.

Women's Access to Health Care Services. Low socioeconomic status creates many barriers to health insurance and health services for Hispanic women. Approximately 30 percent of Hispanics live in poverty, and their rate of unemployment exceeds that of the non-Hispanic population.[243] Hispanics make up more than 25 percent of the 44 million individuals without health insurance in the United States.[244] This lack of access to necessary services has led to poorer medical outcomes. For example, the data available suggest uninsured Hispanic women with breast cancer are more than twice as likely to be diagnosed at a late stage than white women.[245] More traditional Hispanic immigrants and those with limited English proficiency use outpatient health services less frequently than other immigrants. Those who are not citizens may be less willing to use public clinics and other health facilities for fear of deportation, or in fact may be ineligible to do so.[246]

The limited data available concerning prenatal care, although not provided by all four race groups and Hispanic origin, suggest that a smaller percentage of Hispanic women get prenatal care in the first trimester (72.2 percent) than white women (87.4 percent), but a larger percentage of Hispanic women receive these services than African American women (71.4 percent).

Wellness and Prevention. Cultural traditions regarding privacy and gender roles discourage some Hispanic women from receiving screening services. Hispanic women, for example, are the least likely group of women to receive mammograms and colorectal cancer screening and the second least likely group to have been screened for cervical cancer in the last three years. They are more likely than white women to be overweight. They are as likely as other groups of women to eat the recommended servings of fruit and vegetables and they are less likely to smoke than white women. It is important to note that there are great disparities in the rates of exercise, weight and obesity within the different groups of Hispanic women, particularly between immigrant Hispanic women and U.S.-born Hispanic women.[247]

Key Health Conditions, Diseases and Causes of Death. The leading causes of death for Hispanic women are heart disease, diabetes and stroke. The age-adjusted rankings of causes of death are similar to those of white women except that deaths due to

Leading Causes of Death for Hispanic Women by Age

Per 100,000 Women

All Ages	Diseases of the Heart	65.5
	Diabetes	18.0
	Cerebrovascular Disease	17.3
	Accidents and Adverse Effects	13.6
	Breast Cancer	12.7
	Lung Cancer	8.3
	Pneumonia and Influenza	7.7
	Chronic Obstructive Pulmonary Diseases	7.0
	Cirrhosis, Chronic Liver Disease	6.0
	HIV	5.9
	Colorectal Cancer	5.9
25 to 44	HIV	12.4
	Accidents and Adverse Effects	12.3
	Breast Cancer	5.7
	Homicide	5.1
	Diseases of the Heart	5.0
	Cerebrovascular Disease	2.8
	Suicide	2.5
	Cervical Cancer	2.5
	Cirrhosis, Chronic Liver Disease	2.4
	Diabetes	1.7
	Arthropathies and Related Disorders	1.7
45 to 54	Diseases of the Heart	31.6
	Breast Cancer	27.3
	Cerebrovascular Disease	14.3
	Diabetes	13.2
	Accidents and Adverse Effects	13.2
	HIV	10.8
	Cirrhosis, Chronic Liver Disease	9.7
	Cervical Cancer	7.0
	Lung Cancer	6.8
	Colorectal Cancer	6.4
55 to 64	Diseases of the Heart	130.9
	Diabetes	52.5
	Breast Cancer	43.1
	Cerebrovascular Disease	34.5
	Lung Cancer	26.3
	Cirrhosis, Chronic Liver Disease	19.8
	Accidents and Adverse Effects	18.1
	Colorectal Cancer	17.2
	Chronic Obstructive Pulmonary Diseases	12.5
	Ovarian Cancer	12.2
65 to 74	Diseases of the Heart	392.7
	Diabetes	139.5
	Cerebrovascular Disease	94.8
	Lung Cancer	63.1
	Breast Cancer	54.8
	Chronic Obstructive Pulmonary Diseases	40.0
	Colorectal Cancer	36.7
	Cirrhosis, Chronic Liver Disease	35.6
	Pneumonia and Influenza	35.5
	Accidents and Adverse Effects	23.9
75 to 84	Diseases of the Heart	1133.7
	Cerebrovascular Disease	285.7
	Diabetes	224.6
	Pneumonia and Influenza	137.2
	Chronic Obstructive Pulmonary Diseases	123.4
	Lung Cancer	100.9
	Breast Cancer	77.5
	Colorectal Cancer	74.0
	Accidents and Adverse Effects	49.5
	Nephritis, Nephrotic Syndrome and Nephrosis	43.5
85 and Over	Diseases of the Heart	3794.7
	Cerebrovascular Disease	826.5
	Pneumonia and Influenza	589.7
	Diabetes	360.1
	Chronic Obstructive Pulmonary Diseases	336.2
	Mental Disorders	231.3
	Alzheimer's Disease	131.8
	Atherosclerosis	125.1
	Colorectal Cancer	122.4
	Lung Cancer	117.0

Source: NCHS (See Chapter IX Technical Notes for more information)

lung cancer and chronic obstructive pulmonary disease (COPD) (including asthma, bronchitis, emphysema and other airway obstruction disorders) are much less common for Hispanic women. Hispanic women have the second highest death rate due to HIV—more than three times greater than the rate in white women (5.9 as compared to 1.8 per 100,000 for white women).[248] Hispanic women also have a higher death rate from diabetes than do white women (18 as compared to 10.7 per 100,000). Hispanic women overall are the only group for which the breast cancer death rate is higher than the lung cancer death rate.

The leading cause of death for Hispanic women age 25 to 44 is HIV. Just as it is for most other groups of women, heart disease is the leading cause of death for Hispanic women in all age groups 45 and over. Breast cancer is the second leading cause of death for Hispanic women between the ages of 45 and 54, and diabetes is the second leading cause of death for Hispanic women between the ages of 55 and 74. The second leading cause of death for Hispanic women in all age groups 75 and over is stroke.

There are no data disaggregated for Hispanic women for many of the conditions addressed in the *Report Card*. The limited data that is available, although not provided by all four race groups and Hispanic origin, suggest that Hispanic women have a higher rate of unintended pregnancy (48.6 percent) than white women (42.9 percent), and a lower rate than African American women (50 percent). In addition, 16 percent of Mexican American women (the only group of Hispanic women for which data are available) have osteoporosis, and 54.9 percent of Hispanic women have reported being victims of violence.

Living in a Healthy Community. Hispanic women have the same infant mortality rate as white women (6.3 per 1,000), which is lower than that for African American women (14.7 per 1,000). Hispanic women experience some of the highest rates of poverty, comparable to African American women in most age groups.[249] Nationally, 28.3 percent of all young Hispanic women (age 18 to 44), 21 percent of middle-aged Hispanic women (age 45 to 64), and 27 percent of elderly Hispanic women (age 65 and over) live in poverty.[250] Hispanic women experience a wider wage gap than other women.[251] One reason for Hispanic women's lower earnings is their concentration in jobs with lower than average wages, such as administrative support and service jobs.[252] Hispanic women have the lowest rate of high school graduation, with only 55.8 percent of Hispanic women over age 21 having 12 or more years of education.[253] Hispanic women also have the lowest rate of higher educational attainment, with 10.2 percent of Hispanic women over age 21 having 16 or more years of education.[254] Hispanic women often face discrimination based on language, skin color and national origin.[255] Large proportions of Hispanic women also work in the semiconductor and agriculture industries, both of which have substantial occupational hazards. Agricultural workers, for example, are exposed to pesticides and are often required to use faulty equipment.[256]

Asian American/Pacific Islander Women

Asian American and Pacific Islander women make up 3.8 percent of women in the United States. Asian Americans have ties to more than 20 countries and speak more than 100 different languages. The largest groups of Asian Americans (in descending order) are of Chinese, Filipino, Japanese, Asian Indian, Korean and Southeast Asian ancestry.[257] Pacific Islander Americans come from more than 22 islands (Polynesian, Micronesian or Melanesian) and speak as many as 1,000 different languages. The largest group of Pacific Islanders are Native Hawaiians, who constitute 66 percent of all Pacific Islanders, followed by Samoans, at 15 percent.[258] Cultural differences also exist between women of Asian and Pacific Island descent born in the United States and those born abroad. While efforts are being made to collect and analyze data separately for women of Asian descent and women of Pacific Islander descent (as well as groups within these two categories), most data available conform to the U.S. Bureau of the Census' designation of "Asian and Pacific Islander" as one group. Where available in this section, data specific to Asian Americans, and to women of Pacific Island heritage, are provided.

Women's Access to Health Care Services. Many Asian American women must confront language barriers, cultural differences and race and sex-based stereotypes that limit their ability to meet their health needs. While Asian American/Pacific Islander women tend to have health insurance (81 percent have public and/or private insurance), some groups, particularly those from Southeast Asia, have high poverty rates and are significantly less likely to have insurance.[259] Simply having insurance, however, may not meet Asian American women's health care needs since some traditional Asian models of medicine, such as acupuncture and herbal medicines, are often not covered by health insurance plans. Communication barriers further limit Asian women's ability to obtain appropriate health care services. Even women who speak English well may have difficulty translating medical terms without help.[260]

Wellness and Prevention. Asian American women do not have adequate access to reproductive health care providers.[261] Asian American/Pacific Islander women are least likely to have had a Pap smear within the last three years (70.9 percent).[262] However, among women age 50 and over, they are the most likely to have had a mammogram (69.5 percent) and fare similarly to other

groups for colorectal cancer screening in having low rates.[263] Although Asian American/Pacific Islander women in general have the lowest rates of overweight (9.6 percent), Native Hawaiian and American Samoan women (63 percent and 66 percent, respectively) have the highest occurrence of obesity of any other major racial or ethnic group or specific population within those major groups.[264] Asian American/Pacific Islander women are also the least likely population to smoke (10.3 percent overall), but there is great variation among groups. Studies in California have revealed that 19 percent of Japanese American women smoke as compared to fewer than one percent of Vietnamese women.[265]

Key Health Conditions, Diseases and Causes of Death. Asian American women constitute a heterogeneous group and there are few data on Chinese American, Japanese American, or Southeast Asian populations specifically. Asian American/Pacific Islander women die primarily of heart disease and stroke. Age-adjusted death rates are dramatically lower for Asian American/Pacific Islander women compared with white American women for HIV (0.4 compared to 1.8 per 100,000),[266] COPD (5.5 compared to 18.2 per 100,000), heart disease (51.0 compared to 92.7 per 100,000) and lung cancer (11.4 compared to 27.4 per 100,000). As is true for other women, for Asian American/Pacific Islander women there are great differences in the key causes of death by age. The leading cause of death for younger Asian American/Pacific Islander women (age 25 to 44) is accidents. Asian American/Pacific Islander women age 45 to 54 are unique among women in this age group because breast cancer is the leading cause of death instead of heart disease. For Asian American/Pacific Islander women in all age groups 55 and over, the leading causes of death are heart disease followed by stroke.

There are no data disaggregated for Asian American/Pacific Islander women for many of the conditions addressed in the *Report Card*. The limited data available, although not provided by all four race groups and Hispanic origin, suggest that Asian American women have the lowest rate of arthritis (10.8 percent) and the lowest rate of experiencing violence in their lifetimes (51.9 percent) than any other racial or ethnic group. The differences between Asia and the United States make the acculturation process difficult and isolating for many Asian women, which may contribute to the prevalence of mental health conditions among this population. Older Asian American women also experience a high rate of depression and suicide, often due to familial pressures, discrimination and poverty.[267]

Living in a Healthy Community. Asian American/Pacific Islander women experience high rates of poverty.[268] Many women are employed in small businesses or factories with unsafe and unhealthy working conditions and no employment benefits such as health insurance. Although there is a great degree of difference in the level of educational attainment among the different groups of Asian American/Pacific Islander women, overall Asian American/Pacific Islander women have the second highest high

Leading Causes of Death for Asian/Pacific Islander Women by Age

Per 100,000 Women

All Ages	Diseases of the Heart	51.0
	Cerebrovascular Disease	21.0
	Accidents and Adverse Effects	11.5
	Lung Cancer	11.4
	Breast Cancer	9.6
	Diabetes	8.2
	Pneumonia and Influenza	7.2
	Colorectal Cancer	6.4
	Chronic Obstructive Pulmonary Diseases	5.5
	Suicide	3.5
25 to 44	Accidents and Adverse Effects	8.3
	Breast Cancer	4.9
	Diseases of the Heart	4.2
	Suicide	4.0
	Homicide	2.7
	Cerebrovascular Disease	2.2
	Lung Cancer	1.6
	Colorectal Cancer	1.5
	Cervical Cancer	1.3
	Arthropathies and Related Disorders	1.2
45 to 54	Breast Cancer	25.2
	Diseases of the Heart	19.4
	Cerebrovascular Disease	15.8
	Accidents and Adverse Effects	11.7
	Lung Cancer	10.9
	Colorectal Cancer	7.5
	Ovarian Cancer	6.8
	Cervical Cancer	5.6
	Suicide	4.7
	Diabetes	4.2
55 to 64	Diseases of the Heart	87.0
	Cerebrovascular Disease	39.4
	Lung Cancer	33.7
	Breast Cancer	31.8
	Diabetes	20.1
	Accidents and Adverse Effects	16.0
	Colorectal Cancer	15.6
	Ovarian Cancer	11.5
	Chronic Obstructive Pulmonary Diseases	10.0
	Cervical Cancer	9.2
65 to 74	Diseases of the Heart	286.6
	Cerebrovascular Disease	109.5
	Lung Cancer	80.6
	Diabetes	58.0
	Colorectal Cancer	39.0
	Breast Cancer	37.5
	Chronic Obstructive Pulmonary Diseases	31.8
	Accidents and Adverse Effects	31.4
	Pneumonia and Influenza	27.3
	Ovarian Cancer	15.9
75 to 84	Diseases of the Heart	993.4
	Cerebrovascular Disease	405.0
	Pneumonia and Influenza	151.6
	Lung Cancer	150.4
	Diabetes	143.4
	Chronic Obstructive Pulmonary Diseases	104.8
	Colorectal Cancer	82.9
	Accidents and Adverse Effects	68.7
	Nephritis, Nephrotic Syndrome and Nephrosis	51.3
	Breast Cancer	45.0
85 and Over	Diseases of the Heart	3452.2
	Cerebrovascular Disease	1150.0
	Pneumonia and Influenza	742.1
	Chronic Obstructive Pulmonary Diseases	232.2
	Mental Disorders	227.8
	Diabetes	219.2
	Lung Cancer	188.8
	Colorectal Cancer	157.3
	Accidents and Adverse Effects	125.8
	Nephritis, Nephrotic Syndrome and Nephrosis	119.3

Source: NCHS (See Chapter IX Technical Notes for more information)

Leading Causes of Death for American Indian/Alaskan Native Women by Age

Per 100,000 Women

All Ages	Diseases of the Heart	75.3
	Accidents and Adverse Effects	33.8
	Diabetes	28.9
	Cerebrovascular Disease	20.1
	Cirrhosis, Chronic Liver Disease	18.0
	Lung Cancer	15.9
	Chronic Obstructive Pulmonary Diseases	11.8
	Breast Cancer	10.9
	Pneumonia and Influenza	10.7
	Mental Disorders	7.8
25 to 44	Accidents and Adverse Effects	38.7
	Cirrhosis, Chronic Liver Disease	17.9
	Diseases of the Heart	11.2
	Mental Disorders	8.9
	Suicide	7.5
	Homicide	6.9
	Diabetes	4.7
	Cerebrovascular Disease	4.4
	Breast Cancer	4.1
	HIV	3.6
45 to 54	Diseases of the Heart	63.1
	Cirrhosis, Chronic Liver Disease	44.4
	Accidents and Adverse Effects	39.6
	Diabetes	25.8
	Breast Cancer	23.8
	Cerebrovascular Disease	18.4
	Mental Disorders	13.6
	Lung Cancer	13.6
	Colorectal Cancer	10.5
	Pneumonia and Influenza	9.3
55 to 64	Diseases of the Heart	192.1
	Diabetes	96.8
	Lung Cancer	59.0
	Cirrhosis, Chronic Liver Disease	51.0
	Cerebrovascular Disease	41.1
	Breast Cancer	38.7
	Chronic Obstructive Pulmonary Diseases	36.3
	Accidents and Adverse Effects	33.5
	Colorectal Cancer	20.3
	Pneumonia and Influenza	19.0
65 to 74	Diseases of the Heart	496.5
	Diabetes	222.7
	Lung Cancer	121.3
	Cerebrovascular Disease	116.3
	Chronic Obstructive Pulmonary Diseases	81.6
	Pneumonia and Influenza	54.6
	Breast Cancer	53.2
	Cirrhosis, Chronic Liver Disease	52.5
	Nephritis, Nephrotic Syndrome and Nephrosis	46.8
	Accidents and Adverse Effects	46.1
75 to 84	Diseases of the Heart	1064.7
	Cerebrovascular Disease	331.8
	Diabetes	298.3
	Lung Cancer	172.3
	Chronic Obstructive Pulmonary Diseases	165.9
	Pneumonia and Influenza	141.4
	Accidents and Adverse Effects	86.2
	Colorectal Cancer	75.9
	Nephritis, Nephrotic Syndrome	66.9
	Mental Disorders	55.3
	Breast Cancer	55.3
85 and Over	Diseases of the Heart	2099.9
	Cerebrovascular Disease	649.8
	Pneumonia and Influenza	531.6
	Diabetes	280.6
	Mental Disorders	251.1
	Chronic Obstructive Pulmonary Diseases	206.8
	Accidents and Adverse Effects	147.7
	Colorectal Cancer	127.0
	Septicemia	109.3
	Atherosclerosis	82.7
	Alzheimer's Disease	82.7

Source: NCHS (See Chapter IX Technical Notes for more information)

school graduation rates after white women. Nationally, an average of 83.0 percent of Asian American/Pacific Islander women over age 21 have 12 or more years of education.[269]

American Indian/ Alaskan Native Women

Native American women (used throughout the *Report Card* to mean "American Indian and Alaskan Native" women) constitute 0.8 percent of all women in the United States. There are more than 550 recognized tribes, and 300 spoken languages. Although this population is very diverse, their shared experiences have had a direct impact on their socioeconomic and health status. These experiences include the rapid and forced change from a cooperative and clan-based society to a capitalistic and nuclear family based system, and the outlawing of language and spiritual practices.[270]

Women's Access to Health Care Services. The Indian Health Service (IHS) is charged with providing health care services to approximately 1.5 million members (60 percent) of federally recognized Indian tribes and their descendants. Nonetheless, Native American women face logistical and cultural barriers to obtaining health care services. Because many women live in rural communities, have limited access to transportation and do not have many appointment options at a small number of facilities, they face great difficulties in obtaining needed care. Many older Native American women are uncomfortable being examined by male health care professionals due to the tradition that only women provide care for other women.[271] Communication barriers also limit access. Many of the commonly spoken languages do not include words for cancer, and it is a common belief that talking about a disease will bring it on, making women less likely to seek preventive services.[272]

Wellness and Prevention. Over 83 percent of Native American women have had recent cervical cancer screenings but only 65.6 percent of Native American women have had a mammogram and fare similarly to other groups for colorectal cancer screenings in having low rates. Native American women also have the second highest rate of being overweight (more than 35 percent) which places them at high risk for diabetes (Native American women have the highest diagnosed rate at 9.7 per 100,000).[273] Native American women by far have the highest rate of smoking (30.7 percent). Native American women have the highest rate of alcohol use, but do not receive adequate treatment for addiction, and face jail and loss of their parental rights.[274] The limited data available, although not provided by all four race groups and Hispanic origin, suggest that existing addiction treatment programs are culturally inaccessible and ineffective for many

Native American women because they fail to incorporate healing elements from Native American cultures.[275]

Key Health Conditions, Diseases and Causes of Death. Although the primary cause of death for Native American women is cardiovascular disease, Native American women are unique among the population groups in that accidents rank as the second most common cause of death. Overall Native American women also have the highest age-adjusted death rates for diabetes (28.9 per 100,000) as well as cirrhosis and chronic liver disease (18 per 100,000) compared to other groups. Native American women's health also differs greatly from other populations when examined by age. The leading cause of death for young Native American women (age 25 to 44) is accidents. Although accidents are also the leading cause of death for young white women, the accident rate for young Native American women is more than twice that for white women (38.7 per 100,000 for Native American women as compared to 15.6 per 100,000 for white women). The second leading cause of death among young Native American women (age 25 to 44) is cirrhosis (chronic liver disease). The cirrhosis rate for these women is more than four times greater than that of African American women this age. Cirrhosis is not one of the top five leading causes of death among women age 25 to 44 for any other population group. The limited data available, although not provided by all four race groups and Hispanic origin, suggest that young Native American women have the highest mortality rate from suicide of all women age 15 to 24.[276]

Like other women, the leading cause of death among Native American women in age groups 45 and over is heart disease. However, Native American women age 45 to 54 are unique as their second leading cause of death is chronic liver disease and the third is accidents. The second leading cause of death for Native American women age 55 to 74 is diabetes. For Native American women over 75, the second leading cause of death is stroke.

There are no data disaggregated for Native American women for many of the conditions addressed in the *Report Card*. The limited data available, although not provided by all four race groups and Hispanic origin, suggest that Native American women have the highest rate of arthritis (24.5 percent) and the highest rate of reporting being victims of violence in their lifetimes (64.8 percent) as compared to any other racial or ethnic group.

Living In A Healthy Community. Native American women experience higher rates of poverty than white women: 23.8 percent of all Native American women live in poverty.[277] Native American women have lower rates of high school graduation than white and black women, with 76.4 percent of Native American women over age 21 getting 12 or more years of education.[278] Forced relocation of Native Americans has resulted in race discrimination and hostility from non-Native neighbors, which in turn has led to high unemployment and poverty rates. Native American women's health is also affected by environmental degradation. Many live in poor quality housing (often with poisonous lead-based paint) and are exposed to local toxins. Fifty percent of Native Americans live in areas with uncontrolled toxic waste sites, and a large number of their homes lack access to a safe water supply or sewage disposal treatment, placing them at greater risk of illness and disease. On some reservations, 20 percent of homes do not have indoor plumbing.[279]

Lesbians

The lack of attention to health issues facing lesbians presents a significant barrier to their health and well-being—adversely affecting access to health care, health research and data collection.[280] A number of the health problems faced by lesbian women are faced by bisexual and transgendered women as well. A recent report by the Institute of Medicine identified the serious limitations in current knowledge about lesbian health, and an urgent need for more research.[281]

Women's Access to Health Care Services. There is some indication that lesbians are less likely to have insurance coverage than other women—both because lesbians are often not covered by their partner's insurance (one of the main sources of coverage for heterosexual married women is their husband's insurance) and because employment discrimination bars lesbians from jobs that offer insurance coverage.[282] Presumptions that patients are heterosexual, stereotyping of lesbians and misconceptions about lesbians' health needs can all create significant barriers to comprehensive, quality health care.[283]

Lesbians face a lack of health care providers who adequately provide services to them—either due to outright discrimination or to damaging misconceptions—making it difficult for them to get comprehensive care and actually inhibiting their willingness to seek care.[284] In fact, studies indicate that lesbians generally seek health care less often than other women do.[285] Managed care worsens the problem of finding and keeping health care providers competent to treat lesbians by limiting the choice of providers and preventing new enrollees from selecting providers.[286] Third-party insurance systems also raise privacy concerns where explicit medical information must be provided for expenses to be approved, and they hinder candid

communication between provider and patient.[287] Due to a lack of legal recognition of partners, many lesbians are denied financial support and other benefits during illness, including family leave, workers' compensation, and rights concerning medical care and treatment decisions, organ donation and hospital visitation.

