

**Testimony of Marcia D. Greenberger
Co-President, National Women's Law Center**

**Committee on Health, Education, Labor, and Pensions
What Women Want: Equal Health Care for Equal Premiums**

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Madame Chairwoman and members of the Committee on Health, Education, Labor and Pensions, thank you for this opportunity to testify on behalf of the National Women's Law Center. The Center is a non-profit organization that has worked to expand the possibilities for women and girls in this country since 1972. Since its founding, the Center has confronted the health care coverage problems that women face, which have extracted a high toll on women and their families. The health care reform legislation now under debate can provide the major improvements in health care quality and affordability that women and their families so desperately need.

Introduction

In particular, I want to focus on the results of the Center's research for a report we published in 2008 called *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*, supplemented by the stories of many individual women who have told us about the challenges they encounter in the health system every day. A copy of the report is attached as an appendix to my testimony. Among the most deplorable of these obstacles are the harmful and discriminatory practices of insurance companies, including gender rating and coverage exclusions of health care services that only women need. Regardless of whether they receive their coverage from an employer via the group health insurance market or are left to purchase health insurance directly from insurers through the individual market, health insurance practices can hinder a woman's ability to obtain affordable and comprehensive health care coverage.

The majority of American women have health insurance either through an employer or through a public program such as Medicaid. In 2008, nearly two-thirds of all women aged 18 to 64 had insurance through an employer, and another 16% had insurance through a public program.¹ In addition, about 7% of nonelderly women purchase health coverage directly from insurance companies in what is known as the "individual market."² For the 18% of women who are currently uninsured³—largely those who lack access to employer coverage and who do not qualify for public programs—the individual insurance market is often the last resort for coverage.

While women who get health insurance from their employer are partially protected by both federal and state employment discrimination laws, states are left to regulate the sale of health insurance in the individual market with no minimum federal standards. In the vast majority of states, few if any such protections exist for women who purchase individual health coverage. Furthermore, those seeking health coverage in the individual market are often less able to afford insurance without the benefit of an employer to share the cost of the premium.

The individual health insurance market presents numerous problems for women, but even those who obtain group health insurance from their employer are adversely affected by some of the same harmful practices that impede access to affordable coverage in the individual market.

Women Face Many Challenges in the Individual Insurance Market

To learn more about the experiences of women seeking coverage in the individual insurance market, between July and September 2008, the National Women’s Law Center (“NWLC” or “the Center”) gathered and analyzed information on over 3,500 individual health insurance plans available through the leading online source of health insurance for individuals, families and small businesses.⁴ The Center investigated two phenomena: the “gender gap”—the difference in premiums charged to female and male applicants of the same age and health status—in plans sampled from each state and the District of Columbia (D.C.), and the availability and affordability of coverage for maternity care across the country.⁵ NWLC examined state statutes and regulations relating to the individual insurance market to determine whether the states and D.C. have protections against premium rating based on gender, age, or health status in the individual market, and to determine whether states have any maternity coverage mandates requiring insurers in the individual market to cover comprehensive maternity care (defined as coverage for prenatal and postnatal care as well as labor and delivery for both routine and complicated pregnancies).

Based on this research, NWLC found that the individual insurance market is a very difficult place for women to buy health coverage. Insurance companies can refuse to sell women coverage altogether due to a history of any health problems whatsoever, or charge women higher premiums based on factors that include gender, age and health status. This coverage is often very costly and limited in scope, and it fails to meet women’s needs. In short, women face too many obstacles obtaining comprehensive, affordable health coverage in the individual market—simply because they are women.

- **Women often face higher premiums than men.** Under a practice known as gender rating, insurance companies are permitted in most states to charge men and women different premiums. This costly practice often results in wide variations in rates charged to women and men for the same coverage. The Center’s 2008 research on gender rating in the individual market found that among insurers who gender rate, the majority charge women significantly more than men until they reach around age 55, and then some (though not all) charge men only somewhat more.⁶ The Center also found huge and arbitrary variations in each state and across the country in the difference in premiums charged to women and men. For example, insurers who practice gender rating charged 40-year-old women from 4% to 48% more than 40-year-old men.⁷ The huge variations in premiums charged to women and men for identical health plans highlight the arbitrariness of gender rating, and the financial impact of gender rating is compounded when insurers also omit coverage for services that women need (like maternity care) or charge a higher premium because a woman has a pre-existing condition.

