Nowhere to Turn:

How the Individual Health Insurance Market Fails Women

Reform Matters

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

About the Center

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

Authors

This Report was a collaborative endeavor that relied upon the work of many individuals. The primary authors—Lisa Codispoti, Brigette Courtot and Jen Swedish—were greatly assisted by Marcia Greenberger, Judy Waxman, Julia Kaye, Ellen Newcomb, Gretchen Borchelt, Golda Philip, Sarah McGinnis, Amanda Maldonado, Amanda Stone, and Lisa M. LeMair. The authors would also like to acknowledge the helpful advice and guidance provided by Cheryl Fish-Parcham, Deputy Director of Health Policy at Families USA, and Terry Fromson, Managing Attorney with the Women's Law Project.

Disclaimer

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Reform Matters

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

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Introduction & Executive Summary

The majority of American women have health insurance either through an employer or through a public program such as Medicaid. In 2007, nearly two-thirds of all women aged 18 to 64 had insurance through an employer, and another 16% had insurance through a public program.

In contrast, a very small percentage of nonelderly women—just 7% in 2007—purchase health coverage directly from insurance companies in what is known as the "individual market." Because this is the least common way to get health insurance, few people have any idea just how difficult it can be to purchase coverage in the individual market. For the 18% of women who are currently uninsured—those who lack access to employer coverage, or who earn too much to qualify for public programs—the individual insurance market is often the last resort for coverage.

Buying insurance in the individual market is very different from getting health insurance through an employer. Women who get health insurance from their employer are protected by several important federal and state laws. For example, most employers cannot charge their employees different premiums for their health insurance. And employers must include maternity coverage in the health insurance that they provide to their employees. In contrast, states are left to regulate the sale of health insurance in the individual market; and in the vast majority of states, few if any such protections exist for women who purchase individual health coverage. Furthermore, those seeking health coverage in the individual market are often less able to afford insurance without the benefit of an employer to share the cost of the premium.

Why understand the individual insurance market?

Recent trends, as well as several prominent health reform proposals, could lead to an expanded role for the individual insurance market. For example, some reform proposals would provide tax credits for people to obtain health insurance in the individual insurance market and discourage favorable tax treatment for employer-sponsored coverage. Moreover, recent reports describe employers who on their own have decided to give their employees a fixed sum to buy individual insurance coverage instead of providing employer-sponsored health insurance. But without substantial changes to the individual insurance market, **such assistance will be meaningless** for those who cannot get coverage at any price or worth less for those who face higher premiums due to common insurance company practices such as setting premiums based on gender, age or health history.

To learn more about the experiences of women seeking coverage in the individual insurance market, between July and September 2008, the National Women's Law Center ("NWLC" or "the Center") gathered and analyzed information on over 3,500 individual health insurance plans available through the leading online source[1] of health insurance for individuals, families and small businesses. The Center investigated two phenomena: the "gender gap"—the difference in premiums charged to female and male applicants of the same age and health status—in selected plans sampled from each state and the District of Columbia (D.C.) and among states' and D.C.'s best-selling plans; and the availability and affordability of coverage for maternity care across the country.[2] In addition, NWLC examined state statutes and regulations relating to the individual insurance market to determine whether the states and D.C. have protections against premium rating based on gender, age, or health status in the individual market, and to determine whether states have any maternity coverage mandates requiring insurers in the individual market to provide coverage for prenatal and postnatal office visits as well as labor and delivery for both routine and complicated pregnancies.

Based on this research, **NWLC found that the individual insurance market is a very difficult place for women to buy health coverage**. Insurance companies can refuse to sell women coverage altogether due to a history of any health problems, or charge women higher premiums based on factors such as their gender, age and health status. This coverage is often very costly and limited in scope—and it often fails to meet women's needs.

In short, too many women face too many obstacles obtaining comprehensive, affordable health coverage in the individual market—simply because they are women.

- **Women often face higher premiums than men.** Under a practice known as gender rating, insurance companies are permitted in most states to charge men and women different premiums. NWLC research determined that this costly practice often results in wide variations in rates charged to women and men for the same coverage; these arbitrary differences harm women's ability to get the health care they need. The Center found that among insurers who gender rate, the majority charge women more than men until they reach around age 55, and then some (though not all) charge men more. **The Center found huge and arbitrary variations in each state and across the country in the difference in premiums charged to women and men.** For the capital city in each of 47 states and D.C., NWLC sampled two plans for the same-aged men and women among individual insurance plans. The Center found that insurers who practice gender rating charged 25-year-old women anywhere from 6% to 45% more than 25-year-old men; charged 40-year-old women from 4% to 48% more than 40-year-old men; and charged 55 year-old women premiums that ranged from 22% less to 8% more than 55-year-old men. The huge variations in premiums charged to women and men for identical health plans highlight the arbitrariness of gender rating, and the financial impact of gender rating is compounded when insurers also charge more for age and health status when setting insurance premiums.

- **It is difficult and costly for women to find health insurance that covers maternity care.** The vast majority of individual market health insurance policies that NWLC found do not cover maternity care at all. A limited number of insurers sell separate maternity coverage for an additional fee known as a "rider," but this supplemental coverage is often expensive and limited in scope. Moreover, insurers that sell maternity riders typically offer just a single "one size fits all" rider option. Typically, a woman has no option to select a more or less comprehensive rider policy—her only option is to purchase the limited rider or go without maternity coverage altogether.

  In the capital cities of four states—Hawaii, New Mexico, North Dakota and South Dakota—NWLC was unable, using the leading online provider described in the research methods, to find an offer of maternity coverage at any price. Not a single individual market insurance plan found through this online provider covered maternity, nor offered a maternity rider. After significant additional research efforts, NWLC was able to identify only a few health plans with maternity coverage in the four state capitals.

  In another three state capitals, NWLC found just one option for maternity coverage using the leading online provider: a limited maternity rider offered by the same insurance company. This particular rider covers just $2,000 of a woman's maternity expenses for the first two years that she is enrolled in the plan. Such limited coverage is far below the actual cost of maternity care in the United States, exposing a woman and her family to high levels of out-of-pocket spending. In 2006, the average cost of a hospital-based uncomplicated vaginal birth was $7,488; based

on this figure, a woman enrolled in the rider described above could be responsible for nearly $5,500 of the cost of an uncomplicated labor and delivery, in addition to the cost of her rider premium.

The challenges encountered during this exercise—even for seasoned health policy experts—highlight the difficulties that a typical woman would face when trying to obtain individual health insurance that includes coverage for maternity care, as well as the very few options available even after scouring the market.

- **Insurance companies can reject applicants for health coverage for a variety of reasons that are particularly relevant to women.** For example, it is still legal in nine states and D.C. for insurers to reject applicants who are survivors of domestic violence. Insurers can also reject women for coverage simply for having previously had a Cesarean section (C-section).

- **While both women and men face additional challenges in the individual insurance market, these problems compound the affordability challenges women already face.** Insurance companies also engage in premium rating practices that, while not unique to women, compound the affordability issues caused by gender rating. These include setting premiums based on age and health status.

Based on NWLC research, this report reviews the challenges that women face in the individual insurance market and explores various ways states have addressed these challenges. Finally, the Report provides the following recommendations for reform to address these challenges:

1. Because the individual insurance market is so deeply flawed, adequate alternatives must be developed to eliminate or substantially reduce the need for people to resort to its use. This can be done by making employer-sponsored coverage easier to obtain and afford, or by creating purchasing pools that are large enough to accommodate everyone who needs coverage.

2. In the short term, until adequate alternatives to the individual market exist, there must be strong regulation of insurers offering health coverage through the individual market. To ensure that comprehensive health coverage is easier to obtain and afford, these regulations must end the unfair practices of gender rating, rejecting applicants due to health history, excluding pre-existing conditions, and rating based on age and health history.

3. All health insurance policies should cover vital reproductive health services such as maternity care.

Without these changes, health reform will be meaningless for far too many women; rather than improve women's access to health care, reform that does not address these flaws in the individual market will leave women in the exact same place where they are today. Too many women will have nowhere to turn for health coverage or will be left on their own at the mercy of health insurers. Inadequate and unaffordable coverage may be their only choice, if they can find coverage at all.

I. Background

Employer-sponsored health insurance is the most common form of health coverage in the U.S. In 2007, nearly two-thirds of nonelderly American women aged 18 to 64 received health benefits through their own or their spouse's employer.[3] In contrast, very few women buy insurance directly from insurance companies in what is known as the individual market. In 2007, only 7% of women aged 18 to 64—slightly over 6.5 million women—had coverage purchased in the individual market.[4]

A. Buying Health Insurance: Important Differences Between Obtaining Health Insurance from an Employer versus the Individual Market

In the **group market**, employers and groups, such as associations, obtain coverage for their employees or members—and are thus able to spread medical risk or costs over the group. Health insurance available in the group market is thus often more comprehensive and affordable than the **individual market**, where there are no groups to spread medical risk or costs. In the individual market, individuals are on their own to try to buy health insurance directly from an insurance company. In contrast to employer-provided health insurance, people with a history of health problems often struggle to obtain coverage in the individual market. When available, coverage sold in the individual market is often expensive and more limited than insurance offered by employers. Accordingly, when compared to employer coverage, very few people obtain coverage in the individual market—only 7% of nonelderly women have individually-purchased coverage versus 65% with employer-sponsored coverage.[5]

Different rules apply to insurance offered by employers versus insurance sold directly to individuals. For example, important state and federal anti-discrimination protections apply to employer-provided health insurance—but not to health insurance sold in the individual market . Under Title VII of the Civil Rights Act of 1964, employers with 15 or more employees are prohibited from charging employees different premiums for health insurance based on gender or other factors.[6] Almost every state has a law against sex discrimination in employment along the same lines as Title VII.[7] The majority of these state laws have an employee threshold that is lower than Title VII, meaning that the state prohibition on sex discrimination in employment could apply to employers that are too small to be covered by Title VII.[8] Courts and state officials have applied these laws to employer's health benefit plans.[9] Thus, employers unlawfully discriminate under state and federal law if they charge female employees more than male employees for the same health coverage.

Similarly, state and federal anti-discrimination protections ensure that most employer-sponsored insurance covers maternity expenses. The Pregnancy Discrimination Act of 1978 amended Title VII to specify that discrimination on the basis of pregnancy, childbirth, or related medical conditions constitutes unlawful sex discrimination under Title VII.[10] Under the Pregnancy Discrimination Act, any health insurance provided by an employer with 15 or more employees must cover pregnancy on the same basis as other medical conditions.[11] Correspondingly, the fair employment laws in almost all states consider discrimination based on pregnancy to be sex discrimination,[12] and the majority of these laws apply to employers that are too small to be covered by Title VII.[13] As a result of state and federal anti-discrimination protections, most women with job-based health insurance receive maternity benefits.

In addition to state and federal anti-discrimination protections, different rules apply to employer-sponsored insurance under the federal law known as "HIPAA," the Health Insurance Portability and Accountability Act of 1996.[14] Under HIPAA, covered employers are prohibited from charging similar employees different premiums for health insurance based on age or health status, and employees cannot be denied coverage based on health status.

In contrast, the regulation of insurance has traditionally been a state responsibility,[15] and few states limit what individual insurers can do. Unlike employer-sponsored health coverage, which is subject to many state and federal protections, the vast majority of states subject the individual market to few, if any, such protections.

Because the regulations imposed by particular states vary a great deal, there are dramatic differences between individual health insurance markets from state to state. For example, while one state may prohibit gender rating in the individual market, similarly-situated men and women in many other states may be charged vastly divergent premiums for the same coverage. Another state may require individual insurance companies to issue coverage to everyone who applies, while many other states allow insurers to reject applicants for virtually any reason.

State governments have enacted one type of insurance law to protect consumers: mandates to cover specific health benefits. These laws are intended to prevent insurance companies from excluding coverage for certain conditions and from placing stringent limits on covered services. Many of these laws relate to health care services that women need to lead healthy and productive lives, including requirements to cover important preventive health care benefits like mammography and cervical cancer screenings. Some mandated benefit laws also guarantee that women have access to the safe and reliable contraception that is an essential component of their reproductive health care.[16] These existing laws are important, but at best they form only a "patchwork" of health protections that vary based on where a woman lives. This patchwork leaves many gaps remaining.

B. Obtaining Coverage in the Individual Insurance Market

When a person applies for coverage in the individual market, insurance companies may engage in "medical underwriting." Medical underwriting is the process by which an insurance company decides whether to sell the applicant coverage and what premium to charge. While a few state and federal laws limit the ability of insurance providers to reject applicants for coverage and to vary the premiums they charge, many insurers have great latitude in the underwriting process.