Wellness and Prevention. Many factors limit lesbians' receipt of adequate preventive health care, including the general barriers to health care discussed above.[288] The fact that lesbians do not usually use contraception means that they also may lose the benefit of other important preventive services, such as breast and cervical cancer screenings, cholesterol tests and blood pressure monitoring that often take place during visits to family planning programs.[289] Surveys on important risk factors, including smoking and overweight, often fail to inquire about sexual orientation, but those that do reveal a higher prevalence of both among lesbians.[290] In addition, there is little information about alcohol and drug use among lesbians, both because studies have failed to inquire about sexual orientation, and because some older surveys used subjects recruited at bars, thus creating serious questions about the applicability of the data to all lesbians.[291]

Key Health Conditions, Diseases and Causes of Death. Given the little information about the incidence of specific health conditions among lesbians, even basic data on the causes of death have not been collected.[292] However, existing information does suggest areas needing further research. For example, domestic violence among lesbians is a neglected topic. Even those trained to help victims of domestic violence often are not well versed in the dynamics of violence between same-sex partners, and lesbian perpetrators find little support in treatment groups made up primarily of men.[293] Research is needed on mental health issues, including those related to chronic stress resulting from discrimination and public acknowledgment of sexual orientation.[294] Studies indicate a lower prevalence of STDs among lesbians, possibly due to physiological factors and relative social isolation.[295] HIV among lesbians, especially the risks of transmission between women, is another area where research is needed.[296]

Living in a Healthy Community. The failure of the federal and state governments to recognize the status of lesbian partners has had a substantial impact on lesbians' financial well-being and their ability to afford health care.[297] Hate crimes against lesbians present another serious health threat. While surveys vary, one study reported that more than three-fourths of lesbians surveyed had been verbally harassed, and one in ten had been physically assaulted because of her sexual orientation.[298] In addition, the *Report Card* reviews state enactment of laws to prevent employment discrimination based on sexual orientation. Thirty states and the federal government have not enacted such laws.

Women With Disabilities

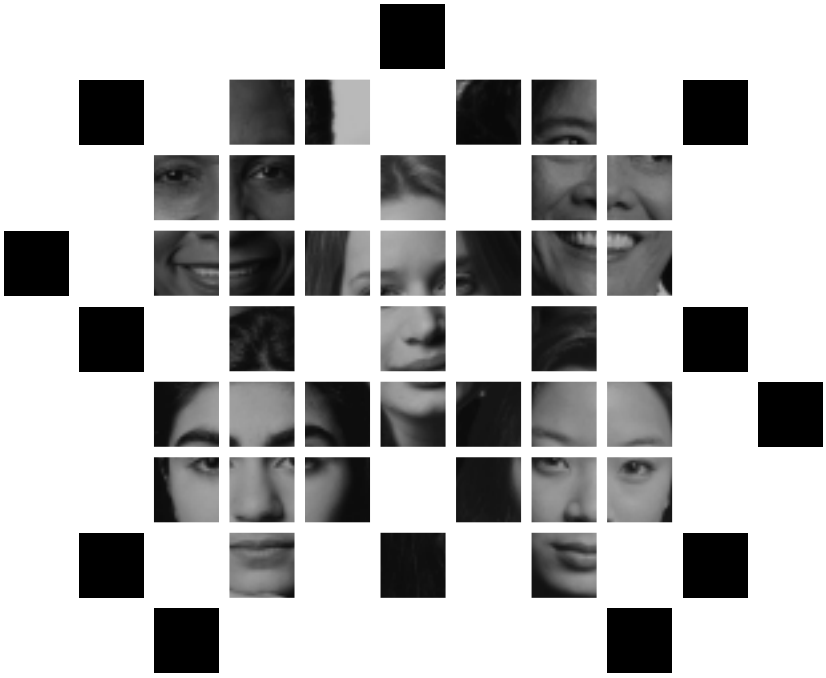
Under the Americans with Disabilities Act (ADA), an individual with a disability is defined as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such an impairment."[299] It is estimated that approximately half of the 54 million people in the United States who currently experience some level of disability are women and girls,[300] and approximately 5.5 million of these women receive Social Security benefits.

Women's Access to Health Care Services. Women with disabilities face unique barriers to health care, including physical inaccessibility of medical offices and equipment, limited availability of health information because it is in print format only, and a lack of transportation and related services.[301] In addition, many women with disabilities experience inadequate treatment or outright refusals to be treated by health care providers. Although health care providers must take steps to eliminate these barriers through compliance with accessibility requirements under the ADA, compliance is not yet uniform.[302] The nationwide shift to managed care, particularly in the context of Medicaid, is creating new problems for disabled women.[303] Heath maintenance organizations have traditionally placed strict limits on therapeutic, supportive and home care services, thus restricting opportunities for people with disabilities to obtain independent living support.[304] Restricted access to specialists, and the inability to name a specialist as a primary care provider, has strong implications for women with disabilities since disabled women use specialists more often than nondisabled women and only specialists may have the necessary training to treat certain disabilities.[305]

Wellness and Prevention. There is a concern that women with disabilities face barriers to preventive health care and health promoting activities. One example of such a barrier to screening that women with disabilities face is that mammography screening standards for all women do not take into account the fact that women with disabilities face special barriers to obtaining these services (e.g., lack of adaptive equipment, providers' lack of familiarity or sensitivity to special needs of women with disabilities).[306]

Key Health Conditions, Diseases and Causes of Death. There is little research on special health issues faced by women with disabilities, but special risks and barriers in mental health issues, reproductive health, and violence have been identified. The failure to focus on health issues specific to women with disabilities often means that policies promoting women's health generally are applied to disabled women, regardless of whether they will actually benefit this population. Disabled women and girls face particular issues regarding mental health. They are at a very high risk for depression, facing struggles with employment discrimination and a lack of accessible and affordable health care, housing and transportation.[307] A recent study found that eating disorders are more prevalent among female adolescents with disabilities than non-disabled adolescents.[308] Women with disabilities also face stereotypes about their sexuality that adversely affect their reproductive health. Disabled women have been subjected to forced sterilizations, coerced abortions, unauthorized hysterectomies, and x-ray screening without protection of their reproductive organs. Women with disabilities have a significantly higher rate of hysterectomy as a method of birth control than nondisabled women, and disabled women are also more likely to not use birth control at all.[309]

Living in a Healthy Community. Despite enactment of the Americans with Disabilities Act (ADA) in 1990, people with disabilities continue to face discrimination. Further, women and girls with disabilities are more likely than nondisabled women and girls to experience emotional, physical and sexual abuse by partners, family members and caregivers.[310] Disabled women are less likely to be believed, however, when they report incidents of abuse or assault, and many of these crimes go unreported.[311] Caregiver abuse is a particular issue faced by women with disabilities. It can include denial of medications or oversedation, disconnecting a wheelchair's power supply and other forms of abuse. Girls with disabilities are also almost twice as likely to be sexually abused as nondisabled children, and women and girls with developmental disabilities are far more likely to be sexually assaulted (and revictimized by the same person).[312] Disabled girls also experience higher rates of sexual harassment in school than disabled boys or nondisabled children.[313]



CHAPTER VI

RESEARCH AND DATA COLLECTION NEEDS

Many limitations of data and weaknesses in research affected the *Report Card*, both in identifying potential indicators and obtaining consistent state-by-state data. This section of the *Report Card* describes: (1) general issues related to the methods of collection, reporting and analysis of data, and (2) issues related to the scope and breadth of research on specific areas of concern for women.

Overarching Gaps in Data and Research

Gaps in research and data collection limit the scope of biomedical and behavioral research on women, and prevent informed decision making about policies and resources that affect women's lives.

- ***Data are often not collected, analyzed, and/or reported by gender and other important factors.*** At both the state and the national levels, data are often not reported by gender, and even when gender is reported, data are not further reported by standard age groups, race, ethnicity, disability, sexual orientation or socioeconomic status. For example, state statistics on the number of people living in medically underserved areas are not reported by gender. Data on individuals' sexual orientation and disability status are rarely collected.
- ***There is a lack of uniform definitions of key health conditions and services.*** Inconsistent use of terms and definitions for health conditions or services make it difficult to compare data and to understand fully the issues surrounding women's health and well-being. For example, states' varying definitions of "rape" and "sexual assault" make aggregation and comparison across states difficult or impossible.
- ***The data on women's health are often limited, incomplete or dated.*** Several key data sources for women's health are national surveys that do not accurately represent the state-level data (e.g., data on homelessness).[314] Other sources include single-point-in-time studies which also limit the use of data for state comparison. Yet other data sets are based on samples that are too small to be considered representative of particular groups of women (e.g., lesbians) or do not provide a sufficient

amount of information about a condition. In addition, the schedules for some data collection and the lag between collection and publication limit access to timely data.

- ***Morbidity data need to be more consistently collected by gender.*** Some morbidity data (i.e., data on conditions, illness and disease) are difficult to find, or have limited comparability across states and/or populations because of differences in how the data were collected. These inconsistencies make it difficult to describe variations in the prevalence and experience of some conditions among different age and race/ethnic groups of women.

- ***Significant gaps exist in data available and the research focused on the health of women in general and of minority women and specific populations of women.*** There are limited data and research on the health of women of color,[315] disabled women, homeless women and lesbians. Inadequate and unreliable data on homeless people and lesbians make it difficult to understand health aspects of homelessness and sexual orientation. There are very little data on the number of women and men in the United States who self-identify as gay, lesbian, bisexual or transgendered. The limited information that is available is not provided on a state-by-state basis and most sources generalize findings from small samples, which can lead to inaccuracies.[316] The state-by-state data on the number of women with disabilities is also very limited. For example, although the Current Population Survey is a state-by-state population-based survey, the criteria by which women are deemed disabled are very narrow (between the ages of 19 and 60 and receiving Social Security benefits, or below the age of 65 and did not work because of a disability).[317] Nationally, this number (5.5 million women) represents only 20 percent of the estimated number of women with disabilities.[318]

- ***There is insufficient attention to women in clinical research trials.*** Clinical trials should include sufficient numbers of women (including women of color, older women and women of childbearing age) to make the results valid for the broader population of women. Researchers and funders must build on the progress made since the early 1990s, to ensure that data are analyzed and reported by gender, and further analyzed by race, ethnicity, and age.[319] Recent agendas for biomedical research on women's health include more calls for investigation that both addresses the health of women throughout their life cycle, and integrates different disciplines of research (e.g., biological and social sciences). The *Report Card* effort underscores specific issues that need to be addressed in future research, including: substance use and abuse (tobacco, alcohol and drug); bone and musculoskeletal disorders; cancer; cardiovascular disease; digestive disease; autoimmune diseases; infectious disease; mental health; neuroscience; oral health; pharmacology; reproductive health; and urologic conditions.[320]

- ***Efforts to collect information on or describe the content of and support for programs serving women have been inconsistent.*** The efforts to develop policy indicators were hampered by the lack of mechanisms for comparing programs and services across states. It is also extremely difficult to ascertain the state funding of certain programs because federal, state, municipal and private funds are often combined to support the same programs, but no accounting of the funding by state is publicly available. State record keeping does not always clearly indicate which funding streams support which specific programs. These problems impede efforts to compare service content or quality. Comprehensive data are needed to determine how well states fund programs that provide services or support to specific populations of women. One effort to address this problem is the Centers for Disease Control and Prevention's recently published inventory of services and funding sources for programs designed to prevent violence against women, which serves as a useful first step in evaluating state services for women who are victims of violence.[321]

Specific Data and Research Gaps

Women's Access To Health Care Services

Access to care is crucial to women's health and well-being. A variety of different approaches are required to measure its multiple dimensions adequately. Gaps in the data and the limits on research that impede the assessment of women's access to care are identified below.

- ***The lack of adequate information hampers the assessment of women's access to care.*** More research is needed to identify the number of women who are eligible for publicly funded health insurance programs but are not participating. There is inadequate information on the range of barriers (such as transportation, child care, linguistic and cultural barriers) that keep women from either enrolling in programs or securing services. These data are not systematically collected through national or state surveys. There is no consistent reporting on state investments in outreach programs that help to identify and enroll eligible women in insurance programs.

- ***Further research is needed to evaluate the "cultural competency" of health care services, including both physical and behavioral health.*** Although there is a growing commitment to ensuring the "cultural competence" of health care services and delivery, few efforts or methods are widely used to assess the range and quality of these services.[322] These gaps in research severely limit the understanding of the overall picture of access to health care for women of color, lesbians, the disabled, and women in general.

- ***There is a lack of data regarding state support to safety net providers.*** In a recent report evaluating the nation's safety net providers, the Institute of Medicine (IOM) identified the need for comprehensive safety net monitoring. The IOM suggested tracking several measures, including the providers' financial stability and their ability to meet the health care needs of the uninsured and other vulnerable populations.[323]

- ***There is inadequate information on women's access to long-term care.*** There are major gaps in data and research on women and long-term care. Existing state-level data is limited, making it very difficult to evaluate the range of long-term care options, especially those that support women living in their homes. Analysts need to evaluate further: state-mandated nursing home staffing levels; state support for home and community-based care; state enforcement of federal and state nursing home standards; and state support for respite care.

- ***Further research is needed on the benefits of care provided by nurse midwives and nurse-practitioners.*** Certified Nurse Midwives are nursing professionals with specialized training in reproductive health care, including prenatal care, childbirth, gynecological care, newborn care, family planning and menopause.[324] Initial studies have found that pregnant women and their infants often have better health outcomes when tended to by a midwife.[325] While access to specialized obstetric care remains important, nurse midwives can provide excellent care for more routine conditions. There is strong evidence that midwives serve traditionally underserved populations, and further research is needed on the impact of midwifery and nurse-practitioner services on women's access to health care.[326]

- ***More research is needed on how medical errors affect the quality of care.*** In 1999, the Institute of Medicine issued a report estimating that hospital medical errors are responsible for 44,000 to 98,000 deaths annually in the United States, making medical errors a major cause of death. It is not clear whether a patient's gender increases the likelihood of errors, and whether mandatory or voluntary error reporting (or state or federal control, or any combination) is the most effective way to reduce these errors.[327]

Coverage of Women's Health Services: According to the Kansas Insurance Commissioner, women spend an average of 68 percent more on out-of-pocket health care costs in managed care settings than do men. This finding, together with the results of a 1998 Commonwealth Fund survey on women's health, suggest that one reason for gender disparities in health care costs is that services and drugs that specifically affect women's health (like contraceptives and the diagnosis, treatment and management of osteoporosis) tend not to be fully covered by managed care plans.[X]

Barriers to Substance Abuse Treatment for Women: In general, women face different and usually greater barriers to substance abuse treatment than men: referral sources are often limited and geographically inaccessible; health care professionals do not recognize the patterns of symptoms as they occur in women; women often have limited support systems and may face opposition from significant others; women may be victims of violence; women have significant care-taking responsibilities; women with substance abuse problems often face great social stigma; and women have fewer resources to pay for treatment.[Y]

- ***More research is needed into complementary and alternative medicines.*** The federal government's National Center for Complementary & Alternative Medicine (NCCAM) is at the beginning stages of facilitating the evaluation of many of these types of care. Among the women's health concerns that NCCAM addresses are: menopausal symptoms, depression, breast cancer, cold and flu symptoms and dietary supplements.[328]

Addressing Wellness and Prevention

Very little information exists about women's health behavior. While some data are available on women's smoking patterns and selected eating habits, other aspects of women's activities that contribute to wellness are especially poorly measured.

- ***More data on exercise, physical activity, and nutrition programs are needed.*** There is very little comparable information regarding states' commitment to exercise, physical activity and nutrition programs, despite evidence that exercise and good nutrition are central to women's health and well-being.

- ***Data on the efficacy of prevention and treatment programs and the impact of policies should be collected consistently.*** Evaluating the effectiveness of programs intended to prevent illness or promote wellness is essential to making informed decisions about policies affecting women's health. Currently, few ongoing efforts evaluate the value of many programs that serve women. Similarly, there is a significant lack of research regarding approaches to facilitating healthy behavior (e.g., nutrition programs) and approaches to daily prevention activities (e.g., exercise habits) among women.

- ***Data on drug and alcohol abuse need to be strengthened.*** There are several data gaps concerning the incidence and prevalence of drug and alcohol abuse. More information is necessary about drug and alcohol addiction among women and the treatment available to them. For example, no state-level data on the incidence and prevalence of drug use by gender are available. The lack of state-level data makes comparisons across states impossible, even though there are valuable data concerning drug use in some metropolitan areas. There is also a lack of consensus concerning which indicators are best for measuring drug use and abuse. In

addition, data are not available regarding the number of women who need substance abuse treatment, the number of women who use the available programs, or the effectiveness of existing programs at treating women. Although there are state-by-state data on the number of women admitted to treatment each year, these data are not helpful without information about the need for the services, retention and graduation rates, and recidivism rates.[329]

Key Health Conditions, Diseases and Causes of Death

There are a variety of data and research limitations on the major health conditions, diseases, and causes of death for women.

- ***Although ongoing data collection efforts address many key conditions, significant data gaps persist.*** At the state level, health status data that are collected and reported by gender, and further broken down by age, race and ethnicity tend to be limited to mortality data. Only limited data on morbidity and other aspects of health conditions are available for specific groups of women.

- ***A changing research base prevents clear consensus around some approaches to measurement, treatment and appropriate programming or resources for some key health conditions.*** For some key health conditions that affect women, there is significant debate as to the intensity of the problem, appropriate measures to accurately describe the scope of the concern, and the most effective prevention or treatment measures. In some cases (e.g., the lack of a screening mechanism for ovarian cancer, the advisability of hormone replacement treatment for menopausal women), consensus has shifted over time, as recommendations and guidelines have reflected improved knowledge and new research findings.

- ***There is a lack of data about specific conditions.*** The lack of state-level data and the reliance on national data make it difficult to ascertain the incidence, prevalence and availability of screening and treatment for key health conditions, diseases and causes of death. The list that follows delineates many of the limitations the *Report Card* effort identified. This list, however, is by no means exhaustive of the limitations in data concerning key conditions in women's health:

  HIV: Reported data measures people living with AIDS and not people living with HIV, the virus that causes AIDS.[330]

  Osteoporosis: There are no consistent data collected at the state level on the number of women with osteoporosis, or who receive bone-density screening.

  Arthritis: There are no consistent data collected at the state level on the number of women with arthritis. Surveillance data are limited to self-reports of any type of arthritis at the national level. A national arthritis action plan has been developed that proposes strategies for improved national and state surveillance through development of survey modules on arthritis, standardization and consistent use of common terms in gathering of data, and collection and examination of information about available clinical treatments.[331]

  Unintended Pregnancies: There are no state-by-state data on the percentage of pregnancies that are unintended.

  Mental Health: Although there are accepted definitions for specific conditions, research is needed to help establish nationally accepted definitions and clinical parameters for overall mental health. The *Report Card* indicator for mental health status is self-reported via the CDC's Behavioral Risk Factor Surveillance System. There is no universally agreed upon risk assessment or clinical database at the national or state level for mental health status.

  Violence Against Women: There are limited data on the number of women who are victims of domestic violence in the United States. States may collect this type of data through various mechanisms, but generally there are not sufficient data for comparison among the states. The Centers for Disease Control and Prevention has begun to address these concerns, particularly in the context of intimate partner violence. It is developing guidelines for data collection to better understand intimate partner violence, its impact, prevention and treatment.[332] There are limited data and research on the policies related to the incidence of sexual assault. State statutes vary greatly in the way they define sexual assault and other violent crimes. Appropriate data and research would evaluate state statutes' definitions of sexual assault, as well as data on the services and programs for prevention and treatment.

  Asthma: States do not consistently collect population-based data about the incidence or prevalence of asthma. More investigation is also needed to identify factors that cause and worsen asthma.[333]

  Eating Disorders: There are no state-level data concerning eating disorders prevalence, incidence or the availability and use of treatment.

  Ovarian Cancer: More research into ovarian cancer is needed, particularly research focused on developing accurate screening tools, precise diagnostic tools and non-toxic therapies.[334]

Living in a Healthy Community

Women's homes, communities and work environments all affect their health. There are serious research gaps in each of these areas:

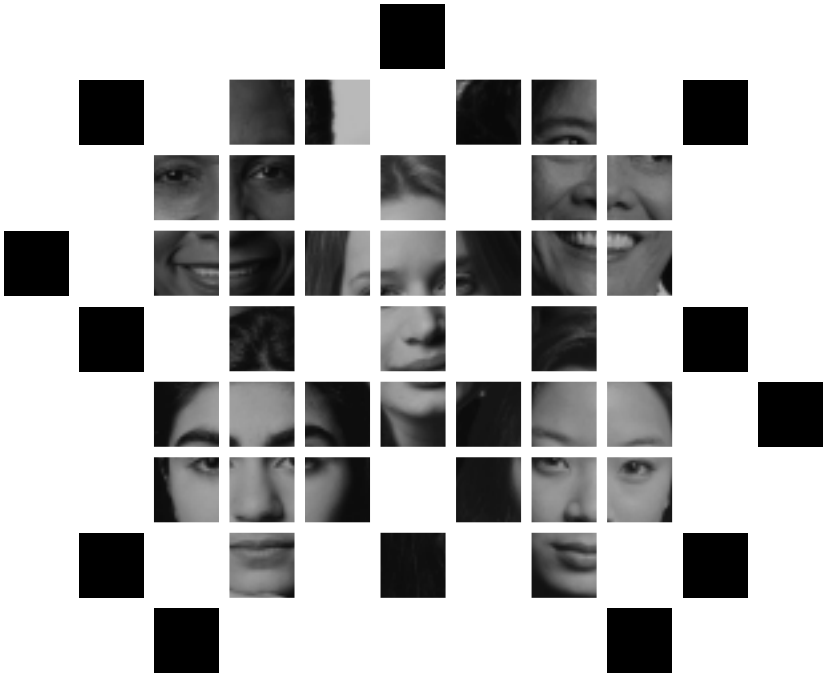
- ***Data are needed on the incidence of discrimination against women.*** Understanding discrimination against women or particular groups of women is essential to defining a healthy community. There are no national or state-by-state data (or agreed upon ways to measure data) on the incidence of discrimination against women.