- **Insurance companies can deny applicants health coverage for a variety of reasons that are particularly harmful to women.** In the vast majority of states, individual market insurers can use evidence of a “pre-existing” condition to deny coverage or exclude important health benefits. Simply being pregnant or having had a Cesarean section is grounds enough for insurance companies to reject a woman’s application.⁸ And in eight states and the District of Columbia, insurers are allowed to use a woman’s status as a survivor of domestic violence to deny her health insurance coverage.⁹
- **It is difficult and costly for women to find health insurance that covers maternity care.** After reviewing over 3,500 policies available to women across the nation in 2008, NWLC found that the vast majority of individual market health insurance policies do not cover maternity care at all. Just 12 percent included comprehensive maternity coverage (i.e. coverage for pre- and post-natal visits as well as labor and delivery, for both routine pregnancies and in case of complications) within the insurance policy.

While women in some states may be able to purchase optional maternity coverage (called a “rider”) for an additional premium, the extra cost can be prohibitively expensive; NWLC identified maternity riders that cost over \$1000 per month, in addition to a woman’s regular insurance premium. Riders may also involve a waiting period (one or two years, for example) and benefits are often limited in scope.¹⁰ Moreover, insurers that sell maternity riders typically offer just a single rider option. Typically, a woman cannot select a more or less comprehensive rider policy—her only option is to purchase the limited rider or go without maternity coverage altogether.¹¹

Other research confirms the dearth of maternity coverage in the individual health insurance market. In California, for example, the California Health Benefits Review Program found that only 22 percent of the estimated 1,038,000 people in the individual market in California in 2009 had maternity benefits—a dramatic decrease from the 82% of people with individual policies that covered maternity in 2004.¹²

- **Both women and men face problems in the individual insurance market that gender rating compounds.** 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.¹³

Women Face Similar Challenges in the Group Insurance Market

The practice of gender rating also occurs in the group health insurance market, most notably when employers obtain coverage for their employees.¹⁴ Insurance companies in most states are allowed to use the gender make-up of an insured group as a rating factor when determining how much to charge the group for health coverage. From the employee’s perspective, this disparity may not be apparent, since employment discrimination laws prohibit an employer from charging male and female employees

different rates for coverage, and employers themselves often do not know the factors that determine the rates they are charged. Yet gender rating in the group insurance market can present a serious obstacle to affordable health coverage for an employer and all of its employees. If the overall premium is not affordable, a business may forgo offering coverage to workers altogether, or shift a greater share of health insurance costs to employees.

- **Gender rating may affect health premium costs for employers of varying sizes.** As a result of state and federal employment discrimination protections that apply to employer-provided fringe benefit plans including health insurance, gender rating—while still present in the group market—manifests itself differently than in the individual market. Under federal and most state laws, employers unlawfully discriminate if they charge female employees more than male employees for the same health coverage.

Nonetheless, when a business applies for health insurance, the majority of states allow insurance companies to determine the premium that will be charged using a process known as “medical underwriting.” As part of this process, an insurer considers various criteria—such as gender, age, health status, claims experience, or occupation—and decides how much to charge an applicant for health coverage. In the large group market, insurers underwrite the group as a whole rather than considering the health-related factors of each employee—but this limitation provides little relief for employers with a high proportion of female workers.¹⁵ Under the premise that women have, on average, higher hospital and physicians’ costs than men, insurance companies that gender rate may charge employers more for health insurance if they have a predominantly female workforce. This can raise premiums for all employees and potentially move the employer to forgo providing health coverage all together.

In the wide range of industries in which women dominate the workforce, gender rating makes group health plan premiums harder to afford. The fields of home health care and child care, for instance, are majority-female (90% and 95%, respectively).¹⁶ More than three-quarters of people employed by hospitals and physician’s offices are women, as are an estimated 82 percent of the employees in dentists’ offices.¹⁷ Women dominate the workforces of pharmacies and drug stores (63%), retail florists (70%), and community service organizations (69%).¹⁸ Over two-thirds of employees in the nonprofit industry are women.¹⁹

Discriminatory Insurance Industry Practices Contribute Significantly to Women’s Affordability Challenges

Unfair insurance industry practices—including gender rating, denials based on pre-existing conditions and exclusion of coverage for essential needs like maternity care—exacerbate the affordability problems that women are especially likely to face. Greater health care needs,²⁰ combined with a disadvantaged economic status and discriminatory industry practices, make it difficult for many women to afford necessary care.