1. How Insurers Decide Whether to Sell Insurance to an Applicant

When determining whether to sell an individual health insurance and what premium to charge, insurance companies examine a number of criteria, including health status and health history (including "pre-existing conditions"), age, gender, and other factors. Except where prohibited in a few states or in the extremely limited circumstance of an eligible individual leaving group coverage,[17] insurers in the individual market are generally free to deny coverage to applicants who have health conditions or a history of health problems. Applicants with any history of health problems such as HIV/AIDS, temporary conditions such as pregnancy, or even minor conditions such as hay fever can be rejected, unless state law directs otherwise.[18]

2. How Insurers Determine Premiums

Once an insurance company decides to sell coverage to an individual, it will determine what premium to charge the applicant. During the medical underwriting process, insurers consider a number of factors to predict how much money they will have to spend on their enrollees' health services in the year ahead. Depending on state law and insurance company practice, insurers set premiums based on a number of factors, which can include health status, demographic factors such as geography, age, and gender, industry (i.e. the applicant's line of employment), and experience (i.e. insurance claims history). As described in greater detail below, rating factors such as gender, health status and age all present barriers to coverage for women.

II. Findings

A. Women Face Many Obstacles Buying Health Insurance in the Individual Market

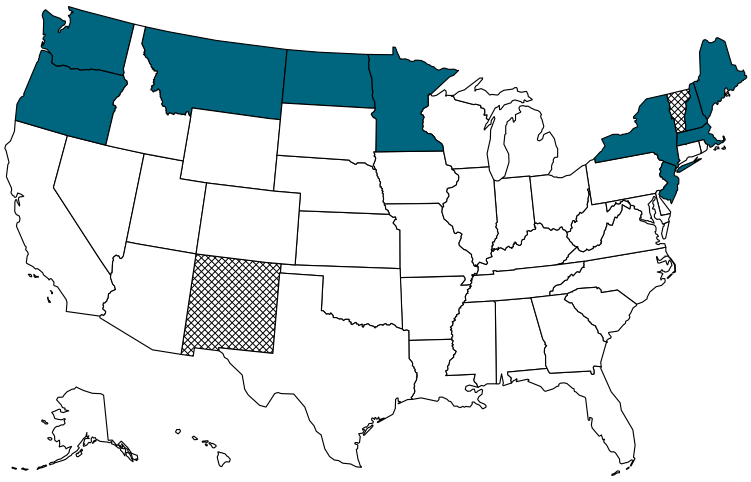
1. Rejection: Insurers Refusing to Sell Women Coverage

In most states, insurers are free to reject individuals applying for coverage in the individual market. Many women face such rejection at this underwriting stage of purchasing insurance for a wide range of reasons. For example, women have greater health needs than men and are more likely than men to suffer from a chronic condition requiring ongoing treatment, like asthma or arthritis.[19] These conditions can lead to rejection of coverage. In addition, if during the medical underwriting process the insurer discovers that an applicant underwent a past C-section, the company may charge her a higher premium, impose an exclusionary period during which it refuses to cover another C-section or pregnancy, or even reject her for coverage altogether unless she has been sterilized or is no longer of childbearing age. [20] Insurers in D.C. and the following nine states are allowed to deny coverage to domestic violence survivors: Arkansas, Idaho, Mississippi, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, and Wyoming.[21] In addition, recent news reports documented the practice of insurance companies obtaining prescription drug histories as a basis to reject applicants for health coverage.[22] Women are more likely than men to be potentially affected by this practice—at any age they are more likely than men to take prescription medications on a regular basis.[23]

2. Gender Rating: Charging Women More than Men for Insurance

Except where prohibited in ten states,[24] or limited in two states, [25] insurance carriers are free to charge women and men different premiums for individually-purchased insurance under a practice known as gender rating.[26] This discriminatory and arbitrary practice creates substantial financial barriers for women seeking to obtain the health care they need; as such, the use of gender rating should be abandoned.

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



State has protections against the use of gender to set premiums in the individual health insurance market

State limits the use of gender to set premiums in the individual health insurance market with a rate band

State does not have protections against the use of gender to set premiums in the individual health insurance market

Many states that allow gender rating require that any difference in rates between women and men be "justified by actuarial statistics,"[27] which means that the rating differential must be based on true variations in health costs between women and men.[28]

Representatives of the insurance industry argue that gender rating is actuarially justified—or that it reflects actual differences in the cost of providing health insurance to women versus men; they contend that premiums are higher because women, on average, have higher hospital, physicians' and other health care costs than men.[29]

In contrast, over forty years ago the insurance industry voluntarily abandoned the practice of using race as a rating factor, despite their position that it was actuarially based,[30] and several states adopted statutes expressly banning the practice.[31] Just as in the case of race, it is bad public policy to allow this discrimination to continue outside of the employer-provided benefits setting, where gender rating has been banned nationwide for over thirty years.

First, many women have fewer health expenses than men of the same age; actuarial statistics are cold comfort for these women. Secondly, in the employment context, the Supreme Court has held "Title VII requires employers to treat their employees as *individuals*, not 'as simply components of a racial, religious, sexual, or national class.'"[32] As such, even though women as a class may have higher health costs, an employer unlawfully discriminates if it charges a female employee more than a male employee for the same health coverage. The same principle should apply to the individual market; individual insurance providers should not charge a higher premium based on a generalization about women as a class that is not necessarily applicable to the individual woman being insured.

Recent trends also suggest the need to eliminate gender rating in the individual market to avoid erosion of important federal protections against gender discrimination in the provision of health benefits by employers.[33] Some employers have stopped offering health insurance and are instead providing financial assistance to employees to purchase coverage in the individual insurance market.[34] Because gender rating in the individual market too often results in more expensive coverage for women than men, female employees in such a situation have lost these important federal protections and are facing de facto benefit discrimination when compared to their male counterparts.

Further, given the prevalence of gender rating, proposals to provide a set amount of a tax credit to purchase health insurance on the individual market will be less valuable to women than men.[35] An equal tax credit for women and men would ultimately result in unequal and less adequate coverage for women. Regardless of the insurance industry's attempted defense of gender rating, women are even less able to afford the higher premiums charged for individual coverage, because today, on average, women earn only 78 cents for every dollar that men earn.[36]

Despite the common requirement that gender rating be actuarially justified, NWLC research demonstrates that in practice, the use of gender rating is often arbitrary and the wide swings in rates charged could hardly be actuarially justified, thereby underscoring the dangers of allowing rates based on gender. At the outset, it is important to note that women are charged higher rates even though the vast majority of best-selling individual health insurance plans NWLC examined that gender rate do not include maternity benefits. Of the 347 identified best-selling plans with gender-rated premiums, just 6% include maternity coverage in the individual health insurance policy.[37] Thus, the presence or absence of maternity coverage does not, by itself, explain the variations in premiums that NWLC research revealed. NWLC findings included:

- **Wide variation in gender-based premiums across the country.** As shown in greater detail in Appendix 1, among insurers who gender rate, the range in the different premiums based on gender is quite wide. NWLC calculated the different premiums charged to women and men at ages 25, 40 and 55 for identical health plans, and selected similar health insurance plans (similar coverage, co-pays and deductibles, and excluding maternity) for comparison. NWLC

found that among the plans examined, at age 25, women were charged between 6% and 45% more than men for individual market health plans; at 40-years-old, women's monthly premiums ranged between 4% and 48% higher than men's monthly premiums; and at age 55, women were charged 22% less to 8% more than the rates men were charged.

- **Wide variation in gender-based premiums within a state.** NWLC also found wide variations in the different premiums charged to women and men within a state. NWLC examined all "best-selling" plans (as identified by the online vendor) offered in the capital city in each state for a 40-year-old woman and man, as reflected in Appendix 2. For example, one insurer in Missouri charges 40-year-old women a whopping 140% more than men while another charges women 15% more than men. In Arkansas, all ten best-selling plans gender rate, and the difference in premiums ranged from 13% to 63% more for women. At the same time, not all plans use gender as a rating factor. For example, only some of South Carolina's ten best-selling plans gender rate, but among those that do, NWLC found that 40-year-old women are charged between 15% and 54% more than men for the same plan.

The wide range of differences in premiums charged women and men shows the arbitrary nature of gender rating in practice. Given the unfair and discriminatory nature of gender rating, and the financial barrier this practice creates for women to obtain necessary health care, the use of gender rating should be abandoned.

3. Maternity Coverage in the Individual Market: Expensive, Limited and Difficult to Obtain

Although most women with job-based health insurance receive maternity benefits as a result of state and federal anti-discrimination protections, no such protection exists in the individual insurance market. In this market, women face multiple challenges in obtaining comprehensive or affordable health insurance that covers maternity care.

Individual market insurers may consider pregnancy as grounds for denying a woman's application, or as a "pre-existing condition" for which coverage can be excluded. An uninsured woman who wants to purchase individual market coverage *after* she is already pregnant will probably not receive any offers of maternity coverage at all—in most states, individual market insurers are allowed to deny coverage altogether to a pregnant applicant. Even if they are required to issue a policy, insurers are generally allowed to consider the pregnancy as a "pre-existing condition" and will exclude coverage for maternity services.[38]

A woman's age has an impact on whether maternity benefits are available in a health insurance policy, and at what cost—a 25-year-old woman is likely to have significantly more options, at a more affordable price, for maternity benefits than her 35-year-old counterpart.[39] Past maternity care experiences can also have an impact on the ability to obtain health insurance; women who have given birth by C-section may encounter additional barriers when trying to purchase coverage through the individual market. An insurance company may charge a woman who underwent a previous C-section a higher premium or impose an exclusionary period during which it refuses to cover another C-section.[40]

The vast majority of individual market health insurance policies that NWLC found do not cover maternity care at all. Even if a woman is not currently pregnant, it is unlikely that an insurer will provide or even offer maternity benefits as part of her regular insurance policy. Of the over 3,500 individual insurance market insurance policies that NWLC analyzed for this report, just 12% include comprehensive maternity coverage, and these are available in less than half of the capital cities examined (23 of 47 states, as shown in Appendix 3).[41, 42] Another 9% of plans provide coverage for maternity care that is not comprehensive.[43]

In some states, women may be able to purchase supplemental maternity benefits (called a "rider") for an additional premium, but this coverage is often expensive and limited in scope. NWLC found that a woman living in the capital city of 31 states could purchase a maternity rider as a supplement to her individual insurance policy. In seven of those cities, a rider was the only type of maternity coverage offered by the leading online provider. Even when a maternity rider is offered, the additional cost can be prohibitively expensive; a rider may cost far more than the monthly premium for the health insurance policy. For instance, some maternity riders found in the capitals of Kansas and New Hampshire cost over $1,100 *per month*. (See Appendix 3.)

In addition to their prohibitive cost, maternity benefit riders may involve a waiting period (one or two years, for example) before the coverage even takes effect[44] and the actual benefits provided through riders are very often limited in scope. NWLC's extensive analysis of maternity riders available across the nation indicates that it is quite common for a rider to limit the total maximum benefit to amounts such as $3,000 (available only after a 10-month waiting period for a D.C. rider option) or $5,000 (available only after a 12-month waiting period for an Arkansas rider option). Yet in 2006, the average cost of even an uncomplicated hospital-based vaginal birth was $7,488—well above typical rider coverage limits; notably, this estimate is for labor and delivery only and does not even include charges for prenatal visits or postpartum care.[45] Using this and additional estimates of the cost of childbirth, Table 1 examines how a woman enrolled in two health plans with maternity riders might fare under four different maternity scenarios. These examples highlight two of the major problems that exist with riders:

The first example demonstrates the **high levels of out-of-pocket spending** that a woman faces if she is enrolled in a rider with an unreasonably low benefit limit. A woman with the rider in Example 1 who has an uncomplicated vaginal delivery would spend at least $6,760 for her maternity care over the course of a year—$5,488 for her hospital charges plus the $1,272 she pays for 12 months of rider premiums. Since pre- and postnatal services are not included in these estimates, a woman's out-of-pocket spending would likely be even greater than this. However, since the maximum rider benefit is capped, the insurer's contribution to her maternity care will never be greater than $2,000, even if the cost of her maternity care increases. Should she require an uncomplicated C-section, for instance, this hypothetical woman's spending on maternity care would grow to $12,466 yet her insurer would still contribute only $2,000.

The second example demonstrates how, depending on the type of maternity experience a woman enrolled in a rider has, she may end up spending far more on her maternity care than she would if she did not purchase the rider at all (in other words, **a maternity rider can be a bad deal for women**). A woman with the rider in Example 2 who has an uncomplicated vaginal delivery would spend at least $9,682 for her maternity care over the course of a year—$3,898 for her hospital charges plus the $5,784 she pays for 12 months of rider premiums. Yet, her total hospital charges were just $7,488 under this scenario, $2,000 less than what she paid! But should this same woman require a C-section with complications, she would spend an estimated $11,583 for maternity care—considerably less than her hospital charges of $16,996.