- ***Further research is needed on the impact of the environment on women's health.*** Research can determine the extent to which environmental conditions endanger women's health generally and affect particular groups of women.[335] State-by-state evaluations of environmental policies (e.g., regulating toxic waste, and state "need to know" policies and their implementation) need to be structured to facilitate responsible comparison among the states.[336]

- ***Further research is needed concerning occupational health.*** There are more than 60 million women (approximately 60 percent of women age 16 and over) in the U.S. workforce, making up almost half of working adults. Many studies have found a positive relationship between women's employment and better health. Nevertheless, work-related injuries and illnesses are significant health concerns. Women face some special occupational hazards, due in large part to continuing and widespread gender segregation at work. This results in different patterns of exposure to chemical and physical hazards for men and women. For example, although women suffer fewer fatal injuries at work than men, a much higher proportion of those workplace fatalities are homicides, occurring especially in retail sales and the service sector. Psychosocial strain results from high job demands and low latitude for decision making, but little is known about its physical health effects. In addition, there are other psychosocial stressors such as workplace discrimination and sexual harassment. The greater burden of household work borne by women, compared with men, has barely been studied with respect to its physical demands, psychosocial features, and interaction with paid employment. There are also many unanswered questions regarding possible biological differences that affect susceptibility to a range of potentially complex exposures. Other factors, like gender differences in literacy or representation by unions, affect the resources available to help women address their workplace problems. The need for more research on these issues was corroborated by Healthy People 2010.[337] More study is needed of the nature and frequency of hazardous exposures in the workplace and of the broad range of health effects, not solely those related to reproductive health.[338]

Ergonomic/Musculoskeletal Disorders: A significant number of women suffer from health problems related to ergonomic hazards. Musculoskeletal disorders (MSDs) (including hand, arm and lower back pain) are the single largest category of work-related illnesses in the nation. One-third of all serious work-related injuries stem from ergonomic hazards, and women have about two-thirds of the repetitive strain injuries (230,000 women in 1999). A federal ergonomics regulation has been proposed but not yet promulgated when the *Report Card* went to press.[Z]

The New York Occupational Health Program: New York has created a network of occupational health clinics funded by a surcharge on worker's compensation premiums. The clinics offer a wide array of services, including diagnoses for work-related diseases, screening for workers at risk, and training and education for workers, employers, unions, and health care providers. They accept public and private insurance and no one is denied care based on inability to pay.[AA]



CHAPTER VII

METHODOLOGY FOR INDICATOR SELECTION AND EVALUATION

The *Report Card* is designed to present an accurate, broad assessment of women's health and the challenges that the nation and the states must meet to improve women's health and well-being. The health status and policy indicators included in this *Report Card* address the most important issues affecting women's health and well-being within the parameters of the data that were available. Wherever possible, the *Report Card* presents the most recent data available for each indicator. In some cases, the *Report Card* uses slightly older data if these included information by race or ethnicity. Data collection for the *Report Card* ended in Spring 2000. It is likely that additional data will have become available and some state policies will have changed between the time when data collection ended and the *Report Card* was published.

Health Status Indicator Methodology

Criteria for Indicator Selection

Health status indicators were selected based primarily on whether they had a significant impact on women's quality of life, functioning and well-being, and whether they affected a large number of women generally or a large number of women in a specific population and/or age group. Additional criteria were whether the indicator could be affected through intervention, prevention or improvement; was potentially measurable; was commonly used or there existed broad consensus on use; or reflected an emerging important issue where the problem was increasing in prevalence, incidence, or severity.

Women's health status varies by ethnic and racial groups as well as by age. Wherever possible, the state data for the status indicators are disaggregated by these categories. In many cases, state data on these specific populations of women were not available. The available information is presented in Chapter V, Key Health Disparities by Race, Ethnicity, Sexual Orientation and Disability.

Data Sources and Limitations

The *Report Card* uses data from population-based surveys whenever the data were available. With few exceptions, the data presented in the *Report Card* were collected at the state level and reported by sex. Exceptions include a few indicators based on data not reported by sex, but where general population data were viewed as a reliable reflection of women's health status (such as the number of people living in medically underserved areas). Similarly, some data applied to different age groups or are reported without reference to sex. These qualifications are included in the technical notes for the individual indicators. Some national data on key measures of women's health are included, even though there were no state data available for the state indicators (arthritis, osteoporosis and unintended pregnancies), given their importance to women's health. Data are also presented by race, by ethnicity and by age wherever possible. Although reporting data by income level also would have been desirable, time and data constraints precluded their inclusion in this first *Report Card*. Data sources and limitations are more fully described in Chapter IX, Technical Notes on Indicators.

Grading and Benchmarks

Where possible, the *Report Card* uses the overall Healthy People 2000 objectives as benchmarks. These objectives are based on benchmarks for both men and women that were primarily drawn from the ten-year health objectives set for the nation by the U.S. Department of Health and Human Services' Healthy People 2000. In January 2000, the U.S. Department of Health and Human Services released Healthy People 2010 benchmarks. However, data have not always been collected to reflect the new goals. Where a Healthy People 2000 goal did not exist, and data were available, the *Report Card* uses the Healthy People 2010 benchmark. In cases where there is no Healthy People benchmark, states are ranked, not graded, except for a few instances where another benchmark was available. For example, in the case of life expectancy, the Healthy People 2010 goal is to increase life expectancy, but no specific target is provided. The *Report Card* adopted Japan's life expectancy for women as a benchmark, since it is a highly industrialized nation with the highest life expectancy for women. Because the Healthy People benchmarks and the status benchmarks are incremental, the *Report Card* gave a highest grade of "Satisfactory" ("S") to states that met the benchmark. States that were within ten percent of the benchmark received an "Unsatisfactory" ("U"). States that missed the benchmark by more than ten percent received a "Fail" ("F").

Each state was given a total grade and a total rank for the status indicators. The total grade is an average of the grades for the 25 status indicators that were awarded individual grades. Each status indicator grade was given equal weight in calculating the total grade. The total rank is based on the state's rank on each of the 28 status indicators that are ranked. Each status indicator's rank was given equal weight when calculating the total rank.

Health Policy Indicator Methodology

The state policy indicators examine state policies and programs important to women's health. The type of state action considered—whether statutes, regulations, executive orders, or other manifestations of state policies and programs—vary from indicator to indicator, and are listed in the technical notes for each indicator. The strength of the state policies are indicated on the state report cards by the designations "Meets the Policy," "Limited Policy," "Weak Policy," and "No Policy."

Criteria for Indicator Selection

The criteria used to select the indicators for state health policies are similar to those used to select the health status indicators. State policy indicators were selected based on whether they addressed and could have a significant positive impact on the critical women's health issues reflected in the status indicators; whether they were measurable and able to be compared across states; and whether they had been adopted by at least one state.

While the status and policy indicators are closely connected, some state policy indicators are included even though there is no status indicator that correlates directly to those policies. In cases where there were no reliable data for every state describing the extent of a major women's health problem, such as domestic violence, the *Report Card* included state policies that addressed that problem, and identified the need for better research and data collection.

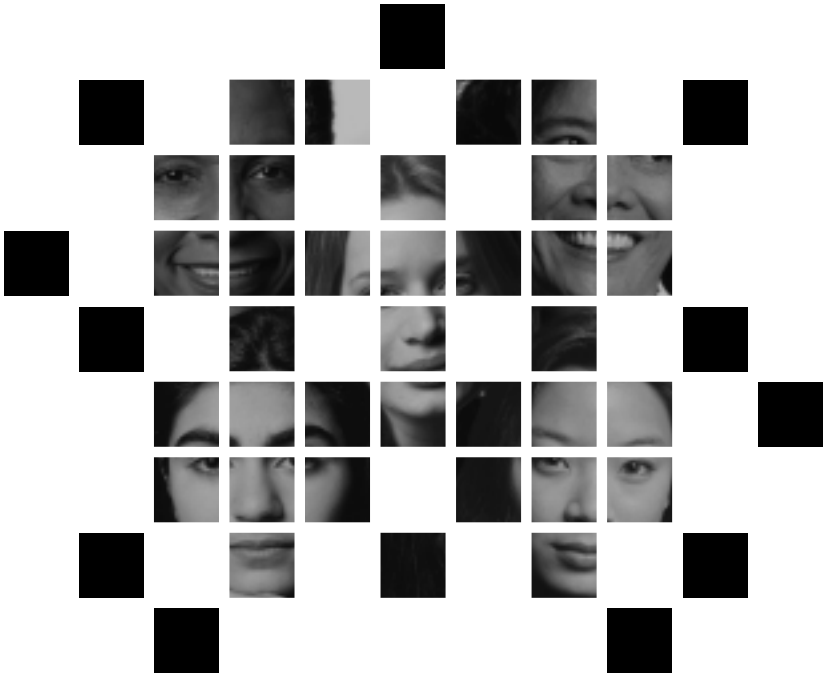
Data Sources and Limitations

Generally, the *Report Card* includes state health policy information that was collected from published or on-line sources, such as *State Legislated Actions on Tobacco Issues* published by the American Lung Association, which was the source for the data regarding indoor smoking restrictions. The National Conference of State Legislatures (NCSL) collected information on state insurance policies regarding Medicaid coverage and private insurance requirements for the *Report Card*. Sources for all data are provided in Chapter IX, Technical Notes on Indicators.

Adopting the state policy indicators can improve women's health, but the states' actual implementation is a crucial component in determining whether and how much the policies improve women's health. Generally, the *Report Card* does not explore the effectiveness of state implementation efforts or subsequent judicial actions because such data are not routinely or consistently available.

Demographic Profile Methodology

The Demographic Profile includes 14 categories of data that provide the context for the *Report Card* status and policy indicators. The Profile offers a "snapshot" of the population of women in each state, and the nation as a whole, based on general descriptions. The Demographic Profile includes: (1) total population of women; (2) sex ratio of women to men; (3) percent and number of women by race; (4) percent and number of women by age; (5) median age of women; (6) number of households headed by single women; (7) median earnings for women; (8) number of women who have completed two years post high school; (9) number of women who have completed four years post high school; (10) number of women prisoners; (11) number of women who are disabled and receiving Social Security; (12) number of women residing in urban areas; (13) number of women living in linguistic isolation; and (14) percent of births attended to by midwives. This information is included on the national and state report cards as a supplement to the status and policy indicators.



CHAPTER VIII

THE ADVISORY COMMITTEE

The Advisory Committee played a vital role in all aspects of the *Report Card*. Its members participated in the many facets of the *Report Card*'s development, including the selection criteria for the indicators, the array of indicators themselves, the relative weights to be given to the indicators, the nature of the information to be highlighted beyond the indicators, and the identification of other experts to consult. While the help and support generously given by the Advisory Committee were essential, responsibility for the *Report Card* and for its ultimate decisions remains with the *Report Card* authors. The Advisory Committee members are:[339]

Claire Brindis, Dr.P.H.
Director
Center for Reproductive Health Research and Policy
University of California, San Francisco

Pam Charney, M.D.
Professor of Clinical Medicine
Associate Professor of Clinical Obstetrics & Gynecology and Women's Health
Albert Einstein College of Medicine
Director, General Internal Medicine—Women's Health Residency Track
Jacobi Medical Center

Mary K. Chung
President and CEO
National Asian Women's Health Organization

Carolyn Clancy, M.D.
Director
Center for Outcomes and Effectiveness Research
Agency for Healthcare Research and Quality

Cathy Collette
Director
Women's Rights Department
American Federation of State, County and Municipal Employees

Alice Dan, Ph.D.
Professor and Director
Center for Research on Women and Gender
University of Illinois at Chicago

Jacqueline E. Darroch, Ph.D.
Senior Vice President and Vice President for Research
The Alan Guttmacher Institute

Lee Dixon
Director, Health Policy Tracking Service
National Conference of State Legislatures

Pamela S. Douglas, M.D.
Professor of Medicine
Head, Cardiovascular Medicine Section
University of Wisconsin Medical School

Sally Fogerty
Assistant Commissioner
Bureau of Family and Community Health
Massachusetts Department of Public Health

Nancy Fugate Woods, Ph.D., R.N., F.A.A.N.
Dean, School of Nursing
University of Washington

Phyllis Greenberger, M.S.W.
President and CEO
Society for Women's Health Research

Rita Harding, R.N., M.N., C.N.A.A.
Nurse Program Officer
Billings Area Indian Health Service

Heidi Hartmann, Ph.D.
Director and President
Institute for Women's Policy Research

Maureen Hatch, Ph.D.
Director, Division of Epidemiology
Associate Professor, Department of Community and Preventive Medicine
Mount Sinai School of Medicine

Janet Henrich, M.D.
Associate Professor of Medicine & Obstetrics & Gynecology
Primary Care Center
Yale University School of Medicine

Sylvia Drew Ivie
Executive Director
T.H.E. Clinic Incorporated (To Help Everyone)

Wanda K. Jones, Dr.P.H.
Deputy Assistant Secretary for Health (Women's Health)
U.S. Department of Health and Human Services

Shiriki K. Kumanyika, Ph.D., M.P.H., R.D.
Professor of Epidemiology and
Associate Dean for Health Promotion and Disease Prevention
University of Pennsylvania
School of Medicine

Joan M. Leiman, Ph.D.
Executive Deputy Vice President for Health Sciences
Columbia University, College of Physicians and Surgeons

Nancy C. Lee, M.D.
Director, Division of Cancer Prevention and Control
Centers for Disease Control and Prevention

Judith Lichtman, Esq.
President
National Partnership for Women and Families

Kim I. Mills
Education Director
Human Rights Campaign

Roberta Ness, M.D., M.P.H.
Director, Women's Health Program
Graduate School of Public Health
University of Pittsburgh

Judy Norsigian
Program Director
Boston Women's Health Book Collective

Vivian Pinn, M.D.
Director
Office of Research on Women's Health
National Institutes of Health

Carolina Reyes, M.D.
Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology
Cedars-Sinai Medical Center
Assistant Professor, UCLA School of Medicine

Elena Rios, M.D.
President
National Hispanic Medical Association

Anthony Robbins, M.D.
Chairperson
Department of Family Medicine and Community Health
Tufts University School of Medicine

Helen Rodriguez-Trias, M.D.
Pediatrician/Consultant in Health Programs

Martha Romans
Executive Director
Jacobs Institute of Women's Health

Allan Rosenfield, M.D.
Dean
Mailman School of Public Health
Columbia University

Julia R. Scott, R.N.
President/CEO
National Black Women's Health Project

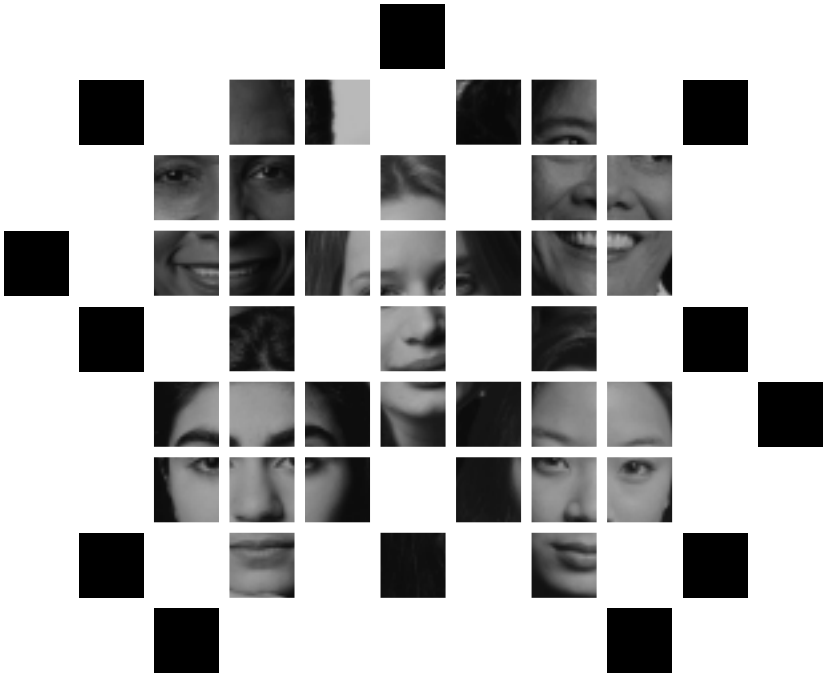
Judy Waxman, Esq.
Deputy Executive Director
Families USA

Carol S. Weisman, Ph.D.
Professor
Department of Health Management & Policy
Director, Interdepartmental Concentration in Reproductive and Women's Health
School of Public Health, The University of Michigan

Nanette K. Wenger, M.D.
Professor of Medicine (Cardiology)
Emory University School of Medicine
Chief of Cardiology, Grady Memorial Hospital

Lynne S. Wilcox, M.D., M.P.H.
Director
Division of Reproductive Health
Centers for Disease Control and Prevention

Linda M. Williams, Ph.D.
Co-Director
National Violence Against Women Prevention Research Center
Wellesley Centers for Women
Wellesley College



CHAPTER IX

TECHNICAL NOTES ON INDICATORS AND DEMOGRAPHICS

Below are descriptions of the sources for the indicators and the demographics. The indicators are listed in the order in which they appear in the *Report Card* text (Chapter III). The shortened name of the indicator or demographic is in bold. These names are followed by (if applicable) a parenthetical describing the unit of measurement (e.g., "%" if the data appear as a percent). The time periods to which the data apply also appear in bold. Following the date is the citation to the source from which the data were drawn. When the data source or explanation for particular states or the nation are different than the source or explanation for the indicator generally, the specific state name (or "national") is italicized. Most notes include an explanation of how the data were obtained and caveats or limitations that might apply. Sources cited at the beginning of each note apply to the entire note unless otherwise indicated. For informational purposes, Healthy People 2010 objectives are noted in specific indicators that use Healthy People 2000 objectives as benchmarks.

SHORTENED CITATIONS: The shortened versions for sources are listed in bold before each full citation below.

BRFSS 1998 (citation followed by page number): Centers for Disease Control and Prevention, *1998 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998) [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pdf/98prvrpt.pdf, accessed 16 June 2000. (BRFSS is the acronym for Behavioral Risk Factor Surveillance System.)

BRFSS 1997 (citation followed by table number): Centers for Disease Control and Prevention, *1997 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1997) [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pdf/97prvrpt.pdf, accessed 16 June 2000.

BRFSS 1992 to 1994: Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention," *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107.

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

NCSL: National Conference of State Legislatures, unpublished data, 1999. EXPLANATION: The Health Policy Tracking Service (HPTS) at the National Conference of State Legislatures collected the information from September through December 1999. The information is current as of January 1, 2000. The data were collected by various means including: searching HPTS' databases of state legislation, reviewing information published on-line by state Medicaid agencies and contacting key staff in the state agencies and legislatures.

U.S. Bureau of the Census: U.S. Bureau of Labor Statistics and U.S. Bureau of the Census, *Current Population Survey, March 1997 and March 1998 Supplements* (Washington, D.C.: U.S. Bureau of the Census, 1997, 1998) (databases) (unpublished data analyses by The Lewin Group). To compensate for small size, The Lewin Group combined the applicable data from the two supplements and averaged them to arrive at more reliable estimates.

DEFINITIONS: Unless otherwise indicated, the following definitions apply throughout the *Report Card*:

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

"Stroke" and **"Cerebrovascular Disease"** are used interchangeably in the *Report Card*, and refer to the same ICD-9 codes (430-438). "Stroke" is used in accordance with the definition of the American Heart Association. American Heart Association, *1999 Heart and Stroke Statistical Update* (Dallas: American Heart Association, 1998).

Women's Access to Health Care Services

Eligibility and Outreach for Publicly Funded Health Insurance

STATUS INDICATOR: Women Without Health Insurance (%), 1998. BRFSS 1998, 17. EXPLANATION: This measure includes women age 18 to 64 in the non-institutionalized civilian population who report that they do not have health insurance. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

POLICY INDICATOR: Medicaid Income Eligibility Expansions
(a) Pregnant Women Medicaid Eligibility Incomes (% FPL), 1999. NCSL. Information was updated for certain states in conversations during March 2000. *California:* Jeanette Lopez, Access for Infants and Mothers; *Hawaii:* Med Quest representative; *Mississippi:* Catherine Berry, Economic Assistance; *Nevada:* Shirley Allison, Nevada State Welfare Division; *New Hampshire:* Mickey Grimes, Department of Health and Human Services; *New York:* William Armstrong, New York Department of Health.

(b) Single Parents Medicaid Eligibility Incomes (% FPL), 2000. Guyer, Jocelyn and others, Center on Budget and Policy Priorities, *Employed but Not Insured* (Washington, D.C.: Center on Budget and Policy Priorities, 1999). Data were updated in conversation with Matthew Broaddus, Center on Budget and Policy Priorities, March 2000. Earning threshold data are current as of November 1999. The poverty level is for FY 2000.

(c) Aged and Disabled Medicaid Eligibility Incomes (% FPL), 1999. Families USA, "1999 Medicaid Eligibility Guidelines for Individual Seniors," in *Expanding Medicaid: State Options* (Washington, D.C.: Families USA, 1999). EXPLANATION: To obtain the eligibility levels as a percentage of the federal poverty level for this indicator, the highest figure included for each state, except for Alaska and Hawaii, is divided by the federal poverty guideline for 1999 ($687 a month). The 1999 federal poverty guidelines for Alaska and Hawaii are $860 and $791, respectively. "Aged" is defined as 65 or older and "disability" is defined as "a physical or mental impairment that keeps a person from performing any 'substantial' work, and is expected to last 12 months or result in death." 42 U.S.C. §§ 1396d(a)(iii), 1396d(a)(viii).

POLICY INDICATOR: Methods to Expand Medicaid Coverage and Outreach
(a) 100-Hour Rule for Two-Parent Families, 2000. State Policy Documentation Project, "Table 7: Treatment of Two-Parent Families Under Medicaid," 16 February 2000 [Online]; Available: WWW URL: http://www.spdp.org/medicaid/table_7.htm, accessed 12 May 2000.

(b) Presumptive Eligibility for Pregnant Women, 1997. National Conference of State Legislatures (NCSL), Table 3-14, "Strategies to Streamline Eligibility," in *Medicaid Survival Kit* (Washington, D.C.: NCSL, 1999). District of Columbia data are from the District of Columbia Department of Health and Human Services, Income Maintenance Administration, *District of Columbia Medicaid Manual, Part IV: Non-Financial Eligibility Requirements* (Washington, D.C.: District of Columbia Department of Health and Human Services, February 2000), Sec. 6.1, Pt. IV.

(c) Joint Parent/Child Simplified Mail-in Application, 1999. Memorandum from Laura Cox, Center on Budget and Policy Priorities, 5 October 1999. EXPLANATION: The *Report Card* does not consider states to have the policy if they allow simplified mail-in applications for children but do not allow parents to apply jointly with their children.

(d) Assets Test for Parents, 2000. State Policy Documentation Project, "Table 6: States' Asset Rules Under the Medicaid Family Coverage Category and TANF," 16 February 2000 [Online]; Available: WWW URL: http://www.spdp.org/medicaid/table_6.htm, accessed 15 May 2000.