Regardless of whether they have health insurance, women face more cost-related challenges to securing access to health care than men.²¹ They generally have less income,

earning only 77 cents, on average, for every dollar that men earn.²² Roughly 57 percent of the adults living in poverty (i.e. with incomes below 100 percent of the federal poverty level) are women.²³ In 2008, the median earnings of female workers working full time, year round, were \$35,745, compared to \$46,367 for men.²⁴

Women spend a greater share of their income on out-of-pocket medical costs than men, and are more likely to avoid needed health care because of cost. In 2007, for example, 52% of all nonelderly women reported a cost-related access barrier—including not filling a prescription, skipping a recommended test or treatment, or not getting needed basic or specialist care because of cost—compared to 39% of all nonelderly men.²⁵

Women are also more likely than men to experience significant financial hardship as a result of medical bills. In 2007, one-third of women, compared to one-quarter of men, were either unable to pay for food, heat or rent; had used up all of their savings; had taken out a mortgage or loan against their home; or had taken on credit card debt because of medical bills.²⁶ Overall, seven in ten women are either uninsured or underinsured, struggling to pay a medical bill, or experiencing another cost-related problem in accessing needed care.²⁷

Some States Have Taken Action to Protect Consumers in the Individual and Small Group Markets

Some states have taken action to address the challenges that women, and employers with female employees, face in the individual and group markets.

- **Protections against gender rating:** Because the regulation of insurance has been largely left to the states,²⁸ no federal law provides protections against gender rating in the individual and group markets. Overall, 39 states and D.C. allow gender rating in the individual market, with two of these states limiting the amount premiums can vary based on gender through “rate bands.”²⁹ However, even states that ban gender rating allow some plans to use this practice, such as the bare-bones basic and essential plans offered in New Jersey.³⁰ There are three basic approaches to prohibit or limit gender rating in the individual market:
 - **Explicit Protections against Gender Rating:** Five states in the individual market have passed laws prohibiting insurers from considering gender when setting health insurance rates: California,³¹ Minnesota,³² Montana,³³ New Hampshire,³⁴ and North Dakota.³⁵ California became the most recent state to ban gender rating, through a bill that Governor Schwarzenegger signed into law on October 11, 2009.
 - **Community Rating:** Currently, six states prohibit the use of gender as a rating factor under community rating statutes: New York imposes pure community rating³⁶; while Maine,³⁷ Massachusetts,³⁸ New Jersey,³⁹ Oregon,⁴⁰ and Washington⁴¹ impose modified community rating that, in addition to prohibiting rating based on health status, also bans rating based on gender.
 - **Gender Rate Bands:** Some states have passed laws limiting insurers’

ability to base premiums on gender by establishing a “rate band,” which sets limits between the lowest and highest premium that a health insurer may charge for the same coverage based on gender. In the individual market, two states—New Mexico⁴² and Vermont⁴³—use rate bands to limit insurers’ ability to vary rates based on gender.

In the group market, twelve states have banned gender rating altogether. Three states have applied gender “rate bands,” and one state prohibits gender rating unless the carrier receives prior approval from the state insurance commissioner.

- Explicit Protections against Gender Rating: 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 “unisexual 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.⁴⁴

In addition, California,⁴⁵ Colorado,⁴⁶ Michigan,⁴⁷ and Minnesota,⁴⁸ specifically prohibit insurers from considering gender when setting health insurance rates in the small group market.

- Community Rating: New York⁴⁹ imposes pure community rating in its small group market, while Maine,⁵⁰ Maryland,⁵¹ Massachusetts,⁵² New Hampshire,⁵³ Oregon,⁵⁴ and Washington⁵⁵ ban gender-based rating under modified community rating.
- Gender Rate Bands: Three states—Delaware,⁵⁶ New Jersey,⁵⁷ and Vermont⁵⁸—limit the extent to which insurers may vary premium rates based on gender through a rate band.
- Other: One state, Iowa,⁵⁹ prohibits gender rating unless a small group insurance carrier secures prior approval from the state insurance commissioner.

It is important to note that with the exception of Montana, the states’ group market gender rating regulations apply 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.⁶⁰ In nearly all of the states with 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.