Although plans with optional maternity riders outnumber those that include maternity care as part of a woman's regular health insurance policy, as Table 1 reveals, riders may offer a low benefit for a high cost. Even with a supplemental maternity rider, a woman could be exposed to considerable out-of-pocket expenses for care that is not covered because it occurs during a waiting period or because she has reached her maximum benefit limit. Maternity riders are often no substitute for comprehensive maternity coverage.

Table 1: Estimated Costs of Maternity Care for Women with Maternity Riders

Scenarios assume a single pregnancy in a 30-year-old woman. Charges are for hospital-based maternity care associated with labor and delivery only, and do not reflect the cost of pre- or post-natal care. Estimates do not include the cost of the underlying health insurance policy associated with each supplemental maternity rider.

Total Hospital Charges[2] (National Average, 2006)		*Maternity Rider Examples*[1]	
		Example 1[3] Offered in Tallahassee, FL **Rider Cost**: $106 per month **Coverage Details:** 20% coinsurance; maximum benefit limit of $2,000 in Years 1 and 2, $4,000 in Years 3 and 4, and $6,000 in Year 5 and beyond *Scenario assumes that pregnancy and birth occur in first benefit year.*	**Example 2**[4] Offered in Topeka, Kansas **Rider Cost**: $482 per month **Coverage Details:** $3,000 deductible; 20% coinsurance after deductible; Outpatient maternity care (i.e. obstetrician visits) not covered
$7,488 Vaginal Delivery without Complications	Woman Pays	**Total: $6,760** **$1,272** (in rider premiums each year) **+ $5,488** (in cost-sharing for hospital charges: $1,498 coinsurance + $3,990 over benefit limit)	**Total: $9,682** **$5,784** (in rider premiums each year) **+ $3,898** (in cost-sharing for hospital charges: $3,000 deductible + $898 coinsurance)
	Rider Covers	**$2,000** (towards hospital charges)	**$3,590** (towards hospital charges)
$9,617 Vaginal Delivery with Complications	Woman Pays	**Total: $8,889** **$1,272** (in rider premiums each year) **+ $7,617** (in cost-sharing for hospital charges: $1,923 coinsurance + $5,694 over benefit limit)	**Total: $10,107** **$5,784** (in rider premiums each year) **+ $4,323** (in cost-sharing for hospital charges: $3,000 deductible + $1,323 coinsurance)
	Rider Covers	**$2,000** (towards hospital charges)	**$5,294** (towards hospital charges)
$13,194 Cesarean Delivery without Complications	Woman Pays	**Total: $12,466** **$1,272** (in rider premiums each year) **+ $11,194** (in cost-sharing for hospital charges: $2,639 coinsurance + $8,555 over benefit limit)	**Total: $10,822** **$5,784** (in rider premiums each year) **+ $5,038** (in cost-sharing for hospital charges: $3,000 deductible + $2,038 coinsurance)
	Rider Covers	**$2,000** (towards hospital charges)	**$8,156** (towards hospital charges)
$16,996 Cesarean Delivery with Complications	Woman Pays	**Total: $16,268** **$1,272** (in rider premiums each year) **+ $14,996** (in cost-sharing for hospital charges: $3,399 coinsurance + $11,597 over benefit limit)	**Total: $11,583** **$5,784** (in rider premiums each year) **+ $5,799** (in cost-sharing for hospital charges: $3,000 deductible + $2,799 coinsurance)
	Rider Covers	**$2,000** (towards hospital charges)	**$11,197** (towards hospital charges)

Notes

1. Rider plans highlighted here were selected from among 696 rider plans that NWLC analyzed for this research report. Descriptive information about each rider plan was obtained from www.ehealthinsurance.com; see notes accompanying Appendix 3 for methodology. Maternity riders may include certain features not represented by these examples, such as waiting periods or copayments.
2. Estimates for hospital charges associated with four maternity experiences represent average costs in 2006, obtained from the Agency for Healthcare Research and Quality, Health Care Costs and Utilization Project Online Query System (HCUPnet), *Statistics for U.S. Community Hospital Stays, Diagnosis Related Groups (DRGs)*, 2006, http://hcupnet.ahrq.gov/ (last accessed September 10, 2008) (examining DRG Codes 370-375).
3. This particular rider was offered by a large national health insurance company in the capitals of 25 states across the country; in 10 state capitals, this was the only maternity rider option available.
4. Scenario assumes maternity hospital charges are subject to full deductible level of $3,000.

In the capital cities of four states—Hawaii, New Mexico, North Dakota and South Dakota—NWLC was unable, using the leading online provider described in the research methods, to find an offer of maternity coverage at any price. Not a single individual market insurance plan offered through the online provider covered maternity, nor offered a maternity rider. After significant additional research efforts, NWLC was able to identify only a few plans with maternity coverage in the four state capitals.[46] The challenges encountered during this exercise—even for seasoned health policy experts—highlight the difficulties that a

typical woman might face when trying to obtain individual health insurance that includes coverage for maternity care. Without knowing where else to turn, a woman may assume after looking online that there are no maternity coverage options available to her.

The importance of adequate maternity care—especially prenatal care—cannot be overstated. If a woman visits a healthcare provider early and regularly during her pregnancy, birth defects and other complications can be prevented or appropriately managed. But a precursor to timely care is having the finances or insurance coverage to pay for it; when pregnant women are uninsured, they are considerably less likely to get proper prenatal care.[47] Adequate and affordable maternity coverage is essential for the health of mothers and their children—it should not be a luxury to which only some women have access.

4. Additional Challenges Women Face in the Individual Market

a. Health Status Rating

It is common for insurers in the individual health insurance market to charge higher premiums to applicants with health conditions that might increase the chance that they will need care. Health status rating is problematic for both women and men, but because women are more likely than men to need health care services throughout their lifetimes and are also more likely to have chronic conditions requiring ongoing treatment (such as arthritis and asthma), this practice may have a greater impact on them.[48]

b. Age Rating

Most insurers charge higher premiums to older individuals than to younger ones, because older people are more likely to need health care services. On average, the expected health costs of people over age 50 are more than twice as high as the expected health costs of people under age 20.[49] Age rating provides an additional barrier for older women seeking coverage in the individual market; older women ages 55 to 64 are more likely than men of the same age to be uninsured, and thus more women at this age are left to purchase individual insurance.[50] These women often seek individual coverage because their older spouses qualify for Medicare, causing them to lose dependent coverage and become uninsured.[51]

B. Some States Have Taken Action to Address Challenges Women Face in the Individual Market

1. State Efforts to Protect Against Gender Rating

Because the regulation of insurance has traditionally been a state responsibility,[52] no federal law provides protections against gender rating in the individual market. Overall, 40 states and D.C. allow gender rating in the individual market, with two of these states limiting the amount premiums can vary based on gender through "rate bands." (See Appendix 4.) However, even states that ban gender rating allow some plans to gender rate, such as the bare-bones basic and essential plans offered in New Jersey.[53] There are three basic approaches to prohibit or limit gender rating:

a. Explicit Protections Against Gender Rating

A few states have simply passed laws prohibiting the use of gender as a rating factor in setting premiums. Four states in the individual market—Minnesota, Montana,[54] New Hampshire, and North Dakota[55] prohibit insurers from considering gender when setting health insurance rates.[56]

Both Montana and Minnesota prohibit gender rating in the individual market because they consider gender rating to be discrimination against women. Montana enacted its "unisex insurance law" in 1983, forbidding the use of gender as a rating factor in any type of insurance policy issued within the state, and in 1992, Minnesota implemented health care reform legislation including prohibitions on gender rating in the individual health insurance market.

Advocates of the bans in both states argued that gender rating constitutes discrimination against women.[57] Comparing the use of gender as a rating factor to the bygone practice of life insurers using race as a rating factor,[58] advocates contended that society considers gender discrimination to be just as repugnant as racial discrimination and, thus, insurers should stop gender rating just as they voluntarily stopped insurance rating based on race in response to societal pressure in the 1950s and 1960s.[59] Additionally, in Montana, the state Equal Rights Amendment (ERA) provided support to those who opposed gender rating and served as strong legal justification when the governor vetoed a bill to repeal the "unisex insurance law" four years after it passed.[60]

b. Community Rating

Several states have ultimately eliminated gender rating in the individual market through the imposition of "community rating." Community rating is a method of calculating health insurance premiums based on the average or anticipated health costs across a whole community, rather than based on the particular characteristics of an individual.[61]

Under "pure community rating," insurers must set the same premium for everyone who has the same coverage, regardless of age, health status, gender, or other factors.[62] "Modified community rating," on the other hand, prohibits insurers from varying premiums based on health status or claims history but allows rating based on limited demographic characteristics, which can include factors such as gender, age, and/or geographic location.[63]

Currently, six states prohibit the use of gender as a rating factor under community rating statutes: New York imposes pure community rating; while Maine, Massachusetts, New Jersey, Oregon, and Washington impose modified community rating that, in addition to prohibiting rating based on health status, also bans rating based on gender.[64]

c. Gender Rate Bands

Some states have passed laws limiting insurers' ability to base premiums on gender by establishing a "rate band," which sets limits between the lowest and highest premium that a health insurer may charge for the same coverage based on gender. In the individual market, two states—New Mexico and Vermont—use rate bands to limit insurers' ability to vary rates based on gender.[65]

Typically, an insurer will establish an average premium, or "index rate," and the rate band will set a floor below and a ceiling above that index rate to designate the amount by which an insurer can vary premiums based on gender. For example, if a state's rate band were to allow an insurer to vary premiums from the index rate by plus or minus 25% and an insurer's index rate is $400, the lowest premium allowed under the rate band would be $300 and the highest allowable premium would be $500.[66] In many states, premiums can also be adjusted above or below the gender rate bands due to other factors, such as health status or age. The size of the rate band is important: narrow rate bands more effectively constrain insurers' ability to base premiums on gender than do wide rate bands.[67]

Table 2: Summary of State Protections Against Gender Rating

Gender Rating Protections	Number of States
Outright ban	4
Pure community rating	1
Modified community rating	5
Gender rate band (limited protection)	2
Total with Protections	12
Total without Protections	39*

*Includes the District of Columbia

2. State Efforts to Ensure Access to Maternity Care

A handful of states have recognized the importance of ensuring that maternity coverage—including prenatal, birth, and postpartum care—is a part of basic health care by establishing a "benefit mandate" law that requires insurers to include coverage for maternity services in all individual health insurance policies sold in their state. Currently, just five states have enacted mandate laws that require all insurers in the individual market to cover the cost of maternity care. These states are: Massachusetts,[68] Montana,[69] New Jersey,[70] Oregon,[71] and Washington.[72] In New Jersey and Washington, individual insurance providers are allowed to offer bare-bones plans that are exempt from the mandate and exclude maternity coverage.[73]

Mandated maternity coverage is not always imposed by state legislation or via administrative regulations. Montana's mandate is the result of a 1993 state Supreme Court decision which held that a health plan excluding maternity coverage unconstitutionally discriminated based on gender.[74] In response to this court decision, the Montana Insurance Commissioner issued an order that all insurers in the state must include maternity benefits.[75]

Beyond this short list of five, other states have adopted limited-scope mandate laws that require maternity coverage only for certain types of health plan carriers, certain types of maternity care, or for specific categories of individuals. Limited-scope mandate laws address the provision of maternity care but may fall short of providing women with full coverage for the care they need:

- In California,[76] Illinois,[77] and Georgia,[78] for example, only Health Maintenance Organizations (HMOs) are subject to state laws that mandate maternity benefits in the individual insurance market. In New York,[79] only HMOs and nonprofit health insurers are subject to such laws.
- In Vermont, insurance companies are required to provide coverage only for complications of pregnancy whose diagnoses are distinct from pregnancy.[80]
- In Minnesota, maternity coverage is only mandated for people who are transitioning from the group to the individual insurance market (often referred to as "conversion" policies).[81]
- Maine[82] and New Hampshire[83] have laws that, rather than requiring an insurer or plan to provide maternity coverage in all policies, require insurance companies in the individual market to merely offer potential enrollees one or more plans that cover maternity benefits. A mandate to offer maternity coverage simply makes the coverage available—usually with an additional or higher premium, and perhaps at a high and unaffordable cost for those who need the benefit. The optional maternity rider coverage described in earlier sections, for instance, might satisfy state laws that require plans to simply offer maternity services, yet rider coverage can be prohibitively expensive and extremely limited in scope (See Table 1 for typical examples of maternity rider coverage).

