DIAGNOSING DISPARITIES IN HEALTH INSURANCE FOR WOMEN: A PRESCRIPTION FOR CHANGE

Jeanne M. Lambrew
George Washington University

August 2001

The author gratefully acknowledges funding from The Commonwealth Fund Task Force on the Future of Health Insurance, and thanks Cathy Schoen for her thoughtful review and comments. Chris Jennings of Jennings Policy Strategies provided critical help in conceptualizing and writing the study. Additionally, sincere thanks go to Danielle Ferry and Sherry Glied of the Joseph L. Mailman School of Public Health, Columbia University and Michelle Doty of The Commonwealth Fund for their analysis of the data presented in this report.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the author and should not be attributed to The Commonwealth Fund or its directors, officers, or staff, or to members of the Task Force on the Future of Health Insurance.

Copies of this report are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering publication number 493. The report can also be found on the Fund's website at www.cmwf.org.

CONTENTS

LIST OF FIGURES AND TABLES

EXECUTIVE SUMMARY

Women face unique and, compared with men, frequently greater challenges in accessing affordable health insurance. Even though they are more likely to need health care, women are more likely than men to encounter barriers to receiving it. Women, who more often than men are caring for a child or aging relative, are thus less likely to have good access to health care themselves.

Patterns of insurance coverage are also different for women. Slightly fewer women are uninsured, mostly because their higher poverty rate and greater eligibility for public insurance have meant that women are covered by Medicaid at twice the rate of men. However, should current trends continue, the number of uninsured women will surpass the number of uninsured men by 2005.

Uninsured women are older, more likely to be married, and more likely to work part-time than men. In addition, women are less likely to have direct access to employer-based health insurance and slightly more likely to purchase individual insurance. These findings together suggest that combining proposals to make existing private and public insurance options more affordable for women may be the best short-term strategy for meeting their health care needs.

This study explores the difficulties women encounter in obtaining health insurance. It then evaluates some major approaches to expanding health coverage for their potential to address these challenges.

WOMEN'S NEED FOR HEALTH CARE IS GREATER, BUT ACCESS IS LOWER

- Overall, women need and use more health care than men. Because of their reproductive health needs, women require more regular care than men throughout their lifetimes. In addition, more women have chronic illnesses and more report being in fair or poor health. Women are also more likely to use services such as mental health care and, as they age, prescription drugs.

- Women are more likely to have difficulty obtaining care. Uninsured women are nearly 20 percent more likely than uninsured men to experience trouble obtaining health care (25% vs. 21%). Among Americans ages 50 to 64,

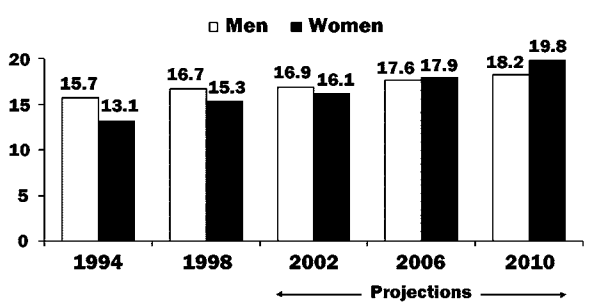
women are nearly twice as likely as men to have problems accessing care (13% vs. 7%).

- Older women are more likely than older men to need prescription drugs. Eighty-one percent of women ages 50 to 70 rely regularly on prescription drugs, compared with 71 percent of men this age.

UNINSURED WOMEN ARE DIFFERENT THAN UNINSURED MEN

- The uninsured rate among women is growing more rapidly. Over the past five years, the number of women without health coverage has grown three times faster than the number of men without coverage. If this pace continues, uninsured women will outnumber uninsured men for the first time in 2005 (Figure ES-1).

Figure ES-1. Number of Uninsured Women Is Growing Faster, and Could Surpass Men If Trend Continues



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March Current Population Survey from 1995 to 2000.

- Older women are 20 percent more likely than older men to be uninsured. As women age, their need for health care grows. Nevertheless, about 16 percent of women ages 55 to 65 are uninsured versus 13 percent of men. As the baby boom generation begins turning 55 in the next decade, the number of uninsured women in this age group will likely increase by at least 50 percent.

- Uninsured women are more likely than uninsured men to be married. Among the uninsured, approximately 49 percent of women are married compared with 40 percent of men. The majority (54%) of these women live on low incomes. Lower-income married women and men are often ineligible for Medicaid, even though their children may be enrolled in (or at least eligible for) Medicaid or CHIP (the State Children's Health Insurance Program). Older married women (ages 55 to 65) are nearly 40 percent more likely to be uninsured than older married men, in part because their husbands meet Medicare's age 65 coverage requirement and they do not.

- ➢ As couples near the age of Medicare eligibility, women married to older men are at high risk of being uninsured. One of four women ages 50 to 70 who has an older spouse reported in the survey that she was uninsured when her spouse became eligible for Medicare. Of these uninsured women, nearly 40 percent lost coverage when their husband enrolled in Medicare.

- Uninsured working women are one-third more likely to be employed part-time. About half of uninsured working women are part-time employees, compared with 38 percent of uninsured working men.

IMPACT OF COVERAGE EXPANSION PROPOSALS ON WOMEN

- Increasing coverage through employer-based insurance. Some proposals would attempt to make job-based health insurance more affordable by helping families pay their share of the premium, or make it more accessible by increasing the number of workers eligible for job-based insurance.

  - ➢ About 20 percent of uninsured women have the option of enrolling in employer-based insurance but do not participate—one-third more than men (15%). Since three of five of these women have low incomes, providing them with premium assistance, or using Medicaid and CHIP to allow them to "buy into" their employer plan, could be effective in reaching this group. Such approaches are likely to be more effective than simple tax credits in helping low-wage workers afford private employer-sponsored insurance.

  - ➢ Employees of small firms are less likely to be offered a health plan, with women even less likely than men to have the opportunity to participate (44% vs. 47%). Small-business purchasing coalitions are one possible way to help women access health plan choices. However, if purchasing coalitions offer substandard benefits, or exclude firms that are likely to employ sicker people, then women may not benefit. In fact, they could be hurt if the policy results in higher premiums for small businesses that do not belong to these coalitions.

  - ➢ Policies that extend access to job-based health coverage to include part-time workers would disproportionately benefit women. Women are not only more likely than men to work part-time (35% of uninsured women vs. 32% of uninsured men), they are also more likely to take up coverage when it is offered (90% of women vs. 85% of men). It may be difficult, however, to

construct effective policy options for assisting uninsured part-time workers without also distorting patterns of employment for part-time workers.

- Increasing coverage through individual health insurance. Some proposals subsidize insurance in the individual insurance market by means of tax credits or deductions.

  ➢ At least 80 percent of uninsured women live in states that allow companies offering individual insurance to deny coverage to applicants. Furthermore, about 75 percent of uninsured women live in states that lack any constraints on the premiums that can be charged. Even if they are offered coverage, these women often find that individual insurance premiums are too expensive, even with a tax credit. A typical individual insurance policy for a 60-year-old costs about $5,700, according to a recent study.[1] Moreover, employer-based insurance could become less affordable if healthy people are drawn into the individual market, leaving employers to pay for the sicker, more expensive workers.

  ➢ Without minimum benefit standards, health coverage policies purchased with the individual insurance tax credit are likely to exclude maternity care, limit prescription drug and mental health coverage, or otherwise carve out services that women need—common practices in today's insurance market.

- Increasing coverage through federal and state programs. Some policy proposals target specific groups of people for enrollment in such programs as Medicare, Medicaid, and CHIP.

  ➢ Low-income mothers—who represent one of four uninsured women and three of five low-income, uninsured parents—would be eligible for Medicaid or CHIP if these programs were expanded to parents at the same income levels currently prevailing for their children. But without additional federal dollars, states are unlikely to expand coverage to low-income, working parents.

  ➢ Since a greater percentage of older women are uninsured than older men, women would disproportionately benefit from a Medicare buy-in program or similar policies that seek to create more affordable insurance options. However, such options would need to include premium assistance, or else premium rates would still be too high for most uninsured older women. Of additional

concern is that Medicare's benefits are less generous than those available in typical employer health plans, particularly with respect to prescription drug coverage.

The study's findings suggests that uninsured women are more likely than uninsured men to benefit from policies that target part-time workers, low-income parents, and older adults, as well as those who need premium assistance in order to participate in job-based plans. Building on insurance options that already exist, from employer-sponsored plans to Medicaid and CHIP, could rapidly reduce the number of uninsured women. Nonetheless, any one, or even all, of these initiatives will not be adequate to cover the 15 million uninsured women in the United States. To do so will require the laying of a groundwork for larger coverage expansions in the face of increasing health premiums, a slowing economy, and changing demographics—all of which will likely cause the number of uninsured, especially women, to rise.

DIAGNOSING DISPARITIES IN HEALTH INSURANCE FOR WOMEN: A PRESCRIPTION FOR CHANGE

INTRODUCTION

Research has clearly documented that uninsured women have greater needs for health care than insured women and encounter higher barriers to obtaining care. Less attention, however, has been paid to the differences between men's and women's health insurance coverage. In part, this is because policymakers' concerns about equity prevent them from enacting coverage expansion policies that target only men or only women.[2] Yet significant differences exist in how women get health insurance, and these differences matter when designing strategies to reduce the number of uninsured. As Congress debates insurance issues, including coverage expansions, this year, information concerning disparities in coverage patterns will be essential to the design of effective legislation.

This study provides new data analysis of differences in women's access to care and health insurance coverage, based on the Current Population Survey (primarily from March 2000), the Medical Expenditure Panel Survey (1996), and The Commonwealth Fund Health Care Survey of Adults Ages 50 to 70 (1999). The study also assesses selected policies aimed at reducing the number of uninsured through the prism of their effect on women. It concludes with a discussion of the implications for efforts to expand health coverage.