POLICY INDICATOR: Other State Insurance for Adults, 2000. Families USA, "State Programs to Provide Health Coverage to Adults Without Regard to Disability," unpublished data, January 2000; NCSL. *Connecticut:* Conversation with Jocelyn Watrous, Connecticut Department of Social Services, 23 February 2000; Connecticut Department of Social Services, *Questions and Answers about State-Administered General Assistance* (SAGA), Pub. No. 97-1 (Hartford: Connecticut Department of Social Services, July 1998). *Kansas:* Information about Kansas General Assistance levels were obtained in conversation with Barbara Silliman, Kansas Medical Assistance Eligibility Department, 17 February 2000. *Utah:* Division of Health Care Financing, State of Utah Department of Health, *UMAP: Utah Medical Assistance Program* (Salt Lake City: Bureau of Eligibility Services, 1998). *Wisconsin:* Wisconsin Department of Health and Family Services, "Eligibility: Wisconsin BadgerCare," undated [Online]; Available: WWW URL: http://www.dhfs.state.wi.us/badgercare/html/eligrequire.htm, accessed 29 June 2000; "HIRSP: Wisconsin Health Insurance Risk," undated [Online]; Available: WWW URL: http://www.dhfs.state.wi.us/hirsp/coverage/coverage2.htm, accessed 29 June 2000. *District of Columbia:* Conversation with Linda Flowers, District of Columbia's Medical Assistance Administration, 17 February 2000.

Overcoming Barriers to Health Care Beyond Insurance Coverage

STATUS INDICATOR: People in "Medically Underserved Areas" (%), 1998. American Association of Retired Persons (AARP), *Reforming the Health Care System: State Profiles, 1999* (Washington, D.C.: AARP, 1999). EXPLANATION: The term "underserved" was developed by the Division of Shortage Designation within the U.S. Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, and indicates a population-to-practitioner ratio of greater than 2,000:1. The measure applies to both women and men, and assumes that in states where there are fewer practicing primary care physicians, there is reduced access to primary care services. "Practitioner" or "primary care physician" here means all allopathic (M.D.) or osteopathic (D.O.) practitioners who provide primary care services, and does not focus on their discipline or specialty. The measure is calculated based on Bureau of Primary Health Care data adjusted by the U.S. Bureau of the Census, Population Estimates.

POLICY INDICATOR: Safety Net Services

(a) State Funding of Comprehensive Primary Medical Care Practice Programs, 1995. Sara Rosenbaum and others, "State Funding of Comprehensive Primary Medical Care Service Programs for Medically Underserved Populations," *American Journal of Public Health 88* (March 1998), 357-363. EXPLANATION: "Comprehensive primary medical care practice" is defined as follows: "the practice provides not only preventive services but also on-site medical diagnostic treatment for which the services of a licensed medical care practitioner are required; the practice operates under the medical direction of a physician (who need not be on site on a full-time basis); the practice offers 24-hour medical care coverage on a 7-days-per-week basis; and the practice either employs or contracts with physicians who have the capacity to provide medical treatment and to refer or admit patients to a hospital in order to provide or oversee inpatient treatment." *Ibid.*, 358. The indicator measures only whether a state funds the *operation* of comprehensive primary medical care practice programs (which means funding both the implementation of the program and subsidizing the cost of running it) rather than whether a state funds merely the *development* of such programs because the former better reflects a state's commitment to this issue. Conversation with Sara Rosenbaum, November 1999.

(b) Medicaid Reimbursement for Federally Qualified Health Centers (FQHCs), 2000. National Association of Community Health Centers (NACHC), *Health Centers and the BBA: A Mixed Review on State Efforts; A Federal Call to Action* (Washington, D.C.: NACHC, 21 December 1999). Data were updated in conversations with Heather Mizeur, NACHC, June 2000, and are current through June 2000. EXPLANATION: FQHCs offer primary and preventive care, dental care, auxiliary services (x-rays, lab test, pharmacy services), health education, transportation, translation, and prenatal services to the medically underserved. In addition, they link patients to welfare, Medicaid, substance abuse treatment, and other related services. Under 1999 changes to the Balanced Budget Act of 1997 (BBA), 42 U.S.C. § 1396a(a)(13)(C)(i), the current phase-out plan is as follows: the federal mandate for cost-based reimbursement is reduced to 95 percent for FY 2000 through FY 2002, 90 percent for FY 2003, 85 percent for FY 2004, and 50 percent for FY 2005-2006, after which time states decide at what level they will reimburse FQHCs with no more minimal federal protection. This indicator measures only what states have chosen to do in the first year of implementation of the BBA, when they can choose to pay five percent more in reimbursement than the law requires. Administrative agreements are generally in the form of letters from the state Medicaid Director stating that the Medicaid agency intends to continue full reimbursement, but since they are not binding contracts, the Medicaid agency legally may discontinue full reimbursement. Conversation with Heather Mizeur, NACHC, 2 March 2000.

POLICY INDICATOR: Family and Medical Support
(a) Family and Medical Leave, 1999. National Partnership for Women and Families, "Work & Family: State Family Leave Laws That Are More Expansive than the Federal Family and Medical Leave Act," 25 March 1999 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/statelaw.htm, accessed 21 September 1999. EXPLANATION: The following are ways that this source measures state expansions upon the FMLA: (1) States that have comprehensive or less than comprehensive family and medical leave laws that apply to employers for fewer than 50 employees; (2) states that allow leave for participation in children's educational activities; (3) states that require leave for family medical needs not covered by the federal law; (4) states that use a more expansive definition of a "family member" whose illness may justify leave; and (5) states that provide longer periods of family and medical leave. While there are some states that specifically provide additional family or medical leave benefits to their state employees, the state indicator measures only those states with laws applying to private sector *and* state employees.

(b) Temporary Disability Insurance, 1999. National Partnership for Women and Families, "Chart: Temporary Disability Insurance Policies," 23 November 1999 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/tdichart.htm, accessed 16 June 2000. Data are current through 1999 per conversation with Sandhya Subramanian, National Partnership for Women and Families, June 2000.

POLICY INDICATOR: Patients' Protections in Managed Care
(a) Direct Access to Obstetric, Gynecologic and Reproductive Health Services, 1999. Kaiser Family Foundation, *State Policies on Access to Gynecological Care and Contraception* (Washington, D.C.: Kaiser Family Foundation, November 1999).

(b) Continuity of Care, 1999. Families USA Foundation, "State Managed Care Patient Protections," October 1999. Data clarified through facsimiles from Danielle Neal, Families USA, 7 February 2000. Protections listed were enacted as of 20 September 1999; NCSL. EXPLANATION: Optimally, managed care companies would be required to cover continued care with the provider for pregnant women regardless of when during the pregnancy the services began. However, the *Report Card* treats states that require continued coverage if services begin in the second trimester as having the policy discussed, since this coverage is an important first step.

(c) Clinical Trials, 2000. Society for Women's Health Research, unpublished data, March 2000. EXPLANATION: Georgia requires private insurers to cover clinical trials only for children under age 19.

(d) External Review, 1999. Families USA Foundation, "State Managed Care Patient Protections," October 1999. Protections listed were enacted as of September 30, 1999. EXPLANATION: The *Report Card* does not consider Arizona, Delaware, Kentucky, and North Carolina as having external review procedures, because their reviews are only for limited circumstances or because they allow any providers, including those employed by the managed care plan, to be panel reviewers.

POLICY INDICATOR: Linguistic Access, 1997. Jane Perkins and others, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* National Health Law Program (NHeLP) (Los Angeles: Kaiser Family Foundation, 1998). Categorized with the assistance of Jane Perkins. Considerations included level of specific guidance provided by state, variety of settings included, general statements endorsing goal of linguistic access and mandatory or optional nature of statutes and regulations. Sources reviewed included administrative regulations regarding hearings on Medicaid and Medicare eligibility.

Methods to Improve Access to Specific Health Services

STATUS INDICATOR: First Trimester Prenatal Care (%), 1996. *National Vital Statistics Report* 47 (7 October 1998), Table 9. EXPLANATION: This measure is the percentage of mothers who reported on their child's birth certificate that they received prenatal care in the first trimester of pregnancy. The Healthy People 2010 Objective 16-6a is to increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.

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

POLICY INDICATOR: Pharmaceutical Coverage

(a) Medicaid Prescription Number Limits, 1998. National Pharmaceutical Council (NPC), *Pharmaceuticals Benefits Under State Medical Assistance Programs* (Reston: NPC, 1998), 4-42.

(b) Medicaid Prescription Co-payments ($), 1998. National Pharmaceutical Council (NPC), *Pharmaceuticals Benefits Under State Medical Assistance Programs* (Reston: NPC, 1998), 4-45. EXPLANATION: In both Arizona and Tennessee, individual managed care and pharmacy benefit management organizations make decisions, within federal and state guidelines, about the amount of co-payments. Arizona has no co-payments for generic drugs (or brand-name drugs when no generic drugs are available), but allows the organization to charge co-payments (amount not specified) when the consumer chooses brand names. Conversation with Brian Brown, Health Program Manager, Arizona Medicaid Office, 15 June 2000. Tennessee does not allow co-payments for people with incomes under 100 percent of FPL, and allows organizations to charge co-payments based on a sliding scale for people over 100 percent of FPL. NPC, Tennesssee-2. Accordingly, both Arizona and Tennessee are listed in the *Report Card* as states with co-payments of two dollars or less.

(c) Non-Medicaid Pharmaceutical Programs, 2000. David Gross and Sharon Bee, *State Pharmacy Assistance Programs* (Washington, D.C.: AARP, April 1999); National Conference of State Legislatures, "State Senior Pharmaceutical Assistance Programs," 9 June 2000 [Online]; Available: WWW URL: http://www.ncsl.org/programs/health/drugaid.htm, accessed 15 June 2000.

(d) HIV/AIDS: AIDS Drug Assistance Programs (ADAP) (% FPL), 2000. Arnold Doyle and Richard Jefferys, *National ADAP Monitoring Project: Annual Report* (New York: National Alliance of State and Territorial AIDS Directors and AIDS Treatment Data Network, 2000). EXPLANATION: Montana's ADAP program is "need based," but all of the recipients are below 200 percent of FPL. Utah's ADAP eligibility is determined by a sliding scale, but it is categorized at 250 percent of FPL since that is the point at which the co-payment becomes burdensome for low-income people.

POLICY INDICATOR: Long-Term Care

(a) Paid Ombudsman Program Staff, FY 1998. Administration on Aging, "1998 National Ombudsman Reporting System Data Tables, Table A-1: Selected Information by State," [Online]; Available: WWW URL: http://www.aoa.ltcombusdman/98hors/default.htm, accessed 14 June 2000. EXPLANATION: The ratio of paid ombudsman program staff (funded by state, regional, and local governments; the state has some oversight responsibility of the regional and local programs) to the number of beds in all facilities is obtained by comparing the number of paid ombudsman program staff (not including clerical staff, see Table A-8, "Staff and Volunteers for FY 1998") to the number of beds in all facilities (licensed nursing facilities, and licensed board and care and similar facilities). Although states may have an effective volunteer ombudsmen corps, the IOM report determined that the appropriate measure involved *paid* ombudsmen. The number used in the *Report Card* is for full-time equivalents (FTEs), i.e., not all of the ombudsmen serve this role in a full-time capacity.

(b) Spousal Impoverishment, 2000. Eric M. Carlson, "Appendices, Section 7.401 State-Specific Chart of Resource and Income Allowances, and Average Monthly Private Pay Rates," in *Long-Term Advocacy* (Los Angeles: Matthew Bender, 1999), 7-133 to 7-135. Data were updated in correspondence with Eric M. Carlson, May 2000. EXPLANATION: For the "community spouse resource allowance," states must allow the community spouse to retain the greater of: (1) a minimum of $16,824 and a maximum of $84,120 in assets or (2) half the couple's joint assets up to $84,120. For the "income allowance," the community spouse can retain his or her own income, but also has the right to retain some or all of the resident's income, according to the state-established Minimum Monthly Maintenance Needs Allowance (MMMNA) that, according to federal law, must be at least $1,407 and no more than $2,103. Hawaii and Alaska are set higher because of a higher poverty level. Carlson, 7-44; 42 U.S.C. § 1396r-5(d); *Federal Register* 65 (15 February 2000), 7555.

(c) Home and Community-Based Care (number per 1,000, age 18 and over) 1997, Data Inflated for 1998. The Lewin Group (Steven Lutzky) provided in February 2000 an unpublished analysis of HCFA Form 372 data, U.S. Census Bureau data and data provided by Charlene Harrington at the University of California, San Francisco. EXPLANATION: "Home and Community-Based Services" (HCBS) and "Home and Community-Based Care" (HCBC) are often used interchangeably to refer generally to services provided in the home and the community. However, the home and community based HCB "waiver" program specifically refers to the Medicaid waiver program under section 1915(c) of the Social Security Act (42 U.S.C. Ch. 7) and is narrower than home and community-based care generally. The indicator includes both these 1915(c) "waiver" programs and "personal care" programs, but not "home health" because home health can address more acute than long-term care needs. Because Lewin had only 1997 data for 1915(c) waiver recipients and 1998 data for Personal Care Option recipients, Lewin inflated 1997 waiver recipients to 1998 using state-specific assumptions. Lewin did not analyze Arizona data. Lewin also addressed duplication across the programs using information from the Waiver Application form as well as information gathered directly from the state so that, for example, people who receive HCB services through two programs are only counted once.

POLICY INDICATOR: Mental Health

(a) Mental Health Parity, 1999. National Mental Health Association (NMHA), *What Have States Done to Pass Parity?* (Washington, D.C.: NMHA, 1999); D.C. Code §§ 35-2302,

35-2304 and 35-2305, as analyzed in consultation with Jennifer Heffron, NMHA, 16 June 2000. EXPLANATION: Missouri is considered to be in the limited category because the law requires insurers to cover mental health services only after a person spends a certain amount out of pocket.

(b) Eating Disorder Parity, 1999. National Mental Health Association (NMHA), *What Have States Done to Pass Parity?* (Washington, D.C.: NMHA, 1999); D.C. Code §§ 35-2302, 35-2304 and 35-2305. Data were analyzed in consultation with Jennifer Heffron, NMHA, January and June 2000.

(c) Depression Parity, 1999. National Mental Health Association (NMHA), *What Have States Done to Pass Parity?* (Washington, D.C.: NMHA, 1999); D.C. Code §§ 35-2302, 35-2304 and 35-2305. Data were analyzed in consultation with Jennifer Heffron, NMHA, January and June 2000.

POLICY INDICATOR: Diabetes Supplies and Education, 1999.
American Diabetes Association, "States That Have Enacted Diabetes Insurance Coverage," undated [Online]; Available: WWW URL: http://www.diabetes.org/advocacy/states.asp, accessed 13 April 2000. Data about required offering of coverage were obtained from NCSL.

POLICY INDICATOR: Health Services Related to Mastectomy
(a) Reconstructive Breast Surgery, 1999. NCSL.

(b) Hospital Stay After Mastectomy, 1999. NCSL.

POLICY INDICATOR: Family Planning
(a) Contraceptive Coverage, 2000. Alan Guttmacher Institute (AGI), *The Guttmacher Report on Public Policy* (Washington, D.C.: AGI, 1999), 11. Data were updated in conversation with Cynthia Dailard, AGI, 12 May 2000; NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000).

(b) Family Planning Medicaid Waiver, 1999. Alan Guttmacher Institute, unpublished data, 1999. EXPLANATION: Waivers expand coverage for women in one of the following categories: (1) women after postpartum period; (2) women losing Medicaid for any reason; and (3) women who meet specific income requirements. Eight states (Alabama (Mobile County only), Arizona, Florida, Maryland, Missouri, New York, Rhode Island, Washington) have applied for or have received waivers to extend coverage to women after the postpartum period. One state (Delaware) extends coverage to women losing Medicaid for any reason. Eight states (Alabama: 133 percent, Arkansas: 133 percent, California: 200 percent, Kentucky: 185 percent, New Mexico: 185 percent, Oregon: 185 percent, South Carolina: 185 percent, and Washington: 200 percent) extend coverage to women who meet the income requirements listed as percentage of FPL. The waivers for Alabama (income-based), California, Kentucky, Missouri and Washington were still pending as of September 1999.

POLICY INDICATOR: Maternity Stays/Infertility Treatment
(a) Maternity Stays, 1999. NCSL. EXPLANATION: Florida law states that an insurer cannot limit the amount of coverage for the length of the maternity stay. Indiana, Maine, and Virginia law follows guidelines set by the American College of Obstetricians and Gynecologists (ACOG), which state that the length of the maternal stay should be determined by the physician. Delaware has a resolution that requests that inpatient care decisions be made by the physician in consultation with the mother.

(b) Infertility Treatment, 1995. RESOLVE: The National Infertility Association, *Health Insurance Coverage of Infertility Treatment*, 1999 [Online]; Available: WWW URL: http://www.resolve.org/advstlaws.htm, accessed 10 March 2000.

POLICY INDICATOR: Abortion Access
(a) Clinic Access, 1999. Alan Guttmacher Institute (AGI), *The Status of Major Abortion-Related Policies in the States* (Washington, D.C.: AGI), 1999; NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000). EXPLANATION: Similar to FACE, Washington's law protects both those seeking and providing reproductive health services from physical attacks and the threats thereof, requires unimpeded entrance to and exit from health care facilities, and protects facilities from property damage. In addition, the Washington law has criminal penalties, allows victims to go into court to stop any actions forbidden by the law, and allows victims to sue the violators for monetary damages and attorneys' fees. Revised Code of Washington, §§ 9A.50.005 to 9A.50.902.

(b) Access to all Medically Accepted Abortion Procedures, 1999. NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000).

(c) Abortions without Parental Consent/Notification, 1999. NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000).

(d) Abortions without Waiting Periods, 1999. NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000).

(e) Public Funding for all Medically Necessary Abortions, 1999. NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000).

POLICY INDICATOR: Violence Against Women
(a) Health Care Provider Mandates for Domestic Violence Protocols, Training and Screening, 2000. Family Violence Prevention Fund, Chart, "State Statutes on Health Care and

Domestic Violence," February 3, 2000 (to be published in Family Violence Prevention Fund, *Health Care and Domestic Violence State-by-State Report Card*, forthcoming). This information is current as of January 2000 and does not reflect data from 2000 state legislative sessions. Conversation with Debbie Lee, Family Violence Prevention Fund, June 2000.

(b) Domestic Violence Discrimination Prohibitions in Insurance, 1999. Terry Fromson and Nancy Durburow, *Insurance Discrimination Against Victims of Domestic Violence* (Harrisburg: Pennsylvania Coalition Against Domestic Violence Publications, 1998, updated December 1999) (joint report by Pennsylvania Coalition Against Domestic Violence and the Women's Law Project). EXPLANATION: "Accident" on the update is the same as "disability," and "property and casualty" on the update is the same as property on the original chart. Conversation with Terry Fromson, Women's Law Project, January 2000.

(c) Sexual Assault Training for Health Care Providers and Police/Prosecutors, 1998. Neal Miller, *Review of State Sexual Assault Laws, 1998 Legislative Codes* (Alexandria: Institute for Law and Justice, 1999) [Online]; Available: WWW URL: http://www.ilj.org/sa/sexaltpr.htm, accessed 5 October 1999.

Addressing Wellness and Prevention

Screening

Status Indicator: Pap Smears (%), 1998 (race/ethnicity data on national table only 1992 to 1994). BRFSS 1998, 91; BRFSS 1992 to 1994. *California:* not included in the BRFSS 1998 summary report; California data are from Behavioral Risk Factor Surveillance System, "Prevalence Data: California—1998 Risk Factors and Calculated Variables," 15 May 2000 [Online]; Available: WWW URL: http://www2.cdc.gov/nccdphp/brfss/display.asp?cat=RF&yr=1998&qkey=4405&state=CA, accessed 5 June 2000. EXPLANATION: This measure includes women age 18 and over (national data by race/ethnicity, age 20 and over) in the non-institutionalized civilian population with a uterine cervix who reported that they have had a pap test within the past one to three years. To be consistent with the Healthy People 2000 goal, the data from the surveys were converted from the negative to the positive: "percentage of women who report that they did *not* have a Pap test within the past three years" to "percentage of women who report that they *did* have a Pap test within the past three years." *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. The Healthy People 2010 Objective 3-11 is to increase the proportion of women age 18 and over who received a Pap test within the preceding three years to 90 percent.

Policy Indicator: Pap Smears, 1999. NCSL.

Policy Indicator: Chlamydia Screening, 1999. Division of STD Prevention, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention, *STD Prevention Letter* No. 2, January 2000.

Status Indicator: Mammograms, (%), 1998 (race/ethnicity data on national table only 1993). BRFSS 1998, 75; BRFSS 1992 to 1994. *California:* not included in the BRFSS 1998 summary report, but obtained from Behavioral Risk Factor Surveillance System, "Prevalence Data: California—1998 Risk Factors and Calculated Variables," 15 May 2000 [Online]; Available: WWW URL: http://www2.cdc.gov/nccdphp/brfss/display.asp?cat= RF&yr=1998&qkey=4404&state=CA, accessed 5 June 2000. EXPLANATION: This measure includes women age 50 and over in the non-institutionalized civilian population who reported that they had a mammogram within the past two years. To be consistent with the Healthy People 2000 goal, the data from the surveys were converted from the negative to the positive: "percentage of women who report that they did *not* have a mammogram within the past two years" to "percentage of women who report that they *did* have a mammogram within the past two years." *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. The Healthy People 2010 Objective 3-13 is to increase the proportion of women age 40 and over who have had a mammogram within the past two years to 70 percent.

Policy Indicator: Mammograms, 1999. NCSL. *New Jersey:* Bureau of National Affairs, *Health Care Policy Report* 8 (17 January 2000), 104.

Policy Indicator: Osteoporosis Screening, 1999. NCSL. Data for this indicator were analyzed by Susan Davidson, National Osteoporosis Foundation, February 2000.

Status Indicator: Colorectal Cancer Screening (%), 1997 (race/ethnicity data on national table only 1993). BRFSS 1997, Table 25.1; BRFSS 1992 to 1994. EXPLANATION: This measure includes women age 50 and over in the non-institutionalized civilian population who reported ever having had a sigmoidoscopy. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. Healthy People 2010 Objective 3-12b is to increase the proportion of adults age 50 and over who have ever had a sigmoidoscopy to at least 50 percent.

Policy Indicator: Colorectal Cancer Screening, 1999. NCSL.

Prevention

Status Indicator: No Leisure-Time Physical Activity, (%), 1998. BRFSS 1998, 23. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized

civilian population who reported that they did not have any leisure-time physical activity during the past month. *National*: The national number is the median of all 50 states, the District of Columbia and Puerto Rico. The Healthy People 2010 Objective 22-1 is to reduce the proportion of adults who engage in no leisure-time physical activity to 20 percent.