- **Maternity mandates**: The federal Pregnancy Discrimination Act protects women in covered employer-provided health plans against the exclusion of maternity benefits,⁶¹ but no similar federal protection exists for women in the individual market. A handful of states have recognized the importance of ensuring that maternity coverage—including prenatal, birth, and postpartum care—is a part of

basic health care by establishing a “benefit mandate” law that requires insurers to include coverage for maternity services in all individual health insurance policies sold in their state. Currently, just five states have enacted mandate laws that require all insurers in the individual market to cover the cost of maternity care. These states are: Massachusetts,⁶² Montana,⁶³ New Jersey,⁶⁴ Oregon,⁶⁵ and Washington.⁶⁶ In New Jersey and Washington, individual insurance providers are allowed to offer bare-bones plans that are exempt from the mandate and exclude maternity coverage.⁶⁷

Beyond this short list of five, other states have adopted limited-scope mandate laws for the individual market that require maternity coverage only for certain types of health plan carriers, certain types of maternity care, or for specific categories of individuals. Limited-scope mandate laws address the provision of maternity care but may fall short of providing women with full coverage for the care they need. In California,⁶⁸ Illinois,⁶⁹ and Georgia,⁷⁰ for example, only Health Maintenance Organizations (HMOs) are subject to state laws that mandate maternity benefits in the individual insurance market.

With regard to the group market, some states have taken an additional step to guarantee that women who work for small businesses have access to employer-sponsored insurance that includes maternity benefits, since employers with fewer than 15 workers are not subject to the federal Pregnancy Discrimination Act law requiring businesses to provide the same level of coverage for pregnancy as is provided for other medical conditions. By adopting laws that mandate the inclusion of maternity benefits in policies sold through the state’s group health insurance market, states ensure that all women with group health plans have access to these important benefits, no matter how small the employer. Fifteen states have enacted such laws, though they may apply only to certain types of health plans such as managed care plans.⁷¹ Therefore, it is possible that in some states women who obtain ESI through a small business do not receive maternity benefits as part of that coverage.

- **State maternity coverage programs:** In a few instances, state governments have stepped in (at taxpayer expense) to fill gaps in private health insurance by establishing programs to assist pregnant women who have private coverage that does not meet their maternity care needs. At least two states have such programs: California’s *Access for Infants and Mothers* (AIM) program is a low-cost coverage program for pregnant women who are uninsured and ineligible for Medi-Cal (the state’s Medicaid program).⁷² New Mexico’s *Premium Assistance for Maternity* (PAM) program is a state-sponsored initiative that provides maternity coverage for pregnant citizens who are ineligible for Medicaid.⁷³ According to program officials in New Mexico, PAM was established expressly because of the gaps that existed in private market maternity coverage. If maternity care was included as a basic benefit in comprehensive and affordable health insurance policies, such programs would be unnecessary.

Recommendations for Health Care Reform

Health reform holds the promise of making affordable care available to millions of women who need it. As the legislation progresses in the coming weeks, however, it is essential that robust insurance market reforms are included, as well as other provisions to ensure that health care is truly affordable. If these key pieces are absent from the final legislation, health reform will provide inferior coverage and protection to the millions of women who are currently struggling to get the care they need. Specifically, to protect women and their families health care reform must:

- *Include insurance market reforms that protect ALL women, whether they obtain coverage on their own, get health benefits from an employer, or secure coverage from other types of plans.* Health reform must eliminate unfair and discriminatory practices, such as gender rating and pre-existing condition exclusions, by applying reforms broadly across the individual market and for all groups of all sizes. It must ensure that reforms protect women from unfair practices regardless of whether they obtain coverage through the new Health Insurance Exchanges, from an employer of any size (not just a small business), or 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 and squanders an opportunity to ensure uniform and fair rules for all women with health insurance. It allows moderate-sized and large groups to continue facing unfair and costly insurance practices related to the sex, age, or health claims history of their employees.

Eliminating gender rating and other discriminatory practices for individuals and groups of all sizes is especially important given other potential health reform provisions, such as the proposed excise tax on so-called “high-cost” health plans. Plans - and ultimately individuals- may be subject to the tax due to the gender, age, or health status of the enrolled individual or group if unfair premium rating practices are allowed to continue.

- *Ensure affordable coverage.* Affordability in health reform is especially important for women. There are more than 14 million uninsured women (ages 18-64) with incomes below 400% of the federal poverty level.⁷⁴ Without sufficient subsidies to help with the cost of health insurance, women in this income range would struggle to afford newly-available coverage and could even join the ranks of the underinsured. For a single mom with two children at 400% of poverty, the average premium cost for a Blue Cross standard policy alone would be almost 18% of her income.