I. WOMEN'S NEED FOR HEALTH INSURANCE

Women need different and, on average, more health care than men. Women are more likely than men to need health care throughout their lifetimes. Their reproductive health needs require women to get regular check-ups, even if they do not have children. Furthermore, women are somewhat more likely than men to have a chronic illness and to report limitations on their daily activities caused by chronic conditions (13.4% vs. 13.1%).[3] More women report fair or poor health status than men (9.4% vs. 8.8%). Older women, meanwhile, have a greater need than older men for regular prescription medications (81% of women vs. 71% of men ages 50 to 70). Finally, women tend to have a higher incidence of certain mental health problems, including depression.[4]

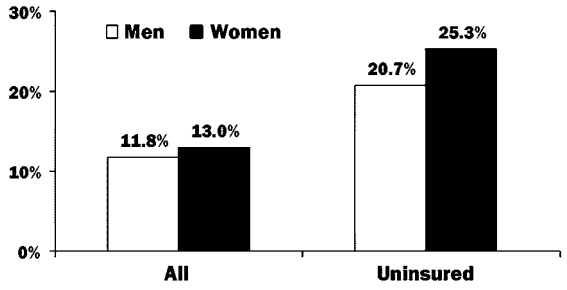
Women use more health care than men. Due to their different and often greater health needs, women use more health services than men do. In 1996, a greater proportion of women had health care expenses (89% vs. 81%), women's average total expense per person was higher ($2,453 vs. $2,316), and a greater proportion of their total health care expenses were paid out-of-pocket (19% vs. 16%).[5] A recent study found that

women's rate of visits to primary care physicians was 58 percent higher than men's, adjusted for age. While the differential rate of use among men and women narrows with age, women ages 45 to 64 are still 34 percent more likely to use ambulatory care than men.[6] Women are also much more likely to have expenses for prescription medications than men.[7]

Women are more likely to have difficulty obtaining health care. Overall, women are somewhat more likely than men to have trouble obtaining needed health care (13.0% vs. 11.8%). However, the difference is more dramatic for uninsured women: they are nearly 20 percent more likely to have trouble obtaining care than uninsured men (25.3% vs. 20.7%) (Figure 1).

Figure 1. Uninsured Women Are 20 Percent More Likely to Have Access Barriers

Percent of Adults with Difficulty Accessing Health Care, 1996



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of 1996 Medical Expenditure Panel Survey.

Health care access differences between men and women are more pronounced in the older population. Among people ages 50 to 64, women are nearly twice as likely as men to have any access problem (13% vs. 7%), especially uninsured women (29% vs. 16% of uninsured men in this age group) (Appendix Table 3). Of all women, those in the 50-to-64 group experience the most difficulty getting health care, since women over age 65 gain Medicare coverage (e.g., the percentage who had a problem paying medical bills declines from 20 to 17 percent from ages 50 to 64 to ages 65 to 70).[8] Meanwhile, younger women, as well as men of all ages, require fewer services than older women.

While it is not clear why men and women's difficulties with health care access differ, health insurance clearly matters. Women without health coverage are more than twice as likely to have at least one access problem as are continuously insured women.[9] Uninsured women are also 40 to 60 percent less likely to receive a mammogram or Pap smear and are significantly more likely to be hospitalized for avoidable conditions such as diabetes and pneumonia.[10,11]

II. WOMEN FACE DIFFERENT BARRIERS TO HEALTH INSURANCE

Health Insurance for Men and Women: How Is It the Same?

Health insurance coverage in the United States is similar for adult men and women in a number of ways. About two-thirds of men and women are covered by employer-based

insurance, primarily a result of the advantages of group coverage and ease of enrollment[12] (Table 1). Another 5 percent of men and 6 percent of women purchase their health coverage through the individual insurance market; 4 percent are insured through Medicare, military health coverage, or other sources. More women are insured through Medicaid than men (6% vs. 3%), while more men are uninsured (20% vs. 18%).

Table 1. Health Insurance of Adults Ages 19–64, 1999

	Men		Women	
	Millions	Percent	Millions	Percent
Employer	54.8	68%	56.1	67%
Individual	4.2	5%	4.9	6%
Medicare, Other	3.4	4%	3.2	4%
Medicaid	2.1	3%	4.9	6%
Uninsured	16.4	20%	14.9	18%
Total	81.0	100%	84.1	100%

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

Note: Mutually exclusive categories (see Methodology). Numbers may not sum to total due to rounding.

Uninsured men and women share several major characteristics:

- They are both primarily low-income. About 62 percent of uninsured adults have incomes below 200 percent of the federal poverty level (approximately $35,000 for a family of four). Since a greater proportion of all women are low-income compared with men, a slightly greater percentage of uninsured women are low-income as well (65% vs. 60%) (Appendix Table 4). Lack of coverage affordability remains the primary reason why people are uninsured in the United States.

- They both work in small businesses. While virtually all large firms (those with 200 or more employees) offer health insurance, only 67 percent of businesses with from three to 199 workers offer it—a percentage that declines with firm size.[13] Small businesses tend to pay lower wages and have greater challenges finding affordable health insurance.[14] Consequently, about half of uninsured workers are employed by small businesses.

- They disproportionately belong to a racial or ethnic minority group. African-American and Hispanic adults are more likely than whites to lack health insurance (25% and 40%, respectively, compared with 14% for whites). Women in these groups are slightly more likely than men to have insurance coverage because

of their higher enrollment in Medicaid. Immigrants face particularly severe challenges accessing health insurance. Among low-income noncitizens, 58 percent were uninsured—nearly twice the average rate for all low-income people.[15]

- They are younger. Compared with the overall adult uninsured rate of 19 percent, about 31 percent of people ages 19 to 24, and 23 percent ages 25 through 34, are uninsured. Lack of health coverage among younger women may have particularly serious implications, since these are the years when prenatal and maternity coverage is most needed.

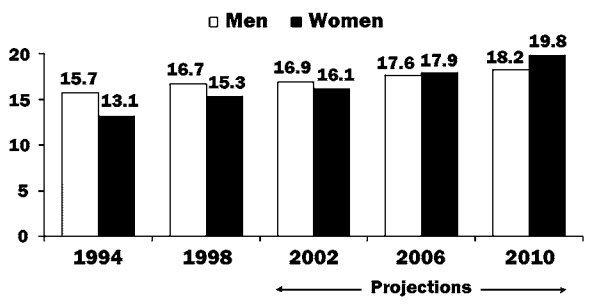
- They are less likely to be married. About 56 percent of uninsured adults are single, compared with 37 percent of all adults. Single men are more likely to be uninsured (31%) than single women (24%). However, single adults are in general more likely to be uninsured than married adults.

How Do Uninsured Rates and Patterns Differ Between Women and Men?

Number of uninsured women growing faster than men. Over the past five years, the number of uninsured women has grown three times faster than the number of uninsured men. Two trends help explain this increase. First, Medicaid's differential coverage of women and men narrowed, in part due to welfare reform.[16] The number of men covered by Medicaid dropped 3 percent from 1997 to 1999, while the number of women covered by Medicaid fell 12 percent. The declining gender difference in Medicaid coverage could also reflect the increase in the number of states extending coverage to two-parent families. Second, more older women are becoming uninsured than men. From 1997 to 1999, the number of women ages 55 to 64 who were uninsured increased by 9 percent, compared with an increase of 4 percent for uninsured men in this age group and virtually no increase in the number of uninsured adults of all ages.

If this pace continues, the number of uninsured women will exceed the number of uninsured men for the first time in 2005 (Figure 2). The recent growth in the number of uninsured women may, however, turn out to be a one-time result of recent declines in Medicaid enrollment. Furthermore, the number of uninsured

Figure 2. Number of Uninsured Women Is Growing Faster, and Could Surpass Men If Trend Continues



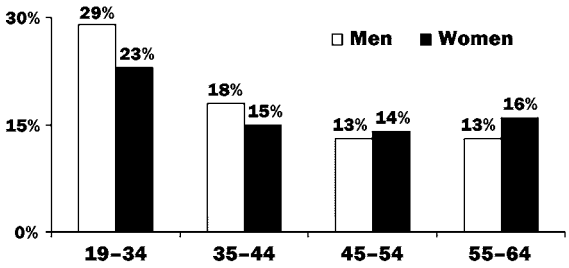
Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March Current Population Survey from 1995 to 2000.

Americans declined in 1999 for the first time in 12 years. Still, most experts forecast that the combination of a slowing economy, cutbacks in state insurance programs, and rapid health insurance premium growth will eventually increase the number of uninsured.[17]

Older women are 20 percent more likely to be uninsured than older men. As women age and their need for health care grows, their likelihood of being uninsured grows. Sixteen percent of women ages 55 to 64 are uninsured versus 13 percent of men in this group (Figure 3). One survey found that 23 percent of 50-to-64-year-old women were uninsured at some time since age 50, compared with 20 percent of their male counterparts.[18] Lack of insurance is a particular problem for older adults: more than one of 10 people ages 50 to 64 pay more than 10 percent of their family income on health expenses, including one of five of the uninsured in this age group. Nearly half of older uninsured individuals (46%) either could not pay a medical bill or were contacted by a collection agency.[19]

Figure 3. Older Women Are More Likely to Be Uninsured

Percent Who Are Uninsured by Age, 1999



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

An increasing uninsured rate among older women will be a growing concern over time. This year, the baby boom generation will begin to move through the 55-to-64-year-old age bracket. Coupled with the continued decline of employer-based insurance for older Americans, this trend could result in a large increase in the number of uninsured ages 61 to 64, according to one study.[20] Even assuming today's rates of coverage, the demographic change alone suggests that there will be 50 percent more uninsured women ages 55 to 64 in the year 2010. The proportion of uninsured women who are older could rise from 13 to 19 percent (compared with an increase from 9 to 13 percent for uninsured, older men).[21]

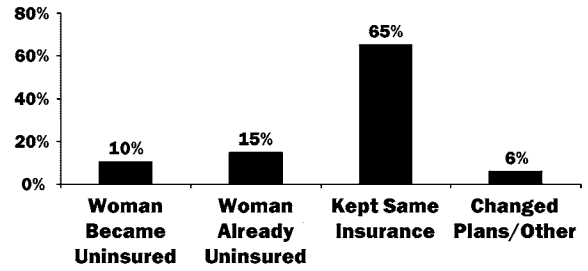
Twenty percent more uninsured women than men are married. While single people in general are more likely to be uninsured, married women comprise a greater proportion of uninsured people than married men (49% vs. 40%). Part of this is a result of Medicaid's traditional coverage of single mothers rather than two-parent families. As such, the rate of low-income, uninsured married women with children is higher than that of single women with children (33% vs. 29% uninsured). Another reason why more married women are uninsured is that, especially among older women, they are more

vulnerable to changes in their husband's insurance status. About 15 percent of married women ages 55 to 64 are uninsured, compared with 11 percent of men that age.