Policy Indicator: Exercise (years), 1997. National Association for Sport and Physical Education (NASPE), *Shape of the Nation Report: A Survey of Physical Education Requirements* (Washington, D.C.: NASPE, 1997). Data for 1997 graduation requirements for certain states were updated in conversations between January and February 2000 with the states' departments of education. *Illinois:* Jim Johnson; *Massachusetts:* Susan Farb; *Minnesota:* Mary Lilibee; *Nebraska:* Jalane Hill; *New Jersey:* Linda Morese; *New Mexico:* Dr. William Owen Blair; *Pennsylvania:* John Emminger; *Rhode Island:* Steve Nardelli; *Wyoming:* Annette Bolling. *District of Columbia:* 1997 graduation requirements were obtained from conversation with Dr. Robinson, District of Columbia Public Schools, March 2000. EXPLANATION: The indicator focuses on the number of years, also counted as units, of physical education required for graduation in ninth through twelfth grades; these data allow for state-by-state comparison. This measure does not take into account states where school graduation requirements are decided by the local districts, nor does the measure differentiate among states that count health as P.E. or that allow for substitutions.

Status Indicator: Overweight (%), 1998 (race/ethnicity data on national table only 1992 to 1994). BRFSS 1998, 44; BRFSS 1992 to 1994. EXPLANATION: This measure includes women age 18 and over who have a body mass index (BMI) of 27.3 or greater. Body mass index is a measure that adjusts body weight for height. It is calculated as weight in kilograms divided by height in meters squared. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. The Healthy People 2010 Objective 19-2 is to reduce the proportion of adults (age 20 and over) who are obese (defined as having a BMI of 30 or more) to 15 percent.

Status Indicator: Eating Five Fruits and Vegetables A Day (%), 1998 (race/ethnicity data on national table only 1992 and 1994). BRFSS 1998, 32; BRFSS 1992 to 1994 EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who reported that they eat five or more servings of fruits and vegetables each day. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. To be consistent with the Healthy People 2000 goal, the data from the BRFSS are converted from the negative to the positive: "percentage of women who report that they did *not* eat five or more servings of fruits and vegetables each day" to "percentage of women who report that they *did* eat five or more servings of fruits and vegetables each day."

Policy Indicator: Nutrition

(a) Food Stamps Outreach, FY 1999. *Food Research and Action Center (FRAC), Food Research and Action Center Special Analysis: A Guide to Food Stamp Outreach* (Washington, D.C.: FRAC, 2000).

(b) Nutrition Education, 2000. U.S. Department of Agriculture (USDA), Food and Nutrition Service, Food Stamp Program, "Food Stamp Nutrition Education State Financial Expenditures," 1999. Data were updated in conversation with Alice Lockett, U.S. Department of Agriculture, March 2000 and are current through 2000.

Status Indicator: Smoking (%), 1998 (race/ethnicity data on national table only 1992 to 1994). BRFSS 1998, 41; BRFSS 1992 to 1994. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who report ever smoking 100 cigarettes in their lifetime and reported smoking every day or some days. *National*: The national number is the median of all 50 states, the District of Columbia and Puerto Rico. The Healthy People 2010 Objective 27-1a is to reduce to no more than 12 percent the number of adults (age 18 and over) who smoke cigarettes.

Policy Indicator: Smoking

(a) Medicaid Smoking Cessation Treatment Coverage, 1998. Helen Halpin Schauffler and others, *Medicaid Coverage for Tobacco Dependence Treatments* (Princeton: Robert Wood Johnson Foundation, 7 December 1999). EXPLANATION: If a state covers any one of the possible treatments under a category, the *Report Card* considers the state to cover that category, as one form of treatment within a category is not necessarily better than another (e.g., patch versus gum or individual versus group counseling). Virginia did not participate in the data collection survey, so it is not included in this indicator.

(b) Sales Rate to Minors (%), FY 1999. Center for Substance Abuse and Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "State Non-Compliance Rate Change Analysis Table, FFY 1997-1999," undated [Online]; Available: WWW URL: http://www.samhsa.gov/csap/SYNAR/97-99RATES-2.htm, accessed 20 May 2000. EXPLANATION: Louisiana's FY 1999 sales rate is 20.30 percent, but the federal government counts Louisiana among the 21 states that have reached the 20 percent compliance goal set by the Synar Amendment.

(c) Laws Restricting Indoor Smoking (Environmental Tobacco Smoke), 1999. Cassandra Welch, ed., *State Legislated Actions on Tobacco Issues* (Washington, D.C.: American Lung Association, 1999). Data for Maine and Arizona were updated in conversation with Cassandra Welch, March 2000. Data for South Carolina and South Dakota were clarified in conversation with Cassandra Welch, April 2000. EXPLANATION: The complete list of places of public access included in this

indicator are: arts/cultural facilities, elevators, gyms/arenas, jury/courtrooms, public meetings, public transit, restrooms, retail/grocery stores, and shopping centers. "Comprehensive" means that the state prohibits smoking in all of the areas and any designated smoking areas must be separately enclosed and ventilated to the outside. "Extensive" means that the state prohibits smoking in day care centers and schools, requires restrictions in restaurants, and in general prohibits or restricts smoking in public areas. "Moderate" means that the state prohibits or restricts smoking in schools, and the state has more than a minimal number of restrictions in public places. "Minimal" means that the state has no complete prohibition of smoking in any of the areas. "None" means that there are no restrictions on smoking in any of the areas.

(d) Smoking Excise Tax ($), 1999. Cassandra Welch, ed., "Appendix D: States Cigarette Excise Tax, 1999," in *State Legislated Actions on Tobacco Issues* (Washington, D.C.: American Lung Association, 1999).

Status Indicator: Binge Drinking (%), 1997. BRFSS 1997, Table 20.2. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who reported having five or more drinks on at least one occasion in the last month. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

Policy Indicator: Diabetes Control Programs, 1999. *Data about Comprehensive and Core Capacity Programs from the Centers for Disease Control and Prevention*, undated [Online]; Available: WWW URL: http://www.cdc.gov/diabetes/projs/assist.htm, accessed 5 October 1999. Data about state-supplemented funding were obtained from Dara Murphy, Program Services Branch, Diabetes Control Program, Centers for Disease Control and Prevention, 21 October 1999.

Policy Indicator: Arthritis Programs, FY 1999. Arthritis Foundation. *NAAP State Funding*, unpublished data, 15 October 1999. Conversation with Joe Sniezek, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 11 November 1999.

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

Policy Indicator: Sexuality and STD/HIV Education in Public Schools

(a) Sexuality Education, 1999. NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000).

(b) STD/HIV Education, 1999. NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000).

Key Health Conditions, Diseases and Causes of Death

Key Causes of Death

Status Indicator: Heart Disease (rate per 100,000 women), 1995-1997. NCHS. EXPLANATION: The heart disease death rates for women are three-year averages, per 100,000 estimated population. Death rates are calculated by dividing the number of deaths in 1995-1997 in the population by the midyear 1996 resident population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 1940 standard population. The Healthy People 2010 Objective 12-1 is to reduce coronary heart disease deaths to no more than 166 per 100,000 people.

Status Indicator: Stroke (rate per 100,000 women), 1995-1997. NCHS. EXPLANATION: death rates for women are three-year averages, per 100,000 estimated population. Death rates are calculated by dividing the number of deaths in 1995-1997 in the population by the midyear 1996 resident population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 1940 standard population. The Healthy People 2010 Objective 12-7 is to reduce stroke deaths to no more than 48 deaths per 100,000 people.

Status Indicator: Lung Cancer (rate per 100,000 women), 1995-1997. NCHS. EXPLANATION: Lung cancer includes malignant neoplasms of the trachea, bronchus and lung. Lung cancer death rates for women are three-year averages, per 100,000 estimated population. Death rates are calculated by dividing the number of deaths in 1995-1997 in the population by the midyear 1996 resident population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 1940 standard population. The Healthy People 2010 Objective 3-2 is to reduce the lung cancer death rate to no more than 44.8 deaths per 100,000 people.

Status Indicator: Breast Cancer (rate per 100,000 women), 1995-1997. NCHS. EXPLANATION: Breast cancer death rates for women are three-year averages, per 100,000 estimated population. Death rates are calculated by dividing the number of deaths in 1995-1997 in the population by the midyear 1996 resident population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 1940 standard population. The Healthy People 2010 Objective 3-3 is to reduce the breast cancer death rate to no more than 22.2 deaths per 100,000 females.

Chronic Conditions

Status Indicator: High Blood Pressure (%), 1997. BRFSS 1997, Table 8.2. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who reported having ever been told by a health care professional that they have high blood pressure. *National*: The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

Status Indicator: Diabetes (%), 1998 (race/ethnicity on national table only 1992 to 1994). BRFSS 1998, 20; BRFSS 1992 to 1994. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who reported ever being told by a doctor that they have diabetes. In the *Report Card*, the Healthy People 2000 goal was converted to a percentage (e.g., 25 per 1,000 was converted to 2.5 percent) in order to grade this indicator. *National*: The national number is the median of all 50 states, the District of Columbia and Puerto Rico. The Healthy People 2010 Objective 5-3 is to reduce the overall rate of diabetes that is clinically diagnosed to no more than 25 cases per 1,000 people.

Status Indicator: AIDS (rate per 100,000 women), 1998. Centers for Disease Control and Prevention, "Figure 2: Female Adult/Adolescent Annual AIDS Rates per 100,000 Population for Cases Reported in 1998, United States," *HIV/AIDS Surveillance Report* 10(2) (1998), 12. EXPLANATION: This measure includes female adult/adolescent (age 13 and over) annual AIDS rates per 100,000 women, for cases reported in 1998. The Healthy People 2010 Objective 13-1 is to reduce AIDS among adolescents and adults to no more than one new case per 100,000 people.

Status Indicator: Arthritis (National Only) (%), 1989-1991. Centers for Disease Control and Prevention, "Prevalence and Impact of Arthritis Among Women—United States, 1989-1991," *Morbidity Mortality Weekly Report* 44 (5 May 1995), 329-334. EXPLANATION: This measure includes women age 15 and over in the non-institutionalized civilian population who self-reported having arthritis in the National Health Interview Survey during 1989-1991. This analysis uses the definition of arthritis, which includes arthritis and other rheumatic conditions, developed by the National Arthritis Data Workgroup. Only data for race and ethnicity are age-adjusted. Although more recent data are available from the 1997 National Health Interview Survey, the *Report Card* uses the older data because they, unlike the 1997 data, are analyzed by race, ethnicity and age.

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

Reproductive Health

Status Indicator: Chlamydia (%), 1998. Division of Sexually Transmitted Diseases and Prevention, *Sexually Transmitted Disease Surveillance 1998 Supplement: Chlamydia Prevalence Monitoring Project* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1999), 11. EXPLANATION: This measure includes females age 15 to 24 testing positive for chlamydia in family planning clinics. Data were obtained through routine screening of women at family planning clinics. The percentage of women testing positive was calculated by dividing the number of women testing positive for chlamydia by the total number of women tested for chlamydia. Not all states use the same tests, and test sensitivity varies. The denominator may contain multiple tests from the same individual if that person was tested more than once during a year. Data for Rhode Island were reported only for July to December of 1998. *National:* The national number is the median of all 50 states and the District of Columbia. The Healthy People 2010 Objective 25-1a is to reduce chlamydia infections among females age 15-24 tested in family planning clinics to no more than three percent.

Status Indicator: Unintended Pregnancy (National Only) (%), 1994. Stanley K. Henshaw, "Unintended Pregnancy in the United States," *Family Planning Perspectives* 30 (January/February 1998), 24-29, 46. EXPLANATION: This measure includes women age 15 to 44 who had an unintended pregnancy in 1994. Data from the 1995 National Survey of Family Growth (NSFG) and from other sources are used to provide estimates, for 1994, on the percentage of pregnancies that were unintended. The estimated proportion of women who have ever had an unintended pregnancy is calculated by first adding the number of women who had an unplanned birth to the number who had had an abortion, and then subtracting those who were counted twice because they had had both an unplanned birth and an abortion. The Healthy People 2010 Objective 9-1 for this indicator is to reduce the proportion of pregnancies that are unintended to 30 percent.

Status Indicator: Maternal Mortality (ratio per 100,000 live born infants), 1987-1996. Centers for Disease Control and Prevention, "State-Specific Maternal Mortality Among Black and White Women—United States, 1987-1996," *Morbidity and Mortality Weekly Report* 48 (18 June 1999), 492-496. EXPLANATION: Maternal Mortality data are from Centers for Disease Control and Prevention's National Center for Health Statistics, and have been aggregated to include data from 1987 through 1996. Aggregation is necessary to control for the unreliability of the small values. The Maternal Mortality ratio is not based on the total population, but rather on deaths per 100,000 live-born

infants. The Healthy People 2010 Objective 16-4 is to reduce the rate of maternal deaths to no more than 3.3 maternal deaths per 100,000 live births.

Mental Health

Status Indicator: Days Mental Health Was "Not Good" in Past 30 Days (%), 1998. BRFSS 1998, 8. EXPLANATION: This measure includes the mean number of days during the past 30 days that women age 18 and over in the non-institutionalized civilian population reported that their mental health was "not good." *National*: The national number is the median of the 50 states, the District of Columbia and Puerto Rico.

Violence Against Women

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

Living in A Healthy Community

Overall Health

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

Status Indicator: Days Activities Were Limited in Past 30 Days (%), 1998. BRFSS 1998, 11. EXPLANATION: This measure includes the mean number of days during the past 30 days that women in the non-institutionalized civilian population age 18 and over reported not being able to perform their usual activities due to poor physical or mental health. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

Status Indicator: Infant Mortality (rate per 1,000 live births), 1995. National Center for Health Statistics (NCHS), undated [Online]; Available: WWW URL: http://www.cdc.gov/nchs/data/lf33_95.pdf, accessed February 2000. EXPLANATION: This measure is the number of deaths occurring to infants under one year of age per 1,000 live births. Although more recent data from 1997 are available, the *Report Card* uses the 1995 data because they contain additional race categories for Hispanic and Unknown. The Healthy People 2010 Objective 16-1 is to reduce fetal and infant deaths to no more than 4.5 per 1,000 live births.

Economic Security and Education

Status Indicator: Poverty (%), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: The measure is based on total family income level, and includes all women age 18 and over who live in a household that is defined by the census as below the federal poverty level.

Status Indicator: Wage Gap (%), 1994-1996. Institute for Women's Policy Research, *The Status of Women in the States*, 2nd ed. (Washington, D.C.: Institute for Women's Policy Research, 1999), 42, 48. EXPLANATION: The wage gap is a term used to describe the difference of median annual income earned by women and by men. It is a ratio of the median earnings of women to those of men. The analysis in the cited report was based on data from the 1994-1997 Annual Demographics Files from the *Current Population Survey*, U.S. Bureau of the Census.

Status Indicator: High School Completion (%), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This indicator measures the percent of women over age 21 who have completed 12 years of education. In addition, information about the percentage of women who have 13 to15 years completed, and 16 or more years completed is also provided in the demographic profile for each state. These data were collected as "Level of School Completed/Degree Received" in the March 1997 and March 1998 *Current Population Survey*. Educational attainment applies only to progress in "regular" school. Such schools include

graded public, private, and parochial elementary and high schools (both junior and senior high), colleges, universities, and professional schools, whether day schools or night schools. Thus, regular schooling is that which may advance a person toward an elementary school certificate or high school diploma, or a college, university, or professional school degree. Schooling in other than regular schools is counted only if the credits obtained are regarded as transferable to a school in the regular school system. The indicator is graded based on the Healthy People 2010 Objective 7-1 to increase high school completion to 90 percent of people age 18 to 24. The objective is an educational attainment goal developed by the National Education Goals Panel in Washington, D.C. Though the data used in the Healthy People objective are different from the data the *Report Card* measures (all women over age 21), high school educational attainment rates for people age 18 to 24 and for women over age 21 are very similar. Research by the National Education Goals Panel suggests that this is because most high school (or 12 years of education) attainment is gained by age 24, largely unchanged by an individual's aging. This data similarity makes the Healthy People 2010 objective an appropriate benchmark for the broader population of women measured in the *Report Card*.

POLICY INDICATOR: Economic Security

(a) Child Support Pass-Through, 1999. Paula Roberts, *State Policy Re: Pass-through and Disregard of Current Month's Child Support Collected for Families Receiving TANF-Funded Cash Assistance* (Washington, D.C.: Center for Law and Social Policy, January 1999) [Online]; Available: WWW URL: http://www.clasp.org/pubs/childenforce/1999cht.htm, accessed 14 June 2000. EXPLANATION: The *Report Card* does not consider Iowa to have the pass-through policy because Iowa permits only families who received a pass-through before 1996 to continue to receive a pass-through until they are no longer receiving assistance. The *Report Card* categorizes West Virginia as having a pass-through even though it does not have pass-through provisions *per se*, since TANF grants are increased by up to $50 a month for those on whose behalf current support is collected.

(b) Child Support Collection (%), FY 1998. Administration for Children and Families, Office of Child Support Enforcement, Division of Policy and Planning, *Preliminary Data Report* (Washington, D.C.: U.S. Department of Health and Human Services, May 1999). EXPLANATION: The percentage of collection is determined by dividing the number of cases with some successful collection by the number of cases requiring collection. This method does not identify how the percentage of child support is actually collected in a particular "successful" collection. Contrary to the data in this source, North Carolina is placed in the middle category because accurate data are unavailable and because North Carolina's collection rates generally fall in the middle range. Washington is included in the first category—states collecting child support in at least 40 percent of their child support cases—because the collection rate of 37.9 percent was rounded up to 40 percent.

(c) State Supplement of SSI Grant, 2000. U.S. Social Security Administration, *A Desktop Guide to SSI Eligibility Requirements, SSI State Supplements*, SSA Publication No. 05-11001 (Washington, D.C.: Social Security Administration, January 2000) [Online]; Available: WWW URL: http://www.ssa.gov/pubs/11001.html, accessed 13 April 2000. EXPLANATION: "Aged" is defined as 65 or older. "Blindness" is defined as "corrected vision of 20/200 or less in better eye or field of vision less than 20 degrees." "Disability" is defined as "a physical or mental impairment that keeps a person from performing any 'substantial' work, and is expected to last 12 months or result in death." 42 U.S.C. §§ 1382c(a)(1), 1382c(a)(2), 1382c(a)(3). Delaware and Montana are categorized as not having supplements because supplements are available only to persons in "protective care" arrangements. In Delaware, protective care arrangements are for people "living in an approved adult residential care facility." In Montana, the facilities include: personal care facilities; group homes for the mentally disabled or mentally ill; community homes for the physically or developmentally disabled; child and adult foster care; and transitional living services for the developmentally disabled. U.S. Social Security Administration, *State Assistance Programs for SSI Recipients January 1999* (Washington, D.C.: Social Security Administration, July 1999), 19-20, 60-62 [Online]; Available: WWW URL: http://www.ssa.gov/statistics/ssi_sap/index.html, accessed 2 June 2000.

(d) Percentage of Income Paid in State and Local Taxes (%), 1995. Michael Ettinger and others, *Who Pays? A Distributional Analysis of the Tax Systems in All 50 States, Appendix I: Detailed State-by-State Tables* (Washington, D.C.: Citizens for Tax Justice and The Institute on Taxation & Economic Policy, 1996) [Online]; Available: WWW URL: http://www.ctj.org/, accessed 29 February 2000. EXPLANATION: Taxes are state and local taxes, and include sales, excise, property, and income taxes. Data look at the share of family income for non-elderly and married couples. Tax credits are included in the calculation of state income taxes. *Ibid.*, App. V, 2.

(e) Minimum Wage ($), 2000. U.S. Department of Labor, *Minimum Wage and Overtime Premium Pay Standards Applicable to Nonsupervisory Nonfarm Private Sector Employment Under State and Federal Laws* (Washington, D.C.: U.S. Department of Labor, 1 January 2000) [Online]; Available: WWW URL: http://www.census.gov/hhes/poverty/threshld/99prelim.html, accessed 19 January 2000. The estimates of weighted average poverty thresholds from 1999 are from the U.S. Department of Commerce, U.S. Bureau of the Census, *Poverty Thresholds, Preliminary Estimate of Weighted Average Poverty Thresholds for 1999*, 2 February 2000 [Online]; Available: WWW URL: http://www.census.gov/hhes/poverty/threshld/99prelim.html, accessed 1 June 2000. EXPLANATION: The U.S. Department of Labor data are current for all states through January 2000, and include some already determined state updates through 2001. The U.S. Census Bureau estimates that the poverty threshold in

1999 for a family of three is $13,290. This estimate is divided by 2080 (40 hours per week times 52 weeks per year) to obtain the $6.39 benchmark. This means that a person working full-time, year-round would need to earn $6.39 per hour for her family of three to reach the estimated poverty threshold for 1999.

Discrimination

POLICY INDICATOR: Discrimination

(a) Employment Discrimination and Sexual Orientation, 2000. Human Rights Campaign, "Non-Discrimination in the Workplace," undated [Online]; Available: WWW URL: http://www.hrc.org/issues/worknet/nd/, accessed 12 May 2000. Data for public employees were obtained in conversation with Daryl Herrshaft, Human Rights Campaign, 18 May 2000.

(b) Policy Indicator: Genetic Anti-Discrimination, 1999. National Human Genome Research Institute (NHGRI), National Institutes of Health. Unpublished data, 1999.

Gun Control

POLICY INDICATOR: Gun Control. Because Washington D.C. bans all handguns entirely, the *Report Card* considers it to have adopted each of the handgun policies below even though, technically, it did not adopt the specific requirements. For all components of this indicator, the sources are: Handgun Control [Online]; Available: WWW URL: http://www.handgun-control.org/facts/index.asp, accessed 20 December 1999. Data were updated in conversation with Joe Sudbay in January 2000, and are current as of January 2000. For the District of Columbia, see D.C. Code § 6-2301 et seq.

(a) Licensing/Permits and Waiting Periods, 2000.

(b) Safe Storage and Safety Locks, 2000.

(c) Concealed Weapon Prohibition, 2000. EXPLANATION: States that do not prohibit concealed weapons generally are divided into "may issue" and "shall issue," describing policies that allow more and less limited access, respectively.

Environment

POLICY INDICATOR: Environment

(a) Monitoring Potentially Environment-Related Diseases/Conditions, 1997. Centers for Disease Control and Prevention, "Monitoring Environmental Disease—United States, 1997," *Morbidity Mortality Weekly Report* 47 (3 July 1998), 522-525 [Online]; Available: WWW URL: http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00053687.htm, accessed 14 June 2000. Perri Zeitz and others, "1997 CSTE-CDC-ASPH Survey of Statewide Surveillance Systems of Sentinel Environmental Diseases: Status and Trends," Table A-1. Information available: WWW URL: http://www.cste.org/archive_may97.htm. EXPLANATION: States are evaluated based on whether they monitor the following diseases/conditions: (1) childhood and adult lead poisoning (counted only if both are monitored); (2) mercury poisoning; (3) pesticide poisoning; (4) carbon monoxide poisoning; (5) acute chemical poisoning; and (6) asthma.

