STILL NOWHERE TO TURN:

INSURANCE COMPANIES TREAT WOMEN LIKE A PRE-EXISTING CONDITION

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

About the Center

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

Authors

This Report was a collaborative endeavor that relied upon the work of many individuals. The primary authors—Brigette Courtot and Julia Kaye—were greatly assisted by Marcia Greenberger, Judy Waxman, Lisa Codispoti, Grace Lesser, Micole Allekotte, Kelli Garcia, Jenifer Rajkumar, Amanda Stone, Michelle Han, Sofia Rosenblum, and Lisa M. LeMair. Jen Swedish and Golda Philip, formerly of the National Women's Law Center, conducted research on the status and substance of state laws in the individual and group health insurance markets.

Disclaimer

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Reform Matters

This report is part of the National Women's Law Center's project, "Reform Matters: Making Real Progress for Women and Health Care." More information and resources for advocates regarding women and health reform are available at http://www.nwlc.org/reformmatters.

Summary of Findings

The National Women's Law Center ("NWLC" or "the Center") has examined the current status of the widespread individual market insurance practices that it first reviewed in a 2008 report, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*. These include gender rating, or the practice of charging same-aged women and men different premiums for identical health coverage; exclusions of coverage that only women need, like maternity care; and rejecting applicants for insurance coverage for reasons that include status as a survivor of domestic violence. In addition, in this report NWLC has investigated two previously unexplored issues: whether individual health insurance premiums are higher for a non-smoking woman even when compared to a man of the same age who reports tobacco usage, and the use and impact of gender rating in the group health insurance market.

NWLC has found that women continue to face unfair and discriminatory practices when obtaining health insurance in the individual market—as well as in the group health insurance market. Women are charged more for coverage simply because they are women, and individual market health plans often exclude coverage for services that only women need, like maternity care. In short, in the health insurance system, being a woman amounts to being treated like a "pre-existing condition." Specifically, the Center has found:

- Gender rating remains rampant in the individual health insurance market and among best-selling health plans. NWLC examined the best-selling plans (generally the top 10) in each state capital and found that 95% practice gender rating, compared to 93% of such plans in 2008.
- Using the same random sampling methods as in 2008, NWLC found even more egregious examples of gender rating among 25-year-olds in 2009. At this age, women are charged up to 84% more than men for individual health plans that exclude maternity coverage.
- Despite the bleak landscape, two states made improvements since the Center issued its *Nowhere to Turn* report in 2008. In April 2009, Arkansas passed a law expressly prohibiting health insurance companies from using a woman's status as a domestic violence survivor to deny coverage, and in October 2009, California became the eleventh state to ban gender rating in the individual health insurance market.
- New research revealed that, in most states, it is common for a female non-smoker to be charged more than a male smoker in the individual insurance market simply because she is a woman:
    - More than 60% of best-selling plans charge a 40-year-old woman who doesn't smoke more than a 40-year-old man who does.
    - Among those plans that charge female non-smokers more, the difference in premiums varies widely. Across the country, women who do not smoke are charged between 1% more (in Oklahoma City, Oklahoma) and 63% more (in Little Rock, Arkansas) than men who smoke.
- Maternity coverage remains largely unavailable in the individual market, with virtually no improvement in access. In 2009, 13% of the health plans available to a 30-year-old woman across the country provide maternity coverage, compared to 12% in 2008.

- New research revealed the extent to which gender rating can also occur in the group health insurance market, where insurance companies are allowed to determine premiums based on the number of women a business employs, meaning that predominately female workforces—such as in child care centers, physician's offices, or nonprofits—end up paying significantly more for coverage.
    - Just fifteen states have laws protecting group health plans from gender rating, but the protections are limited to small groups—defined by these states as groups with 50 or fewer members.
    - Moderate-sized and larger groups are subject to gender rating in all states except Montana, which bans gender rating across all health insurance markets and for groups of all sizes.

Introduction

In its 2008 report *Nowhere to Turn: How the Individual Insurance Market Fails Women* the National Women's Law Center examined women's experiences in the individual health insurance market, where people try to purchase coverage directly from insurers, and concluded that is a very difficult place for women to buy health coverage.[1] Specifically, in 2008 NWLC found that:

- **Women often face higher premiums than men.** Under a practice known as gender rating, insurance companies in most states are permitted to charge men and women different premiums in the individual market. Among insurers who gender rate, the majority charge women more than men until they reach around age 55, and then some, though not all, charge men more. NWLC found that gender rating is prevalent in health plans across the country, even when maternity care is excluded from the plan. Moreover, the costly and unfair practice of gender rating results in wide variations in rates charged to women and men for the same coverage; these arbitrary differences harm women's ability to get the health care they need.

  Insurance companies also engage in premium rating practices that, while not unique to women, compound the affordability issues caused by gender rating. These include setting premiums based on age and health status.

- **It is difficult and costly for women to find health insurance that covers maternity and other vital care they need.** The vast majority of individual market plans that NWLC examined did not cover maternity care at all. A limited number of insurers sell separate maternity coverage for an additional fee known as a "rider," but this supplemental coverage is often expensive or limited in scope.

- **Insurance companies can reject applicants for health coverage for a variety of reasons that are particularly harmful to women.** It is still legal for insurers in some states to reject applicants who are survivors of domestic violence. Insurers can also reject women for coverage for simply for being pregnant or for having previously had a Cesarean section.

Building on the 2008 research on the individual health insurance market, in October 2009 the Center again gathered and analyzed information on individual health plans offered through eHealthInsurance.com, the leading online source of health insurance for individuals, families and small businesses. Accordingly, this report provides very recent estimates of the prevalence of gender rating, the extent of the difference in premiums charged to women versus men (or the "premium gender gap"), and the availability of coverage for key needs of women—specifically, maternity coverage. It also investigates two previously unexplored issues: whether individual health insurance premiums are higher for a woman even when compared to a man of the same age who reports tobacco usage (in other words, does it cost more to be a woman than a male smoker in the individual market?); and the presence and impact of gender rating in the group health insurance market (i.e., where employers obtain coverage for their employees).