- Some laws require insurers to provide a certain level of maternity care only if the plan includes maternity coverage in the first place. These laws are analogous to conditional statements. A California law, for example, states that every individual insurance plan that provides maternity benefits "shall provide coverage for participation in the Expanded Alpha Feto Protein (AFP) program."[84] A mandate law in New Mexico stipulates that insurance plans offering maternity coverage must provide transportation to a hospital for a medically high-risk pregnant woman when necessary to protect the life or health of the mother or infant.[85]

While "offer" and "conditional coverage" laws do impose requirements for insurers—leading some to characterize these efforts as "mandate laws"[86]—from a pregnant woman's perspective, they may hold little or no benefit at all. If maternity coverage is not available to begin with, a law defining certain aspects of that (unavailable) maternity coverage is meaningless. Appendix 3 demonstrates just how illusory limited-scope mandate laws may be. Many of the states with such laws have very few options for maternity care in their individual insurance markets. New Mexico, for instance, has one type of maternity mandate law that only affects plans that already cover maternity care. Yet, using the leading online provider described in the research methods, NWLC could not find any plans that offered maternity coverage in New Mexico's capital city—either in an insurance policy or as a supplemental rider.

In a few instances, state governments have stepped in (at taxpayer expense) to fill gaps in private health insurance by establishing programs to assist pregnant women who have private coverage that does not meet their maternity care needs. At least two states have such programs:

- New Mexico's *Premium Assistance for Maternity* (PAM) program is a state-sponsored initiative that provides maternity coverage for pregnant citizens who are ineligible for Medicaid. To participate in PAM, a woman must be uninsured or *have insurance that does not include maternity coverage*. For a fee of $150 (enrollment during the first 20 weeks of pregnancy) or $300 (enrollment during the second 20 weeks of pregnancy), PAM enrollees receive comprehensive maternity coverage including prenatal and postnatal care, delivery, and other pregnancy-related health services. PAM coverage continues through the second month postpartum.[87]

- California's *Access for Infants and Mothers* (AIM) program is a low-cost coverage program for pregnant women who are uninsured and ineligible for Medi-Cal (the state's Medicaid program). AIM is also available to women who *have health insurance if their deductible or copayment for maternity coverage is more than $500*. For a fee equal to 1.5% of her annual household income, an AIM enrollee receives coverage for all medically necessary services (regardless of whether they are pregnancy-related) until 60 days after the pregnancy has ended.[88]

Although these programs represent a critically important commitment to healthy pregnancies that should not be overlooked, their existence begs the question of why scarce public dollars are even necessary to supplement private coverage that does not meet women's needs. According to program officials in New Mexico, PAM was established expressly because of the gaps that existed in private market maternity coverage. If maternity care was included as a basic benefit in comprehensive and affordable health insurance policies, such programs would be unnecessary.

3. State Efforts to Address Additional Challenges Women Face

In addition to gender rating and the difficulty obtaining maternity-related coverage, women applying in the individual market face challenges related to age and health status, which may also prove to be insurmountable obstacles to getting and affording health insurance. Only sixteen states

have passed laws limiting insurers' ability to use age or health status rating in the individual market. In addition, only five states have passed laws requiring insurers to issue coverage to anyone who applies in the individual market.

a. "Guaranteed Issue" Laws: Protecting Applicants from Rejection Based on Health History

Although the federal law known as "HIPAA," the Health Insurance Portability and Accountability Act, requires individual insurers to issue policies to certain people leaving group health plans and seeking coverage in the individual market, far too many people who apply for individual insurance coverage are not eligible for these protections.[89] Unless state laws provide otherwise, insurance carriers can refuse to sell individual health insurance coverage to applicants who have health conditions or problems.

Five states—Maine,[90] Massachusetts,[91] New Jersey,[92] New York,[93] and Vermont[94]—prohibit this practice through "guaranteed issue" requirements, which mandate that individual insurance providers accept anyone who applies for coverage, regardless of health status. Although guaranteed issue laws prohibit insurers from denying coverage, they do not address the premium that may be charged. While the premiums can be very high, women in these five states do at least have additional protections under their states' community rating requirements, which also prohibit insurers from charging women higher premiums based on health status.

b. Protections Against Age Rating

Unless prohibited by state law, insurers generally charge higher premiums to older people in the individual market. Overall, 42 states and D.C. allow unlimited age rating in the individual market. (See Appendix 4.) In the individual market, only one state, New York, prohibits age rating through its pure community rating requirement for individually-purchased insurance. In addition, seven states impose a rate band limiting the use of age as a rating factor in the individual market.[95]

Table 3: Summary of State Protections Against Age Rating

Age Rating Protections	Number of States
Outright ban	0
Pure community rating	1
Modified community rating	0
Age rate band (limited protection)	7
Total with Protections	8
Total without Protections	43*

*Includes the District of Columbia

c. Protections Against Health Status Rating

Like age, unless prohibited by state law, insurers may charge higher premiums based on health status in the individual market. Overall, 35 states and D.C. allow health status rating without limit in individually-purchased insurance. (See Appendix 4.)

In the individual market, seven states ban the use of health status as a rating factor by requiring pure or modified community rating, and eight more states limit how much rates can vary due to health status through rate bands.[96]

Table 4: Summary of State Protections Against Health Status Rating

Health Status Rating Protections	Number of States
Outright ban	0
Pure community rating	1
Modified community rating	6
Health status rate band (limited protection)	8
Total with Protections	15
Total without Protections	36*

*Includes the District of Columbia

III. Policy Recommendations

As described above, while a few states have taken actions to address challenges women face in the individual insurance market, most have not. This leaves too many women with nowhere to turn for affordable, comprehensive health insurance.

Various health reform proposals at the state and national level envision very different roles for the individual market. Some plans would reduce the need for the individual market, others would reform the individual market, while others still would simply increase reliance on the individual market as a place for people to buy insurance—without any changes in the way the market currently operates. ***It is imperative that any health reform proposal that relies on the individual market address the challenges that women face. Ultimately, reform proposals should eliminate or reduce the need for the individual market.*** But in the short term, proposals should eliminate the discrimination that women face by banning gender rating, ensuring all health plans include maternity coverage as part of the basic benefits package, and eliminating the practices of rejecting applicants due to health history, excluding pre-existing conditions, and rating based on age and health history.

✓ Recommendation 1: Policymakers should eliminate or reduce the need for the individual market.

The individual market is deeply flawed. Even in the states that have taken incremental action to address its many challenges, this market remains an expensive, difficult way for women to obtain health coverage. Rather than advocating an expansion of the individual market, proposals should:

- **Make employer-sponsored insurance easier to obtain.** The primary vehicle for health insurance coverage in the United States is through the workplace, but the number of Americans receiving coverage through their employer continues to decrease.[97] In fact, the decline in employer-sponsored insurance coverage is the dominant factor underlying the growth in the number of uninsured Americans over time.[98]

  For too many part-time employees, employer health insurance coverage is either not offered or unaffordable. Uninsured women are more likely than uninsured men to work part time.[99] State or federal assistance to employers that provide affordable health benefits to these employees will help expand health coverage.

  Efforts to make employer-sponsored health insurance easier to obtain should focus on help for small employers because they are less likely than their larger counterparts to offer health benefits.[100] And women are more likely than men to work for small employers who do not offer health insurance.[101] There are a variety of ways that states or the federal government can help small businesses provide their employees with health insurance, such as offering financial help

and incentives, or creating purchasing pools. For example, Montana offers refundable tax credits to small businesses with two to nine employees that are currently providing health insurance to their workers.[102]

- **Create health insurance pools large enough to accommodate everyone who needs coverage.** Massachusetts, for example, has merged its individual and small group markets to create one large pool.[103] This approach can improve the availability and affordability of insurance for both individuals and small businesses; it pools risk among a larger group of insured people, saves administrative costs, and—by building on the current insurance system—it gives people the ability to keep their existing coverage.[104] Early reports out of Massachusetts suggest that the new pool has decreased the cost of individual insurance premiums and increased the number of plans available to people purchasing individual health insurance.[105] This model could be adopted by other states, or it could be applied nationally by the federal government.

✓ Recommendation 2: In the short term, until adequate alternatives to the individual market exist, individual insurance coverage must be made easier to obtain and afford.

Insurers should be prohibited from considering gender when establishing premiums in the individual market. Applicants applying for individual coverage also should not be subjected to rating based on age or health status, and insurance companies should not be permitted to reject them for coverage because they have pre-existing health conditions or a history of health problems.

The District of Columbia and the 40 states that have not already done so should eliminate gender rating altogether, either by banning the practice or adopting pure community rating requirements for individually-purchased insurance that requires insurers to set the same premium for everyone who has the same coverage. Although pure community rating eliminates rating based on gender, age, and health status, it can result in higher premiums; affordability must also be addressed.[106]

✓ Recommendation 3: Ensure that all health insurance policies sold include coverage for vital health services such as maternity care.

The difficulties that NWLC encountered in identifying an individual health insurance plan with maternity coverage for women living in the capital cities of four states—Hawaii, New Mexico, North Dakota and South Dakota—highlight the challenges women face when trying to obtain individual health insurance that includes coverage for maternity care. Even where maternity coverage is available, women confront outrageous prices, unacceptable waiting periods and skimpy benefit packages. Health reform must ensure that women have access to comprehensive health benefits that meet their needs; adequate maternity coverage must certainly be part of every plan.

IV. Conclusion

Today, women face far too many obstacles in obtaining affordable, comprehensive health coverage in the individual insurance market. Any health reform proposal that relies upon the individual market as a mechanism to expand coverage must squarely address the challenges that women face. Failure to do so will leave too many women either uninsured or with unaffordable coverage that does not meet their needs—and with nowhere to turn.

Report Methodology

To learn more about the experiences of women seeking coverage in the individual insurance market, between July and September 2008, NWLC gathered and analyzed information on individual health insurance plans offered through eHealthInsurance, the leading online source of health insurance for individuals, families and small businesses.[107] NWLC's research sought to examine the impact of two insurance practices: gender rating—or the different amount insurers charge same-aged women and men for identical health coverage—and whether maternity coverage is included in available health insurance policies.

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

To examine the practice of gender rating, NWLC created two study scenarios. For the first, NWLC submitted information for three hypothetical female applicants and three hypothetical male applicants at ages 25, 40 and 55 living in the 50 states and D.C. Applicants were listed as healthy non-smokers living in the state's capital city. Where available, two plans with comparable cost-sharing requirements and coverage (and both of which excluded maternity coverage) were sampled in each state and D.C. For each plan, at the three ages listed above, the Center calculated the "gender gap"—the difference in premiums charged to female and male applicants of the same age and health status. These findings are reflected in Appendix 1.

For the second gender rating study scenario, NWLC calculated the gender gap in premiums charged to hypothetical 40-year-old, healthy, non-smoking male and female applicants living in the state's capital city among each of the individual insurance plans identified as "best-selling" in 47 states and D.C.[108] These findings are reflected in Appendix 2.

To determine the availability of maternity care coverage, NWLC created a third study scenario and examined over 3,500 individual health insurance plans offered for sale to a healthy, non-smoking 30-year-old woman living in the capital city in 47 states and D.C. These findings are reflected in Appendix 3.

Finally, for all 50 states and D.C., NWLC examined statutes and regulations relating to the individual insurance market to determine whether the states and D.C. place any regulations on premium rating based on gender, age, or health status in the individual market. Additionally, based on previously published research, the Center compiled a list of 20 states with maternity coverage mandates of some form.[109, 110] NWLC then examined the statutes and regulations in those 20 states to confirm whether their maternity coverage mandates met certain criteria, including a requirement that all insurers selling private health plans through the state's individual health insurance market provide coverage for prenatal and postnatal office visits as well as labor and delivery for both routine and complicated pregnancies.

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

Endnotes

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

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

3 National Women's Law Center analysis of 2007 data on health coverage from the Current Population Survey's Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.

4 Id.

5 Id.

6 42 U.S.C. § 2000e-2(a)(1) (2008) (Title VII of the Civil Rights Act of 1964 makes it an unlawful employment practice "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex or national origin"). See also U.S. Equal Employment Opportunity Comm'n, *Directives Transmittal No. 915.003 EEOC Compliance Manual Chapter 3: Employee Benefits* (Oct. 3, 2000), http://www.eeoc.gov/policy/docs/benefits.html ("health insurance benefits must be provided without regard to the race, color, sex, national origin, or religion of the insured. An employer must non-discriminatorily provide to all similarly situated employees the same opportunity to enroll in any health plans it offers. An employer must also ensure that the terms of its health benefits are non-discriminatory.").

7 For more information about a particular state's fair employment law, please contact the National Women's Law Center.

8 Alaska's fair employment law, for example, reaches any employer with at least one employee; Connecticut's reaches employers with at least three employees; and the Kansas law reaches employers with at least four employees. See Alaska Stat. § 18.80.220 (prohibiting employers from discriminating on the basis of sex); Alaska Stat. § 18.80.300 (defining employer as having one or more employees); Conn. Gen. Stat. § 46a-60(a)(1) (prohibiting employers from discriminating on the basis of sex); Conn. Gen. Stat. § 46a-51(10) (defining employer as having three or more employees); Kan. Stat. Ann. § 44-1009 (prohibiting employers from discriminating on the basis of sex); Kan. Stat. Ann. § 44-1002 (defining employer as having four or more employees).