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

Demographics

Total Population of Women (%), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure includes all females, all ages, in the civilian, non-institutionalized population as a percentage of the total state population.

Sex Ratio, 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure is the ratio of all women to all men, age 18 and over, in the civilian, non-institutionalized population.

Percentage and Number of Women by Race (%), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure includes all females, all ages, in the civilian, non-institutionalized population in the following categories: white (non-Hispanic), black (non-Hispanic), Native American/Alaskan Native (non-Hispanic), Asian/Pacific Islander (non-Hispanic), and Hispanic. Data are provided as a percentage of total women in the state. In the *Report Card*, the terms "African American" and "black" are used to describe all descendents of Africans living in the United States regardless of country of origin or immigrant status.

Percentage and Number of Women by Age (%), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure includes all females, all ages, in the civilian, non-institutionalized population (see definition of "institutionalized population" above) in the following categories: ages 0 to 14, 15 to 25, 26 to 44, 45 to 64, 65 to 84, 85 and over. Data provided as percentage of total women in the state.

Median Age of Women (years), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure includes the ages of all females in the civilian, non-institutionalized population. The median age divides the age distribution into two equal parts; half fall above the median and half fall below.

Households Headed by Single Women (%), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure includes female-headed families with children and no spouse present.

Median Earnings for Women ($), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure includes wages, salaries, self-employment income and farm income for women age 17 and over who reported full-time, full-year employment.

Women Who Have Completed Two Years Post-High School Education, 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure includes the percentage of women who have 13 to15 years of education completed. These data were collected as "Level of School Completed/Degree Received" in the March 1997 and March 1998 *Current Population Survey*. Educational attainment applies only to progress in "regular" school. Such schools include graded public, private, and parochial elementary and high schools (both junior and senior high), colleges, universities, and professional schools, whether day schools or night schools. Thus, regular schooling is that which may advance a person toward an elementary school certificate or high school diploma, or a college, university, or professional school degree. Schooling in other than regular schools is counted only if the credits obtained are regarded as transferable to a school in the regular school system.

Women Who Have Completed Four Years Post-High School Education, 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: This measure includes the percentage of women who have 16 or more years of education completed. These data were collected as "Level of School Completed/Degree Received" in the March 1997 and March 1998 *Current Population Survey*. Educational attainment applies only to progress in "regular" school. Such schools include graded public, private, and parochial elementary and high schools (both junior and senior high), colleges, universities, and professional schools, whether day schools or night schools. Thus, regular schooling is that which may advance a person toward an elementary school certificate or high school diploma, or a college, university, or professional school degree. Schooling in other than regular schools is counted only if the credits obtained are regarded as transferable to a school in the regular school system.

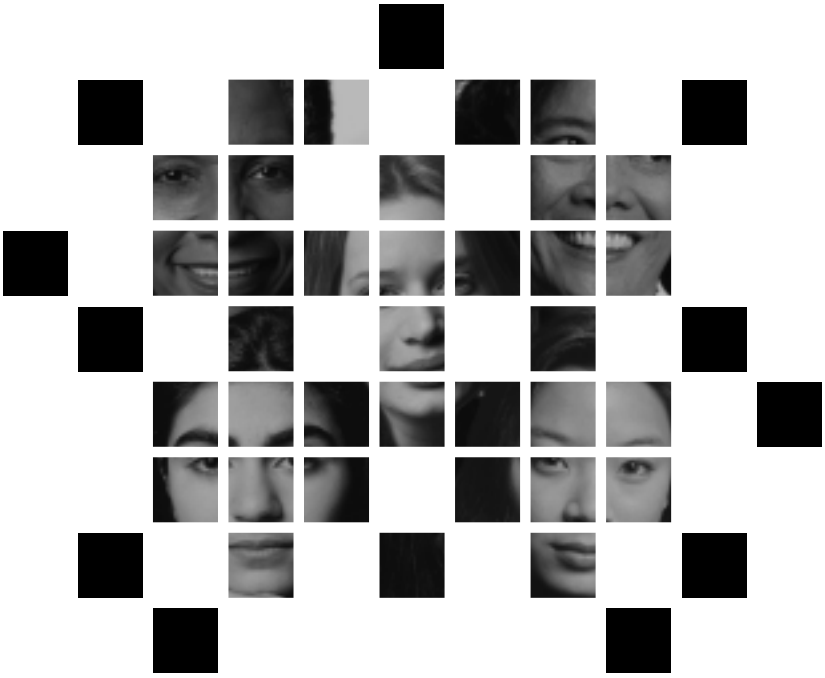
Women Prisoners (%), 1996. U.S. Bureau of Justice Statistics, *National Prisoner Statistics Data Series (NPS-1)* (Washington, D.C.: U.S. Bureau of Justice Statistics, 1998). EXPLANATION: This measure includes female prisoners age 18 and over under state jurisdiction (state and federal "Adult Correction Facilities") as of December 31, 1996 as a percentage of the state's female population age 18 and over.

Disabled Women Receiving Social Security (%), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: Women were assumed to be disabled if they were between the ages of 19 and 60 and received Social Security benefits, or if they were below the age of 65 and did not work because of a disability. The data are reported as a percentage of the state's total female population.

Women Residing in Urban Areas (%), 1997 and 1998. U.S. Bureau of the Census. EXPLANATION: The data include the number of women (all ages) residing in counties that are included in Metropolitan Statistical Areas (MSAs), 1990 Decennial Census. Four states (Alaska, Connecticut, New Jersey and Rhode Island) have 100 percent of their population included in an MSA because all of the counties in the state are located in an MSA. One hundred percent of the population of the District of Columbia lives in an MSA.

Women Living in Linguistic Isolation (%), 1990. U.S. Population Reference Bureau, *What the 1990 Census Tells Us About Women: A State Factbook* (Washington, D.C.: U.S. Population Reference Bureau, 1993). EXPLANATION: A person living in "linguistic isolation," as defined by the Census, is in a household in which no person 14 years or over speaks only English, and no person 14 years or over who speaks a language other than English speaks English "very well." All the members of a linguistically isolated household are tabulated as linguistically isolated. This measure includes all females in these households as a percentage of the total population of women age five and over in a state. The data in the report are from the 1990 U.S. Census.

Births Attended by Midwife (%), 1997. Centers for Disease Control and Prevention, National Center for Health Statistics, Table 2, "Trends in the Attendant, Place and Timing of Births, and in Use of Obstetric Interventions: United States, 1989-1997," *National Vital Statistics Reports* 47 (1999), 8. EXPLANATION: This measure includes the percentage of live births attended by a midwife using data reported on birth certificates. Although the percentage of birth records that contains missing information for the attendant is very small (less than one percent), there is some evidence that midwife-attended births are under-reported on the birth certificates. According to the results of the 1994 membership survey of the American College of Nurse Midwives, about six percent of midwives reported that they were not identified as the attendant at delivery for some births that they attended. L.V. Walsh and others, "Findings of the American College of Nurse-Midwives, Annual Membership Survey, 1993 and 1994," *Journal of Nurse Midwifery* 41 (1996), 230-235.



CHAPTER X

ENDNOTES

Endnotes for Main Text

[1] Deborah Lewis-Idema and others, *Health Care Access and Coverage for Women* (New York: The Commonwealth Fund, 1999), 4 (reporting that 14 percent of women nationally were uninsured in 1993, and 18 percent in 1998). Statistics on the national percentage of women who are uninsured may vary depending on data source. Differences in survey methodology (e.g., sample size, weighting, etc.) may yield different results.

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

[3] Medicaid National Summary Statistics, *Medicaid Recipients as a Percentage of Population by Sex* (Washington, D.C.: Health Care Financing Administration, 1998) [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/2082-10.htm, accessed 1 June 2000 (1996 figures).

[4] 42 U.S.C. §§ 1396-1396v; 42 C.F.R. Ch. IV; 45 C.F.R. Subtitle A; see also HCFA, *Medicaid Eligibility*, 2 August 1999 [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/meligib.htm, accessed 1 June 2000.

[5] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and Their Access to Health Care," May 2000 [Online]; Available: WWW URL: http://www.kff.org/content/2000/1420/pub%201420.pdf, accessed 27 June 2000. The Federal Poverty Level is the federal government's working definition of poverty that is used to set the income standard for Medicaid eligibility for certain categories of beneficiaries, and is updated every year. Kaiser Commission on Medicaid Basics, *Medicaid: A Primer* (Washington, D.C.: Kaiser Commission, 1999), 12.

[6] Because no state covers the aged and disabled at 200 percent of FPL, and because 100 percent of FPL is the highest level at which states have the option to cover aged and disabled individuals and still receive matching funds (42 C.F.R. § 435.120), the *Report Card* sets the benchmark at that level. Brian K. Gruen and others, *State Usage of Medicaid Coverage Options for Aged, Blind and Disabled People* (Washington, D.C.: The Urban Institute, 1999), 5-6.

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

[8] 42 C.F.R. § 435.904.

[9] 42 C.F.R. § 435.904.

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

[11] The *Report Card* uses 74 percent of FPL as a benchmark because the federal minimum income at which states must cover single parents under Medicaid varies among states. Federal Medicaid law requires states to cover the aged and

disabled who are eligible for Supplemental Security Income (SSI). 42 C.F.R. § 435.120. In 1998, the income threshold for SSI, and therefore for Medicaid coverage, was approximately 74 percent of FPL. This is the minimum standard adopted by the *Report Card*. "1998 Cost-of-Living Increase and Other Determinations," *Federal Register* 62 (1997), 58,762.

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

[13] One hundred percent of FPL is the highest income eligibility level at which states can get federal matching funds. The Omnibus Reconciliation Act of 1986, Pub. L. No. 99-509, § 9402, 100 Stat. 1874.

[14] 42 C.F.R. § 435.120; "1998 Cost-of-Living Increase and Other Determinations," *Federal Register* 62 (1997), 58,762.

[15] HCFA, *Supporting Families in Transition: A Guide to Expanding Health Coverage in Post-Welfare Reform* (Washington, D.C.: HFCA, 1999), 1. Although welfare reforms in 1996 ended welfare eligibility for some recipients, it allowed some of these individuals to maintain their Medicaid eligibility. However, Medicaid-eligible individuals who are not welfare beneficiaries are often erroneously denied participation in the program or are not aware that they remain Medicaid-eligible. Liz Schott and others, *Assuring That Eligible Families Receive Medicaid When TANF Assistance is Denied or Terminated* (Washington, D.C.: Center on Budget and Policy Priorities, 1998); Letter from Timothy Westmoreland, HCFA Director, to State Medicaid Directors, 7 April 2000 [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/smd40700.htm, accessed 15 June 2000 (urging states to identify individuals who have been terminated improperly and to reinstate them).

[16] HCFA, *Supporting Families in Transition: A Guide to Expanding Health Coverage in Post-Welfare Reform* (Washington, D.C.: HFCA, 1999), 7; Jocelyn Guyer and others, *Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents Through Medicaid* (Washington, D.C.: Center on Budget and Policy Priorities, 1998). The U.S. Department of Health and Human Services issued a regulation on 7 August 1998 eliminating this restriction that was a remnant of the old welfare system. "Medicaid and Title IX-E Programs; Revision to the Definition of an Unemployed Parent," *Federal Register* 63 (1998), 42270 (codified at 45 C.F.R. § 233.100).

[17] 42 U.S.C. § 1396r-1 (states may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period); see also HCFA, "Optional Coverage of Categorically Needy Groups," in *State Medicaid Manual* § 3500.2, 1997 [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/wrcvi.htm, accessed 1 June 2000.

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

[19] 42 U.S.C. § 1396u-1(b)(2)(c).

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

[21] Bureau of Primary Health Care, *Uniform Data System*, 1998 [Online]; Available: WWW URL: http://www.bphc.hrsa.gov/databases/mua/searchbk.cfm, accessed 14 June 2000.

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

[23] Sara Rosenbaum and others, "State Funding of Comprehensive Primary Medical Care Service Programs for Medically Underserved Populations," *American Journal of Public Health* 88 (March 1998), 357; Conversation with Heather Mizeur, National Association of Community Health Centers, February 2000; see also Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, D.C.: National Academy Press, 2000).

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

[25] Bureau of Primary Health Care, "Community Health Center Program," 1999; National Association of Community Health Centers, *Access to Community Health Care: A National and State Data Book* (Washington, D.C.: National Association of Community Health Centers, 1993), 7.

[26] 42 U.S.C. § 1396a(a)(13)(C)(i); National Association of Community Health Centers, Inc. (NACHC), *Health Centers and the BBA: A Mixed Review on State Efforts: A Federal Call to Action* (Washington, D.C.: NACHC, 1999); Letter from Sally K. Richardson, HCFA Director, to State Medicaid Directors, 23 October 1998 [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/bba10238.htm, accessed 9 June 2000.

[27] The Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 *et seq*., applies to businesses with 50 or more employees and requires them to allow workers to take up to 12 weeks of unpaid leave a year to care for a newborn, newly adopted child, seriously ill child, spouse, or parent, or to recover from their own serious health conditions; National Partnership for Women and Families, "Family Leave Initiative," 1998 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/initiativemain.htm, accessed 26 June 2000.

[28] National Partnership for Women and Families, "State Family-Leave Income Initiatives: Making Family Leave More Affordable," April 2000 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/flinsur.htm, accessed 1 June 2000.

[29] National Partnership for Women and Families, "State Family-Leave Income Initiatives: Making Family Leave More Affordable," April 2000 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/flinsur.htm, accessed 1 June 2000. Limitations include: women with disabilities arising from pregnancy or childbirth can receive TDI, but only through the period of maternal disability, not for any leave taken beyond that period. Furthermore, TDI does not cover leave to care for a newly adopted child, paternity leave, or leave to care for seriously ill family members. *Ibid.*

[30] The maximum benefits and maximum length of benefits vary among these five states. California leads the five with a maximum of 52 weeks per year allowed and a maximum amount of $490 per week. National Partnership for Women and Families, "Chart: State Temporary Disability Insurance Policies," 23 November 1999 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/tdichart.htm, accessed 1 June 2000.

[31] Deborah Lewis-Idema and others, *Health Care Access and Coverage for Women* (New York: The Commonwealth Fund, 1999), 13.

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

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

[34] *Healthy People 2010*, 16-28, 16-29.

[35] National Center for Health Statistics, *Healthy People 2000 Review, 1997* (Hyattsville: U.S. Public Health Service, 1997), Objective 14.11 (hereafter *"Healthy People 2000"*).

[36] NARAL and NARAL Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000), iii.

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

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

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

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

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

[42] Claudia Schlosberg and Sareena Jerath, National Health Law Program (NHeLP), "Fact Sheet: Prescription Drug Coverage Under Medicaid," July 1999 [Online]; Available: WWW URL: http://nhelp.org/pubs/19990808MedicaidDrugs.html, accessed 1 June 2000 (citing HCFA 2082 Data, 1997, Table 3, "Medicaid Recipients by Type of Service and By State: FY 1997").

[43] 42 U.S.C. §§ 1396a(a)(1)(A)(ii), 1396d(a)(6) to 1396d(a)(16), 1396d(a)(18); 42 C.F.R. §§ 436.300 to 436.330.

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

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

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

[47] Arnold Doyle and Richard Jeffreys, *The AIDS Drug Assistance Monitoring Project, Annual Report* (New York: Kaiser Family Foundation, 2000).

[48] "Long-term care" includes both nursing homes and services provided in the home or in the community. Such care can include various medical services and assistance with daily living activities (e.g., dressing, bathing, and eating) for people with chronic long-term conditions that reduce their ability to function independently. *All About Long-Term Care* (Washington, D.C.: Long-Term Care Campaign, 1998) [Online]; Available: WWW URL: http://www.ltccampaign.org/allabout/whatisltc.htm, accessed 1 June 2000.

[49] NCHS, National Nursing Home Survey, 1995 [Online]; Available: WWW URL: http://www.cdc.gov/nchs/datawh/statab/pubd/ad289tb1.htm, accessed 14 June 2000; NCHS, National Home and Hospice Care Survey, 1996 [Online]; Available: WWW URL: http://www.cdc.gov/nchs/datawh/statab/pubd/ad297tb5.htm, accessed 14 June 2000.

[50] Long-Term Care Campaign, *All About Long-Term Care* (Washington, D.C.: Long-Term Care Campaign, 1998) [Online]; Available: WWW URL: http://www.ltccampaign.org/allabout/whatisltc.htm, accessed 1 June 2000 (discussing limitations of Medicaid and private insurance coverage for long-term care).

[51] 42 U.S.C. § 3058g; Administration on Aging, "Long-Term Care Program," 28 April 1999 [Online]; Available: WWW URL: http://www.aoa.gov/factsheets/ombudsman.html, accessed 23 June 2000.

[52] Institute of Medicine, *Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act* (Washington, D.C.: National Academy Press, 1994), 175, Table 5.5d.

[53] Administration on Aging, *1998 National Ombudsman Report System Data Tables* (Washington, D.C.: Administration on Aging, 1999) [Online]; Available: WWW URL: http://aoa.gov/ltcombudsman/98nors/default.htm, accessed 1 June 2000.

[54] 42 U.S.C. § 1396r-5; Eric M. Carlson, *Long-Term Care Advocacy* (New York: Matthew Bender, 1999), 7-24 to 7-48.

[55] 42 C.F.R. §§ 440.180 to 440.181; 42 C.F.R. Pt. 441, Subpts. G and H; see also Enid Kassner and Lee Shirley, *Medicaid Financial Eligibility for Older People: State Variations in Access to Home and Community-based Waiver and Nursing Home Services* (Washington, D.C.: AARP, 2000).

[56] Lisa Alecxih and others, *The Efficacy of Using Home and Community-Based Care as an Alternative to Nursing Facility Care in Three States* (Washington, D.C.: AARP, 1996).

[57] A "mental disorder" is "a health condition marked by an alteration in thinking, mood, or behavior (or some combination thereof) that is associated with distress and/or impaired functioning." U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999), 227.

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

[59] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center

for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999), 426.

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

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

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

[63] M.F. Owings and L.J. Kozak, "Ambulatory and Inpatient Procedures in the United States, 1996," *Vital and Health Statistics* 13, No. 139 (Washington, D.C.: National Center for Health Statistics, 1998), 95.

[64] 143 Cong. Rec. E159-01 (5 February 1997) (Statement of Hon. Susan Molinari on the Women's Health and Cancer Rights Act of 1997).

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

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

[67] *Healthy People 2010*, 9-15.

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

[69] A federal bill, the Equity in Prescription Insurance and Contraceptive Coverage (EPICC) Act (H.R. 2120), is pending and would require any insurer that covers prescription drugs and devices to also cover FDA-approved prescription contraceptive drugs and devices. In addition, in 1998, a federal law was enacted that required all health insurance plans made available to federal employees to include coverage of prescription contraceptives if other prescription drugs are covered. Appropriations, 2000—Treasury, Postal Service, Executive Office of the President, and General Government, Pub. L. No. 106-58, § 635, 113 Stat. 430.

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

[71] Rachel Benson Gold, "State Efforts to Expand Medicaid-Funded Family Planning Show Promise," *The Guttmacher Report on Public Policy* 2 (April 1999), 8-11. Federal delays have meant that many state applications have not been processed, despite state commitment and efforts to secure approval. *Ibid.*

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

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

[74] 142 Cong. Rec. S9903-05 (5 September 1996) (Statement of Senator Bill Bradley on the Newborns' and Mothers' Health Protection Act of 1996).

[75] American Medical Association, Policy H-320.957, *AMA Policy: Women Physicians and Women's Health Issues*, 1999 [Online]; Available: WWW URL: http://www.ama-assn.org/mem-data/wmmed/policy/policy.htm, accessed 1 June 2000 (regarding length of hospital stay being determined by physician).

[76] A 1996 federal law, the Newborns' and Mothers' Health Protection Act of 1996, provides some protections for new mothers by requiring insurance companies and HMOs to cover 48-hour stays for vaginal deliveries, and 96-hour stays for cesareans. 29 U.S.C. § 1185, 42 U.S.C. §§ 300gg-4, 300gg-51.

[77] *Roe v. Wade,* 410 U.S. 113 (1973); NARAL and NARAL Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights,* 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000), iii.

[78] National Abortion Federation, *1999 Year-End Analysis of Trends of Violence and Disruption Against Reproductive Health Care Clinics* (Washington, D.C.: National Abortion Federation, January 2000); National Abortion Federation, "Chronology of Abortion-Related Murders and Shootings," undated [Online]; Available: WWW URL: http://www.prochoice.org/violence/shootchrono.html, accessed 5 June 2000; National Abortion Federation, "Incidents of Violence and Disruption Against Abortion Providers," 19 May 2000 [Online]; Available: WWW URL: http://www.prochoice.org/violence/extreme.htm, accessed 13 June 2000.

[79] National Abortion Federation, *1999 Year-End Analysis of Trends of Violence and Disruption Against Reproductive Health Care Clinics* (Washington, D.C.: National Abortion Federation, January 2000); National Abortion Federation, "Chronology of Abortion-Related Murders and Shootings," undated [Online]; Available: WWW URL: http://www.prochoice.org/violence/shootchrono.html, accessed 5 June 2000; National Abortion Federation, "Incidents of Violence and Disruption Against Abortion Providers," 19 May 2000 [Online]; Available: WWW URL: http://www.prochoice.org/violence/extreme.htm, accessed 13 June 2000.

[80] 18 U.S.C. § 2481; National Abortion Federation, "Background Information: Freedom of Access to Clinic Entrances Act," undated [Online]; Available: WWW URL: http://www.prochoice.org/violence/faceback.htm, accessed 1 June 2000.

[81] NARAL and NARAL Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000), vi; American Medical Association, Policy H-5.982, *AMA Policy: Late-Term Pregnancy Termination Techniques,* 1999 [Online]; Available: WWW URL: http://www.ama-assn.org/apps/pf_online/pf_online, accessed 13 June 2000.

[82] *Stenberg v. Carhart,* No. 99-830, 530 U.S. ___ (June 28, 2000).

[83] Some states also allow other adult relatives to give consent or receive notice. NARAL and NARAL Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights*, 9th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000), 240-241.

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

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

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

[87] 45 Cong. Rec. H12230, H12400, FY 2000 Consolidated Appropriations Act (H.R. 3424, Tit.V, §§ 508, 509).

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

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

[90] Terry Fromson and Nancy Durburow, *Insurance Discrimination Against Victims of Domestic Violence* (Harrisburg: Pennsylvania Coalition Against Domestic Violence Publications, 1998, updated December 1999), 1 (joint report by Pennsylvania Coalition Against Domestic Violence and the Women's Law Project). Studies in 1994 and 1995 indicated that approximately one out of four insurance companies engaged in these practices, and one study (Pennsylvania) reported that 74 percent of life insurers and 65 percent of health insurers used domestic violence as a criterion in review of new applications. *Ibid.* at 2.

[91] Terry Fromson and Nancy Durburow, *Insurance Discrimination Against Victims of Domestic Violence* (Harrisburg: Pennsylvania Coalition Against Domestic Violence Publications, 1998, updated December 1999), 3-4 (joint report by Pennsylvania Coalition Against Domestic Violence and the Women's Law Project).