Accordingly, there must be adequate sliding scale subsidies for premiums and out-of-pocket costs—as well as reasonable limits on total out-of-pocket costs—so that women can obtain health coverage that they can realistically afford. The legislation reported by the Health, Education, Labor and Pensions Committee (S.1679) provides stronger affordability protections than the legislation reported by the Finance Committee.

- *Prohibit any annual or lifetime benefit caps for all individual and group health insurance plans.* Even benefit limits that appear to be high can be used up quickly

if a woman faces a serious condition, leaving little or no coverage for a woman's other basic health care needs. For example, a woman suffering from coronary artery disease, the leading killer of women in the U.S., could spend over one million dollars over the course of her lifetime on related treatment alone,⁷⁵ and a condition such as multiple sclerosis—which affects twice as many women as men⁷⁶—costs an estimated \$2.2 million over the course of an individual's lifetime.⁷⁷ This critically important protection will help women afford health care when they need it most, as well as avoid medical debt and bankruptcy.

Conclusion

Women's relationship with the health system is characterized by many disadvantages, including continued discrimination by health insurance companies and increasing proportions who report cost-related problems with access to care. Quite simply, there is an urgent need for health reform now, to make affordable, high-quality health care a reality for women across the country.

The country is closer than ever been before to realizing this goal, but the debate over the scope of insurance market reforms and various other provisions to ensure affordable coverage is far from over. 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.

¹ National Women's Law Center analysis of 2008 data on health coverage from the Current Population Survey's Annual Social and Economic Supplement (U.S. Census Bureau, 2009) using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

² *Id.*

³ *Id.*

⁴ This source is eHealthInsurance, available at <http://www.ehealthinsurance.com/>. Notably, eHealthInsurance may not represent all insurance companies licensed to sell individual health insurance policies in every state. However, the company bills itself as the leading online source of health insurance for individuals, families, and small businesses, partnering with over 160 health insurance companies in 50 states and D.C. and offering more than 7,000 health insurance products online. NWLC chose to use eHealthInsurance 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. Any limitations in eHealthInsurance's scope—in tandem with the basic fact that its services are only available online and therefore may not be accessible to individuals without a computer or internet access or who are not web savvy—simply underscores the challenges women (and men) face seeking coverage in the individual market without a government-sponsored system to help facilitate their search.

⁵ While NWLC's review of health insurance plans examined coverage for maternity-related care, it was much more difficult to determine whether other pregnancy-related benefits, such as contraception or pregnancy termination, are covered under a plan; accordingly, our review did not include these important reproductive health benefits. For example, in many plan brochures, if information about either of the above benefits is available at all, it is visible only as part of a long list of exclusions. This obfuscation reflects another challenge women face in assessing the adequacy of a plan's coverage.

⁶ Lisa Codispoti, Brigitte Courtot and Jen Swedish, Nat'l Women's Law Ctr, *Nowhere to Turn: How the Individual Market Fails Women* (Sep. 2008), <http://action.nwlc.org/site/PageServer?pagename=nowheretoturn>.

⁷ *Id.*

⁸ Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, N.Y. TIMES, June 1, 2008, at A26, available at <http://www.nytimes.com/2008/06/01/health/01insure.html>.

⁹ Women's Law Project & Pennsylvania Coalition Against Domestic Violence, *FYI: Insurance Discrimination Against Victims of Domestic Violence, 2002 Supplement 2* (2002), http://www.womenslawproject.org/brochures/InsuranceSup_DV2002.pdf. In the early 1990s, advocates discovered that insurers had denied applications for coverage submitted by women who had experienced domestic violence. *See, e.g.*, 142 CONG. REC. E1013-03, at E1013-14 (June 5, 1996) (statement of Rep. Pomeroy) ("the Pennsylvania State Insurance Commissioner surveyed company practices in Pennsylvania and found that 26% of the respondents acknowledged that they considered domestic violence a factor in issuing health, life and accident insurance"). Since 1994, the majority of states have adopted legislation prohibiting health insurers from denying coverage based on domestic violence, but nine states and D.C. offer no such protection to survivors of domestic violence. Even though Vermont lacks legislation specifically prohibiting discrimination against domestic violence survivors, the state requires guaranteed issue of all individual insurance plans. *See infra* note 94 and accompanying text. Though the report identifies nine states, as well as the District of Columbia, which do not prohibit this practice, Arkansas Gov. Beebe recently signed into law ACT 619, which amends Arkansas Code § 23-66-206(14)(G), to add "status as a victim of domestic abuse" to the list of attributes that insurers may not use as the sole justification for denying an individual health insurance coverage.