Figure 4. Older Married Women Are at Risk of Being Uninsured If Spouse Is First to Become Eligible for Medicare

What happened to woman's insurance when husband went on Medicare?

Base: Married Women Ages 50 to 70 Who Were Younger than Husband, 1999



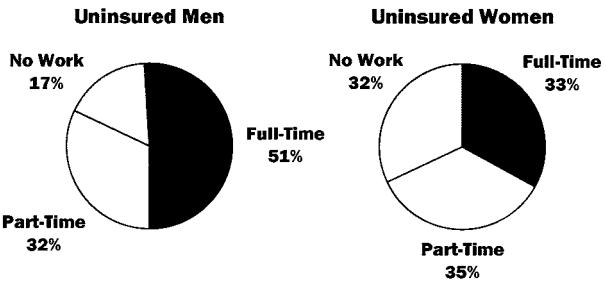
Note: Total does not add to 100% due to "don't know" responses.

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.

To the extent that married older adults rely on their spouses' insurance for coverage, those who are married to an older spouse will be at risk when the spouse reaches the age of Medicare first. Since women are more likely to be the younger partner, they are particularly at risk. According to The Commonwealth Fund Health Care Survey of Adults Ages 50 to 70, at the time their older spouse went on Medicare, one-quarter (25%) of married women ages 50 to 70 said they were uninsured. Of these uninsured women, about 60 percent were already uninsured, but 40 percent became uninsured when their husbands retired and enrolled in Medicare (Figure 4).

Figure 5. Uninsured Women Are Less Likely to Work Full-Time

Distribution of Uninsured by Work Status, 1999



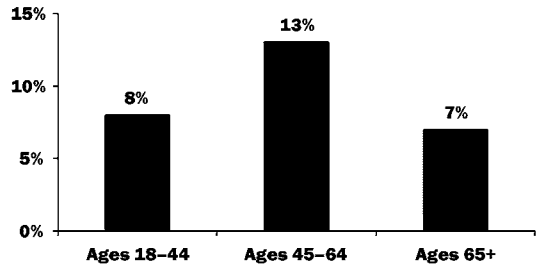
Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

Uninsured working women are one-third more likely to work part-time. While all part-time workers are less likely to be insured, a greater proportion of women work part-time (30% of women vs. 19% of men), and a greater proportion of uninsured women are part-time employees compared with uninsured men (35% vs. 32%) (Figure 5). Excluding nonworkers, over half (52%) of uninsured working women are part-time workers, compared with 38 percent of uninsured working men. For both men and women, part-time workers are half as likely as full-time workers to be offered health insurance (Appendix Table 5). In addition, about one-third of uninsured women do not work, compared with 17 percent of uninsured men; many of these women are involved in raising children. Women are also twice as likely as men to assume caregiving responsibilities for sick or disabled relatives. This

caregiving role extends across women's lifetimes, and is most active during the midlife years (Figure 6).[22]

Figure 6. Midlife Women Are More Likely to Be Caregivers

Percent of Women Who Cared for a Sick or Disabled Family Member, 1998



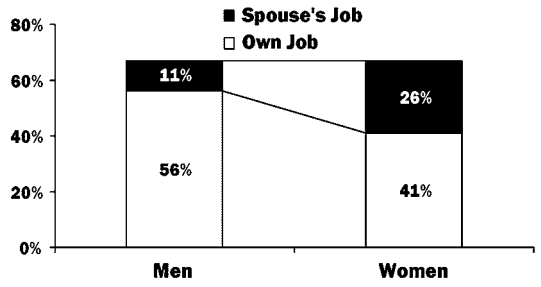
Source: The Commonwealth Fund 1998 Survey of Women's Health.

How Do Sources of Coverage for Women Differ?

Women are about 15 percent less likely to be directly offered job-based health insurance. About half (53%) of adult women have direct access to job-based insurance, compared with 62 percent of men, mostly because of women's different connection to the workforce. While most women work and help take care of the family, a greater percentage of women than men work part-time. While full-time working women are somewhat more likely than men to be offered health insurance (79% vs. 74%), only about 31 percent of part-time workers—regardless of gender—are offered health coverage. Women also tend to work in industries that are less likely to offer health insurance. For example, one-third of low-income working women are employed in service occupations; of these, 40 percent are uninsured.[23]

Figure 7. Women Are More Likely to Have Employer Insurance Through Their Spouses

Percent of Adults by Insurance Status, 1999



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

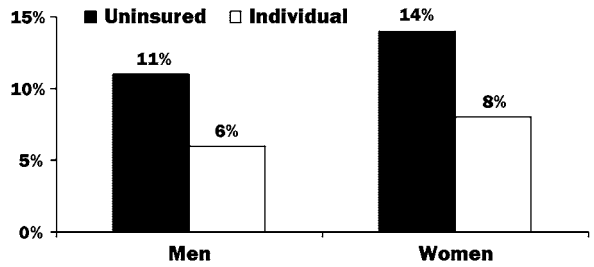
Women are more than twice as likely to get employer-based health coverage through their spouses. Nearly 22 million U.S. women (26%) get job-based health insurance through their spouses' jobs, compared with 9 million men (11%) (Figure 7). Thus, 35 percent more men than women with employer-sponsored insurance get it through their own job (83% vs. 61%). Only about one-third of women who receive health insurance through their husband's job also have the option of receiving coverage through their own job. One study found that, in general, married women—even those who get health insurance through their husbands—are no more likely to lose employer-sponsored insurance than men.[24] However, it appears that part of the reason why the rate of uninsured women is higher among older women is their restricted access to employer-based insurance through their husbands.

More women purchase individual health insurance. More than half (54%) of adults with individual health insurance are women. The rate at which women purchase this type of coverage is slightly higher than that at which men do overall (6% vs. 5%). Generally, people who purchase individual health insurance do so because they have few alternatives. About 80 percent of women purchasing individual health insurance do not have access to insurance through their job. States with the highest rates of individual coverage tend to have a lower than average proportion of private establishments that offer insurance (e.g., rural states) (Appendix Table 6). Compared with men, women who purchase individual insurance are more likely to be single and less likely to have children. They also tend to have lower incomes and be older than men. Approximately 44 percent of women purchasing individual insurance have incomes below 200 percent of the poverty level, compared with 36 percent of men. The rate at which older women ages 55 to 64 purchase individual health coverage is more than 40 percent higher than the rate for older men (8% vs. 6%). One study found that the average age of 50-to-64-year-olds who purchase individual insurance is closer to 65 than 50, because these individuals have often retired or moved into jobs that serve as a bridge to retirement—jobs that typically do not offer health insurance.[25]

A closer look at those insured by the individual market suggests that "cream skimming," or enrollment of mostly healthy people, occurs. By definition, individuals seeking to buy insurance lack the huge advantage of being part of a large, heterogeneous pool of people throughout which risk and administrative costs are spread. Thus, insurers have an incentive—and an opportunity—to make case-by-case determinations of whether to offer individuals coverage, what type of coverage to offer, and what premiums to charge, all based on applicants' health status and risk of future health costs (a practice known as medical underwriting). Although some states have attempted to limit or ban such practices, most have not.[26] As a consequence, women purchasing individual health insurance are healthier: the data show that only 8 percent of individually insured women reported fair or poor health, compared with 11 percent of all women and 14 percent of uninsured women (Figure 8). These findings suggest that women who have a greater need for health insurance face barriers in purchasing individual insurance coverage.

Figure 8. The Uninsured Are Much More Likely to Have Fair or Poor Health Than Are the Individually Insured

Rate of Fair/Poor Health Among Adults, 1999

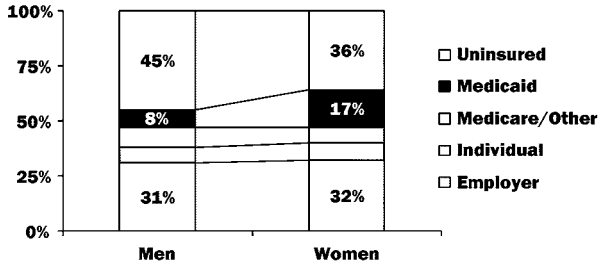


Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

Women are twice as likely to be covered by Medicaid. Medicaid has played a critical role in insuring low-income women (Figure 9). About 2.8 million more women than men are covered through Medicaid—a number greater than the difference in men and women who lack insurance (1.6 million). About 70 percent of adult Medicaid beneficiaries are women, representing 6 percent of all adult women and 17 percent of low-income women (compared with 3 percent of all men and 8 percent of low-income men who are covered by Medicaid). Significant proportions of these women are African-American (28%), Hispanic (21%), or members of other racial or ethnic minority groups (5%). Studies have found that even though Medicaid serves some of the most disadvantaged populations, access to care and use of services by its enrollees are on par with those of people enrolled in private insurance.[27] While Medicaid eligibility was historically limited to single mothers, a growing number of women in two-parent families are gaining Medicaid coverage as federal and state policy transforms Medicaid into a stand-alone health insurance program for low-income families. Still, in over half of states, a woman working full-time at a minimum-wage job with two children would have too much income to qualify for Medicaid; women without children would be ineligible in 40 states.[28]

Figure 9. Medicaid Is Particularly Important to Low-Income Women

Percent of Adults with Incomes Less Than 200% of Poverty, by Insurance Status, 1999



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

III. IMPACT OF COVERAGE EXPANSION PROPOSALS ON WOMEN

For men and women alike, the lack of health insurance presents economic challenges as well as potential threats to health. A wide range of policies would reduce the number of uninsured Americans. Virtually all major ones address the issue of affordability, since it is the primary reason why people become uninsured and sometimes remain without coverage. Proposals differ, however, in how much they subsidize the insurance premium: some pay for the full premium for poor people, while others adopt a voucher-like, fixed-dollar amount. Researchers agree that significant subsidies are needed to help the vast majority of the uninsured afford health insurance.