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

[93] 42 U.S.C. §§ 1395l, 1395m, 1395x, 1395y (mammograms and Pap smears—Medicaid); 42 C.F.R. §§ 410.34, 411.15(k)(6) (mammograms—Medicare); 42 C.F.R. §§ 410.56, 411.15(k)(8) (Pap smears—Medicare).

[94] Jeanne S. Mandelblatt and others, "Breast and Cervix Cancer Screening among Multiethnic Women: Role of Age, Health and Source of Care," *Preventive Medicine* 28 (1999), 418-425; Centers for Disease Control and Prevention, "Trends in Self-Reported Use of Mammograms (1989-1997) and Papanicolaou Tests (1991-1997)—Behavioral Risk Factor Surveillance System," *Morbidity and Mortality Weekly Report* 48 (8 October 1999).

[95] *Healthy People 2000*, Objective 21.2.

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

[97] Centers for Disease Control and Prevention, *Some Facts about Chlamydia* (Atlanta: Centers for Disease Control and Prevention, March 1999), 2 [Online]; Available: WWW URL: http://www.cdc.gov/nchstp/dstd/chlamydia_facts.htm, accessed 13 June 2000.

[98] Gale Burstein and Anne Rompalo, "Chlamydia," in *Women & Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 273, 275 (three million cases per year); Centers for Disease Control and Prevention, "1998 Guidelines for Treatment of Sexually Transmitted Diseases," *Morbidity and Mortality Weekly Report* 47 (23 January 1998); U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services* (Baltimore: Williams & Wilkens, 1996, 2nd ed.), 325-332.

[99] Jeanne S. Mandelblatt and others, "Breast and Cervix Cancer Screening among Multiethnic Women: Role of Age, Health and Source of Care," *Preventive Medicine* 28 (1999), 418-425; Centers for Disease Control and Prevention, "Trends in Self-Reported Use of Mammograms (1989-1997) and Papanicolaou Tests (1991-1997)—Behavioral Risk Factor Surveillance System," *Morbidity and Mortality Weekly Report* 48 (8 October 1999).

[100] *Healthy People 2000*, Objective 21.2.

[101] *Healthy People 2010*, Objective 3-13.

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

[103] Centers for Disease Control and Prevention, *The National Breast and Cervical Cancer Early Detection Program: At-A-Glance 1999* (Washington, D.C.: Centers for Disease Control and Prevention, 1999), 2.

[104] Two of these, the District of Columbia and Texas, actually offer annual mammograms to an even broader group of women, because they have no age limit on the requirement that private insurers cover an annual mammogram.

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

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

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

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

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

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

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

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

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

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

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

[116] The Centers for Disease Control and Prevention have recommended daily P.E. for students in kindergarten through twelfth grade, a reduction in the practice of granting exemptions for P.E. classes, and an increase in the amount of time that students are active in P.E. classes. Centers for Disease Control and

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

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

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

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

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

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

[122] Generally, people are eligible for Food Stamps if they work for low wages, are unemployed or work part-time, receive welfare or other public assistance payments, are elderly or disabled and live on a small income, or are homeless. U.S. Department of Agriculture, Food and Nutrition Service, *Facts about the Food Stamp Program*, undated [Online]; Available: WWW URL: http://www.fns.usda.gov/fsp/menu/apps/facts.htm, accessed 1 June 2000.

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

[124] Smoking accounts for about 20 percent of all deaths (men and women) each year. *Smoking: Truth & Consequences, Public Policy Brief* (New York: American Lung Association, 1999), 1. More than 140,000 women die each year from tobacco-related diseases, including lung and other cancers, cardiovascular diseases, and other diseases (e.g., emphysema). Centers for Disease Control and Prevention, "Perspectives in Disease Prevention and Health Promotion Smoking-Attributable Mortality and Years of Potential Life Lost—United States, 1984," *Morbidity and Mortality Weekly Report* 46 (23 May 1997), 444-451.

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

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

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

[128] Centers for Disease Control and Prevention, "Tobacco Use," 28 July 1999 [Online]; Available: WWW URL: http://www.cdc.gov/od/owh/whtob.htm, accessed 1 June 2000.

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

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

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

[132] National Center for Tobacco-Free Kids, "Comprehensive Statewide Tobacco Prevention Programs Effectively Reduce Tobacco Use," 20 November 1999 [Online]; Available: WWW URL: http://tobaccofreekids.org/research/factsheets/pdf/0045.pdf, accessed 8 June 2000.

[133] In 1992, the federal government enacted a law known as the "Synar Amendment" to prohibit the sale of tobacco to minors. Alcohol, Drug Abuse, and Mental Health Agency Reorganization Act of 1992, § 1926, 42 U.S.C. § 300x-26. In particular, the law required states by 1994 to pass laws banning the sale of tobacco to anyone under age 18 and to enforce these laws in a way that can reasonably be expected to restrict minors' access, including random, unannounced inspections of retailers. Regulations issued by the U.S. Department of Health and Human Services in 1996 set as a goal a 20 percent annual sales rate to minors. 45 C.F.R. § 96.130. As a way to ensure states' compliance, the law requires the U.S. Department of Health and Human Services to reduce states' block grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) by a certain percentage for all subsequent years for which the state is out of compliance.

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

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

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

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

[138] *Healthy People 2010*, 26-31.

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

[140] Centers for Disease Control and Prevention, *Core Versus Comprehensive Assistance*, May 2000 [Online]; Available: WWW URL: http://www.cdc.gov/diabetes/projs/assist.htm, accessed 1 June 2000.

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

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

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

[144] Abstinence-until-marriage curricula are not included, as such curricula have been demonstrated to be ineffective with adolescents. Debra W. Haffner, *Sexuality Information and Education Council of the United States (SIECUS)*

Report: What's Wrong with Abstinence-Only Sexuality Education Programs? 25 (April/May 1997).

[145] American Heart Association, *2000 Heart and Stroke Statistical Update* (Dallas: American Heart Association, 1999), 3 (includes all females; 1997 figures).

[146] American Heart Association, "Facts About Women and Cardiovascular Diseases," 1998 [Online]; Available: WWW URL: http://www.women.americanheart.org/stroke/fs_facts.html, accessed 14 June 2000 (42 percent of women versus 24 percent of men die within one year of a heart attack).

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

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

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

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

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

[152] *Healthy People 2000*, Objective 16.2(a).

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

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

[155] *Healthy People 2000*, Objective 16.3.

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

[157] *Healthy People 2010*, Objective 12-9.

[158] Behavioral Risk Factor Surveillance System, 1998 Survey data, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

[159] *Healthy People 2000*, Objective 2.24.

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

[161] Centers for Disease Control and Prevention Update, National Center for HIV, STD and TB Prevention, *HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk,* August 1999 [Online]; Available: WWW URL: http://www.cdc.gov/hiv/pubs/facts/women.pdf, accessed 1 June 2000 (includes females age 13 and above).

[162] Centers for Disease Control and Prevention Update, National Center for HIV, STD and TB Prevention, *HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk,* August 1999 [Online]; Available: WWW URL: http://www.cdc.gov/hiv/pubs/facts/women.pdf, accessed 1 June 2000.

[163] *Healthy People 2000*, Objective 18.1(d).

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

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

[166] *Healthy People 2010*, 2-5.

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

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

[169] Division of Sexually Transmitted Diseases and Prevention, *Sexually Transmitted Disease Surveillance, 1998* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, September 1999), 5.

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

[171] *Healthy People 2010*, Objective 19.2.

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

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

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

[175] The Maternal Mortality Ratio is not based on the total population, but rather on deaths per 100,000 live-born infants. Note, however, that the numerator includes some maternal deaths that were not related to live-born infants and thus were not included in the denominator.

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

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

[178] *Healthy People 2000*, Objective 14.3.

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

[180] P. Tjaden and others, *Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey* (Atlanta: National Institute of Justice, Centers for Disease Control and Prevention, November 1998), 5.

[181] *Healthy People 2010*, 9.

[182] *Healthy People 2010*, 9.

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

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

[185] *Healthy People 2000,* Objective 14-1.

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

[187] U.S. Bureau of Labor Statistics and the Bureau of the Census, *Current Population Survey, March 1997 and March 1998 Supplements* (Washington, D.C.: U.S. Bureau of the Census, 1997, 1998) (databases) (unpublished data analyses by The Lewin Group). To compensate for small sample size, The Lewin Group combined the applicable data from the two supplements and averaged them to arrive at more reliable estimates.

[188] U.S. Bureau of the Census, "Table 10: Work Experience in 1998—Total Money Earnings in 1998 of People 15 Years Old and Over by Race, Hispanic Origin, and Sex," in *Money Income in the United States, Current Population Reports, Consumer Income,* No. P60-206 (Washington, D.C.: U.S. Government Printing Office, 1999), 38-40.

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

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

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

[192] 42 U.S.C. § 408(a)(3).

[193] 42 U.S.C. § 657(a)(1).

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

[195] Office of Research, Evaluation and Statistics, U.S. Social Security Administration, "Table 3-15: Number and Percentage Distribution of All Persons Receiving Federally Administered Payments By Category, Race, and Sex, Jan. 1, 1997," in *1998 Green Book* (Committee on Ways and Means, U.S. House of Representatives, 105th Congress, 2nd Session, 19 May 1998), 299. SSI is a federal program that makes monthly cash payments to the elderly, the blind and people with disabilities, and provides the primary means of financial assistance to these individuals when they have limited income and resources. 42 U.S.C. § 1381 *et seq.*

[196] Office of Research, Evaluation and Statistics, U.S. Social Security Administration, "Table 3-15: Number and Percentage Distribution of All Persons Receiving Federally Administered Payments By Category, Race, and Sex, Jan. 1, 1997," in *1998 Green Book* (Committee on Ways and Means, U.S. House of Representatives, 105th Congress, 2nd Session, 19 May 1998), 291.

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

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

[199] U.S. Department of Labor, Employment Standards Administration, *The Minimum Wage,* May 2000 [Online]; Available: WWW URL: http://www.dol.gov/dol/esa/public/minwage/main.htm, accessed 1 June 2000.

[200] Although in these seven states employers generally must pay at least the federal minimum wage for all workers covered by the federal law, they may pay lower amounts for the small number of workers exempt from federal coverage, such as babysitters, companions for the elderly, disabled workers, or switchboard operators. U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, *FLSA Advisor: Exemptions* [Online]; Available: WWW URL: http://www.elaws.dol.gov/flsa/screen75.asp, accessed 1 June 2000.

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

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

[203] *Who Dies? A Look at Firearms Death and Injury in America—Revised Edition: Females and Firearms Violence* (Washington, D.C.: Violence Policy Center, February 1999) [Online]; Available: WWW URL: http://www.vpc.org/studies/whofem.htm, accessed 1 June 2000.

[204] *Who Dies? A Look at Firearms Death and Injury in America—Revised Edition: Females and Firearms Violence* (Washington, D.C.: Violence Policy Center, February 1999) [Online]; Available: WWW URL: http://www.vpc.org/studies/whofem.htm, accessed 1 June 2000.

[205] D.C. Code § 6-2301 *et seq.*

[206] Center to Prevent Handgun Violence, *Concealed Weapons, Concealed Risk* 7 December 1999 [Online]; Available: WWW URL: http://www.handguncontrol.org/issue_briefs/ccwmyth.html, accessed 1 June 2000.

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

[208] *Healthy People*, Objective 8-27.

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

[210] For example, states can enact laws that reduce the injuries from transportation-related accidents, including state seat belt laws and state drunk driving laws. National Highway Traffic Safety Administration, *Presidential Initiative for Increasing Seat Belt Use Nationwide: Recommendations from the Secretary of Transportation* [Online]; Available: WWW URL: http://www.nhtsa.dot.gov/people/injury/airbags/presbelt, accessed 13 January 2000. In 1998, 13,873 women were killed nationwide in motor vehicle accidents. Mothers Against Drunk Driving, *Alcohol Related Deaths by Gender 1998* [Online]; Available: WWW URL: http://www.madd.org/stats/98sex.html, accessed 1 June 2000.

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

[212] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Introduction.

[213] Bureau of Labor Statistics, *Current Population Survey, Technical Paper 63*, Design and Methodology (Washington, D.C.: U.S. Department of Labor, Current Population Survey, March 2000); Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin,* (Washington, D.C.: Government Printing Office, September 1998), 3.

[214] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. I.

[215] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. II, Box 2.

[216] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. I.

[217] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. I.

[218] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 5.

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

[220] *Healthy People 2010*, 11; Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. III.

[221] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 40-41.

[222] In 1998, white men working full time earned a median yearly salary of $37,196; white women, $27,304; black men, $27,472; and black women, $23,864. U.S. Bureau of the Census, "Table 7: Median Income of People by Selected Characteristics: 1998, 1997, and 1996," in *Money Income in the United States, Current Population Reports, Consumer Income*, No. P60-206 (Washington, D.C.: U.S. Government Printing Office, 1999), 26-29.

[223] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 60.

[224] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 60-61, 67.

[225] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 60; Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," Population Bulletin 54 (September 1999), Pt. III.

[226] Throughout this section, unless otherwise noted, data about the percentage of women in the United States come from the demographic information for the nation on page 13.

[227] "Factors Affecting the Health of Women of Color: Black Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/black.htm, accessed 5 June 2000.

[228] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 4.

[229] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. II. The Caribbean nations are also a leading source of Hispanic immigrants, who may be of any race, but come from a Spanish-speaking nation. *Ibid.*, Part II, Hispanics.

[230] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. III.

[231] Vernellia R. Randall, "Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African Americans," *Health Matrix* 3 (1993), 127; and N. Murrell, "Racism and Health Care Access: A Dialogue with Childbearing Women," *Health Care for Women International* 17, No. 2 (London: Taylor & Francis Group, 1996), 149-159, both articles as discribed in Vernellia R. Randall, *The Current Status of Minorities' Access to Health Care: Annotated Bibliography* (Spring 1997) [Online]; Available: WWW URL: http://www.udayton.edu/~health/annotate/97unknow.htm, accessed 13 June 2000.

[232] "Access to Health Insurance: Women of Color," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/figure28.htm, accessed 5 June 2000.

[233] "Factors Affecting the Health of Women of Color: Black Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/black.htm, accessed 5 June 2000.

[234] Sheila Parker and others, "Body Image and Weight Concerns among African Americans and White Adolescent Females: Differences that Make a Difference," *Human Organization* 54 (Summer 1995), 103-114. Though there is indication that such disorders are less prevalent, black girls are still vulnerable to eating disorders such as binge eating. "Minority Women's Health Concerns: Psychiatric Disorders," in *The Health of Minority Women* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, May 2000) [Online]; Available: WWW URL: http://www.4woman.org/owh/pub/minority/concerns.htm, accessed 5 June 2000.

[235] Throughout the "Key Health Disparities" Section, the information on deaths due to HIV comes from a data set in which individuals who die from HIV include those who die from AIDS as well as those who die with HIV and/or a condition associated with HIV (as consistent with the ICD-9 definition of HIV infection). National Center for Health Statistics, Centers for Disease

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

[236] For poverty, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as black and Hispanic ethnicity would be considered Hispanic).

[237] U.S. Bureau of Labor Statistics and the U.S. Bureau of the Census, *Current Population Survey, March 1997 and March 1998 Supplements* (Washington, D.C.: U.S. Bureau of the Census, 1997, 1998) (databases) (unpublished data analyses by The Lewin Group). To compensate for small sample size, The Lewin Group combined the applicable data from the two supplements and averaged them to arrive at more reliable estimates.

[238] For high school eduation, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as black and Hispanic ethnicity would be considered Hispanic).

[239] U.S. Bureau of Labor Statistics and the U.S. Bureau of the Census, *Current Population Survey, March 1997 and March 1998 Supplements* (Washington, D.C.: U.S. Bureau of the Census, 1997, 1998) (databases) (unpublished data analyses by The Lewin Group). To compensate for small sample size, The Lewin Group combined the applicable data from the two supplements and averaged them to arrive at more reliable estimates.

[240] "Factors Affecting the Health of Women of Color: Black Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/black.htm, accessed 5 June 2000.

[241] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 6.

[242] "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 6 June 2000.

[243] "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 6 June 2000.

[244] American College of Physicians—American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick: Latino Community at Great Risk* (Philadelphia: American College of Physicians—American Society of Internal Medicine, 2000), White Paper, 6.

[245] American College of Physicians—American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick: Latino Community at Great Risk* (Philadelphia: American College of Physicians—American Society of Internal Medicine, 2000), White Paper, 14.

[246] "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 6 June 2000.

[247] "Minority Women's Health Status," in *The Health of Minority Women* (Washington, D.C.: Office on Women's Health, U.S. Department of Health and Human Services, May 2000) [Online]; Available: WWW URL: http://4woman.org/owh/pub/minority/status.htm, accessed 5 June 2000.

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

[249] For poverty, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as black and Hispanic ethnicity would be considered Hispanic).

[250] U.S. Bureau of Labor Statistics and the U.S. Bureau of the Census, *Current Population Survey, March 1997 and 1998 Supplements* (Washington, D.C.: U.S. Bureau of the Census, 1997, 1998) (databases) (unpublished data analyses by The Lewin Group). To compensate for small sample size, The Lewin Group combined the applicable data from the two supplements and averaged them to arrive at more reliable estimates.

[251] The ratio of Hispanic women's earnings to those of all men in 1996 was only 58 percent, while the overall ratio of women's earnings to those of men was 74 percent. AFL-CIO, "It's High Time—Past Time—for Women of Color to Earn Equal Pay," (Washington, D.C.: AFL-CIO, undated) [Online]; Available: WWW URL: http://aflcio.org/women/f_color.htm, accessed 6 June 2000.

[252] Women's Bureau, U.S. Department of Labor, "Facts on Working Women: Women of Hispanic Origin in the Labor Force" (Washington, D.C.: Women's Bureau, U.S. Department of Labor, April 2000) [Online]; Available: WWW URL: http://www.dol.gov/dol/wb/public/wb_pubs/hispwom2.htm, accessed 6 June 2000.

[253] For high school completion, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as black and Hispanic ethnicity would be considered Hispanic).

[254] U.S. Bureau of Labor Statistics and the U.S. Bureau of the Census, *Current Population Survey, March 1997 and March 1998 Supplements* (Washington, D.C.: U.S. Bureau of the Census, 1997, 1998) (databases) (unpublished data analyses by The Lewin Group). To compensate for small sample size, The Lewin Group combined the applicable data from the two supplements and averaged them to arrive at more reliable estimates.

[255] "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 6 June 2000.

[256] "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 6 June 2000.

[257] "Factors Affecting the Health of Women of Color: Asian Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/asian.htm, accessed 6 June 2000.

[258] "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 6 June 2000.

[259] "Factors Affecting the Health of Women of Color: Asian Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/asian.htm, accessed 6 June 2000.

[260] For example, the Cantonese translation for "cancer" is the word "nham," which loosely translates into English as "growth" but is not mentioned as a disease in texts on Chinese medicine. "Factors Affecting the Health of Women of Color: Asian Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online], Available: WWW URL: http://www.4women.gov/owh/pub/woc/asian.htm, accessed 6 June 2000.

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

[262] Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention," *Journal of American Medical Women's Association* 53 (Spring 1998), 97.

[263] Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention," *Journal of American Medical Women's Association* 53 (Spring 1998), 98.

[264] Marisa Urgo, "New Obesity Guidelines: Minority Women at Risk," in *Closing the Gap* (Washington, D.C.: Office of Minority Health, U.S. Department of Health and Human Services, June/July 1998), 6; "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data* Book (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 6 June 2000.

[265] "Minority Women's Health Status," in *The Health of Minority Women* (Washington, D.C.: Office on Women's Health, U.S. Department of Health and Human Services, May 2000) [Online]; Available: WWW URL: http://4woman.org/owh/pub/minority/status.htm, accessed 6 June 2000.

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

[267] NAWHO, "Mental Health Awareness Campaign," undated [Online]; Available: WWW URL: http://www.nawho.org/depression.html, accessed 6 June 2000.

[268] For poverty, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as Asian and Hispanic ethnicity would be considered Hispanic).

[269] For high school completion, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as Asian and Hispanic ethnicity would be considered Hispanic).

[270] "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 6 June 2000.

[271] Conversation with Rita Harding, Nurse Program Officer, Indian Health Service (24 May 2000).

[272] "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 6 June 2000.

[273] "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 6 June 2000.

[274] "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 6 June 2000.

[275] "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 6 June 2000.

[276] "Minority Women's Health Concerns: Psychiatric Disorders," in *The Health of Minority Women* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, May 2000) [Online]; Available: WWW URL: http://www.4woman.org/owh/pub/minority/concerns.htm, accessed 5 June 2000.

[277] For poverty, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as Native American and Hispanic ethnicity would be considered Hispanic).

[278] For high school education, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as Native American and Hispanic ethnicity would be considered Hispanic).

[279] "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 6 June 2000.

[280] One advocacy group noted that the draft report of the goals and objectives of Healthy People 2010, the nation's health "blue print," was virtually silent on issues of lesbian health, and urged the project to incorporate the findings and recommendations made by the Institute of Medicine, discussed herein. Human Rights Campaign, Press Release, "Federal Blueprint Healthy People 2010 Overlooks Gay and Lesbian Americans, HRC Asserts," 27 January 1999; Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, *Healthy People 2010 Objectives, Draft for Public Comment* (Washington, D.C.: U.S. Department of Health and Human Services, September 1998).

[281] Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future*—Executive Summary (Washington, D.C.: National Academy Press, 1999).

[282] With the exception of Vermont, states do not require insurance companies to offer health insurance coverage for the partners of homosexual employees on par with married spouses. "Vermont: New Civil Unions Law Mandates Plans Cover Same-Gender Couples," *BNA's Health Care Policy Report* 8 (8 May 2000), 737. Employment discrimination also relegates some lesbians to self-employment, freelance work or lower paying jobs that do not offer insurance. Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and*

Transgender Health: Findings and Concerns, Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 10.

[283] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns*, Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 6 (The presumption that a patient is heterosexual, as evidenced by forms that inquire about marital status, and standard questions on birth control use, serve to alienate lesbian women from the health care system, and discourage preventive care); Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future*—Executive Summary (Washington, D.C.: National Academy Press, 1999). Stereotypes and misconceptions, such as the idea that lesbians do not need Pap smears and other gynecological care, still prevail among both community members and providers.

[284] Winnie Stachelberg, "Advancing A Lesbian Health Agenda," *Human Rights Campaign Quarterly* Spring 1996; Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns,* Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 13-14; The Gay, Lesbian, Bisexual and Transgender Health Access Project, *Health Concerns of the Gay, Lesbian, Bisexual and Transgender Community*, Preface to the 2nd Edition (Boston: The Medical Foundation, June 1997).

[285] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns,* Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 35; The Gay, Lesbian, Bisexual and Transgender Health Access Project, *Health Concerns of the Gay, Lesbian, Bisexual and Transgender Community*, Preface to the 2nd Edition (Boston: The Medical Foundation, June 1997).