9 For example, the Oregon Court of Appeals held that an employer's health insurance policy that treated the pregnancy of a male employee's spouse differently from the pregnancy of a female employee was sex discrimination under Oregon's fair employment law. *Hillesland v. Paccar, Inc.*, 722 P.2d 1239 (Or. Ct. App. 1986). Similarly, the Wisconsin Attorney General held that Wisconsin's Fair Employment Act should be interpreted, like Title VII, to prohibit employers from excluding prescription contraceptives from their employee health benefits if other prescription drugs are included. Letter from Wisconsin Attorney General Peggy A. Lautenschlager to State Senator Gwendolynne Moore, Oct. 17, 2003 (on file with the National Women's Law Center).

10 Pub. L. No. 95-555, 92 Stat. 2076 (1978).

11 Id. The Supreme Court has made clear that the Pregnancy Discrimination Act (PDA) also prohibits discrimination on the basis of a woman's ability to become pregnant. *Int'l Union, UAW v. Johnson Controls*, 499 U.S. 187, 198-99 (1991). In 2000, the Equal Employment Opportunity Commission, which enforces Title VII, recognized that this "necessarily includes a prohibition on discrimination related to a woman's use of contraceptives." U.S. Equal Employment Opportunity Commission Decision (Dec, 14, 2000), *available at* http://www.eeoc.gov/docs/decision-contraception.html. The EEOC therefore held that employers may not discriminate in their health insurance plans by denying benefits for prescription contraceptives when they provide otherwise comprehensive prescription benefits. Id. Unfortunately, a divided panel of the Eighth Circuit Court of Appeals recently decided otherwise, holding that the PDA does not extend to contraception. *In re Union Pacific Railroad Employment Practices Litigation*, 479 F.3d 936 (8th Cir. 2007).

12 For more information about a particular state's fair employment law, please contact the National Women's Law Center.

13 See *supra* note 8.

14 42 U.S.C. §§ 300gg to 300gg-23 (2008).

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

16 National Women's Law Center, *Contraceptive Equity Laws in Your State: Know Your Rights-Use Your Rights, A Consumer Guide* (Aug. 2007), http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf.

17 The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 300gg-41 (2008). Although HIPAA requires individual insurers to issue policies to certain people leaving group health plans and seeking coverage in the individual market, far too many people who apply for individual insurance coverage are not eligible for these protections.

18 Karen Pollitz et al., Kaiser Family Foundation, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (2001).

19 Alina Salganicoff et al., Kaiser Family Foundation, *Women and Health Care: A National Profile* 8 (Jul. 2005), http://www.kff.org/womenshealth/7336.cfm.

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

21 Women's Law Project & Pennsylvania Coalition Against Domestic Violence, *FYI: Insurance Discrimination Against Victims of Domestic Violence, 2002 Supplement* 2 (2002), http://www.womenslawproject.org/brochures/InsuranceSup_DV2002.pdf. In the early 1990s, advocates discovered that insurers had denied applications for coverage submitted by women who had experienced domestic violence. See, e.g., 142 Cong. Rec. E1013-03, at E1013-14 (June 5, 1996) (statement of Rep. Pomeroy) ("the Pennsylvania State Insurance Commissioner surveyed company practices in Pennsylvania and found that 26% of the respondents acknowledged that they considered domestic violence a factor in issuing health, life and accident insurance"). Since 1994, the majority of states have adopted legislation prohibiting health insurers from denying coverage based on domestic violence, but nine states and D.C. offer no such protection to survivors of domestic violence. Even though Vermont lacks legislation specifically prohibiting discrimination against domestic violence survivors, the state requires guaranteed issue of all individual insurance plans. See *infra* note 94 and accompanying text.

22 Ellen Nakashima, *Prescription Data Used To Assess Consumers Records Aid Insurers but Prompt Privacy Concerns*, Wash. Post, Aug. 4, 2008, at A01, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2008/08/03/AR2008080302077.html.

23 Elizabeth M. Patchias & Judy Waxman, Commonwealth Fund, *Women and Health Coverage: The Affordability Gap* 4 (2007), http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf.

24 Maine, Massachusetts, Montana, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Oregon and Washington ban the use of gender rating. See *infra* notes 54-64 and accompanying text.

25 See *infra* notes 65-67 and accompanying text.

26 See Appendix 4.

27 See, e.g., Colo. Rev. Stat. Ann. § 10-3-1104(1)(f)(III) (West 2008) (defining "unfair discrimination" as "[m]aking or permitting to be made any classification solely on the basis of marital status or sex, unless such classification is for the purpose of insuring family units or is justified by actuarial statistics"); Okla. Admin. Code § 365:10-1-9(a) (2008) (This section "is not intended to prohibit reasonable and justifiable differences in premium rates based upon sound actuarial principles or actual or reasonably anticipated experience.").

28 Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* 11 (Apr. 2008), http://www.kff.org/insurance/upload/7766.pdf [hereinafter *Primer*].

29 See, e.g., Anne C. Cicero, *Strategies for the Elimination of Sex Discrimination in Private Insurance*, 20 Harv. C.R.-C.L. L. Rev. 211, 214-15 (1985) (citing statement of Ralph J. Eckert, Chairman and Chief Executive Officer, Benefit Trust Life Insurance Co., at Fair Insurance Practices Act: Hearings on S. 372 Before the Comm. on Commerce, Science, and Transportation, 98th Cong., 1st Sess. 2-16 (1983)).

30 See *infra* note 58; see also Robert H. Jerry II & Kyle B. Mansfield, *Justifying Unisex Insurance: Another Perspective*, 34 Am. U.L. Rev. 329, 351-53 (1985).

31 Jerry & Mansfield, *supra* note 30, at 335, n.40 (citing laws in Arizona, California, Connecticut, Illinois, and New Jersey: Ariz. Rev. Stat. Ann. § 20-384(C) (2008); Cal. Ins. Code §§ 10140(a), 10141 (West 2008); Conn. Gen. Stat. Ann. § 38a-816(10) (West 2008); 215 Ill. Comp. Stat. Ann. 5/424(3) (2008); N.J. Stat. Ann. § 17:29B-4(7)(c)(d) (West 2008)).

32 *Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plans v. Norris*, 463 U.S. 1073, 1083 (1983) (quoting *City of Los Angeles, Department of Water and Power v. Manhart*, 435 U.S. 702, 716-17 (1978)).

33 See *supra* notes 6 and 10. See also Jerry & Mansfield, *supra* note 30, at 334 (listing federal laws prohibiting gender discrimination including Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, and the Pregnancy Discrimination Act of 1978).

34 Julie Appelby, *Employers Put Health Coverage in Workers' Hands*, USA Today, Jan. 24, 2008, *available at* http://www.usatoday.com/news/nation/2008-01-23-on-your-own_n.htm.

35 Such tax credits will also be less valuable to those who are older and also face higher premiums. See *infra* notes 49-51 and accompanying text.

36 Press Release, National Women's Law Center, No Progress in Reducing Women's Poverty, Limited Gains for Women in 2007, Census Data Show (Aug. 26, 2008), http://www.nwlc.org/details.cfm?id=3338&section=newsroom.

37 When coverage is not included as part of the policy, it is often only available separately for an additional cost, known as a rider. America's Health Insurance Plans, *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* 24-25 (Dec. 2007), http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf; America's Health Insurance Plans, *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits* 26-27 (Aug. 2005). See also Cicero, *supra* note 29, at 215 n.23 (suggesting that maternity costs may be factored into women's rates even though not covered by their policies).

38 Ed Neuschler, Institute for Health Policy Solutions, *Policy Brief on Tax Credits for the Uninsured and Maternity Care* 3 (March of Dimes 2004), http://www.marchofdimes.com/TaxCreditsJan2004.pdf.

39 Sara R. Collins et al., Commonwealth Fund, *Health Insurance Tax Credits: Will They Work for Women?* 7, 9 (Dec. 2002), http://www.commonwealthfund.org/usr_doc/collins_creditswomen_589.pdf?section=4039 [hereinafter *Health Insurance Tax Credits*].

40 Grady, *supra* note 20.

41 These findings are consistent with an earlier study of 25 cities across the country, which indicated that most available insurance plans did not include maternity benefits—even plans with the highest premium costs—and the few plans that did provide these benefits had waiting periods or high levels of out-of-pocket spending for the services. See *Health Insurance Tax Credits*, *supra* note 39, at ix.

42 Comprehensive maternity coverage includes coverage for the full scope of maternity services, including prenatal care, labor, delivery, and postnatal care, for both routine pregnancy and in case of complications. Some plans that fit within this broad definition of comprehensive maternity coverage may still include features that hinder a woman's access to maternity care, such as waiting periods before coverage begins or prohibitively expensive premium costs.

43 Less-than-comprehensive maternity coverage includes coverage for a limited scope of maternity services, such as coverage for inpatient (i.e. labor and delivery) or outpatient (i.e. prenatal and postnatal office visits) maternity care only, or coverage only for complications of pregnancy.

44 Karen Pollitz et al., Kaiser Family Foundation, *Maternity Care and Consumer-Driven Health Plans* 12 (2007), http://www.kff.org/womenshealth/upload/7636.pdf.

45 Agency for Healthcare Research and Quality, Health Care Costs and Utilization Project Online Query System (HCUPnet), *Statistics for U.S. Community Hospital Stays, Diagnosis Related Groups (DRGs), 2006*, http://hcupnet.ahrq.gov/ (last accessed September 10, 2008) (examining DRG Codes 370-375).

46 These efforts included obtaining a list of insurers licensed to sell individual market health plans in the state—or, in one instance, insurers licensed as Health Maintenance Organizations—via the state Department of Insurance website, and subsequently contacting insurers until a plan which offered maternity coverage in the state's capital city could be identified.

47 Amy Bernstein, Alpha Center, *Insurance Status and Use of Health Services by Pregnant Women* (March of Dimes 1999), www.marchofdimes.com/bernstein_paper.pdf; Susan Egerter et al., *Timing of Insurance Coverage and Use of Prenatal Care Among Low-Income Women*, Am. J. Public Health 92(3): 423-27 (March 2002).

48 Salganicoff, *supra* note 19.

49 *Primer*, *supra* note 28, at 6.

50 Jeanne M. Lambrew, Commonwealth Fund, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* 8 (Aug. 2001), http://www.commonwealthfund.org/usr_doc/lambrew_disparities_493.pdf?section=4039.

51 Id. at 6.

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

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

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

55 Despite the statutory prohibition on gender rating in North Dakota, the only company offering individual policies through www.eHealthInsurance.com does use gender as a rating factor. In an attempt to understand this seeming inconsistency, NWLC contacted the North Dakota Insurance Department, which indicated that this company is a "hybrid situation" and thus permitted to rate its individual policies as if they were sold on the group market; gender rating is allowed within limit for groups in North Dakota. Telephone Interview with North Dakota Insurance Department (Sept. 12, 2008).

56 For statutory citations, please see each state's notes accompanying Appendix 4.

57 Steve Brook, *Gender-Neutral Insurance Mired in Statistics*, St. Paul Pioneer Press, Oct. 3, 1988; "*Unisex" Law Requires Equal Insurance Rates and Benefits*, Houston Chron., Oct. 1, 1985; *Montana Debates Sex-Blind Insurance Law*, NY Times, Feb. 17, 1985.

58 For many years, life insurers charged blacks and whites different rates for life insurance. See Jill Gaulding, Note, *Race, Sex, and Genetic Discrimination in Insurance: What's Fair?*, 80 Cornell L. Rev. 1646, 1658-59 (1995); Jerry & Mansfield, *supra* note 30, at 351-52.

59 Brook, *supra* note 57; *Montana Debates Sex-Blind Insurance Law*, *supra* note 57.

60 Bob Anez, *Montana Governor Vetoes Unisex Insurance Repeal*, A.P. Online, Apr. 10, 1987; *Montana Debates Sex-Blind Insurance Law*, *supra* note 57.

61 Mila Kofman & Karen Pollitz, Georgetown Univ. Health Policy Inst., *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change* 3 (Apr. 2006), http://www.pbs.org/now/politics/Healthinsurancereportfinalkofmanpollitz.pdf.

62 *Primer*, *supra* note 28, at 11.

63 Id.

64 For statutory citations, please see each state's notes accompanying Appendix 4.

65 For statutory citations, please see each state's notes accompanying Appendix 4.

66 Families USA, *Issue Brief: Understanding How Health Insurance Premiums Are Regulated* 5 (Sept. 2006), http://www.familiesusa.org/assets/pdfs/rate-regulation.pdf.

67 For example, consider two hypothetical states, State Y and State Z, which impose two different gender rate bands in their individual markets. In State Y, individual insurance carriers can vary premiums from the index rate based on gender by no more than 10%, while State Z's gender rate band allows for a variation of up to 60%. Assuming an index rate of $400, an individual insurer in State Y could charge no less than $360 and no more than $440 based on gender, while an individual insurer in State Z would be able to vary premiums based on gender between $160 and $640. The narrow gender rate band in State Y constrains insurers much more than the wide gender rate band in State Z.