Health coverage proposals also differ in how they structure the delivery system for health insurance expansions. The structure of these proposals varies across two basic dimensions: how they make insurance more affordable, and what type of insurance system they promote. Insurance subsidies can be administered through the tax system, through

tax credits or deductions, or through directly reduced premiums by way of federal or state government programs. Health insurance products that can be purchased with these subsidies include: employer-sponsored coverage, individual health insurance, or private or public insurance administered through Medicaid, the State Children's Health Insurance Program (CHIP), Medicare, or the Federal Employees Health Benefits Program (FEHBP). These different subsidy mechanisms and insurance products can be mixed and matched, as described below.

The following sections examine several of the major, incremental coverage expansion proposals, focusing on the type of insurance system that each proposes to expand. Since women have different patterns of insurance coverage than men, some proposals will be more effective at targeting uninsured women than others. In addition to describing women's potential eligibility for the expanded coverage, each section discusses the particular issues women may face under each approach. The analysis does not compare the effectiveness of policies or their relative costs; this has already been done in previous studies.[29] Table 2 at the end of this section summarizes the issues discussed.

Increasing Coverage Through Employer-Based Insurance

A number of proposals aim to reduce the number of uninsured by building on the employer-based health insurance system. In general, proponents of this approach argue that it makes sense to expand the most common type of health insurance in the nation. Employers naturally "pool" risks to make insurance more affordable, since they have a cross-section of employees of varying age and health status. The major proposals to expand employer-based insurance do so in two ways: by making the employee premium more affordable when coverage is offered and by increasing the number of employees who are offered coverage. Examples of employer-based insurance expansions and their implications for women are described below.

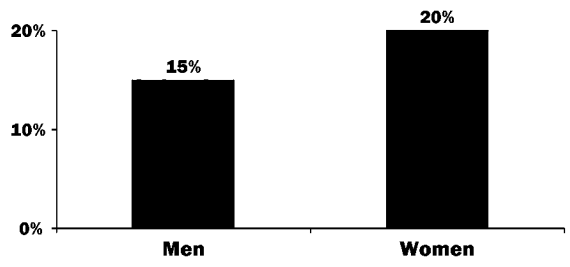
Increasing affordability for people with access to job-based coverage.

Although most people who are offered employer-sponsored insurance take it, the number who cannot afford the premium and consequently do not participate in such coverage has been increasing.[30] Most analysts believe that this has resulted from employers increasing the premium share employees must pay for their health plan. Not surprisingly, higher premium shares have hit low-wage workers particularly hard.[31] Some proposals would make job-based health coverage more affordable through tax deductions or credits.[32] Others would use Medicaid or CHIP funding to provide direct premium assistance to low-wage workers, as some states have already done, to help them pay their share of premium costs.[33]

- *Eligibility of women:* A greater proportion of uninsured women than men—20 percent versus 15 percent—do not participate in their firm's health coverage when it is offered, most likely because of the cost (Figure 10). More of these uninsured women have income below 200 percent of poverty compared with uninsured men (64% vs. 55%) and more work part-time (17% vs. 13%).

Figure 10. One of Five Uninsured Women Could Benefit from Premium Assistance to Participate in Employer Plans

Percent of Uninsured Adults Who Were Offered Employer-Sponsored Health Insurance, 1996



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of 1996 Medical Expenditure Panel Survey.

- *Advantages for women:* Premium assistance would help low-wage women afford coverage through their own job and, for married women, could provide more affordable access to family coverage through a spouse's job. Such an approach is likely to appeal to working women the most. A recent survey, for example, found that a greater proportion of women than men (51% vs. 48%) think that employers should continue to be the main source of health insurance coverage for workers.[34] This may reflect women's greater appreciation of the comprehensive set of services that employer-based insurance typically covers. In addition, this type of insurance is usually less expensive than comparable coverage available through the individual insurance market, especially if the employer helps pay for it.

- *Concerns for women:* Women who do not participate in employer-based insurance are more likely than men to live on a low income (below 200 percent of the poverty level). Tax deductions, which provide the least subsidy to low-income workers, would therefore do little to make employer-sponsored insurance premiums affordable. Tax credit proposals provide more assistance for low-income uninsured people, although they present administrative challenges (e.g., timing of credits, income verification) that could lessen their effectiveness at helping women afford employers' insurance.[35] An alternative approach is to subsidize the family share of employer-sponsored insurance through CHIP or Medicaid, or through a premium-assistance program. Some states have designed such assistance so that employers receive the subsidies directly, thus minimizing problems with the "flow of funds" faced by low-income families. Currently, CHIP subsidies tend to be more generous than those in most tax credit proposals. However, employer

coverage may cover fewer services or have higher cost-sharing than what women would get if insured directly through Medicaid or CHIP.

Policymakers considering ways of helping uninsured people afford job-based coverage would also have to consider whether or not to provide premium assistance to similarly low-income workers who are participating in employer plans. Among all low-income women, only one of three (34%) is offered coverage. However, when coverage is offered, 80 percent of low-income women participate in the plan or are otherwise insured.

A policy that targets only currently uninsured low-income working men or women could be challenged on equity grounds, depending on its design. Excluding low-income women who are participating in employer plans from receiving a tax credit or other form of premium subsidy would be unfair: it would in effect penalize them for responsibly purchasing health insurance without the subsidy. On the other hand, including these workers would increase the cost of premium subsidies.[36] Similar criticism has been leveled at CHIP, since low-income children with job-based coverage are ineligible for the program. A related concern is that employers who currently offer insurance will use the subsidy as an excuse to reduce their own contribution toward health insurance (since the government will pick up the remainder). This unintended consequence would also increase the costs of this type of proposal.

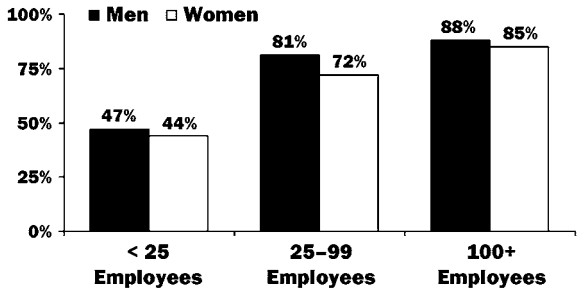
Increasing accessibility of job-based insurance. A different way to expand employer-based coverage is to increase the number of people with access to it. Such proposals typically focus on the types of firms that do not offer coverage today, such as small firms or low-wage businesses. Most proposals involve the use of tax credits or state funding to encourage firms to offer insurance directly or to offer it through purchasing coalitions.[37] Other proposals focus on workers who are ineligible for the coverage offered by their firms: part-time workers, temporary workers, employees still within the waiting period prior to receiving coverage, and people leaving jobs or those too old to qualify for dependent coverage.[38] Following are some examples.

- *Eligibility of women:* Proposals that would create purchasing coalitions are intended to give small employers the advantages of large ones: pooled purchasing power, lower administrative costs, and greater choice of benefits for employees. They either provide subsidies directly to firms who join such coalitions or create tax credits that work only if a worker in a small firm purchases through a coalition. A smaller proportion of uninsured women than men works in businesses with fewer

than 25 employees (28% vs. 41%). However, women who work in small businesses are less likely to be offered health coverage than men (44% vs. 47%) (Figure 11).

Figure 11. Women Are Less Likely to Be Offered Health Insurance, Especially in Small Firms

Percent of Workers Offered Insurance by Firm Size, 1996



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of 1996 Medical Expenditure Panel Survey. Note: Does not control for part-time workers.

Increasing access to employer-based insurance for part-time workers is an alternative approach to expanding such coverage. One study found that increasing eligibility for part-time workers—by reducing the minimum number of hours worked from 30 to less than 25 per week—could increase the overall eligibility rate for health insurance by 11 percentage points.[39] About 35 percent of uninsured women work part-time, compared with 32 percent of uninsured men.

- *Advantages for women:* Purchasing coalitions and other policies to encourage small businesses to offer health insurance have had limited success at reducing costs or increasing access, but still hold potential, according to analysts.[40] Coalitions also could help small businesses afford better health benefits than they offer today, which would help women. Small businesses usually offer fewer health benefits and have higher cost-sharing than larger firms.[41]

  Increasing access to employer-based insurance for part-time workers holds even greater promise for helping uninsured women. As described earlier, more uninsured women than men work part-time. Data suggest that women who are part-time workers are more likely to take employer-based insurance when offered than men: among part-time workers, 90 percent of women with access to job-based insurance are insured, compared with 85 percent of men.

- *Concerns for women:* Purchasing coalition policies would need to be carefully designed in order to offer small firms broad advantages. Some purchasing coalition proposals would allow groups like churches or business associations to form their own purchasing coalitions, rather than basing eligibility on geography (e.g., all small businesses in a particular state). This feature could result in redlining, or exclusion of the types of firms most likely to employ sicker people—and women—such as beauty salons and restaurants.[42] It could also have the effect of

raising premiums for small businesses outside of the coalitions if firms with healthier employees opt in, leaving out firms with sicker employees.[43] Finally, proposals that exempt purchasing coalitions from state benefit mandates would disproportionately affect women, who are the primary beneficiaries of laws that, for example, require coverage of maternity care or breast cancer treatment.

The concern that women may have with proposals to increase eligibility of part-time workers is their potential effect on employment patterns. Such proposals would work by either encouraging firms to extend eligibility to part-time workers through subsidies, or requiring them to do so. The voluntary subsidies for firms would have to be generous to change behavior. Yet if they are too generous, they could create an incentive for employers to cut back the hours of full-time workers. Alternatively, a requirement that firms offer health insurance to part-time workers could cause employers to outsource work to contract employees, hire temporary workers, or otherwise reduce their part-time labor force. Such changes would affect the larger percentage of women who work part-time.