Findings

A. Women Continue to Face Significant Challenges Purchasing Coverage in the Individual Health Insurance Market

Gender Rating Remains Rampant in the Individual Market

In the overwhelming majority of states, insurance carriers are free to practice gender rating in the individual health insurance market, and they do.[14] To assess the prevalence of gender rating among popular plans in the individual health insurance market, NWLC replicated its research from 2008 on gender rating among best-selling plans on eHealthInsurance.com, the leading online source for individual health insurance.

Recent State Efforts to improve Women's Access to Coverage

Among its recommendations in the 2008 *Nowhere to Turn* report, NWLC urged that until adequate alternatives to the flawed individual market exist, individual coverage should be made easier to obtain and afford. Since then, a handful of states have taken steps to improve access to coverage for women in the individual health insurance market. Efforts include:

- In April 2009, Arkansas passed a law expressly prohibiting health insurance companies from using a woman's status as a domestic violence survivor to deny coverage.[2] There are also efforts underway to address health insurance discrimination against survivors of domestic violence in at least four of the eight remaining states that lack such protections: Mississippi,[3] North Carolina,[4] North Dakota,[5] and Oklahoma.[6]
- In October 2009, California became the eleventh state to ban gender rating in the individual health insurance market.[7]
- In the 2009 legislative session, legislation to ban gender rating in the individual health insurance market was introduced in Colorado,[8] Connecticut,[9] Maryland,[10] and New Mexico.[11] Legislation to mandate maternity coverage was considered in California (but ultimately vetoed by the Governor in October 2009),[12] and legislation was introduced in Minnesota[13] that would prohibit insurers from rejecting applications for coverage based on a woman's previous Cesarean delivery.

As shown in Table 1, the Center found that in the capital cities of states that permit gender rating, 95% of best-selling plans charge 40-year-old women more than 40-year-old men for identical coverage, compared to 93% of the best-selling plans examined in 2008. Gender rating is highly prevalent across and within states; in most states, *all* of the best-selling plans engage in this unfair practice. Moreover, the absence or presence of maternity coverage generally cannot explain gender rating. Of the best-selling plans that gender rate in 2009, just 6% include maternity coverage in the individual health insurance policy.

Non-Smoking Women are Charged More Than Male Smokers

After publishing *Nowhere to Turn*, NWLC heard reports that non-smoking women were being charged higher premiums than male smokers in some states. Tobacco use, like gender, age, or health status, is a factor commonly used by insurance companies to vary premiums. NWLC advocates community rating—wherein all enrollees are charged the same premiums, regardless of gender, tobacco usage, or other factors. Yet, many would assume that, in our current health insurance system, males engaging in a behavior with such significant health risks would be charged higher premiums than their female peers.

In 2009, therefore, NWLC performed additional analyses to determine the premium differentials between 40-year-old women non-smokers and 40-year-old men who report tobacco usage within the past 12 months. As Table 1 demonstrates, NWLC found that even when compared to male smokers, most individual health plans still charge a non-smoking woman more for coverage.[15] In the capital cities of states that permit gender rating, 61% of best-selling plans charge a 40-year-old non-smoking woman a higher rate than they charge a 40-year-old male who reports recent tobacco usage.[16]

Among those plans that charge female non-smokers more, the difference in premiums varies widely. Across the country, 40-year-old women who do not smoke are charged between 1% more (in Oklahoma City, Oklahoma) and 63% more (in Little Rock, Arkansas) than men of the same age who smoke (Table 1). This wide variation in premiums provides further evidence of the arbitrary nature of premiums in the individual market.

Wide Variations in the "Premium Gender Gap" Remain, Both Within and Across States

As in 2008, NWLC sought to assess the range of gender rating among comparable plans across the country. To do so, the Center selected plans with a set of similar features (i.e., similar cost-sharing and covered benefits) and calculated the difference in premiums—or the "premium gender gap"—charged to women and men at ages 25, 40, and 55.

As shown in Table 2, gender rating continues to result in wide variations in the premiums charged to women and men for health plans with similar features, both within states and across the country. Gender rating among 25-year-olds varies by an enormous margin. Women at this age are charged between 1% more (in Sacramento, California) and 84% more (in Honolulu, Hawaii) than men for health plans with similar features.

NLWC also found significant variations in the premiums charged to women and men at ages 40 and 55, within ranges similar to those observed in 2008. At 40 years old, women are charged from 4% to 49% more than men for identical coverage, but at age 55, women's premiums range from 11% less to 14% more than men's premiums.

Maternity Coverage Is Still Largely Unavailable

Maternity coverage continues to be largely unavailable in the individual health insurance market, with virtually no improvement in access to this essential health coverage from 2008 to 2009. NWLC examined over 3,600 individual health insurance policies offered to 30-year-old women living in capital cities across the country for 2009, and found that only 468 of those plans—or 13 %—include any coverage for maternity care (in 2008, 12% of plans included maternity benefits).[17] As shown in Table 3, in the capital cities of nearly half of the states there was not a single plan available through eHealthInsurance.com that covered maternity care.