[286] Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future*—Executive Summary (Washington, D.C.: National Academy Press, 1999). "Cultural competency"—a common notion when dealing with other patients across racial, ethnic and linguistic lines—is crucial to increase access and appropriate services. The Gay and Lesbian Medical Association's Physician Referral Program links lesbians with providers who express a commitment to addressing their unique health needs. Gay and Lesbian Medical Association, "Physician Referral Program," undated [Online]; Available: WWW URL: http://www.glma.org/programs/prp/index.html, accessed 1 June 2000.

[287] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns*, Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 11. Vermont's Act 91 also conveys these benefits to same-gender partners. "Vermont: New Civil Unions Law Mandates Plans Cover Same-Gender Couples," *BNA's Health Care Policy Report* 8 (8 May 2000), 737; see also The Mautner Project for Lesbians with Cancer, "Removing the Barriers to Accessing Care for Lesbians," (undated) [Online]; Available: WWW URL: http://www.mautnerproject.org/barriers.html, accessed 22 May 2000.

[288] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns,* Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 35.

[289] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns,* Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 10.

[290] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns*, Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 35.

[291] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns,* Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 33.

[292] A review of national databases on causes of death failed to reveal any national sampling that included sexual orientation as a demographic.

[293] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns,* Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 38.

[294] Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future*—Executive Summary (Washington, D.C.: National Academy Press, 1999); Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns*, Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 26-27.

[295] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns*, Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 32.

[296] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns*, Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 24.

[297] Such benefits include inheritance rights and Social Security benefits for surviving spouses. "Vermont: New Civil Unions Law Mandates Plans Cover Same-Gender Couples," *BNA's Health Care Policy Report* 8 (8 May 2000), 737.

[298] Gay and Lesbian Medical Association and others, *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns,* Conference Ed. (San Francisco: Gay and Lesbian Medical Association, January 2000) (work in progress), 36.

[299] *A Guide to Disability Rights Laws* (Washington, D.C.: U.S. Department of Justice, Civil Rights Division, Disability Rights Section, May 2000), 1.

[300] *Healthy People 2010,* Vol. I, p. 15; Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 3 (stating that one of every five women in the United States is disabled).

[301] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 8; Ronald L. Mace, *Removing Barriers to Health Care: A Guide for Health Professionals* (Raleigh: Center for Universal Design, undated) [Online]; Available: WWW URL: http://www.fpg.unc.edu/~ncodh/rbar/, accessed 23 May 2000.

[302] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 8.

[303] One of every six Medicaid recipients is a person under 65 with a disability, and more than 40 percent of Medicaid beneficiaries are now served by managed care systems. Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 9.

[304] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 8.

[305] M.A. Nosek and others, *National Study of Women with Physical Disabilities: Final Report* (Houston: Center for Research on Women with Disabilities, Baylor College of Medicine, 1997) [Online]; Available: WWW URL: http://www.bcm.tmc.edu/crowd/national_study/national_study.html, accessed 7 June 2000.

[306] *Healthy People* 2010, 6-6, 6-7.

[307] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 10.

[308] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 10.

[309] M.A. Nosek and others, *National Study of Women with Physical Disabilities: Final Report* (Houston: Center for Research on Women with Disabilities, Baylor College of Medicine, 1997) [Online]; Available: WWW URL: http://www.bcm.tmc.edu/crowd/national_study/national_study.html, accessed 7 June 2000.

[310] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 25.

[311] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 27.

[312] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 29; National Center for Injury Prevention and Control, "Sexual Violence Against People with Disabilities," 25 October 1999 [Online]; Available: WWW URL: http://www.cdc.gov/ncipc/factsheets/disabvi.htm, accessed 1 June 2000.

[313] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 29.

[314] Better Homes Fund, *America's Homeless Children: New Outcasts* (Newton: Better Homes Fund, 1999), 54.

[315] The Federal Agency for Healthcare Research and Quality (AHRQ) has developed research grants to address disparities among minorities, including access to care, quality of services, and excess burden of disease among African Americans, Hispanics, Native Americans, Alaskan Natives, Asian Americans and Pacific Islanders. See Federal Agency for Healthcare Research and Quality (AHRQ) [Online]; Available: WWW URL: http://www.ahrq.gov/, accessed 21 June 2000.

[316] Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future*—Executive Summary (Washington, D.C.: National Academy Press, 1999), 256; E.L. Bassuk and others, "The Characteristics and Needs of Sheltered Homeless and Low-Income Housed Mothers," *Journal of the American Medical Association* 276 (August 1996), 640-646.

[317] U.S. Bureau of Labor Statistics and U.S. Bureau of the Census, *Current Population Survey, March 1997 and March 1998 Supplements* (Washington, D.C.: U.S. Bureau of the Census, 1997, 1998) (databases).

[318] Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 3 (stating that one of every five women in the United States is disabled).

[319] As a result of discovering that women and minorities were not being adequately included in NIH-funded clinical research trials, Congress passed the NIH Revitalization Act of 1993, which requires, among other things, that women and minorities be included in research studies. 42 U.S.C. §§ 283-300; U.S. General Accounting Office (GAO), *Women's Health: NIH Has Increased Its Efforts to Include Women in Research* (Washington, D.C.: GAO, 2000); R.M. Vidaver and others, "Women Subjects in NIH-Funded Clinical Research Literature: Lack of Progress in Both Representation and Analysis by Sex," *Journal of Women's Health and Gender-Based Medicine* 9 (June 2000), 495-504.

[320] U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, *Agenda for Research on Women's Health for the 21st Century, A Report of the Task Force on the NIH Women's Health Research Agenda for the 21st Century,* Vol. 1, Executive Summary (Bethesda: NIH Publication No. 99-4385, 1999); U.S. Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000).

[321] *Inventory of Services and Funding Sources for Programs Designed to Prevent Violence Against Women,* 1997 [Online]; Available: WWW URL: http://www.cdc.gov/ncipc/dvp/vawprograms, accessed 27 June 2000.

[322] Cultural competence may be defined as "a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations." U.S. Department of Health and Human Services, Office of Minority Health and Resources for Cross Cultural Health Care, *Assuring Cultural Competence in Health Care: Recommendation for National Standards and an Outcomes-focused Research Agenda; Part One: Recommendations for National Standards* (Washington, D.C.: U.S. Department of Health and Human Services, 1999), 21.

[323] Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, D.C.: National Academy Press, 2000), 8-10.

[324] American College of Nurse-Midwives, *An Introduction to Nurse-Midwifery* (Washington, D.C.: American College of Nurse-Midwives, 1992).

[325] Marian F. MacDorman and Gopal K. Singh, "Midwifery Care, Social and Medical Risk Factors, and Birth Outcomes in the USA," *Journal of Epidemiology and Community Health* 52 (May 1998), 310; Stephanie J. Ventura and others, "Births: Final Data for 1998," *National Vital Statistics Report* 48 (March 2000), 13.

[326] C.M. Dower and others, *Charting a Course for the 21st Century: The Future of Midwifery* (San Francisco: Pew Health Professions Commission and the University of California, San Francisco Center for the Health Professions, April 1999), 39.

[327] L. Kohn and others, eds., Institute of Medicine Commission on Quality of Health Care in America, *To Err is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 1999); Traves Crabtree and others, "Gender-Dependent Differences in Outcomes After the Treatment of Infection in Hospitalized Patients," *Journal of the American Medical Association* 282 (8 December 1999), 2143-2148 (women appear to be at increased risk for death from hospital-acquired pneumonia, even after controlling for other factors).

[328] In March 2000, President Clinton signed Executive Order 13147, establishing a Cabinet-level advisory commission on complementary and alternative medicine. *Federal Register* 65 (10 March 2000), 13233-13234. The NCCAM was initiated through a congressional mandate under the FY 1999 Omnibus appropriations bill signed by President Clinton on October 21, 1998. Before that time, the NCCAM was the Office of Alternative Medicine (OAM). [Online]; Available: WWW URL: http://nccam.nih.gov/nccam/an/general/index.html, accessed 19 June 2000.

[329] Correspondence with Professor Beth Glover Reed, Director, Policy Research on Women and Drugs (PROWD), University of Michigan, School of Social Work, 26 May 2000.

[330] AIDS (rate per 100,000 people), 1998. Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report* 10(2) (1998). Fig. 2.

[331] Arthritis Foundation, Association of State and Territorial Health Officials, and Centers for Disease Control and Prevention, *National Arthritis Action Plan: A Public Health Strategy* (Atlanta: Arthritis Foundation, Association of State and Territorial Health Officials, and Centers for Disease Control and Prevention, 1999), 19-21.

[332] L. Saltzman and others, *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0.* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1999).

[333] Mona Kimbell-Dunn and others, "Asthma," in *Women & Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 724-739.

[334] See, e.g., Ovarian Cancer National Alliance [Online]; Available: WWW URL: http://www.ovariancancer.org/, accessed 26 June 2000; conversation with Ann Kolker, Executive Director, Ovarian Cancer National Alliance, 22 June 2000.

[335] "White House Announces Major New Increase in Funding to Determine Environmental Causes of Disease," Office of the Press Secretary, The White House, 13 January 2000; The Breast Cancer Fund, "Examining the Environmental Links to Breast Cancer: Frequently Asked Questions," 1999 [Online]; Available: WWW URL: http://breastcancerfund.org/faqs.html, accessed 8 June 2000.; Endometriosis Association, "Environmental Health Watch," undated [Online]; Available: WWW URL: http://www.endometriosisassn.org/news.htm#Environmental Health Watch, accessed 8 June 2000.

[336] Several studies describe the different components of state programs, e.g., Environmental Law Institute, *An Analysis of State Superfund Programs: 50-State Study, 1998 Update* (Washington, D.C.: Environmental Law Institute, 1998), but it is extremely difficult to use these to compare levels of state support.

[337] *Healthy People 2010*, 20-6.

[338] Karen Messing, One-eyed Science: *Occupational Health and Women Workers* (Philadelphia: Temple University Press, 1998); "Working Women Face High Risks From Work Stress, Musculoskeletal Injuries, Other Disorders, NIOSH Finds," 1 June 2000 [Online]; Available: WWW URL: http://www.cdc.gov/niosh/womrisk.html, accessed 28 June 2000; National Institute of Occupational Safety and Health (NIOSH), *Stress At Work* (Cincinnati: NIOSH, 1999) [Online]; Available: WWW URL: http://www.cdc.gov/niosh/stresswk.html, accessed 28 June 2000; Karen Messing and others, *Invisible: Issues in Women's Occupational Health* (Charlottetown, P.E.I.: Gynergy Books, 1995); Shelia Hoar Zahm, ed., "Women at Work," in *Women & Health,* eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 441-522.

[339] Organizations listed for identification purposes only.

Endnotes for Highlighted Boxes

[A] Washington State Department of Health, "Health Insurance Coverage," in *Health of Washington State* (Olympia: Washington State Department of Health, September 1996), 9.6 [Online]; Available: WWW URL: http://www.doh.wa.gov/publicat/96_HWS/hichp5.pdf, accessed 24 June 2000; Correspondence with Kathy Eberle, Acting Deputy Manager of Operations, Basic Health, Health Care Authority, Washington State Department of Health, 22 June 2000.

[B] Robert Pear, "Cash to Ensure Health Coverage for the Poor Goes Unused," *New York Times,* 21 May 2000, 22; Conversation with Matt D. Salo, Director of Health Legislation, National Governors' Association, 2 June 2000.

[C] Division of Reproductive Health, "Participating PRAMS States," 19 June 2000 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/drh/pramstates.htm, accessed 27 June 2000; Division of Reproductive Health, *PRAMS 1996 Surveillance Report* (Atlanta: U.S. Department of Health and Human Services, Division of Reproductive Health, 1999), 1.

[D] R. Schulz and Scott R. Beach, "Caregiving as a Risk Factor for Mortality: The Caregiver Health Effects Study," *Journal of the American Medical Association* 282 (15 December 1999), 2215; Alzheimer's Association State Policy Clearinghouse, *Issue Kit: Respite Care* (Washington, D.C.: Alzheimer's Association, 1999) (describing Pennsylvania's and Connecticut's programs); Alzheimer's Association, *Providing Relief for Family Caregivers: Assessing Statewide Respite Programs* (Washington, D.C.: Alzheimer's Association, undated); Family Caregiver Alliance, "Executive Summary of Survey of Fifteen States' Caregiver Support Programs," undated [Online]; Available: WWW URL: http://www.caregiver.org/issues/execsum9910C.html, accessed 11 November 1999 (review of California, Florida, Illinois, Iowa, Michigan, New Jersey, New York, North Dakota, Ohio, Oregon, Pennsylvania, Texas, Virginia, Washington and Wisconsin).

[E] Violette King, "Restore Staffing Requirements to Improve Care," *St. Louis Post-Dispatch,* 12 September 1999, B3; Bill Smith, "Nursing Home Violations Triple in Two Years: State Citations List Injuries, Assaults and Negligence," *St. Louis Post-Dispatch,* 22 August 1999, A1; Charlene Harrington and others, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991-97* (San Francisco: University of California Department of Social and Behavioral Sciences University of California, San Francisco, January 1999), 58; Gooloo S. Wunderlich and others, eds., *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* (Washington, D.C.: Institute of Medicine, National Academy Press, 1996), 12; National Citizen's Coalition of Nursing Home Reform (NCCNHR), *Staffing Crisis in Nursing Homes: Consensus Statement of the National Citizens' Coalition for Nursing Home Reform's Campaign for Quality Care, Subcommittee on Nursing* (Washington, D.C.: NCCNHR, November 1999), 2.

[F] Nineteen states and the District of Columbia have a PACT model demonstration program. National Alliance for the Mentally Ill (NAMI), "Falling Through the Cracks: The Nation's Continued Failure to Provide Effective Care and Treatment for Individuals with the Most Severe Mental Illnesses," undated [Online]; Available: WWW URL: http://www.nami.org/about/pactstatus.htm, accessed 13 July 1999.

[G] James Trussell and others, "Access to Emergency Contraception," *Obstetrics and Gynecology* 95 (February 2000), 267-70; Jane Hutchings and others, "When the Morning After is Sunday: Pharmacist Prescribing of Emergency Contraceptive Pills," *Journal of the Medical Women's Association* 53 (Fall 1998), 230 (regarding states allowing pharmacists to directly prescribe prescriptions through "collaborative drug therapy agreements").

[H] California: California Penal Code § 679.04. "Advocates" are sexual assault victims' counselors, as defined in § 1035.2 of the California Evidence Code, or victim advocate workers in centers established under § 13835. Illinois: Illinois Law Enforcement Training and Standards Board and Illinois Coalition Against Sexual Assault, *Model Guidelines and Crimes Investigation Manual for Illinois Law Enforcement* (Springfield: Illinois Law Enforcement Training and Standards Board and Illinois Coalition Against Sexual Assault, May 1996); Jim Ryan, Illinois Attorney General, "Guidelines for Medical Response to Sexual Assault Reports," in *Averting the Campus Date Rape Drug Crisis: Seven Solutions for Colleges, Law Enforcement and Medical Professionals* (Springfield: Office of the Illinois Attorney General, 1999); "Sex Offender Management Board Act," Illinois Compiled Statutes Ch. 20, Act 4026, Sec. 15.

[I] Ovarian Cancer National Alliance, "The Critical Need for Research Funds," undated [Online]; Available: WWW URL: http://www.ovariancancer.org/research_funds/research_funding.shtml, accessed 5 June 2000; National Cancer Institute, "What You Need To Know About Ovarian Cancer," 28 September 1998 [Online]; Available: WWW URL: http://www.cancernet.nci.nih.gov/wyntk_pubs/ovarian.htm#1, accessed 15 June 2000.

[J] Joyce Adair Bird and others, "Opening Pathways to Cancer Screening for Vietnamese-American Women: Lay Health Workers Hold a Key," *Preventive Medicine* 27 (November/December 1998), 821-829.

[K] North Carolina Health and Fitness Foundation, *Be Active: A Plan to Increase Physical Activity in North Carolina, 1999-2003* (Durham: North Carolina Health and Fitness Foundation, 1999).

[L] Georgia Division of Public Health, "Stroke and Heart Attack Prevention Program (SHAPP)," 2000 [Online]; Available: WWW URL: http://www.ph.dhr.state.ga.us/programs/cardio/shapp.shtml, accessed 14 June 2000.

[M] In 1997, 89 percent of EFNEP graduates nationwide improved their nutrition practices, 84 percent improved their food resource management practices, and 67 percent improved their food safety practices. Cooperative State Research Education and Extension Service, *Expanded Food and Nutrition Education Program: 30 Years* (Washington, D.C.: U.S. Department of Agriculture, Cooperative State Research Education and Extension Service, April 1999); Cooperative State Research Education and Extension Service, "Expanded Food and Nutrition Education Program Based on FY99 Data," (unpublished).

[N] Campaign for Tobacco-Free Kids, "Status of State Decisions on Spending Tobacco Settlement Money," 1 May 2000.

[O] Gordon C. Sharp and others, "The Missouri Arthritis Program," *Missouri Medicine* (February 1988), 31.

[P] North Carolina Department of Health and Human Services, Division of Public Health, Older Adult Health Unit, Osteoporosis Program, *The North Carolina Osteoporosis Prevention Task Force Report, 1997-1999* (unpublished, October 1999); Bureau of Community Health Promotion, Massachusetts Department of Health, *The Massachusetts Osteoporosis Awareness Program: Program Overview* (unpublished).

[Q] U.S. Department of Health and Human Services, "HHS Approves Maine Medicaid Plan to Provide Early Treatment for HIV," *HHS News,* 24 February 2000 [Online]; Available: WWW URL: http://www.hhs.gov/news/press/2000pres/20000224.html, accessed 13 March 2000; *BNA Health Care Policy Report* 8 (6 March 2000), 367.

[R] Kaiser Family Foundation, *HPV (Human Papillomavirus) and Cervical Cancer* (Washington, D.C.: Kaiser Family Foundation, February 2000) [Online]; Available: WWW URL: http://www.kff.org/content/2000/3002/HPV%20Fact%20Sheet.PDF, accessed 15 June 2000; Kaiser Family Foundation, *National Survey of Public Knowledge of HPV, the Human Papillomavirus* (Washington, D.C.: Kaiser Family Foundation, February 2000) [Online]; Available: WWW URL: http://www.kff.org/content/2000/20000217a/HPVChartpack2.PDF, accessed 19 June 2000; National HPV Prevention and Cervical Cancer Prevention Resource Center, "What's the Difference Between a Pap Smear and an HPV Test?," undated [Online]; Available: WWW URL: http://www.ashastd.org/hpv/hpvrc/info9.html, accessed 15 June 2000.

[S] Maryland Executive Order 01.01.1998.25, "Domestic Violence and the Workplace," [Online]; Available: WWW URL: http://www.gov.state.md.us/gov/execords/1998/html/9825eo.html, accessed 5 June 2000; Robin R. Runge and Marcellene E. Hearn, "Employment Rights Advocacy for Domestic Violence Victims," *Domestic Violence Report* 5 (December/January 2000), 26; NOW Legal Defense and Education Fund, "State Laws Can Help Domestic Violence Victims at Work: Unemployment Insurance" (New York: NOW Legal Defense and Education Fund, April 2000).

[T] Better Homes Fund, *America's Homeless Children: New Outcasts* (Newton: Better Homes Fund, 1999), 54; IQ Solutions, Inc., *Focus Group Summary and Report on Formerly Homeless Women* (Rockville: Center for Mental Health Services, 1998), 35: Ellen L. Bassuk and others, "Prevalence of Mental Health and Substance Abuse Disorders Among Homeless and Low-Income Housed Mothers," *American Journal of Psychiatry* 155 (November 1998), 1561-1564; C. N. Roll and others, "Characteristics and Experiences of Homeless Adults: A Comparison of Single Men, Single Women and Women with Children," *Journal of Community Psychology* 27 (March 1999), 189-198.

[U] Thirty-six states had formally adopted the Family Violence Option as of 1 May 1999. Jody Rafael and Sheila Haennicke, Keeping Battered Women Safe Through the Welfare-to-Work Journey: A Report on the Implementation of Policies for Battered Women in State Temporary Assistance for Needy Family (TANF) Programs (Ann Arbor: Taylor Institute, University of Michigan School of Social Work, 1999) [Online]; Available: WWW URL: http://www.ssw.umich.edu/trapped/pubs_fvo1999.pdf, accessed 27 September 1999; NOW Legal Defense and Education Fund, Dangerous Indifference: New York City's Failure to Implement the Family Violence Option (New York: NOW Legal Defense and Education Fund, 2000).

[V] Environmental Protection Agency, Office of Enforcement and Compliance Assurance, "Environmental Justice: Working Towards Solutions" (August 1997), 20-21, 27 [Online]; Available: WWW URL: http://es.epa.gov/oeca/main/ej/docs/chaps.pdf, accessed 29 June 2000; Environmental Protection Agency, "What Is Environmental Justice?" undated [Online]; Available: WWW URL: http://www.epa.gov/grtlakes/seahome/grants/src/ej-intr.htm, accessed 1 May 2000; Environmental Defense, "Environmental Justice Policy: A Statement by the Board of Trustees," undated [Online]; Available: WWW URL: http://www.edf.org/programs/EJ/ejpolicy.html, accessed 18 April 2000.

[W] California Health and Safety Code, § 25249.5 (also known as "Proposition 65"); California Health and Safety § 44300 *et seq.*; Massachusetts General Laws, § 21I; Nancy Maxwell and others, *Newton Breast Cancer Study* (Newton: Silent Spring Institute, January 1999); Silent Spring Institute, *The Cape Cod Breast Cancer and Environment Study: Results of the First Three Years of Study* (Newton: Silent Spring Institute, 1998).

[X] Karen Scott Collins and others, *Health Concerns Across A Woman's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health* (New York: Commonwealth Fund, 1999), 63; "Kansas: Health Care Cost Parity of Women Tops Commissioner's List for Priorities for 2000," *BNA Health Care Policy Report* 8 (17 January 2000), 103-104.

[Y] Correspondence with Professor Beth Glover Reed, Director, Policy Research on Women and Drugs (PROWD), University of Michigan, School of Social Work, 26 May 2000.

[Z] AFL-CIO, *Women Workers Need OSHA's Ergonomics Standard* (Washington, D.C.: AFL-CIO, updated June 1999); Laura Punnett and Robin Herbert, "Work-Related Musculoskeletal Disorders," in *Women and Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 474-492; *Federal Register* 64 (23 November 1999), 65768-66078.

[AA] New York State Occupational Health Clinic Network, "Protecting the Workers of New York State," undated [Online]; Available: WWW URL: http://www.health.state.ny.us/nysdoh/environ/occupate.htm, accessed 14 April 2000; Robin Herbert and others, "The Diagnosis and Treatment of Occupational Diseases: Integrating Practice with Prevention," *American Journal of Industrial Medicine* 37 (January 2000), 2.

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