Increasing Coverage Through Individual Health Insurance

Some policymakers seek to move away from the current work-based health insurance system and encourage purchase of individual health insurance policies.[44] They argue that linking insurance to work encourages "job lock," meaning that people do not change jobs or work status for fear of losing coverage. Another consequence, they say, is that health insurance becomes less accessible for certain groups, such as those who work part-time or are self-employed. Most proposals to expand individual health insurance coverage include a $1,000 tax credit for individuals and a $2,000 credit for families, which are phased out for higher-income people.

- *Eligibility of women:* In theory, all 15 million uninsured women would be eligible for individual insurance tax credits (assuming no upper-income eligibility limit). However, only 21 percent of uninsured women live in states that guarantee they will not be denied coverage (Figure 12). About one of four uninsured

Figure 12. Few States Guarantee Access to Individual Insurance, 1999

Source: Blue Cross Blue Shield, 2000. Darker-shaded states have pure guaranteed issue; lighter-shaded states have more limited insurance market reforms (Georgetown University).

women live in states with some type of rating reforms. In other words, more than 75 percent of uninsured women might not be able to access or afford an individual health insurance policy, even with a tax credit (Appendix Table 6).

- *Advantages for women:* An advantage of individual health insurance is that it is not linked to employment. Given women's weaker attachment to the labor force relative to men and greater reliance on their spouses for insurance, having coverage that does not rely on either would benefit women.

- *Concerns for women:* Women may find individual insurance inaccessible. One study found that mild conditions such as hay fever were sufficient grounds for denial of coverage in the individual insurance market.[45] Since women are more likely to need and use health care and uninsured women are less healthy than men, they may be particularly vulnerable to being denied coverage.

  Individual insurance may be unaffordable even with the tax credit. Younger women are less likely to be offered standard premium rates, since maternity care is almost always considered a "rider" (i.e., it requires an extra premium).[46] While older women typically are charged lower premiums than men, they are likely to face extra premiums if they have any history of health problems. A recent study found that the average individual insurance premium for a person age 60 is $5,700.[47] The typical $1,000 tax credit would probably be insufficient to encourage an uninsured person to buy this policy.

  Moreover, a tax credit could make job-based health insurance less affordable. The value of the credit is greater than the tax subsidy for employer-based insurance for low-income taxpayers. Thus, healthier, low-income workers may switch from job-based coverage to individual insurance (or firms that employ such people may stop offering coverage and force them to do so). Because this leaves sicker workers in the employer plans, premiums for employer plans could rise, causing more low-income women to decline employer coverage.

  Even if they are accessible and affordable, the benefits offered in the individual market may not meet women's health needs. A recent analysis found that common practices among individual insurers include the carving out of maternity coverage, capping prescription drug benefits or excluding coverage of certain drugs like antidepressants, and limiting mental health coverage—all services that women disproportionately need.[48] In addition, older adults with individual health insurance are three times more likely than those with employer coverage to spend

regularly more than $100 per month on prescriptions. The same study found that older Americans not only pay high premiums for individual coverage but face significant out-of-pocket costs due to the substandard coverage provided.[49]

Increasing Coverage Through Federal and State Programs

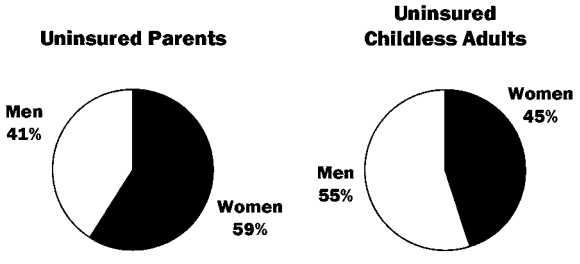
The third major approach to building a stronger health insurance system is to expand existing public programs: Medicaid, CHIP, Medicare, or FEHBP.[50] Unlike individual insurance, public programs have strict eligibility criteria. Medicaid and CHIP are for selected populations (e.g., children and pregnant women) at specified, typically low income levels. Medicare, meanwhile, is restricted to the elderly and certain people with disabilities. Some proposals would modify these eligibility restrictions to add certain other groups, for example by: giving states the option of covering legal immigrants in Medicaid and CHIP; allowing the parents of disabled children to buy into Medicaid; extending the Medicaid transition benefit, which helps women keep their coverage as they move from welfare to work; allowing states to cover poor childless adults in Medicaid; and broadening Medicare's eligibility for people with disabilities. A growing number of proposals would allow certain uninsured people access to FEHBP. This section describes two proposals that would use public programs to assist targeted groups of uninsured Americans.

Extending Medicaid and CHIP to uninsured parents. Because of their greater eligibility for Medicaid and CHIP, low-income children are less likely to be uninsured than their parents (23% vs. 33%).[51] Currently, states can extend health coverage to parents through Medicaid, but federal matching payments are lower than they would be in CHIP. States can also expand coverage to parents through CHIP at its higher federal matching rate, but only through demonstrations that are "budget neutral" (i.e., do not increase overall federal costs). Thus, increasing federal funding to states could encourage them to insure the low-income parents of children they are already covering.

- *Eligibility of women:* About 25 percent of uninsured women are mothers whose children are eligible for Medicaid or CHIP. Three of five uninsured parents are women (Figure 13). Only about 17 states have expanded coverage for parents up to at least the federal poverty level (nearly $18,000 for a family of four).[52]

Figure 13. Women Are Greater Proportion of Uninsured Parents

Percent of Low-Income Uninsured by Gender, 1999



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

- *Advantages for women:* As with employer-sponsored insurance, Medicaid and CHIP offer uninsured women accessible, affordable, comprehensive benefits. Medicaid already insures more women than men. This policy could have the additional advantage of improving the coverage of and care for children. Studies have found that a higher proportion of children are insured in states that extend Medicaid to parents and that children whose parents are insured are more likely to get needed care.[53]

- *Concerns for women:* The challenge associated with this policy is encouraging state participation. Experience with CHIP suggests that providing a higher federal matching rate and greater flexibility in program design will encourage states to expand insurance coverage. Federal funding may be even more important to replicate the success of CHIP with parents. State economies are weaker today than they were in the late 1990s, and many are seeking to cut back on, rather than expand, Medicaid. In addition, most states have upper-income eligibility limits for parents that are well below the poverty threshold. This means that this approach could both help many poor uninsured parents and result in large state costs if states were to make all parents of children eligible for Medicaid and CHIP eligible themselves. Most low-income, uninsured women live in states with tight budgets. Without strong incentives, these states may not take advantage of options to cover uninsured parents.

Allowing certain older adults to buy into Medicare. The rising number of uninsured older Americans has prompted interest in policy options for this group. One strategy would allow people ages 55 to 64 to obtain Medicare coverage by paying a premium. Medicare buy-in proposals differ in their eligibility rules within this age group and the amount of premium assistance for lower-income, older adults.[54] Other strategies would build on different types of insurance for the same population: for example, allowing older people to buy into FEHBP or extending COBRA continuation coverage through employers through age 65. This section focuses on the Medicare buy-in.

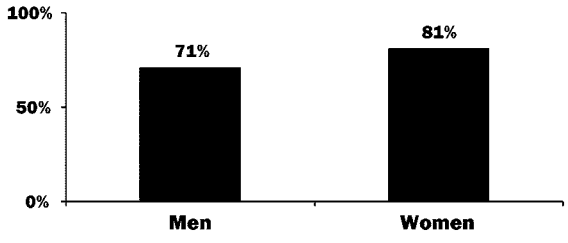
- *Eligibility of women:* About 13 percent of uninsured women are ages 55 to 64, compared with 9 percent of uninsured men. As the baby boom generation begins to retire, the number and proportion of uninsured women in this age bracket are expected to grow. However, the high cost of Medicare buy-in proposals that would subsidize premiums for lower-income enrollees has led to consideration of eligibility restrictions: limiting eligibility to people ages 62 to 64, to people who lack access to employer-sponsored insurance, and/or to displaced workers.

- *Advantages for women:* Older uninsured adults are particularly vulnerable to health problems yet are less likely to have access to job-based health insurance.[55] Private health insurance could be made more available to older adults, but doing so would necessitate significant regulation—for example, rating reforms for the individual market, or requirements that employers allow workers extended eligibility for COBRA coverage. Letting older adults purchase Medicare before age 65 alleviates the need for such regulation. It also is an attractive option for older Americans, particularly women. Partly because a high proportion of 50-to-64-year-old women whose husbands are on Medicare are themselves uninsured, women in this age range are more likely than men to express interest in getting Medicare before turning 65 (66% vs. 59%).[56]

- *Concerns for women:* Concerns have been raised about the affordability of Medicare buy-in proposals, especially for women. According to one study, net premiums for a buy-in that is combined with a 25 percent tax credit would equal about 38 percent of the average income for an uninsured person age 62 to 64.[57] This percentage would be higher for older women, since their average income is lower than men's. Equally important, some proposals would reduce risk selection by having enrollees pay a lower premium at the time of enrollment, with the remainder paid as an add-on to their monthly Medicare Part B premium once they turn 65 and enroll in Medicare. Since women generally live longer than men, they would pay more in premiums for the Medicare buy-in over their lifespans. Some policy proposals have addressed the issue of affordability, but doing so comes at a cost: limiting premium payments to, say, 5 percent of participants' income could cost $2.6 billion for a single year.[58]

Medicare's benefits, furthermore, are not as generous as those available in most employers' health plans. Medicare does not cover outpatient prescription drugs, a major issue for the elderly as well as women. A recent survey by The Commonwealth Fund found that 81 percent of women ages 50 to 70 relied regularly on prescription drugs, compared with 71 percent of older men (Figure 14). This type of concern has led to proposals to allow the same population to buy into FEHBP instead, since that program offers benefits that are significantly more generous.[59]

Figure 14. Older Women Are More Likely to Take Prescription Medicines on a Regular Basis Than Older Men



Source: The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.