¹⁰ It is quite common for a rider to limit the total maximum benefit to amounts such as \$3,000 (available only after a 10-month waiting period for a rider option identified in the District of Columbia) or \$5,000 (available only after a 12-month waiting period for an Arkansas rider option).

¹¹ *Id.*

¹² California Health Benefits Review Program, *Executive Summary: Analysis of Assembly Bill 98: Maternity Services, A Report to the 2009-2010 California Legislature* (Mar. 16, 2009), http://www.chbrp.org/documents/ab_98_fnlsumm.pdf.

¹³ *Nowhere to Turn*, *supra* note 6.

¹⁴ There are also non-employer based group plans that provide insurance, commonly referred to as association health plans.

¹⁵ *Id.*; Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* (Apr. 2008), <http://www.kff.org/insurance/upload/7766.pdf>.

¹⁶ 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>

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ 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/rjk/fellowship/2009papers/McGinnis.pdf>

²⁰ Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers. They are more likely to have chronic conditions that necessitate continuous health care treatment. They also use more prescription drugs on average, and certain mental health problems affect twice as many women as men. See: Elizabeth Patchias and Judy Waxman, *Women and Health Coverage: The Affordability Gap* (2007), National Women's Law Center. An issue brief prepared for the Commonwealth Fund, available at <http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf> (last visited May, 12 2008).

²¹ Sheila D. Rustgi, Michelle M. Doty, and Sara R. Collins, *Women at Risk: Why Many Women are Forgoing Needed Health Care* (New York: The Commonwealth Fund, May 2009)

²² U.S. Census Bureau (Sept 2009), *Men's and Women's Earnings by State: 2008 American Community Survey*, <http://www.census.gov/prod/2009pubs/acsbr08-3.pdf>

²³ National Women's Law Center calculations based on U.S. Census Bureau, "Table POV01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2005, Below 100% of Poverty -- All Races." Current Population Survey Annual Demographic Survey March Supplement, (2006), available at: http://pubdb3.census.gov/macro/032006/pov/new01_100_01.htm. (last visited May 12, 2008).

²⁴ National Women’s Law Center, *Women’s Private Health Coverage, Incomes Decline While Poverty Increases, Census Data Show* (September 2009 Press Release), <http://www.nwlc.org/details.cfm?id=3711§ion=newsroom>

²⁵ *Women at Risk*, supra note 21.

²⁶ *Id.*

²⁷ *Id.*

²⁸ McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (2008).

²⁹ *Nowhere to Turn*, supra note 6.

³⁰ N.J. Dept. of Banking & Ins., *N.J. Individual Health Coverage Program Buyer’s Guide: How To Select a Health Plan—2006 Ed.* (2006), http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcbuygd.html (“carriers may vary the rates for the B&E plan based on age, gender and geographic location”).

³¹ 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.

³² MINN. STAT. § 62A.65(4) (2008) (“No individual health plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan.”).

³³ MONT. CODE ANN. § 49-2-309(1) (2008) (“It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits.”). Montana’s “unisexual insurance law” is not limited to health insurance; it prohibits insurers from using gender as a rating factor in any type of insurance policy issued within the state. *See* MONT. CODE ANN. § 49-2-309(1) (2008) (“It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits”).

³⁴ N.H. REV. STAT. ANN. § 420-G:4(I)(d) (2008) (allowing insurers to base rates in the individual market solely on age, health status, and tobacco use).

³⁵ N.D. CENT. CODE § 26.1-36.4-06(1) (2008) (imposing a rate band under which age, industry, gender, and duration of coverage may not vary by a ratio of more than 5 to 1, but providing that “[g]ender and duration of coverage may not be used as a rating factor for policies issued after January 1, 1997”). Despite the statutory prohibition on gender rating in North Dakota, the only company offering individual policies through www.eHealthInsurance.com does use gender as a rating factor. In an attempt to understand this seeming inconsistency, NWLC contacted the North Dakota Insurance Department, which indicated that this company is a “hybrid situation” and thus permitted to rate its individual policies as if they were sold on the group market; gender rating is allowed within limit for groups in North Dakota. Telephone Interview with North Dakota Insurance Department (Sept. 12, 2008).