B. Gender Rating in the Group Health Insurance Market: A Barrier to Affordable Coverage for Predominately Female Workforces

Health Insurers Practice Gender Rating for Individuals *and* Groups

The 2008 *Nowhere to Turn* report focused exclusively on gender rating in the individual health insurance market, but the practice of gender rating also occurs in the group health insurance market where, for instance, employers obtain coverage for their employees.[18] Insurers in the group market use gender rating (as well as rating based on age and health status) when deciding how much to charge a group for its health insurance policy. Under this practice, insurers determine premiums based on the number of women a business employs, meaning that businesses with predominantly female workforces end up paying significantly more for coverage. While the employer may not charge individual male and female employees different rates for coverage because of laws that prohibit sex discrimination in employment,[19] there is no similar legal protection to prevent an insurance company from charging groups based on the sex of the group members.[20]

Which Businesses Are Likely to Experience the Most Negative Effects of Gender Rating?

Businesses with a predominately female workforce experience the effects of gender rating most acutely, especially if they employ a large share of younger women. Women account for the majority of employees in a wide range of industries. The fields of home health care and child care, for instance, are majority-female (90% and 95%, respectively).[21] More than three-quarters of people employed by hospitals and physician's offices are women, as are an estimated 81% of the employees in dentists' offices.[22] Women dominate the workforces of pharmacies and drug stores (63%), retail florists (70%), and community service organizations (69%).[23] Over two-thirds of employees in the nonprofit industry are women.[24]

Few States Have Protections against Gender Rating in the Group Health Insurance Market

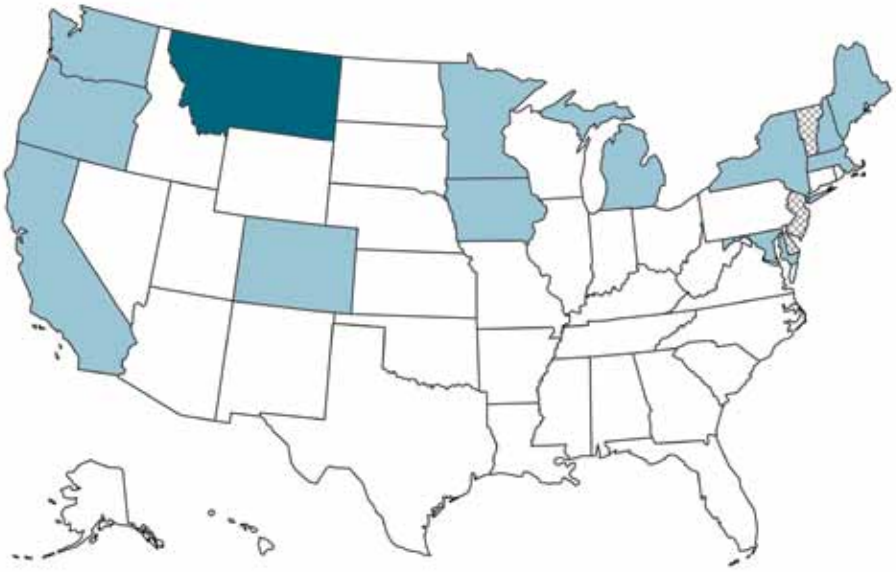
The regulation of insurance has traditionally been a state responsibility[25] and there is no general federal law regulating the premiums charged to groups for health coverage. A handful of states have taken steps to improve access to fair and affordable coverage in the group market by prohibiting or limiting the use of gender when determining health insurance premium rates.

Twelve states have banned gender rating in the small group market, either through community rating provisions (which require an insurer to charge the same premium for all small groups with the same coverage, regardless of the gender, age, health status, or occupation of members) or by specifically prohibiting insurers from considering gender when setting health insurance rates in the small group market. These states are: California,[26] Colorado,[27] Iowa,[28] Maine,[29] Maryland,[30] Massachusetts,[31] Michigan,[32] Minnesota,[33] New Hampshire,[34] New York,[35] Oregon,[36] and Washington.[37]

Three states limit the extent to which insurers may use gender rating to determine premiums for small groups, by using a rate band to set limits between the lowest and highest premium that a health insurer may charge for the same coverage based on gender. These states are: Delaware,[38] New Jersey,[39] and Vermont.[40]

Only one state—Montana—prohibits insurers from using gender as a rating factor in *any* type of insurance policy issued within the state. Montana's distinctive "unisex insurance law" considers gender rating to be discrimination against women and bans the practice among insurers issuing all types of insurance, including health coverage, to individuals and groups of all sizes.[41]

States Protecting Against the Use of Gender to Set Premiums in the Group Health Insurance Market



All groups: State prohibits the use of gender to set premiums for health insurance for groups of all sizes

Small groups: State prohibits the use of gender to set premiums for health insurance for small groups

Small groups: State imposes a rate band to limit the use of gender to set premiums for health insurance for small groups

No groups: State does not have protections against the use of gender to set premiums for health insurance for groups of any size

Where State Protections Exist, They are Typically Limited to Small Groups

With the exception of Montana, protections against gender rating have applied these laws only to health insurance sold to small groups. Most states use an upper size limit of 50 members/employees to define a small group, though a few have established limits as low as 25 members.[42] In nearly all of the states with any group market protections against gender rating, therefore, employers that exceed the state-defined size limit—including those with as few as 51 employees—are still subject to this discriminatory practice.

Employers that exceed the small group threshold have no protection against discriminatory practices such as coverage denials and premium rating based on gender, claims experience, and health status. At the same time, these businesses may not be large enough to "self-insure" their workforce (i.e., when an employer assumes the financial risk of covering its employees and pays medical claims directly from its own resources). Fair and affordable coverage may be out of reach for these employers and, therefore, for their employees as well.

Moreover, when market protections are limited to small groups, employers who grow their workforce *by a single employee* beyond the size limits of the small group market can, in effect, be financially penalized. Employers who lose the insurance protections offered by the small group market could face unfair and costly insurance practices related to premium rating simply because they expanded their workforce.