Table 2. Summary of Implications for Women of Various Coverage Expansion Proposals

Policy	Percentage of Eligible Uninsured Women	Advantages	Issues
Employer-Sponsored Insurance			
Increasing affordability of job-based insurance	20% (15% men)	Expands system that provides good benefits.	Hard to accomplish through tax policy, since most eligible women are low-income.
		Helps uninsured women afford the type of insurance that they prefer the most.	Raises equity concerns if only targeted to the uninsured, since most women take coverage when offered.
Increasing accessibility of job-based insurance	28% in small businesses (41% men)	Purchasing coalitions may offer women more stable benefits, choices than single small firm could.	Poorly designed coalitions could result in worse benefits for members and higher premiums for nonmembers.
	35% part-time workers (32% men)	Part-time female workers are more likely to take job-based coverage when offered.	Hard to promote eligibility for part-time workers without changing employment patterns.
Individual Insurance			
Subsidizing through tax credit	21% (21% men)	Allows women to keep insurance regardless of work or family status.	Without major regulation, women could be charged unaffordable premiums, offered substandard benefits, or denied coverage altogether.
Federal and State Programs			
Extending Medicaid/ CHIP to uninsured parents	25% (15% men)	Targets women whose children are already eligible for coverage.	States may be unwilling to expand to parents without significant federal funding.
Creating Medicare buy-in for uninsured ages 55 to 65	13% (9% men)	Provides access without insurance regulation.	Premiums may be unaffordable for women; Medicare's benefits less valuable than private benefits.

Notes: Data from March 2000 Current Population Survey. See "Methodology" in the Appendix of this report for the percentage of uninsured women with access to the individual tax credit.

IV. CONCLUSION

Congress has the opportunity this year to act on proposals for expanding health insurance coverage. Its budget resolution, as well as the President's budget, sets aside part of the federal surplus for policies intended to reduce the number of uninsured Americans. The recent success of CHIP in helping to reduce the number of uninsured children proves that

incremental reform can work. However, the $28 billion over 10 years that is allocated for this purpose is small relative to the size of the problem and the cost of most proposals.

In light of fiscal constraints, building on health insurance options that already exist—employer-sponsored insurance for those who are eligible but not participating, as well as Medicaid and CHIP—could rapidly reduce the number of uninsured women. With increased federal funding, states could extend Medicaid and CHIP eligibility to the uninsured parents of children whom they already insure. These programs could also be used to help subsidize employer-sponsored insurance plans for low-income workers who do not enroll due to the cost. Both options would disproportionately benefit women. In addition, well-designed policies aimed at increasing insurance options for workers in small business could help a large proportion of the uninsured. Approaches such as these may be the most realistic and targeted avenues to reducing the number of uninsured in the near term, including the growing number of uninsured women.

Attention to the immediate needs of the uninsured must be balanced with laying the groundwork for more fundamental changes to the health care system. Health premiums are increasing, the economy is slowing, and the nation's demographics will likely result in a rising number of uninsured women and men. Long-term strategies to reverse this trend will require a significant investment, since most men and women are uninsured because they cannot afford coverage.

Strategies should also build on the good news of this study: that more women seek out health insurance and, given affordable options, take it. Existing coverage options should be extended by letting people access health coverage earlier (e.g., by eliminating waiting periods for job-based coverage and CHIP and allowing older adults to buy into Medicare) and keep coverage longer (e.g., by extending COBRA continuation coverage, dependent coverage for those too old for family coverage, and Medicaid coverage for those leaving welfare for work). New options should be created for those who have none—for example, by expanding Medicaid to all poor adults, or allowing uninsured workers with no other options to buy into FEHBP. Such policies might not show immediate reductions in the uninsured rate. They do, however, have the long-run potential to create a more seamless, affordable health insurance system for women in this country.

APPENDIX

METHODOLOGY

Most of the data analyses in this paper were produced by Sherry Glied and Danielle Ferry of Columbia University's Joseph L. Mailman School of Public Health for The Commonwealth Fund Task Force on the Future of Health Insurance. The study population consisted of adults ages 19 to 64. Differences were not tested for statistical significance. Most of the data are from the Current Population Survey (CPS) for March 1998 through March 2000, which provides insurance coverage data for the years 1997, 1998, and 1999. All national estimates, unless otherwise noted, are for 1999 (from the March 2000 CPS), while estimates for states are based on a three-year arithmetic average of data from 1997 through 1999. For the purpose of this paper, a family was defined as a health insurance unit—a smaller family unit than that used by the Census Bureau—so less income is counted and thus slightly more low-income uninsured people are reported here. Health insurance is defined hierarchically, so that each individual is assigned one health insurance category, even when he or she reports more than one source of coverage during the year.

Note that the Census Bureau recently announced a change in methodology that downwardly adjusts estimates of the number of uninsured. This paper uses the original definition so that historical trends could be examined. However, the distribution of men and women among the uninsured appears unchanged using the new methodology.[60]

The Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS) for 1996 was also used in this study. Data on access to employer-based health insurance come from the survey's Household Component, Round 1, and represent point-in-time estimates. The access-to-care data come from Round 2 and the full-year consolidated file. Insurance and income were defined as they were in the CPS analysis.

For experiences of older adults, the study drew from unique questions asked in The Commonwealth Fund Health Care Survey of Adults Ages 50 to 70, conducted in 1999. This survey of 2,000 women and men ages 50 to 70 asked specific questions about access to care, attitudes toward Medicare, and insurance status of those whose older spouses were on Medicare.

The projections used in Figure ES-1 and Figure 2 were done by applying the average annual growth in the population of uninsured women and men from 1995 to 1999 (inclusive) to the 1999 estimate of the number of uninsured women and men, respectively.

Estimates of the percentage of uninsured women in states with guaranteed issue and rating reforms were calculated by: (1) calculating the three-year average number of uninsured by state (using the CPS for 1997–99); (2) counting the number of uninsured in states identified as having any type of guaranteed issue or rating reform; and (3) dividing that number by the total number of uninsured women. Information on insurance regulation by state came from Blue Cross Blue Shield (*State Legislative Health Care and Insurance Issues: 2000 Survey of Plans.* Washington, D.C.: Blue Cross Blue Shield Association, February 2001). According to unpublished data from Georgetown University, a much smaller subset of these states has pure guaranteed issue and community rating. Thus, these estimates are conservative.

Appendix Table 3. Percent of Men and Women Ages 50 to 64 Who Needed But Did Not Get Care, by Insurance Status, 1999

	Men	Women
Uninsured	16%	29%
Employer-Sponsored Insurance	4%	10%
Total	7%	13%

Source: The Commonwealth Fund Health Insurance Survey of Adults Ages 50 to 70.

Appendix Table 4. Comparison of Uninsured Men and Women Ages 19–64, 1999

	Men			Women		
	Number (Millions)	Uninsured Rate	Distribution of Uninsured	Number (Millions)	Uninsured Rate	Distribution of Uninsured
Total	16.4	20%	100%	14.9	18%	100%
Income (as a Percent of Poverty)						
<200%	9.9	45%	60%	9.6	36%	65%
200%–449%	4.8	16%	29%	3.5	12%	23%
450%–599%	0.9	8%	5%	0.8	7%	5%
600%+	0.9	5%	5%	1.0	6%	7%
Ages						
19–24	3.8	34%	23%	3.1	28%	21%
25–34	4.9	26%	30%	4.0	20%	26%
35–44	4.0	18%	24%	3.4	15%	23%
45–54	2.3	13%	14%	2.6	14%	17%
55–64	1.4	13%	9%	1.9	16%	13%
Family Status						
Married	6.6	13%	40%	7.3	14%	49%
Single	9.8	31%	60%	7.6	24%	51%
Parents	4.0	14%	24%	5.1	14%	34%
Childless	12.5	24%	76%	9.8	20%	66%
Work Status						
Full-Time	8.5	15%	51%	4.9	12%	33%
Part-Time	5.2	33%	32%	5.2	21%	35%
No Work	2.8	30%	17%	4.8	25%	32%
Firm Size						
<25	6.8	32%	63%	4.1	24%	59%
25–99	2.1	21%	19%	1.4	17%	19%
100+	2.0	15%	18%	1.6	12%	22%

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of the March 2000 Current Population Survey. Subgroup numbers and percents may not sum to totals due to rounding.

Appendix Table 5. Distribution of Men and Women Ages 19–64, by Access to Employer-Sponsored Insurance and Insurance Status, 1996

	Offered Employer-Sponsored Insurance		Not Offered Employer-Sponsored Insurance	
	Insured	Uninsured	Insured	Uninsured
Total				
Men	59%	3%	18%	20%
Women	49%	4%	32%	15%
Income (as a Percent of Poverty)				
Men				
<200%	29%	6%	25%	40%
200%–449%	68%	3%	14%	15%
450%–599%	75%	1%	17%	7%
600%+	76%	1%	17%	6%
Women				
<200%	27%	7%	36%	30%
200%–449%	59%	3%	29%	9%
450%–599%	66%	2%	29%	4%
600%+	64%	1%	30%	5%
Work Status				
Men				
Full-Time	71%	3%	11%	16%
Part-Time	26%	4%	37%	33%
Women				
Full-Time	75%	4%	11%	9%
Part-Time	28%	3%	49%	20%
Firm Size				
Men				
<25	43%	4%	24%	29%
25–99	77%	5%	8%	11%
100+	86%	2%	5%	7%
Women				
<25	41%	3%	35%	21%
25–99	68%	4%	19%	9%
100+	81%	4%	11%	4%

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of the Medical Expenditure Panel Survey, 1996. Subgroup percentages may not sum to 100% due to rounding.