68 Mass. Gen. Laws ch. 176G, §§ 4(c), 4I (2008) (requiring health maintenance organizations to include maternity coverage); Mass. Gen. Laws ch. 176B, § 4H (2008) (requiring medical service corporations to include maternity coverage); Mass. Gen. Laws ch. 176A, § 8H (2008) (requiring non-profit hospital service corporations to include maternity coverage).

69 Mont. Ins. Or. (Feb. 16, 1994); *Bankers Life & Casualty Co. v. Peterson*, 866 P.2d 241 (Mont. 1993).

70 N.J. Stat. Ann. § 17B:26-2.1b (West 2008) (requiring all individual plans, except the bare-bones basic and essential plans, to include maternity coverage). See also N.J. Dept. of Banking & Ins., *supra* note 53.

71 Or. Rev. Stat. § 743A.080 (2008).

72 Wash. Rev. Code § 48.43.041(1)(a) (2008) (requiring all individual plans, except the bare-bones catastrophic plans, to include maternity coverage).

73 Id.; N.J. Dept. of Banking & Ins., *supra* note 53 ("B&E Plans do not provide comprehensive benefits like the standard plans described above," which include prenatal and maternity care).

74 *Bankers Life & Casualty Co*, 866 P.2d at 246 ("Bankers Life's policy excludes normal pregnancy and childbirth expenses from coverage, thus entitling women to fewer benefits in a major medical expense insurance policy because of their sex. We conclude that this differential treatment based on sex is discriminatory on its face.").

75 Mont. Ins. Or., *supra* note 69 ("Any insurance company providing major medical expense insurance to residents of the state of Montana shall not exclude maternity benefits, nor shall they charge an additional premium for a maternity benefit rider.")

76 Cal. Health & Safety Code § 1367(i) (requiring health care service plans to provide basic health care services); A.B. 1962, 2007-2008 Sess. § 1 (Cal. 2008) (recognizing that, in practice, health care service plans are required to provide maternity services as a basic health care benefit).

77 Ill. Admin. Code tit. 50, § 5421.130(e) (2008).

78 Ga. Comp. R. & Regs. 290-5-37-.03(4) (2008).

79 N.Y. Ins. Law §§ 4303(c), 4322(b)(10) (McKinney 2008).

80 21-020-001 Vt. Code R. § 5(M) (2008); see also 21-020-001 Vt. Code R. § 6(E)(3) (2008).

81 Minn. Stat. § 62E.16 (2008).

82 02-031-750 Me. Code R. §§ 5, 6 (Weil 2008).

83 N.H. Rev. Stat. Ann. § 415:6-d (2008).

84 Cal. Health & Safety Code § 1367.54 (2008).

85 N.M. Stat. § 59A-22-35 (2008).

86 Susan S. Laudicina et al., Blue Cross & Blue Shield Association, *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans* (Dec. 2007); Victoria Craig Bunce & JP Wieske, Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2008* (2008), http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf

87 Insure New Mexico, Premium Assistance for Maternity (PAM) Frequently Asked Questions, http://www.insurenewmexico.state.nm.us/PAMFaqs.htm (last visited Sept. 17, 2008).

88 Managed Risk Medical Insurance Board, Access for Infants and Mothers, http://www.aim.ca.gov/english/AIMHome.asp (last visited Sept. 17, 2008).

89 42 U.S.C. § 300gg-41 (2008).

90 Me. Rev. Stat. Ann. tit. 24-A, § 2736-C(3)(A) (2008).

91 Mass. Gen. Laws Ann. ch. 176M, § 3(a), § 1 (West 2008).

92 N.J. Stat. Ann. §§ 17B:27A-4(a), -2 (West 2008).

93 N.Y. Ins. Law § 3231(a) (McKinney 2008).

94 Vt. Stat. Ann. tit. 8, § 4080b(d)(1) (2008).

95 For statutory citations, please see each state's notes accompanying Appendix 4.

96 For statutory citations, please see each state's notes accompanying Appendix 4.

97 Dawn M. Gencarelli, Nat'l Health Policy Forum, *Background Paper: Health Insurance Coverage for Small Employers* 3 (Apr. 2005), http://www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.

98 John Holahan & Allison Cook, *The U.S. Economy and Changes in Health Insurance Coverage, 2000-2006*, Health Affairs, Feb. 20, 2008, at w135-w144.

99 Patchias & Waxman, *supra* note 23, at 2.

100 Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey* (2007), http://www.kff.org/insurance/7672/upload/76723.pdf.

101 Paul Fronstin & Ruth Helman, Employee Benefit Research Inst., *Issue Brief No. 253, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey* 11 (Jan. 2003), http://www.ebri.org/pdf/briefspdf/0103ib.pdf.

102 Insure Montana, Tax Credit, http://www.insuremontana.org/taxcredit.asp (last visited Sept. 17, 2008).

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

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

105 Community Catalyst & Families USA, *supra* note 103.

106 In researching the individual insurance rates for Appendix 1, NWLC found high premiums in New York, where pure community rating is required. One insurance company charged everyone a monthly premium of $425.14, while another insurance company charged $665.88 for coverage, regardless of age, gender, health status, or other factors.

107 eHealthInsurance, http://www.ehealthinsurance.com/.

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

109 See Laudicina et al., *supra* note 86; Neuschler, *supra* note 38.

110 NWLC examined the following states for maternity mandates: California, Colorado, Georgia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Vermont, Virginia, Washington, and West Virginia.

Appendix 1. Percent Difference in Premiums Charged to Women versus Men (the 'Gender Gap') for Health Plans in the Individual Insurance Market (two similar sets of plans called Plan A and Plan B)

The 'gender gap' reflects the difference between premiums charged to same-aged women and men for the same individual insurance market plans sold in their state's capital city. For each state, 'gender gap' comparisons are made for two similar sets of plans—Plan A and Plan B. For instance, a 40-year-old woman living in Montgomery, Alabama, is charged 37 percent more than a 40-year-old man for Plan A. A 55-year-old woman living in Little Rock, Arkansas, is charged 9 percent less than a 55-year-old man for Plan B. Unless otherwise noted, health plans have a deductible of $2,500, require 0% coinsurance, include prescription drug coverage, and exclude maternity coverage.

State	Plan[a]	Gender Gap		
		25-Year-Olds	40-Year-Olds	55-Year-Olds
Alabama	A	22%	37%	4%
	B	10%	15%	-9%
Alaska	A	34%	11%	-3%
	B	41%	11%	-22%
Arizona	A	10%	15%	-9%
	B	24%	37%	5%
Arkansas	A	22%	37%	4%
	B	10%	15%	-9%
California	A	0%	0%	0%
	B	6%	21%	0%
Colorado	A	12%	15%	-9%
	B	23%	38%	5%
Connecticut	A	13%	16%	-10%
	B	42%	4%	-1%
Delaware	A	12%	15%	-9%
	B	6%	21%	0%
District of Columbia	A	12%	15%	-9%
	B	10%	20%	-1%
Florida	A	11%	15%	-9%
	B	23%	37%	5%
Georgia	A	12%	15%	-9%
	B	23%	38%	4%
Hawaii[b]	N/A			
Idaho	A	38%	40%	8%
	B	18%	42%	5%
Illinois	A	24%	38%	5%
	B	6%	21%	0%
Indiana	A	11%	15%	-9%
	B	45%	48%	3%
Iowa	A	10%	15%	-9%
	B	23%	37%	5%
Kansas	A	11%	15%	-9%
	B	22%	37%	4%
Kentucky	A	19%	38%	4%
	B	11%	15%	-9%
Louisiana	A	11%	15%	-18%
	B	22%	37%	4%
Maine[b]	N/A (and Gender rating prohibited)			
Maryland	A	12%	14%	-9%
	B	6%	21%	0%
Massachusetts[b]	N/A (and Gender rating prohibited)			
Michigan	A	10%	15%	-9%
	B	25%	38%	6%
Minnesota	A	Gender rating prohibited		
	B			
Mississippi	A	23%	37%	4%
	B	10%	15%	-9%
Missouri	A	10%	15%	-9%
	B	45%	45%	2%
Montana	A	Gender rating prohibited		
	B			
Nebraska	A	10%	15%	-9%
	B	23%	37%	4%
Nevada	A	12%	15%	-9%
	B	29%	38%	-8%
New Hampshire	A	Gender rating prohibited		
	B			
New Jersey[c]	A	Gender rating prohibited		
	B			
New Mexico	A	0%	15%	-9%
	B	6%	20%	0%
New York	A	Gender rating prohibited		
	B			
North Carolina	A	12%	15%	-9%
	B	23%	37%	4%
North Dakota[d]	A	42%	23%	n/a
Ohio	A	10%	15%	-9%
	B	45%	48%	3%
Oklahoma	A	11%	14%	-9%
	B	22%	37%	4%
Oregon	A	Gender rating prohibited		
	B			
Pennsylvania	A	10%	15%	-9%
	B	6%	21%	0%
Rhode Island[b]	N/A			
South Carolina	A	12%	15%	-9%
	B	23%	37%	4%
South Dakota	A	11%	16%	-9%
Tennessee	A	10%	15%	-9%
	B	23%	37%	4%
Texas	A	12%	15%	-9%
	B	22%	37%	4%
Utah	A	22%	37%	4%
	B	17%	8%	3%
Vermont[b]	N/A (and Gender rating limited)			
Virginia	A	10%	15%	-9%
	B	22%	37%	4%
Washington	A	Gender rating prohibited		
	B			
West Virginia	A	6%	21%	0%
	B	41%	13%	-15%
Wisconsin	A	12%	15%	-9%
	B	24%	38%	5%
Wyoming	A	12%	15%	-9%
	B	42%	13%	-16%

Notes

a. In certain cases, NWLC could not identify a plan with all of the features desired for this analysis (such as a deductible of $2,500, a 0% coinsurance rate, inclusion of prescription drug coverage, and exclusion of maternity coverage). See Appendix 1 methodology notes for more information about those cases.

b. No similar plans available through eHealthInsurance.

c. Gender rating is prohibited in New Jersey, but bare-bones basic and essential plans are exempted from this protection. (See Appendix 4.)

d. Gender rating is prohibited in North Dakota (see Appendix 4), but the only company offering individual policies through eHealthInsurance does use gender as a rating factor. See Report note 55 for detailed explanation.

Appendix I Methodology

The data in Appendix 1 were gathered through eHealthInsurance from its website, http://www.ehealthinsurance.com. NWLC submitted information for three hypothetical female applicants (ages 25, 40, and 55) and three hypothetical male applicants (ages 25, 40, and 55) in 50 states and D.C., using a coverage start date of July 15, 2008. Applicants were listed as healthy non-smokers living in the state's capital city, in the same zip code as the governor's office (in D.C. the zip code of the mayor's office was used). Where coverage was offered in each of the 45 states and D.C., NWLC then selected two distinct individual insurance plans—"Plan A" and "Plan B"—with similar features, including a $2,500 deductible, a 0% coinsurance rate, inclusion of prescription drug coverage, and exclusion of maternity coverage. For both "Plan A" and "Plan B" NWLC obtained quotes for monthly premiums charged to a woman and to a man. NWLC calculated the gender gap—the difference in the premiums charged to a woman versus a man for the same exact health plan, represented as a percentage of the man's premium. This calculation was carried out for men/women at ages 25, 40, and 55, for both "Plan A" and "Plan B."

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

- Health plans in Idaho (Plan B), Minnesota (Plans A and B), and New York (Plans A and B) have a deductible other than $2,500.
- Health plans in Alaska (Plans A and B), Idaho (Plans A and B), Montana (Plans A and B), New Jersey (Plans A and B), Oregon (Plans A and B), Utah (Plan B), Washington (Plans A and B), West Virginia (Plan B), and Wyoming (Plan B) have coinsurance rates other than 0%.
- Health plans in Alaska (Plan A), Minnesota (Plans A and B), Montana (Plans A and B), New Jersey (Plans A and B), New York (Plans A and B), and Oregon (Plans A and B) include maternity coverage.
- In North Dakota and South Dakota only one insurance company offers a plan through eHealthInsurance that fits NWLC's specification.
- Plan B in Washington does not include prescription drug coverage.
- Plan A in North Dakota requires applicants to be younger than 50 years old.

Notably, eHealthInsurance may not represent all insurance companies licensed to sell individual health insurance policies in every state. However, the company bills itself as the leading online source of health insurance for individuals, families, and small businesses, partnering with over 160 health insurance companies in 50 states and D.C. and offering more than 7,000 health insurance products online.