Caught in the Middle: A Moderate-Sized Business' Experience with Health Insurance[43]

"Maine Home Health" is a woman-owned business in Maine that provides home health care and other services. Most of the 200 employees covered under the group's health insurance plan are women. Though Maine has modified community rating requirements, Maine Home Health exceeds the size limit for these protections, which apply only to insurance companies selling coverage to small groups with 50 or fewer employees. Accordingly, Maine Home Health has struggled to find affordable health coverage. When the time came to renew coverage last year, the business found that its group health premium would increase by a whopping 38%. In ensuing discussions with the health insurance company, Maine Home Health learned that the gender makeup of its workforce was factored into the cost of its health insurance policy. Unable to afford the rate increase but still committed to providing health benefits for its workforce, Maine Home Health was forced to make changes to its health insurance plan. The business substituted its traditional coverage plan with a high-deductible health plan, shifting a greater portion of costs to workers and their families.

Conclusion and Recommendations

Women continue to face unfair and discriminatory practices in the health insurance system, in both the individual and the group health insurance markets. The health insurance inequities described in NWLC's 2008 *Nowhere to Turn* report remain evident one year later, and in some instances have become even more pronounced. Women are charged more for coverage simply because they are women, and insurers often exclude coverage for services that only women need, like maternity care. In the health insurance system, being a woman amounts to being treated like a "pre-existing condition."

Health reform holds the promise of making fair and affordable health insurance available to millions of women who need it. The country is closer than ever before to realizing this goal, but the debate over the scope of insurance market reforms and various other provisions to ensure equitable coverage is far from over. Specifically, to protect women and their families, health care reform must:

✓ **Eliminate unfair and discriminatory practices, such as gender rating, by applying reforms broadly across the individual market and for all groups of all sizes.**

Allowing insurers to use gender (as well as other factors such as health status and claims experience) to determine premiums is wrong, regardless of whether they are selling coverage to an individual or a group of any size. These rating practices can present a barrier to obtaining high-quality and affordable coverage, particularly for businesses with workforces that are predominately female or that have a disproportionate share of workers who are older or in poorer health. Unaffordable premiums can ultimately compel an employer to forgo offering coverage to workers altogether or shift a greater share of health insurance costs to employees.

Insurance market reforms should protect ALL women from unfair practices, whether they obtain coverage through newly-established Health Insurance Exchanges, from an employer of any size (not just a small business), or through an association health plan. Limiting reforms to a subset of the health insurance market—such as for individuals and small groups only—creates a loophole for insurance companies to continue the discriminatory practice of gender rating and squanders an opportunity to ensure uniform and fair rules for all women with health insurance. It allows moderate-sized and larger groups—including those with as few as 51 employees—to continue facing unfair and costly insurance practices related to the gender, age, or health claims history of their employees.

✓ Ensure that essential health services such as maternity care are included in all health insurance policies.

Adequate and affordable maternity coverage is imperative to the health of mothers and their children and should not be a luxury to which only some women have access. All health benefit packages—whether offered through a Health Insurance Exchange, an employer, or another group plan—should cover this type of care. Comprehensive health benefits, including maternity care and the full range of reproductive health services, are a key piece of health reform that meets women's needs.

✓ Prohibit insurers from rejecting applicants or excluding coverage for "pre-existing conditions."

Insurers in the individual market can reject a woman's application altogether or exclude coverage for the care she needs based on "pre-existing conditions," which may include pregnancy, having previously had a C-section or received fertility treatment, being a survivor of domestic violence, or having had medical treatment following a sexual assault. While it is important that some states are taking positive steps on their own, it is essential that health reform eliminates these unfair practices across the nation, so that all women are protected.

The protections that are of fundamental importance for women are essential components of health reform. For women and their families, health reform that assures affordability and fairness will mean the difference between securing access to quality health care, and going without.

Report Methodology

As in 2008, NWLC created two study scenarios to examine the practice of gender rating. For the first, NWLC calculated the difference in premiums (or the "premium gender gap") charged to hypothetical 40-year-old, healthy, non-smoking male and female applicants living in the state's capital city among each of the individual insurance plans identified as "best-selling" in 48 states and D.C.[44] For our 2009 study, NWLC additionally calculated the difference in premiums charged to a hypothetical 40-year-old male reporting tobacco usage during the previous 12 months as compared to a hypothetical 40-year-old female who identifies as a non-smoker, among best-selling plans. These findings are reflected in Table 1.

For the second gender rating study scenario, NWLC submitted information to eHealthInsurance.com for three hypothetical female applicants and three hypothetical male applicants at ages 25, 40 and 55 living in the 50 states and D.C.[45] Applicants were listed as healthy non-smokers living in the state's capital city. Where available, two plans with comparable cost-sharing requirements and coverage (both of which excluded maternity coverage) were sampled in each state and D.C. For each plan, at the three ages listed above, the Center calculated the "premium gender gap"—the difference in premiums charged to female and male applicants of the same age and health status. These findings are reflected in Table 2.

To determine the availability of maternity care coverage, NWLC examined all of the individual health insurance plans available to a healthy, non-smoking 30-year-old woman living in the capital city in 48 states and D.C. (a total of 3,613 plans). These findings are reflected in Table 3.

Finally, for all 50 states and D.C., NWLC examined statutes and regulations relating to the group insurance market to determine whether the states and D.C. place any limitations on premium rating based on gender.

Notably, eHealthInsurance.com may not represent all insurance companies licensed to sell individual health insurance policies in every state. However, the company bills itself as the leading online source of health insurance for individuals, families, and small businesses, partnering with over 160 health insurance companies in 50 states and D.C. and offering more than 7,000 health insurance products online. NWLC used eHealthInsurance.com for this study because it presents the clearest available picture of the individual market across the country, and because it is the most readily available tool for individuals seeking private insurance who do not wish, or cannot afford, to employ the services of an insurance agent.

Endnotes

1 Lisa Codispoti, Brigette Courtot, and Jen Swedish, National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (2008), http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf.