Appendix Table 6. State Individual Insurance Coverage, Individual Market Reforms, and Percent of Firms Offering Coverage

	Number of People with Individual Insurance		Percent with Individual Insurance		Individual Market Reform		Percent of Private-Sector Establishments Offering Insurance
	Men	Women	Men	Women	Guaranteed Issue	Any Rate Reform	
Alabama	75,886	77,885	6%	6%			56%
Alaska	9,524	10,238	5%	5%			42%
Arizona	76,764	102,857	6%	7%			54%
Arkansas	41,974	46,652	6%	6%			44%
California	609,085	700,329	6%	7%			54%
Colorado	71,569	81,730	6%	6%			57%
Connecticut	30,545	54,609	3%	5%			63%
Delaware	6,234	7,934	3%	3%			58%
District of Columbia	8,285	11,774	5%	7%			74%
Florida	284,720	321,764	7%	7%			55%
Georgia	131,960	117,253	6%	5%			52%
Hawaii	15,787	17,629	4%	5%			83%
Idaho	29,972	23,482	8%	7%	1	1	42%
Illinois	158,962	183,865	5%	5%			58%
Indiana	89,327	109,277	5%	6%			53%
Iowa	75,771	81,543	9%	10%	1	1	51%
Kansas	62,928	75,083	8%	10%			51%
Kentucky	41,197	51,866	3%	4%	1	1	54%
Louisiana	64,362	68,038	5%	5%		1	47%
Maine	18,045	24,077	5%	6%	1	1	49%
Maryland	68,815	84,631	5%	5%			61%
Massachusetts	93,286	102,109	5%	5%	1	1	64%
Michigan	121,153	135,299	4%	5%			60%
Minnesota	97,368	103,921	7%	7%		1	56%
Mississippi	40,475	54,631	5%	6%			45%
Missouri	105,453	108,807	7%	7%			55%
Montana	24,193	28,429	9%	11%			na
Nebraska	48,440	57,244	10%	12%			46%
Nevada	19,224	25,621	4%	5%		1	57%
New Hampshire	21,634	17,955	6%	5%	1	1	66%
New Jersey	108,928	135,199	5%	5%	1	1	57%
New Mexico	26,624	21,675	5%	4%		1	48%
New York	207,728	251,216	4%	4%	1	1	58%
North Carolina	104,924	126,913	5%	5%			57%
North Dakota	23,296	23,914	13%	13%		1	na
Ohio	117,709	172,062	4%	5%	1		62%
Oklahoma	48,043	51,326	5%	5%			46%
Oregon	57,748	73,013	6%	7%		1	50%
Pennsylvania	204,304	231,941	6%	6%			63%
Rhode Island	17,136	17,708	6%	6%			54%
South Carolina	56,544	65,114	5%	5%			54%
South Dakota	26,577	27,424	13%	13%	1	1	na
Tennessee	89,221	103,677	5%	6%			50%
Texas	249,482	306,354	4%	5%			50%
Utah	36,261	37,331	6%	6%	1	1	57%
Vermont	12,826	15,966	7%	9%	1	1	na
Virginia	106,820	109,270	5%	5%			55%
Washington	109,393	138,048	6%	7%	1	1	54%
West Virginia	17,201	15,977	3%	3%		1	53%
Wisconsin	86,430	83,582	5%	5%			57%
Wyoming	10,376	11,046	7%	8%			44%
United States	4,260,509	4,905,288	5%	6%	13	19	na

Sources: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 1998–2000 Current Population Surveys; insurance reform data from Blue Cross Blue Shield Survey of Plans, 2000. Firms offering data from AHRQ MEPS survey, as reported by State Health Facts Online, Henry J. Kaiser Family Foundation.

NOTES

[1] E. Simantov, C. Schoen, and S. Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August 2001): 139–149.

[2] The exceptions include policies related to particular illnesses or conditions unique to women; e.g., Medicaid expansion to low-income pregnant women and to women with breast cancer.

[3] National Center for Health Statistics, *Health, United States, 2000* (Hyattsville, Maryland: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000).

[4] National Institute of Mental Health, *Women Hold Up Half the Sky: Women and Mental Health Research* (Rockville, Maryland: National Institutes of Health, U.S. Department of Health and Human Services, NIH Publication Number 01-4607, 2001).

[5] J.W. Cohen, S.R. Machlin, and S.H. Zuvekas, *Health Care Expenses in the United States,* Research Findings Number 12 (Rockville, Maryland: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2000).

[6] K.M. Brett and C.W. Burt, *Utilization of Ambulatory Medical Care by Women: United States: 1997–98* (Hyattsville, Maryland: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, DHHS Publication No. (PHS) 2001-1720, July 2001).

[7] J.W. Cohen, S.R. Machlin, and S.H. Zuvekas, *Health Care Expenses in the United States,* Research Findings Number 12 (Rockville, Maryland: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2000).

[8] K.S. Collins, *Midlife Women: Insurance Coverage and Access,* Issue Brief (New York: Women's Research and Education Institute, May 2001).

[9] K.S. Collins et al., *Health Concerns Across a Women's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health* (New York: The Commonwealth Fund, May 1999).

[10] C. Hoffman and A. Schlobohm, *Uninsured in America: A Chart Book,* Second Edition (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, May 2000).

[11] American College of Physicians/American Society of Internal Medicine, *Health Insurance: Enough to Make You Sick: Uninsured Women at Risk* (Philadelphia: ACP-ASIM Working Paper, March 14, 2001, available at www.acponline.org/uninsured/index.html).

[12] S.A. Glied, "Challenges and Options for Increasing the Number of Americans with Health Insurance," *Inquiry* 38 (Summer 2001): 90–105.

[13] Kaiser/HRET, *Employer Health Benefits 2000 Annual Survey* (Menlo Park, California: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, 2000).

[14] J.R. Gabel, P.B. Ginsburg, and K.A. Hunt, "Small Employers and Their Health Benefits, 1988–1996: An Awkward Adolescence," *Health Affairs* 16 (September/October 1997): 103–110.

[15] J. Hudman, *Immigrants' Health Care: Coverage and Access* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, August 2000).

[16] R. Wyn et al., *Falling Through the Cracks: Health Insurance Coverage of Low-Income Women* (Menlo Park, California: The Henry J. Kaiser Family Foundation, February 2001).

[17] Association for Health Services Research and Health Policy Annual Meeting (June 11, 2001). Panel: "Health Insurance Coverage: Effects of the Economy, Rising Costs, & Programs to Help the Uninsured, & Prospects for the Near Future," Chair: Katherine Swartz, Harvard School of Public Health; Panelists: Linda Bilheimer, The Robert Wood Johnson Foundation; Michael

Chernew, University of Michigan; Catherine McLaughlin, University of Michigan; Len Nichols, The Urban Institute.

[18] K.S. Collins, *Midlife Women: Insurance Coverage and Access,* Issue Brief. (New York: Women's Research and Education Institute, May 2001).

[19] C. Schoen et al., *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (New York: The Commonwealth Fund Task Force on the Future of Health Insurance, July 2000).

[20] S.A. Glied and M. Stabile, "Covering Older Americans: Forecast for the Next Decade," *Health Affairs* 18 (January/February 1999): 208–213.

[21] Calculated by applying uninsured rates for those ages 19 to 54 and 55 to 64 to population projections for 2010 from Census Bureau, "Projections of the Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series" NP-T3-A (Washington, D.C.: U.S. Department of Commerce, January 13, 2000).

[22] K. Donelan, M. Falik, and C.M. DesRoches, "Caregiving: Challenges and Implications for Women's Health," *Women's Health Issues* 11 (May/June 2001): 185–200.

[23] R. Wyn et al., *Falling Through the Cracks: Health Insurance Coverage of Low-Income Women* (Menlo Park, California: The Henry J. Kaiser Family Foundation, February 2001).

[24] P.F. Short, "Gaps and Transitions in Health Insurance: What Are the Concerns of Women?" *Journal of Women's Health* 7 (August 1998): 725–737.

[25] E. Simantov, C. Schoen, and S. Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August 2001): 139–149.

[26] Blue Cross Blue Shield Association, *State Legislative Health Care and Insurance Issues: 2000 Survey of Plans* (Washington, D.C.: Blue Cross Blue Shield Association, February 2001, available at http://www.bcbshealthissues.com); and unpublished data, K. Pollitz, Georgetown University.

[27] A. Salganicoff and R. Wyn, "Access to Care for Low-Income Women: The Impact of Medicaid," *Journal of Health Care for the Poor and Underserved* 10 (November 1999): 453–467.

[28] Families USA, *The Health Care Safety Net: Millions of Low-Income People Left Uninsured* (Washington, D.C.: Families USA, July 2001).

[29] See S.A. Glied, "Challenges and Options for Increasing the Number of Americans with Health Insurance" *Inquiry* 38 (Summer 2001): 90–105; and J. Feder, C. Uccello, and E. O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance* (Washington, D.C.: The Kaiser Project on Incremental Health Reform, The Henry J. Kaiser Family Foundation, October 1999).

[30] P.F. Cooper and B.S. Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs* 16 (November/December 1997): 142–149; and J.R. Gabel, "Job-Based Health Insurance, 1977–1998: The Accidental System," *Health Affairs* 18 (December 1999): 62–74.

[31] J.R. Gabel et al., "Embraceable You: How Employers Influence Health Plan Enrollment," *Health Affairs* 20 (July/August 2001): 196–208; and E. O'Brien and J. Feder, *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, May 1999).

[32] See M. Merlis, "Public Subsidies for Employee Contributions to Employer-Sponsored Insurance," *Inquiry* 38 (Summer 2001): 121–132; and J. Lemieux, D. Kendall, and R. Levine, *A Progressive Path Toward Universal Health Coverage* (Washington, D.C.: Progressive Policy Institute, December 2000).

[33] Institute for Health Policy Solutions, *Coordinating State Children's Health Insurance Programs with Employer-Based Coverage: Design and Implementation of Premium Assistance Programs* (Washington, D.C.: Institute for Health Policy Solutions and National Governors' Association, October 5, 1999); and Centers for Medicare and Medicaid Services, Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative (Washington, D.C.: U.S. Department of Health and Human Services, August 6, 2001). Note that current law includes this option; the new demonstration policy allows states to waive the "cost-effectiveness" and apparently some benefit requirements in both Medicaid and CHIP.

[34] L. Duchon et al., *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (New York: The Commonwealth Fund Task Force on the Future of Health Insurance, January 2000).

[35] J. Feder, C. Uccello, and E. O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance* (Washington, D.C.: The Kaiser Project on Incremental Health Reform, The Henry J. Kaiser Family Foundation, October 1999); and J.A. Meyer, S. Silow-Carroll, and E.K. Wicks, *Tax Reform to Expand Health Coverage: Administrative Issues and Challenges* (Menlo Park, California: The Henry J. Kaiser Family Foundation, January 2000).