³⁶ N.Y. INS. LAW § 3231(a) (McKinney 2008) (defining community rating as “a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation”).

³⁷ ME. REV. STAT. ANN. tit. 24-A, § 2736-C(2)(B) (2008) (prohibiting insurance carriers from varying the community rate due to gender or health status). ME. REV. STAT. ANN. tit. 24-A, § 2736-C(2)(D)(3) (2008) (imposing a rate band under which insurance carriers may only vary the community rate due to age by plus or minus 20% for policies issued after July 1, 1995).

³⁸ MASS. GEN. LAWS ch. 176M, § 1 (2008) (defining “modified community rate” as “a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a guaranteed issue health plan is the same without regard to health status; provided, however, that premiums may vary due to age, geographic area, or benefit level for each rate basis type as permitted by this chapter”). MASS. GEN. LAWS ch. 176M, § 4(a)(2) (2008) (imposing a rate band under which the “premium rate adjustment based upon the age of an insured individual” may range from 0.67 to 1.33).

³⁹ 2008 N.J. Sess. Law Serv. Ch. 38, page nos. 12, 15 (Senate 1557) (West) (amending N.J. STAT. ANN. § 17B:27A-2 (West 2008) to define “modified community rating” as “a rating system in which the premium for all persons under a policy or a contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographic location or any other

factor or characteristic of covered persons, other than age,” and amending N.J. STAT. ANN. § 17B:27A-4 (West 2008) to require individual health benefits plans to “be offered on an open enrollment, modified community rated basis”). New Jersey law excludes bare-bones basic and essential plans from the modified community rating requirement.

⁴⁰ OR. REV. STAT. § 743.767(2) (2008) (“The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age.”).

⁴¹ WASH. REV. CODE § 48.43.005(1) (2008) (defining “adjusted community rate” as “the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities”); WASH. REV. CODE § 48.44.022(1)(a) (2008) (allowing insurers to only vary the adjusted community rate based on geographic area, family size, age, tenure discounts, and wellness activities).

⁴² N.M. STAT. § 59A-18-13.1(A) (2008) (allowing gender rating); N.M. STAT. § 59A-18-13.1(B) (2008) (providing that “the difference in rates in any one age group that may be charged on the basis of a person’s gender shall not exceed another person’s rates in the age group by more than twenty percent of the lower rate”).

⁴³ VT. STAT. ANN. tit. 8, § 4080b(h)(1) (2008) (prohibiting the use of the following rating factors when establishing the community rate: demographics including age and gender, geographic area, industry, medical underwriting and screening, experience, tier, or duration); VT. STAT. ANN. tit. 8, § 4080b(h)(1) (2008), 21-020-034 VT. CODE R. § 93-5(11)(G), (13)(B)(6) (2008) (providing that upon approval by the insurance commissioner, insurers may adjust the community rate by a maximum of 20% for demographic rating including age and gender rating, geographic area rating, industry rating, experience rating, tier rating, and durational rating).

⁴⁴ MONT. CODE ANN. § 49-2-309(1) (2008)

⁴⁵ 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).

⁴⁶ 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).

⁴⁷ 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).

⁴⁸ MINN. STAT. § 62L.08(5) (2008) (prohibiting the use of gender as a rating factor for small employer insurance carriers).

⁴⁹ 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”).

⁵⁰ 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).

⁵¹ 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).

⁵² 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).

⁵³ 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).