2 2009 Ark. Acts 619.

3 Mississippi Insurance Commissioner Mike Chaney has called on the state legislature to take action banning discrimination against survivors of domestic violence. Ryan Griffin, *Sensitivity Training: GOP Senator Batters Witness Over Domestic Violence Report*, The Huffington Post (2009), at http://www.huffingtonpost.com/2009/10/16/sensitivity-training-gop_n_323714.html.

4 North Dakota Insurance Commissioner Adam Hamm and Governor John Hoeven are working to change the present policy in their state. *Ibid.*

5 North Carolina Insurance Commissioner Wayne Goodwin stated that he would ask the legislature to clarify current state law and that he would implement new administrative rules that would prohibit insurers from discriminating against domestic violence survivors in the individual market. State law already prohibits such discrimination in group plans. *Ibid.*

6 State Senator Jim Wilson intends to introduce SB 1251, which would prohibit any insurance plan issued or renewed on or after Nov. 1, 2010, from considering domestic abuse as a pre-existing condition. *Ibid.*

7 2009 Cal. Stat. AB 119 (effective January 2011).

8 The bill, HB 1224, would have amended Colo. Rev. Stat. § 10-16-107 to prohibit gender rating in the individual market. Instead, the bill was amended to commission a study on the issue, and ultimately signed by the Governor in May 2009.

9 SB 822 was referred to the Committee on Insurance and Real Estate where it did not advance.

10 HB 1280 did not advance from the Maryland House Health and Government Operations Committee.

11 HB 110 was reported out of the Health and Government Affairs Committee, but did not advance from the Business and Industry Committee.

12 AB 98 was passed by both the State Senate and Assembly, but was vetoed by Governor Arnold Schwarzenegger in October 2009.

13 SF 1469 passed the Senate but was not heard in the House before committee deadlines in late March. The bill is expected to be brought up in the House during the next session, in January 2010.

14 Insurance companies in the individual market are prohibited from gender rating in ten states: Maine, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New York, North Dakota, Oregon, and Washington. In two states—New Mexico and Vermont—the practice of gender rating is limited in the individual market with a rate band. [For full statutory citations, see *Nowhere to Turn supra* note 1.] In addition, on October 11, 2009, California governor Arnold Schwarzenegger signed Assembly Bill 119, which prohibits gender rating in the state's insurance markets, into law. The law affects insurance policies issued or renewed on or after January 1, 2011.

15 Analyses only includes data for 40 states and the District of Columbia where gender rating is not entirely prohibited (with the exception of North Dakota and New Jersey, where some plans are allowed to use gender rating despite state laws that ban the practice) and individual health policies are offered through eHealthInsurance.com.

16 About half as many of these plans—35%—charge male smokers higher premiums than female nonsmokers, and the remaining 4% charge male smokers and female nonsmokers the same premium.

17 To determine whether maternity care was covered in a health plan, NWLC followed the presence or absence of a 'maternity icon' used by eHealthInsurance.com to designate that such benefits were covered within the health insurance policy. Health plans that offer 'maternity riders' at additional cost are not designated as plans that provide maternity care (i.e. the maternity icon is not displayed) and are not included in the estimate of plans that cover maternity care. For 2009, NWLC did not assess whether a plan's maternity coverage was "comprehensive" (coverage for pre—and post-natal visits as well as labor and delivery, for both routine pregnancies and in case of complications) as it did for the 2008 analysis. See Table 3 Methodology notes for further detail.

18 There are also non-employer based group plans that provide insurance, commonly referred to as association health plans.

19 42 U.S.C. § 2000e-2(a)(1) (2008) (Title VII of the Civil Rights Act of 1964 makes it an unlawful employment practice "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex or national origin"). See also U.S. Equal Employment Opportunity Comm'n, *Directives Transmittal No. 915.003 EEOC Compliance Manual Chapter 3: Employee Benefits* (Oct. 3, 2000), http://www.eeoc.gov/policy/docs/benefits.html ("health insurance benefits must be provided without regard to the race, color, sex, national origin, or religion of the insured. An employer must non-discriminatorily provide to all similarly situated employees the same opportunity to enroll in any health plans it offers. An employer must also ensure that the terms of its health benefits are non-discriminatory").

20 Nor is there any prohibition on sex discrimination in health care more generally.

21 U.S. Bureau of Labor Statistics, *Women in the Labor Force: A Data Book, 2008 Edition* (2008), "Table 14: Employed Persons by Detailed Industry and Sex, 2007 Annual Averages", http://www.bls.gov/cps/wlf-databook-2008.pdf.

22 *Ibid.*

23 *Ibid.*

24 Jasmine McGinnis, Georgia State University and Georgia Institute of Technology, *The Young and Restless: Generation Y in the Nonprofit Workforce* (Working Paper, 2009), http://www.utexas.edu/lbj/rgk/fellowship/2009papers/McGinnis.pdf.

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

26 Cal. Ins. Code §§ 10714(a)(2), 10700(t)–(v) (West 2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, and family size, in addition to the benefit plan selected by the employee).

27 Colo. Rev. Stat. §§ 10-16-105(8)(a), 10-16-102(10)(b) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, family size, smoking status, claims experience, and health status).

28 Iowa Code § 513B.4(2) (2008) (prohibiting the use of rating factors other than age, geographic area, family composition, and group size without prior approval of the insurance commissioner).

29 Me. Rev. Stat. Ann. tit. 24-A, § 2808-B(2)(B) (2008) (prohibiting small employer insurance carriers from varying the community rate based on gender, health status, claims experience or policy duration of the group or group members).

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

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

32 Mich. Comp. Laws § 500.3705(2)(a) (2008) (prohibiting commercial small employer insurance carriers from setting premium rates based on characteristics of the small employer other than industry, age, group size, and health status).