[36] See analysis of this type of tax credit in S.A. Glied, "Challenges and Options for Increasing the Number of Americans with Health Insurance," *Inquiry* 38 (Summer 2001): 90–105.

[37] R.E. Curtis, E. Neuschler, and R. Forland, "Private Purchasing Pools to Harness Individual Tax Credits for Consumers," *Inquiry* 38 (Summer 2001): 159–176; J.A. Meyer and E.K. Wicks, "A Federal Tax Credit to Encourage Employers to Offer Health Coverage," *Inquiry* 38 (Summer 2001): 202–213; S. Rosenbaum, P.C. Borzi, and V. Smith, "Allowing Small Businesses and the Self-Employed to Buy Health Coverage Through Public Programs," *Inquiry* 38 (Summer 2001): 193–201; and C.N. Kahn and R.F. Pollack, "Building a Consensus for Expanding Health Coverage," *Health Affairs* 20 (January/February 2001): 40–48.

[38] K. Davis, C. Schoen, and S.C. Schoenbaum, "A 2020 Vision for American Health Care," *Archives of Internal Medicine* 160 (December 11/25, 2000): 3357–3362; and J.R. Gabel et al., "Embraceable You: How Employers Influence Health Plan Enrollment," *Health Affairs* 20 (July/August 2001): 196–208.

[39] J.R. Gabel et al., "Embraceable You: How Employers Influence Health Plan Enrollment," *Health Affairs* 20 (July/August 2001): 196–208.

[40] E.K. Wicks, "Health Purchasing Coalitions Struggle to Gain Bargaining Clout: Small Size and Lack of Support from Health Plans a Factor," *Health Care Financing & Organization Findings Brief 4* (Washington, D.C.: Academy for Health Services Research and Health Policy, June 2000); R.E. Curtis, E. Neuschler, and R. Forland, "Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?" *Health Affairs* 20 (January/February 2001): 164–168; and S. Trude and P.B. Ginsburg, "Tax Credits and Purchasing Pools: Will This Marriage Work?" *Center for Health System Change Issue Brief 36* (Washington, D.C.: Center for Health System Change, April 2001).

[41] J.R. Gabel, P.B. Ginsburg, and K.A. Hunt, "Small Employers and their Health Benefits, 1988–1996: An Awkward Adolescence," *Health Affairs* 16 (September/October 1997): 103–110.

[42] R.E. Curtis, E. Neuschler, and R. Forland, "Private Purchasing Pools to Harness Individual Tax Credits for Consumers," *Inquiry* 38 (Summer 2001): 159–176.

[43] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts* (Washington, D.C.: Congressional Budget Office, January 2000).

[44] L. Zelenak, "A Health Insurance Tax Credit for Uninsured Workers," *Inquiry* 38 (Summer 2001): 106–120.

[45] K. Pollitz, R. Sorian, and K. Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington, D.C.: The Henry J. Kaiser Family Foundation, June 2001).

[46] D.J. Chollet and A.M. Kirk, *Understanding Individual Health Insurance Markets* (Menlo Park, California: The Henry J. Kaiser Family Foundation, March 1998).

[47] E. Simantov, C. Schoen, and S. Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August 2001): 139–149.

[48] K. Pollitz, R. Sorian, and K. Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington, D.C.: The Henry J. Kaiser Family Foundation, June 2001).

[49] E. Simantov, C. Schoen, and S. Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August 2001): 139–149.

[50] See K. Davis, *Expanding Public Programs to Cover the Sick and Poor Uninsured. Testimony before the U.S. Senate Finance Committee* (New York: The Commonwealth Fund, March 15, 2001); J. Feder et al., "Covering the Low-Income Uninsured: The Case for Expanding Public Programs," *Health Affairs* 20 (January/February 2001): 27–39; and B.C. Fuchs, "Increasing Health Insurance Coverage Through an Enhanced FEHBP," *Inquiry* 38 (Summer 2001): 177–192.

[51] J.M. Lambrew, *Health Insurance: A Family Affair—A National and State-by-State Analysis of Uninsured Parents and Their Children* (New York: The Commonwealth Fund Task Force on the Future of Health Insurance, May 2001).

[52] Families USA, *The Health Care Safety Net: Millions of Low-Income People Left Uninsured* (Washington, D.C.: Families USA, July 2001).

[53] K.L. Hansen, "Patterns of Insurance Coverage Within Families with Children," *Health Affairs* 20 (January/February 2001): 240–246; and J.M. Lambrew, *Health Insurance: A Family Affair—A National and State-by-State Analysis of Uninsured Parents and Their Children* (New York: The Commonwealth Fund Task Force on the Future of Health Insurance, May 2001).

[54] K. Davis, C. Schoen, and S.C. Schoenbaum, "A 2020 Vision for American Health Care," *Archives of Internal Medicine* 160 (December 11/25, 2000): 3357–3362; P.F. Short, D.G. Shea, and M.P. Powell, "A Workable Solution for the Pre-Medicare Population," *Inquiry* 38 (Summer 2001): 214–224.

[55] J. Budetti et al., *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Insurance* (New York: The Commonwealth Fund Task Force on the Future of Health Insurance, January 2000).

[56] C. Schoen et al., *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (New York: The Commonwealth Fund Task Force on the Future of Health Insurance, July 2000).

[57] J. Sheils and Y.J. Chen, *Medicare Buy-In Options: Estimating Coverage and Costs* (New York: The Commonwealth Fund Task Force on the Future of Health Insurance, February 2001).

[58] J. Sheils and Y.J. Chen, *Medicare Buy-In Options: Estimating Coverage and Costs* (New York: The Commonwealth Fund Task Force on the Future of Health Insurance, February 2001).

[59] B.C. Fuchs, "Increasing Health Insurance Coverage Through an Enhanced FEHBP," *Inquiry* 38 (Summer 2001): 177–192; and C.F. Caplan and L.A. Foley, *Structuring Health Care Benefits: A Comparison of Medicare and the FEHBP* (Washington, D.C.: AARP Public Policy Institute, May 2000).

[60] See Table 1 in C.T. Nelson and R.J. Mill, "The March CPS Health Insurance Verification Question and Its Effect on Estimates of the Uninsured," (Suitland, Maryland: U.S. Census Bureau, Housing and Household Economic Statistics Division, August 2001).

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering by number. These items can also be found on the Fund's website at www.cmwf.org. Other items are available from the authors and/or publishers.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#457 *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?* (July 2001). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, The Pennsylvania State University. The authors conclude that the loss of employer insurance should not be used as the primary justification for implementing Medicare buy-in or other reforms for over-55 and over-62 age groups, but instead propose that the better justification for such reforms is the poorer average health status of those nearing age 65.

#468 *Market Failure? Individual Insurance Markets for Older Americans* (July/August 2001). Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman. *Health Affairs,* vol. 20, no. 4. This new study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

#469 *Embraceable You: How Employers Influence Health Plan Enrollment* (July/August 2001). Jon Gabel, Jeremy Pickreign, Heidi Whitmore, and Cathy Schoen. *Health Affairs,* vol. 20, no. 4. In this article, the authors reveal that high employee contributions for health insurance often deter low-income workers from signing up for coverage, even when they are eligible.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author explains that the Medicare+Choice options available to beneficiaries have diminished: existing plans have withdrawn from M+C, few new plans have entered the program, greater choice has not developed in areas that lacked it, and the inequities in benefits and offerings between higher- and lower-paid areas of the country have widened rather than narrowed.

#449 *How the New Labor Market Is Squeezing Workforce Health Benefits* (June 2001). James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy. To understand how labor market trends have contributed to the decline in the proportion of private-sector workers receiving benefits from their own employers—and to anticipate future trends—this study examines changes over a 19-year period, 1979 to 1998.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#453 *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

Preparing for the Future: A 2020 Vision for American Health Care (April 2001). Karen Davis. *Academic Medicine,* vol. 76, no. 4. Copies are available from Karen Davis, President, The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692.

#462 *Expanding Public Programs to Cover the Sick and Poor Uninsured* (March 2001). Karen Davis. In invited testimony before the Senate Finance Committee, the Fund's president presented a compelling case for expanding existing public health insurance programs to provide coverage for the most vulnerable segments of the nation's 42.6 million uninsured. She stressed the importance of expanding Medicaid and the Children's Health Insurance Program (CHIP) to cover parents of covered children.

#441 *Medicare Buy-In Options: Estimating Coverage and Costs* (March 2001). John Sheils and Ying-Jun Chen, The Lewin Group, Inc. This paper examines the need for insurance expansions for Americans approaching retirement age and analyzes the likely impact of Medicare buy-in options on program costs and their effectiveness in reducing the numbers of uninsured.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication #424 (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series Strategies to Expand Health Insurance for Working Americans.

#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication #415, presents a detailed side-by-side look at the 10 option papers in the series Strategies to Expand Health Insurance for Working Americans.

#459 *Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare* (January/February 2001). Dennis G. Shea, Pamela Farley Short, and M. Paige Powell. *Health Affairs,* vol. 20, no. 1. The article examines whether eligibility for a Medicare buy-in should be based on age or ability to pay.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs,* vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

How a Changing Workforce Affects Employer-Sponsored Health Insurance (January/February 2001). Gregory Acs and Linda J. Blumberg. *Health Affairs,* vol. 20, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#438 *A 2020 Vision for American Health Care* (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine,* vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

Tracking Health Care Costs: Inflation Returns (November/December 2000). Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel. *Health Affairs,* vol. 19, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

Customizing Medicaid Managed Care—California Style (September/October 2000). Debra A. Draper and Marsha Gold. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

Inadequate Health Insurance: Costs and Consequences (August 11, 2000). Karen Donelan, Catherine M. DesRoches, and Cathy Schoen. *Medscape General Medicine.* Available online at www.medscape.com/ Medscape/GeneralMedicine/journal/public/mgm.journal.html.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 *Current Population Survey* and *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this report examines reasons why 9 million of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.