Appendix 2. Prevalence of Gender Rating and Range in the 'Gender Gap' Among Best-Selling Plans in the Individual Insurance Market

The 'gender gap' reflects the difference between premiums charged to same-aged women and men for best-selling individual insurance market plans offered by the leading online provider in their state's capital city. For instance, all ten of the best-selling plans available to a 40-year-old woman living in Jefferson City, Missouri use gender to set premium rates. Depending on the best-selling plan she selects, this woman is charged at least 15 percent more and up to 140 percent more than a 40-year-old man for the same coverage.

State	Proportion of Best-Selling Plans That Gender Rate[a,b]	Range in Percentage Difference in Premiums Between 40-Year-Old Women and Men, Among Plans that Gender Rate	
		Minimum	*Maximum*
Alabama	All	11%	44%
Alaska	All	10%	24%
Arizona	All	2%	51%
Arkansas	All	13%	63%
California	Some	10%	39%
Colorado	Some	8%	43%
Connecticut	All	4%	41%
Delaware	Some	13%	25%
District of Columbia	Some	11%	24%
Florida	All	14%	44%
Georgia	All	15%	47%
Hawaii	All	23%	23%
Idaho	All	42%	44%
Illinois	All	15%	39%
Indiana	All	20%	48%
Iowa	All	15%	44%
Kansas	All	10%	49%
Kentucky	All	15%	48%
Louisiana	All	13%	38%
Maine[c]	N/A		
Maryland	Some	12%	22%
Massachusetts[c]	N/A		
Michigan	Some	15%	40%
Minnesota	None	Gender rating prohibited	
Mississippi	All	13%	43%
Missouri	All	15%	140%
Montana	None	Gender rating prohibited	
Nebraska	All	11%	60%
Nevada	All	11%	39%
New Hampshire	None	Gender rating prohibited	
New Jersey[d]	Some	23%	36%
New Mexico	All	19%	21%
New York	None	Gender rating prohibited	
North Carolina	All	11%	43%
North Dakota[e]	All	19%	29%
Ohio	All	15%	48%
Oklahoma	All	11%	40%
Oregon	None	Gender rating prohibited	
Pennsylvania	All	13%	37%
Rhode Island[c]	N/A		
South Carolina	Some	15%	54%
South Dakota	All	20%	25%
Tennessee	All	18%	37%
Texas	All	15%	42%
Utah	Some	8%	37%
Vermont[c]	N/A		
Virginia	All	11%	32%
Washington	None	Gender rating prohibited	
West Virginia	All	13%	34%
Wisconsin	All	14%	45%
Wyoming	All	13%	25%

Notes

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

b. Across the nation, a total of 347 best-selling plans (83%) gender rate. The absence or presence of maternity coverage generally cannot explain gender rating. Of the best-selling plans that gender rate, a total of 21 (6%) include maternity coverage in the individual health insurance policy.

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

d. Although gender rating is prohibited in New Jersey (see Appendix 4), the best-selling plans available through eHealthInsurance include bare-bones basic and essential plans, which are exempted from the state's prohibition on gender rating.

e. Gender rating is prohibited in North Dakota (see Appendix 4), but the only company offering individual policies through eHealthInsurance does use gender as a rating factor. See Report note 55 for detailed explanation.

Appendix 2 Methodology

The data in Appendix 2 were gathered through eHealthInsurance from its website, http://www.ehealthinsurance.com. NWLC submitted information for a hypothetical female applicant and a hypothetical male applicant at age 40 in 50 states and D.C., using a coverage start date of July 15, 2008. Applicants were listed as healthy non-smokers living in the state's capital city, in the same zip code as the governor's office (in D.C. the zip code of the mayor's office was used). For each of the 47 states and D.C. where coverage was offered, NWLC then determined how many of the best-selling individual insurance plans use gender as a rating factor. "Best-selling" status is assigned by eHealthInsurance, and is based on the number of applications submitted through eHealthInsurance's website and approved by the insurance company during the most recent calendar quarter. In the case of North Dakota, because only 12 plans are offered, the website lists all plans rather than only the best-selling plans. For this state, all 12 plans were analyzed. For each plan that gender rates, NWLC calculated the gender gap, or the difference in the premiums charged to a woman versus a similarly-aged man as a percentage of the premium charged to the man. The Appendix indicates the minimum and maximum percentage difference in the premiums charged to a man and a woman among the best selling plans that gender rate.

Notably, eHealthInsurance may not represent all insurance companies licensed to sell individual health insurance policies in every state. However, the company bills itself as the leading online source of health insurance for individuals, families, and small businesses, partnering with over 160 health insurance companies in 50 states and D.C. and offering more than 7,000 health insurance products online.

Appendix 3: Maternity Coverage Available to a 30-Year-Old Woman in the Individual Insurance Market

State[a]	Total Number of Plans Available	Plans with Comprehensive[b] Maternity Coverage	Plans with Less-than-Comprehensive[c] Maternity Coverage	Rider Availability		
				Plans that Offer Riders	*Rider Options (among plans)*	*Rider Costs (per month)*
Alabama	66	0	0	18	1	$106.40
Alaska	48	20	6	8	1	$106.40
Arizona	110	6	32	18	1	$106.40
Arkansas	91	7	6	9	2	$195.34—$246.12
California	106	26	7	0	N/A	N/A
Colorado	95	0	25	15	2	$106.40—$422.80
Connecticut	60	6	0	0	N/A	N/A
Delaware	61	0	7	25	3	$66.50—$227.00
District of Columbia	84	12	0	35	2	$106.40—$126.00
Florida	63	0	0	17	1	$106.40
Georgia	96	9	19	17	3	$66.50—$144.00
Hawaii	2	0	0	0	N/A	N/A
Idaho	32	24	0	0	N/A	N/A
Illinois	138	3	7	40	4	$87.86—$273.13
Indiana	95	0	12	31	3	$87.53—$317.91
Iowa	80	4	8	18	1	$106.40
Kansas	66	0	0	22	6	$292.00—$1149.79
Kentucky	66	0	0	17	1	$106.40
Louisiana	103	0	28	21	4	$0—$243.55
Maine[d]	N/A					
Maryland	98	35	0	14	2	$126.00—$287.84
Massachusetts[d]	N/A					
Michigan	99	0	26	20	2	$94.08—$133.72
Minnesota	49	39	10	0	N/A	N/A
Mississippi	64	0	6	18	1	$106.40
Missouri	126	8	0	33	4	$84.43—$181.86
Montana	30	30	0	0	N/A	N/A
Nebraska	98	4	28	18	1	$106.40
Nevada	106	0	14	10	1	$297.82
New Hampshire	30	2	0	21	1	$1108.57—$1270.33
New Jersey[e]	18	16	2	0	N/A	N/A
New Mexico	60	0	0	0	N/A	N/A
New York	3	2	1	0	N/A	N/A
North Carolina	93	0	7	0	N/A	N/A
North Dakota	12	0	0	0	N/A	N/A
Ohio	120	0	0	32	3	$63.36—$339.10
Oklahoma	83	0	6	26	2	$53.83—$179.95
Oregon	93	93	0	0	N/A	N/A
Pennsylvania	110	16	8	18	1	$106.40
Rhode Island[d]	N/A					
South Carolina	113	0	10	36	3	$38.00—$133.00
South Dakota	27	0	0	0	N/A	N/A
Tennessee	90	0	0	34	2	$106.40—$195.18
Texas	116	5	14	18	1	$106.40
Utah	75	43	0	0	N/A	N/A
Vermont[d]	N/A					
Virginia	78	0	9	18	1	$71.00
Washington[e]	42	14	0	0	N/A	N/A
West Virginia	58	0	6	25	2	$106.40—$279.78
Wisconsin	119	0	0	44	5	$88.34—$271.55
Wyoming	40	0	6	0	N/A	N/A
Total	3,512	424	310	696	67	Varies

Notes

a. Using eHealthInsurance, NWLC identified all plans available to a 30-year-old woman living in each state's capital city with a coverage start date in early September 2008.

b. Comprehensive maternity coverage includes coverage for the full scope of maternity services for both routine pregnancy and in case of complications, including prenatal care, labor, delivery, and postnatal care. Some plans that fit within this broad definition of comprehensive maternity coverage may still include features that hinder a woman's access to maternity care, such as waiting periods before coverage begins or prohibitively expensive premium costs.

c. Less-than-comprehensive maternity coverage includes coverage for a limited scope of maternity services, such as coverage for inpatient (i.e. labor and delivery) or outpatient (i.e. prenatal and postnatal office visits) maternity care only, or coverage only for complications of pregnancy.

d. Individual rate quotes were not available for Maine, Massachusetts, Rhode Island, or Vermont.

e. Even though New Jersey and Washington mandate maternity coverage in the individual market, not all plans in these states include maternity coverage, because the mandates exempt bare-bones individual insurance policies, which are included among the plans available through eHealthInsurance.

Appendix 3 Methodology

The data in Appendix 3 were gathered through eHealthInsurance from its website, http://www.ehealthinsurance.com. For 50 states and D.C., NWLC submitted information for a hypothetical 30-year-old female applicant, listing a coverage start date between September 1, 2008 and September 4, 2008. The applicant was listed as healthy non-smoker living in the state's capital city, in the same zip code as the governor's office (in D.C. the zip code of the mayor's office was used). For each of the 47 states and D.C. where coverage was offered, the following were determined:

- The number of available plans that include comprehensive maternity coverage (defined as coverage for the full scope of maternity services, including prenatal care, labor, delivery, and postnatal care, for both a routine pregnancy and in case of complications);
- The number of available plans that include less-than-comprehensive maternity coverage (defined as coverage for a limited scope of maternity services, such as coverage for inpatient or outpatient maternity care only, or coverage only for complications of pregnancy); and
- The number of available plans that offered an optional maternity rider, as well as the cost of each rider.

NWLC then examined the details of the riders themselves to establish the number of rider options, grouped according to four distinguishing features: 1) insurance company offering the rider; 2) scope of benefits, including covered services and maximum benefit limits; 3) cost-sharing requirements, including coinsurance and deductibles (notably, minimal differences in co-pays were not treated as distinguishing features); 4) and eligibility restrictions such as age limits. If two riders differed in any of these areas—even if they were offered by the same carrier—they were counted as two distinct options. If two riders shared each of these four features, they were counted as a single option, regardless of any differences between the plans to which they were attached (including differences in the plans' premiums) and regardless of any differences in the monthly cost of each rider. In establishing the number of rider options, cost-sharing for out-of-network coverage was not taken into consideration. Additionally, in cases in which relevant coinsurance levels were listed as a range or were otherwise unclear (i.e. one rider stated that coinsurance of either 100 % or 80 % was required, with no accompanying detail) comparisons between riders were based on the lower figure.

Notably, eHealthInsurance may not represent all insurance companies licensed to sell individual health insurance policies in every state. However, the company bills itself as the leading online source of health insurance for individuals, families, and small businesses, partnering with over 160 health insurance companies in 50 states and D.C. and offering more than 7,000 health insurance products online.

For the four states—Hawaii, New Mexico, North Dakota, and South Dakota—in which the initial search revealed no plans that covered maternity care or offered a rider option, follow-up research was conducted. This research effort included obtaining a list of insurers licensed to sell individual market health plans in the state—or, in one instance, insurers licensed as Health Maintenance Organizations—via the state Department of Insurance website, and subsequently contacting each insurer until a plan which offered maternity coverage in the state's capital city could be identified.

Appendix 4: State Laws Protecting Against the Use of Gender, Age, and Health Status to Set Premiums in the Individual Market

See Appendix 4 notes for statutory citations.