33 Minn. Stat. § 62L.08(5) (2008) (prohibiting the use of gender as a rating factor for small employer insurance carriers).

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

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

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

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

38 Del. Code Ann. tit. 18, § 7205(2)(a) (2008) (allowing small employer insurance carriers to vary premium rates based on gender and geography combined by up to 10 percent).

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

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

41 Mont. Code Ann. § 49-2-309(1) (2008).

42 In Louisiana, for instance, a small group is defined as 35 or fewer members. Arkansas and Tennessee define a small group as one that has 25 or fewer members (Unpublished research conducted by the National Women's Law Center, 2009).

43 Based primarily on information collected by the National Women's Law Center through personal communication with the owner of "Maine Home Health" (business name has been changed to protect anonymity) and informed by additional conversations with owners and human resources managers of predominately female workforces in several states during August and September 2009.

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

45 No policies were available on eHealthInsurance.com in the capital cities of Maine, Rhode Island, or Vermont.

Table 1. Prevalence of Gender Rating and Difference in the Premiums Charged to 40-Year-Old Female Non-Smokers and Male Smokers in States' Best-Selling Plans in the Individual Insurance Market[a]

Women who do not smoke are frequently charged higher premiums than men who do smoke for the best-selling plans offered in their state's capital city. For instance, all (100%) of the best-selling plans available to a 40-year-old non-smoking woman living in Boise, Idaho, charge her more in premiums than they charge a 40-year-old man who smokes. Depending on the best-selling plan she selects, the non-smoking woman is charged at least 29% more and up to 46% more than the man who smokes for the same coverage.

State	Best-Selling Plans That Practice Gender Rating[b] (%)	Best Selling Plans that Charge Non-Smoking Women More than Men Smokers (%)	The Range in Difference in Premiums, Among Plans that Charge Non-Smoking Women More than Men Smokers	
			Minimum (%)	*Maximum (%)*
Alabama	100	50	4	12
Alaska	100	90	3	35
Arizona	100	70	2	41
Arkansas	100	70	5	63
California[c]	90	70	5	39
Colorado	90	50	4	49
Connecticut	100	70	4	42
Delaware	80	50	4	14
District of Columbia	70	50	4	41
Florida	100	50	6	34
Georgia	100	82	6	47
Hawaii	100	100	22	24
Idaho	100	100	29	46
Illinois	100	30	6	40
Indiana	100	50	6	40
Iowa	100	60	4	6
Kansas	100	60	6	34
Kentucky	100	70	2	40
Louisiana	100	70	6	15
Maine[d]	N/A (and gender rating prohibited)			
Maryland	50	30	5	40
Massachusetts	Gender rating prohibited			
Michigan	80	40	4	41
Minnesota	Gender rating prohibited			
Mississippi	100	50	4	14
Missouri	100	70	4	48
Montana	Gender rating prohibited			
Nebraska	100	60	4	41
Nevada	100	70	4	40
New Hampshire	Gender rating prohibited			
New Jersey[e]	100	100	23	37
New Mexico[f]	100	50	4	8
New York	Gender rating prohibited			
North Carolina	100	80	4	11
North Dakota[g]	100	0	N/A	N/A
Ohio	100	60	6	40
Oklahoma	100	80	1	34
Oregon	Gender rating prohibited			
Pennsylvania	100	80	6	40
Rhode Island[d]	N/A			
South Carolina	100	60	6	45
South Dakota	100	60	4	18
Tennessee	100	40	6	23
Texas	100	64	2	40
Utah	70	50	2	15
Vermont[d,f]	N/A			
Virginia	100	80	5	11
Washington	Gender rating prohibited			
West Virginia	100	70	4	34
Wisconsin	100	50	1	16
Wyoming	100	38	4	35
United States	**95**	**61**	**1**	**63**

See Table 1 Notes and Methodology, next page.

Table 1 Notes and Methodology

a. "Best-Selling" status is assigned by eHealthInsurance.com, based on the number of applications submitted through eHealthInsurance.com and approved by the insurance company during the most recent calendar quarter.

b. Across the nation, a total of 374 best-selling plans (95 percent) gender rate. The absence or presence of maternity coverage generally cannot explain gender rating. Of the best-selling plans that gender rate, a total of 23 (6 percent) include maternity coverage in the individual health insurance policy.

c. Two of the best-selling plans in California that gender rate charge a 40-year-old non-smoking man more than a 40-year-old non-smoking woman. All of the other best-selling plans identified in this column as practicing gender rating charge a 40-year-old non-smoking woman more than a man of the same age.

d. Individual rate quotes were not available for Maine, Rhode Island, or Vermont through eHealthInsurance.com.

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

f. In Vermont and New Mexico, gender rating is limited by a rate band.

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

The data in Table 1 were gathered through eHealthInsurance.com from its website (http://www.ehealthinsurance.com). NWLC submitted information for a hypothetical female applicant and two hypothetical male applicants at age 40 in 50 states and D.C., using a coverage start date of November 1, 2009. For the female applicant and one of the two hypothetical male applicants, NWLC did not report any tobacco usage within the last twelve months; for the second male applicant, the Center did report tobacco usage within the last twelve months. All applications were listed as living in the state's capital city, in the same zip code as the governor's office (in D.C. the zip code of the mayor's office was used). For each of the 48 states and D.C. where coverage was offered, NWLC then determined how many of the best-selling individual insurance plans use gender as a rating factor when both the male and female applicants identify as non-smokers, and how many plans charge female applicants higher premiums than male applicants of the same age when the male applicants report recent tobacco usage. For each plan that charges female non-smokers more than male smokers, NWLC calculated the difference in premiums. The Table indicates the minimum and maximum percentage difference in the premiums charged to a male smoker and a female non-smoker among the best selling plans that charge non-smoking females more.