⁵⁴ 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%

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- ⁵⁵ 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).
- ⁵⁶ DEL. CODE ANN. tit. 18, § 7205(2)(a) (2008) (allowing small employer insurance carriers to vary premium rates based on gender and geography combined by up to 10 percent). Age: DEL. CODE ANN. tit. 18, §§ 7202(9), 7205 (2008) (allowing the use of age as a rating factor if actuarially justified).
- ⁵⁷ 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%
- ⁵⁸ 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%
- ⁵⁹ 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).
- ⁶⁰ In Louisiana, for instance, a small group has 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)
- ⁶¹ Pub. L. No. 95-555, 92 Stat. 2076 (1978).
- ⁶² MASS. GEN. LAWS ch. 176G, §§ 4(c), 4I (2008) (requiring health maintenance organizations to include maternity coverage); MASS. GEN. LAWS ch. 176B, § 4H (2008) (requiring medical service corporations to include maternity coverage); MASS. GEN. LAWS ch. 176A, § 8H (2008) (requiring non-profit hospital service corporations to include maternity coverage).
- ⁶³ Mont. Ins. Or. (Feb. 16, 1994); *Bankers Life & Casualty Co. v. Peterson*, 866 P.2d 241 (Mont. 1993). Mandated maternity coverage is not always imposed by state legislation or via administrative regulations. Montana’s mandate is the result of a 1993 state Supreme Court decision which held that a health plan excluding maternity coverage unconstitutionally discriminated based on gender.⁷⁴ In response to this court decision, the Montana Insurance Commissioner issued an order that all insurers in the state must include maternity benefits.⁷⁵
- ⁶⁴ N.J. STAT. ANN. § 17B:26-2.1b (West 2008) (requiring all individual plans, except the bare-bones basic and essential plans, to include maternity coverage). N.J. Dept. of Banking & Ins., *N.J. Individual Health Coverage Program Buyer’s Guide: How To Select a Health Plan—2006 Ed.* (2006), http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcbuygd.html (“carriers may vary the rates for the B&E plan based on age, gender and geographic location”).
- ⁶⁵ OR. REV. STAT. § 743A.080 (2008).
- ⁶⁶ WASH. REV. CODE § 48.43.041(1)(a) (2008) (requiring all individual plans, except the bare-bones catastrophic plans, to include maternity coverage).
- ⁶⁷ *Id.*; N.J. Dept. of Banking & Ins., *supra* note 8 (“B&E Plans do not provide comprehensive benefits like the standard plans described above,” which include prenatal and maternity care).
- ⁶⁸ CAL. HEALTH & SAFETY CODE § 1367(i) (requiring health care service plans to provide basic health care services); A.B. 1962, 2007-2008 Sess. § 1 (Cal. 2008) (recognizing that, in practice, health care service plans are required to provide maternity services as a basic health care benefit).
- ⁶⁹ ILL. ADMIN. CODE tit. 50, § 5421.130(e) (2008).
- ⁷⁰ GA. COMP. R. & REGS. 290-5-37-.03(4) (2008).
- ⁷¹ HI, MD, MA, MI, MN, MT, NJ, NY, OR, VT, and WA have enacted laws requiring maternity benefits in all policies for employers in the small group market. ID requires that maternity benefits be covered for employers with five or more employees, and CA, GA, and ME have laws require that maternity be covered by managed care organizations in the small group market. See: Ed Neuschler, Institute for Health Policy Solutions, Policy Brief on Tax Credits for the Uninsured and Maternity Care 3 (March of Dimes 2004), <http://www.marchofdimes.com/TaxCreditsJan2004.pdf>.
- ⁷² Managed Risk Medical Insurance Board, Access for Infants and Mothers, <http://www.aim.ca.gov/english/AIMHome.asp> (last visited Sept. 17, 2008).
- ⁷³ Insure New Mexico, Premium Assistance for Maternity (PAM) Frequently Asked Questions, <http://www.insurenwemexico.state.nm.us/PAMFaqs.htm> (last visited Sept. 17, 2008).

⁷⁴ National Women's Law Center calculations based on health insurance data for women ages 18-64 from the Current Population Survey's 2008 Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.

⁷⁵ Leslee J. Shaw; C. Noel Bairey Merz; Carl J. Pepine et al., The Economic Burden of Angina in Women With Suspected Ischemic Heart Disease, *Circulation* 114 (2006):894-904, <http://circ.ahajournals.org/cgi/content/abstract/114/9/894?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=cardiovascular&searchid=1&FIRSTINDEX=20&resourcetype=HWFIF>.

⁷⁶ Brigham and Women's Hospital, "Focus on Multiple Sclerosis" (April 2008), <http://www.brighamandwomens.org/patient/healthmatters/multiplesclerosis.aspx>.

⁷⁷ Kathryn Whetten-Goldstein, Frank A Sloan, Larry B Goldstein et al., A Comprehensive Assessment of the Cost of Multiple Sclerosis in the United States, *Multiple Sclerosis* 4, no. 5 (1998):419-425, <http://msj.sagepub.com/cgi/content/abstract/4/5/419>.