Table 2. Percent Difference in Premiums Charged to Women versus Men (the "Premium Gender Gap") for Similar Health Plans in the Individual Insurance Market (two similar sets of plans called Plan A and Plan B)

The 'premium gender gap' reflects the difference in premiums charged to same-aged women and men for similar individual insurance market plans sold in their state's capital city. For each state, 'premium gender gap' comparisons are made for two sets of plans - Plan A and Plan B. For instance, a 40-year-old woman living in Montgomery, Alabama is charged 20 percent more than a 40-year-old man for Plan A. A 55-year-old woman living in Sacramento, California is charged 7 percent less than a 55-year-old man for Plan B. Unless otherwise noted, health plans have a deductible of $2,500, require 0% coinsurance, include prescription drug coverage, and exclude maternity coverage.[a]

State	Plan	Premium Gender Gap		
		25-Year-Olds	40-Year-Olds	55-Year-Olds
Alabama	A	10%	20%	-1%
	B	22%	37%	4%
Alaska	A	10%	20%	-1%
	B	12%	15%	-9%
Arizona	A	10%	20%	-1%
	B	24%	37%	5%
Arkansas	A	81%	49%	9%
	B	10%	20%	-1%
California	A	10%	20%	-1%
	B	1%	8%	-7%
Colorado	A	10%	20%	-1%
	B	23%	38%	5%
Connecticut	A	42%	4%	-1%
	B	10%	20%	-1%
Delaware	A	10%	20%	-1%
	B	16%	15%	-9%
District of Columbia	A	10%	20%	-1%
	B	15%	15%	-9%
Florida	A	10%	20%	-1%
	B	23%	37%	5%
Georgia	A	10%	20%	-1%
	B	32%	45%	9%
Hawaii[b]	A	82%	23%	10%
	B	84%	23%	10%
Idaho	A	41%	46%	8%
	B	37%	41%	8%
Illinois	A	10%	20%	-1%
	B	33%	21%	-9%
Indiana	A	33%	38%	7%
	B	10%	20%	-1%
Iowa	A	10%	20%	-1%
	B	44%	39%	14%
Kansas	A	10%	20%	-1%
	B	69%	48%	6%
Kentucky	A	24%	38%	7%
	B	19%	38%	4%
Louisiana	A	10%	20%	-1%
	B	39%	36%	2%
Maine[c]	N/A (and gender rating prohibited)			
Maryland	A	6%	21%	0%
	B	16%	15%	-9%
Massachusetts	A	Gender rating prohibited		
	B			
Michigan	A	10%	20%	-1%
	B	25%	38%	6%
Minnesota	A	Gender rating prohibited		
	B			
Mississippi	A	12%	20%	-1%
	B	23%	37%	4%
Missouri	A	48%	45%	6%
	B	10%	20%	-1%

State	Plan	Gender Gap		
		25-Year-Olds	40-Year-Olds	55-Year-Olds
Montana	A	Gender rating prohibited		
	B			
Nebraska	A	41%	44%	9%
	B	10%	20%	-1%
Nevada	A	6%	21%	0%
	B	22%	37%	4%
New Hampshire	A	Gender rating prohibited		
	B			
New Jersey	A	Gender rating prohibited		
	B			
New Mexico	A	10%	20%	-1%
	B	0%	15%	-9%
New York	A	Gender rating prohibited		
	B			
North Carolina	A	10%	37%	4%
	B	23%	14%	-11%
North Dakota[d]	A	56%	30%	N/A
	B	57%	30%	N/A
Ohio	A	33%	45%	5%
	B	57%	20%	-8%
Oklahoma	A	25%	31%	0%
	B	10%	22%	-8%
Oregon	A	Gender rating prohibited		
	B			
Pennsylvania	A	6%	21%	0%
	B	38%	34%	-4%
Rhode Island[c]	N/A			
South Carolina	A	10%	20%	-1%
	B	23%	37%	4%
South Dakota	A	10%	20%	-1%
	B	11%	16%	-9%
Tennessee	A	10%	20%	-1%
	B	23%	15%	-9%
Texas	A	10%	20%	-1%
	B	22%	37%	4%
Utah	A	22%	37%	4%
	B	0%	0%	0%
Vermont[c]	N/A			
Virginia	A	14%	32%	-1%
	B	45%	21%	-2%
Washington	A	Gender rating prohibited		
	B			
West Virginia	A	10%	20%	-1%
	B	15%	15%	-9%
Wisconsin	A	33%	38%	7%
	B	10%	20%	-1%
Wyoming	A	10%	20%	-1%
	B	12%	15%	-9%

See Table 2 Notes and Methodology, next page.

Table 2 Notes and Methodology

a. In certain cases, NWLC could not identify a plan with all of the "standard" features desired for this analysis (such as a deductible of $2,500, a 0% coinsurance rate, inclusion of prescription drug coverage, and exclusion of maternity coverage). See below for more information about those cases.

b. The corresponding table in the 2008 report *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* did not include data for health plans in Hawaii; at that time, there were no health plans with similar features available for analysis in the state.

c. No rate quotes were available on eHealthInsurance.com in Maine, Rhode Island, or Vermont.

d. Gender rating is prohibited in North Dakota, but the only company offering individual policies through eHealthInsurance.com does use gender as a rating factor. There are no plans available for 55-year-olds living in the state capital of North Dakota on eHealthInsurance.com.

The data in Table 2 were gathered through eHealthInsurance.com from its website (http://www.ehealthinsurance.com). NWLC submitted information for three hypothetical female applicants (ages 25, 40, and 55) and three hypothetical male applicants (ages 25, 40, and 55) in 50 states and D.C., using a coverage start date of November 1, 2009. Applicants were listed as healthy non-smokers living in the state's capital city, in the same zip code as the governor's office (in D.C. the zip code of the mayor's office was used). In the 47 states and D.C. in which coverage was available through eHealthInsurance.com, NWLC then selected for each age group two distinct individual insurance plans—"Plan A" and "Plan B"—with similar features, including a $2,500 deductible, a 0% coinsurance rate, inclusion of prescription drug coverage, and exclusion of maternity coverage. For both "Plan A" and "Plan B" NWLC obtained quotes for monthly premiums charged to a woman and to a man. NWLC then calculated the premium gender gap—the difference in the premiums charged to a woman versus a man for the same exact health plan, represented as a percentage of the man's premium. This calculation was carried out for men/women at ages 25, 40, and 55, for both "Plan A" and "Plan B."

In some cases, NWLC could not identify a plan with all of the features desired for this analysis (such as a deductible of $2,500, a 0% coinsurance rate, inclusion of prescription drug coverage, and exclusion of maternity coverage). In these instances, an alternative plan was selected for inclusion in the analysis. Specifically:

- Health plans in Hawaii (Plans A and B), New York (Plans A and B), and North Dakota (Plans A and B), Oregon (Plans A and B), and Utah (Plan B) have deductibles other than $2,500.
- Health plans in Idaho (Plan A), Minnesota (Plans A and B), Montana (Plans A and B), New Jersey (Plans A and B), New York (Plans A and B), and Oregon (Plans A and B) include coverage for maternity care.
- Health plans in Idaho (Plans A and B), Minnesota (Plan A), New Jersey (Plans A and B), and Washington (Plans A and B) have coinsurance rates other than 0%.

Table 3: Maternity Coverage Available to a 30-Year-Old Woman In the Individual Insurance Market, by State

State[a]	Total Number of Plans Available	Plans that Cover Maternity Care[b] # (%)
Alabama	65	0 (0%)
Alaska	46	16 (35%)
Arizona	106	5 (5%)
Arkansas	102	7 (7%)
California	107	21 (20%)
Colorado	114	0 (0%)
Connecticut	82	2 (2%)
Delaware	61	2 (3%)
District of Columbia	86	30 (35%)
Florida	79	0 (0%)
Georgia	113	14 (12%)
Hawaii	4	0 (0%)
Idaho	41	30 (73%)
Illinois	128	1(1%)
Indiana	95	0 (0%)
Iowa	84	4 (5%)
Kansas	77	0 (0%)
Kentucky	63	0 (0%)
Louisiana	107	0 (0%)
Maine[c]	N/A	
Maryland	105	39 (37%)
Massachusetts[d]	8	8 (100%)
Michigan	99	2 (2%)
Minnesota	52	46 (88%)
Mississippi	61	0 (0%)
Missouri	114	9 (8%)
Montana[d]	26	26 (100%)
Nebraska	95	5 (5%)
Nevada	95	0 (0%)
New Hampshire	30	2 (7%)
New Jersey[e]	21	21 (100%)
New Mexico	54	0 (0%)
New York	3	2 (67%)
North Carolina	91	0 (0%)
North Dakota	12	0 (0%)
Ohio	115	0 (0%)
Oklahoma	95	0 (0%)
Oregon[d]	99	99 (100%)
Pennsylvania	95	8 (8%)
Rhode Island[c]	N/A	
South Carolina	113	0 (0%)
South Dakota	26	0 (0%)
Tennessee	93	0 (0%)
Texas	131	14 (11%)
Utah	71	41(58%)
Vermont[c]	N/A	
Virginia	80	0 (0%)
Washington[e]	58	14 (24%)
West Virginia	52	0 (0%)
Wisconsin	107	0 (0%)
Wyoming	52	0 (0%)
UNITED STATES	3,613	468 (13%)

See Table 3 Notes and Methodology, next page.

Table 3 Notes and Methodology

a. Using eHealthInsurance.com, NLWC identified all plans available to a 30-year-old woman living in each state's capital city with a coverage start date of November 1, 2009.

b. NWLC relied on the presence or absence of a "maternity icon" used by eHealthInsurance.com to determine whether maternity care was covered in a health plan. Health plans that offer "maternity riders" at additional cost are not included in the estimate of plans that cover maternity care. NWLC did not attempt to assess whether maternity coverage was comprehensive.

c. Individual policies were not available for Maine, Rhode Island, or Vermont through eHealthInsurance.com.

d. The state requires that all insurers in the individual health insurance market cover maternity.

e. Though the state requires that all insurers in the individual health insurance market cover maternity, the mandates exempt bare-bones individual insurance policies, which are included among the plans available through eHealthInsurance.com. Therefore, not all plans in these states include maternity coverage.

The data in Table 3 were gathered through eHealthInsurance.com from its website (http://www.ehealthinsurance.com). For 50 states and D.C., NWLC submitted information for a hypothetical 30-year-old female applicant, listing a coverage start date of November 1, 2009. The applicant was listed as a healthy non-smoker living in the state's capital city, in the same zip code as the governor's office (in D.C. the zip code of the mayor's office was used). For each of the 48 states and D.C. where coverage was offered, NWLC calculated the total number of best-selling plans in the state's capital city for which eHealthInsurance.com's "maternity icon" indicated that such benefits were covered within the health insurance policy.

For 2009, NWLC did not assess whether a plan's maternity coverage was "comprehensive" (coverage for pre- and post-natal visits as well as labor and delivery, for both routine pregnancies and in case of complications) as it did for the 2008 analysis. To make proper comparisons between the two years, NWLC performed an analysis of the 2008 plan data that was identical to the 2009 analysis of "maternity icons," and found that 12.4 % of plans examined in 2008 included this icon. This proportion is very similar to the proportion of plans that NWLC determined to have "comprehensive coverage" (12.0%) in the more extensive 2008 analysis.

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