State	Gender	Age	Health Status
Alabama	✕	✕	✕
Alaska	✕	✕	✕
Arizona	✕	✕	✕
Arkansas	✕	✕	✕
California	✕	✕	✕
Colorado	✕	✕	✕
Connecticut	✕	✕	✕
Delaware	✕	✕	✕
District of Columbia	✕	✕	✕
Florida	✕	✕	✕
Georgia	✕	✕	✕
Hawaii	✕	✕	✕
Idaho	✕	✕	⊖
Illinois	✕	✕	✕
Indiana	✕	✕	✕
Iowa	✕	✕	✕
Kansas	✕	✕	✕
Kentucky	✕	✕	⊖
Louisiana	✕	✕	⊖
Maine (modified community rating)	●	⊖	●
Maryland	✕	✕	✕
Massachusetts (modified community rating)	●	⊖	●
Michigan	✕	✕	✕
Minnesota	●	⊖	⊖
Mississippi	✕	✕	✕
Missouri	✕	✕	✕
Montana	●	✕	✕
Nebraska	✕	✕	✕
Nevada	✕	✕	⊖
New Hampshire	●	⊖	⊖
New Jersey (modified community rating)	●	✕	●
New Mexico	⊖	✕	✕
New York (pure community rating)	●	●	●
North Carolina	✕	✕	✕
North Dakota	●	⊖	✕
Ohio	✕	✕	✕
Oklahoma	✕	✕	✕
Oregon (modified community rating)	●	✕	●
Pennsylvania	✕	✕	✕
Rhode Island	✕	✕	✕
South Carolina	✕	✕	✕
South Dakota	✕	⊖	⊖
Tennessee	✕	✕	✕
Texas	✕	✕	✕
Utah	✕	✕	⊖
Vermont (modified community rating)	⊖	⊖	●
Virginia	✕	✕	✕
Washington (modified community rating)	●	✕	●
West Virginia	✕	✕	✕
Wisconsin	✕	✕	✕
Wyoming	✕	✕	✕

Key

● Protections exist

⊖ Limited protections exist (use limited through rate band)

✕ No protections exist

Notes to Appendix 4

Alabama: Ala. Admin. Code r. 482-1-074-.03 (2008) (prohibiting only rates based on blindness as unfairly discriminatory). See also Ala. Code §§ 27-19-1 to -39 (2008), Ala. Admin. Code r. 482-1-024-.01 to -.06 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Alaska: Alaska Stat. §§ 21.36.090(b), 21.51.405 (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory between individuals of the same class). See also Alaska Stat. §§ 21.51.010–.500 (2008), Alaska Admin. Code tit. 3, §§ 28.410–.520 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Arizona: Gender: Ariz. Admin. Code § 20-6-607(G) (2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."); see also Ariz. Admin. Code § 20-6-207(C)(2) (2008) (restricting gender discrimination in insurance "except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under A.R.S. Title 20"). Age: Ariz. Admin. Code § 20-6-607(G) (2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."). Health status: Ariz. Rev. Stat. Ann. §§ 20-1341 to -1382 (2008), Ariz. Admin. Code §§ 20-6-101 to -2201 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Arkansas: Gender and age: Ark. Ins. Dep't, Consumer Frequently Asked Questions, *available at* http://www.insurance.arkansas.gov/Consumers/F_A_Q.htm (last visited Sept. 18, 2008) (explaining that the state's unfair discrimination statute, Ark. Code Ann. § 23-66-206(14)(G) (West 2008), does not prohibit an insurer from basing rates on age or gender, if proven to substantially affect underwriting). Health status: Ark. Code Ann. §§ 23-85-101 to -139 (West 2008), Ark. Code R. 18 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

California: Cal. Dep't of Insurance, Consumers: Individual Health Insurance Underwriting/AB 356, *available at* http://www.insurance.ca.gov/0100-consumers/0070-health-issues/ind-health-insurance-underwriting-ab-356.cfm (last visited Sept. 18, 2008) ("When you apply for individual health insurance, the health insurance company uses a process called underwriting to look at your age, sex, and health history to decide whether it will cover you and how much it will cost to provide you coverage.").

Colorado: Gender: Colo. Rev. Stat. § 10-3-1104(1)(f)(III) (2008) (providing that classifications based solely on gender do not constitute unfair discrimination if justified by actuarial statistics). Age: Colo. Rev. Stat. § 10-16-107(1.5) (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory); see also 3 Colo. Code Regs. § 702-4-2-11(8)(E) (2008) (providing that "use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating" is not prohibited); 3 Colo. Code Regs. § 702-4-2-11(6)(P) (2008) (requiring that the actuarial memorandum display "all other rating factors and definitions, including the area factors, age factors, gender factors, etc., and support for each of these factors in a new rate filing"). Health status: Colo. Rev. Stat. § 10-16-107(1.5) (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory); see also Colo. Rev. Stat. §§ 10-16-101 to -220 (2008), 3 Colo. Code Regs. §§ 4-2-1 to -28 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Connecticut: Conn. Gen. Stat. §§ 38a-481(b), 38a-488 (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory between individuals of the same class). See also Conn. Gen. Stat. §§ 38a-480 to -511 (2008), Conn. Agencies Regs. §§ 38a-78-11 to -16, 38a-434-1, 38a-481-1 to -4, 38a-505-1 to -13 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Delaware: Gender and age: 18-1300-1303 Del. Code Regs. § 7.4 (Weil 2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."); see also Del. Code Ann. tit. 18, §§ 2503(a)(2), 2304(13)(b) (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory between individuals of the same class). Health status: Del. Code Ann. tit. 18, §§ 2503(a)(2), 2304(13)(b) (2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory between individuals of the same class); see also Del. Code Ann. tit. 18, §§ 3301–3355, 3601–3608 (2008), 18-1300-1301 to -1304 Del. Code Regs. (Weil 2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

District of Columbia: D.C. Code § 31-2231.11(b) (2008) (prohibiting only rates that are unfairly discriminatory between individuals of the same class). See also D.C. Code §§ 31-2801 to -3851.13 (2008), D.C. Code Mun. Regs. tit. 26, §§ 100–8899 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Florida: Fla. Stat. § 627.410(8)(a) (2008) (providing that benefits are deemed to be reasonable in relation to premium rates if filed pursuant to a loss ratio guarantee). See also Fla. Stat. §§ 627.601–.6499 (2008), Fla. Admin. Code Ann. r. 69O-149.002–.024, 69O-154.001–.210 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Georgia: Ga. Code Ann. §§ 33-9-4(1), 33-6-4(8)(A)(iv)(I) (West 2008) (prohibiting only rates that are excessive, inadequate, or unfairly discriminatory because based on race, color, or national or ethnic origin). See also Ga. Code Ann. §§ 33-29-1 to -22, 33-9-1 to -44 (West 2008), Ga. Comp. R. & Regs. 120-2-81-.01 to -.20 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Hawaii: Haw. Ins. Div., A Consumer's Guide to Health Insurance in Hawaii 3, *available at* http://hawaii.gov/dcca/areas/ins/consumer/consumer_information/health/Health_Insurance_Consumers_guide.pdf (last visited Sept. 18, 2008) ("The law does not limit what you can be charged for individual health insurance policy and you can be charged substantially higher premiums because of your health status, age, gender, and other factors.").

Idaho: Gender and age: Idaho Code Ann. § 41-5206(f) (2008) ("The individual carrier shall not use case characteristics, other than age, individual tobacco use, geography as defined by rule of the director, or gender, without prior approval of the director."). Health status: Idaho Code Ann. §§ 41-5206(1)(a) (2008) (providing that rates may not vary by more than 50% of the index rate).

Illinois: Gender: Ill. Admin. Code tit. 50, § 2603.40(a) (2008) (allowing insurance companies to differentiate in rates on the basis of gender if such "differentiation is based upon expected claim costs and expenses derived by applying sound actuarial principles"). Age and health status: 215 Ill. Comp. Stat. § 5/352–5/370e (2008), 50 Ill. Admin. Code tit. 50, § 2001.1–2051.100 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Indiana: Ind. Code §§ 27-8-5-1.5(1), 27-4-1-4(7)(B) (2008) (requiring only that benefits be reasonable in relation to the premium charged and prohibiting only unfairly discriminatory rates between individuals of the same class). See also Ind. Code §§ 27-8-5-1 to -5.7-11 (2008), 760 Ind. Admin. Code 1-8 to 1-9-4 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Iowa: Iowa Code § 513C.5(5)(a) (2008) (requiring insurers to disclose "[t]he extent to which premium rates for a specified individual are established or adjusted based upon rating characteristics"); Iowa Code § 513C.3(16) (2008) (defining "rating characteristics" as "demographic characteristics of individuals which are considered by the carrier in the determination of premium rates for the individuals and which are approved by the commissioner"). Health status: Iowa Code § 513C.5(1)(e) (2008) (only limiting an insurer's use of health status as a rating factor within a single block of business, that is all people insured under the same individual health benefit plan).

Kansas: Kan. Stat. Ann. § 40-2404(7)(b) (2008) (prohibiting only rates that are unfairly discriminatory between individuals of the same class). See also Kan. Stat. Ann. §§ 40-2201 to -2259 (2008), Kan. Admin. Regs. §§ 40-4-1 to -42g (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Kentucky: Gender and age: Ky. Rev. Stat. Ann. § 304.17A-0952(6) (West 2008) (allowing the use of gender and age as rating factors). Health status: Ky. Rev. Stat. Ann. § 304.17A-0952(1) (West 2008) (providing that rates may vary by no more than 35% of the index rate between individuals with "similar case characteristics").

Louisiana: Gender and age: La. Rev. Stat. Ann. § 22:228.6(B)(3) (2008) (expressly allowing individual insurance carriers to use gender and age as rating factors). Health status: La. Rev. Stat. Ann. § 22:228.6(B)(2) (2008) (providing that premiums may not deviate according to medical underwriting and screening or experience and health history rating by more than plus or minus 33%). Some reports suggest that Louisiana's health status rate band is not enforced. See Georgetown Univ. Health Policy Inst., *Summary of Key Consumer Protections in Individual Health Insurance Markets* 5 (Apr. 2004), *available at* http://www.healthinsuranceinfo.net/images/discrimination_limits_front.gif.

Maine: Gender and health status: Me. Rev. Stat. Ann. tit. 24-A, § 2736-C(2)(B) (2008) (prohibiting insurance carriers from varying the community rate due to gender or health status). Age: Me. Rev. Stat. Ann. tit. 24-A, § 2736-C(2)(D)(3) (2008) (imposing a rate band under which insurance carriers may only vary the community rate due to age by plus or minus 20% for policies issued after July 1, 1995).

Maryland: Gender: Md. Code Ann., Ins. § 27-208(b)(2) (West 2008) (prohibiting "a differential in ratings, premium payments, or dividends for a reason based on the sex of an applicant or policyholder unless there is actuarial justification for the differential"). Age and health status: Md. Code Ann., Ins. §§ 15-201 to -226 (West 2008), Md. Code Regs. 31.10.01.01–.35.03 (2008) (no statute or regulation restricts the use of age or health status as rating factors in the individual market).

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

Michigan: Gender and age: Mich. Comp. Laws § 500.2027(c) (2008) (prohibiting as unfair competition the "[c]harging of a different rate for the same coverage based on sex, marital status, age, residence, location of risk, disability, or lawful occupation of the risk unless the rate differential is based on sound actuarial principles"). Health status: Mich. Comp. Laws §§ 500.3400–.3475 (2008), Mich. Admin. Code r. 500.1–501.354, 550.101–.302 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Minnesota: Gender: Minn. Stat. § 62A.65(4) (2008) ("No individual health plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan."). Age: Minn. Stat. § 62A.65(3)(b) (2008) (imposing a rate band under which the "[p]remium rates may vary based upon the ages of covered persons . . . [by] up to plus or minus 50 percent of the index rate"). Health status: Minn. Stat. § 62A.65(3)(a) (2008) (mandating that rates may vary no more than 25% above and 25% below the index rate based on health status, claims experience, and occupation).

Mississippi: Miss. Code Ann. § 83-5-35(g)(2) (West 2008) (prohibiting only unfairly discriminatory rates between individuals of the same class). See also Miss. Code Ann. §§ 83-9-1 to -35 (West 2008), Code Miss. R. 28 000 001–095 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Missouri: Gender: Mo. Rev. Stat. § 375.936(11)(b) (2008) (prohibiting only unfairly discriminatory rates between individuals of the same class); Mo. Rev. Stat. § 375.936(11)(e) (2008) (restricting insurers from limiting the amount of coverage available to an individual based on gender); see also Mo. Rev. Stat. §§ 376.770–.823 (2008), Mo. Code Regs. Ann., tit. 20, §§ 400-2.010–.170 (2008) (no statute or regulation restricts the use of gender as a rating factor in the individual market). Age and health status: Mo. Rev. Stat. §§ 376.770–.823 (2008), Mo. Code Regs. Ann., tit. 20, §§ 400-2.010–.170 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Montana: Gender: Mont. Code Ann. § 49-2-309(1) (2008) ("It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits."). Age and health status: Mont. Code Ann. §§ 33-22-201 to -311 (2008), Mont. Admin. R. 6.6.101–.8512 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Nebraska: Gender: 210 Neb. Admin. Code § 28-005 (2008) (requiring insurers to provide, upon request, justification in writing for rating differentials based on gender, providing that "[a]ll rates shall be based on sound actuarial principles, valid classification systems and must be related to actual experience statistics"). Age and health status: Neb. Rev. Stat. §§ 44-710 to -7,102 (2008), 210 Neb. Admin. Code §§ 2-001–81-004 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Nevada: Gender and age: Nev. Rev. Stat. § 689A.680(2) (2008) (allowing the use of gender and age as rating factors). Health status: Nev. Rev. Stat. § 689A.680(3) (2008) (imposing a rate band in which the highest rating factor associated with health status may not exceed the lowest rating factor by more than 75%).

New Hampshire: Gender: N.H. Rev. Stat. Ann. § 420-G:4(I)(d) (2008) (allowing insurers to base rates in the individual market solely on age, health status, and tobacco use). Age: N.H. Rev. Stat. Ann. § 420-G:4(I)(d)(1) (2008) (imposing a rate band in which the maximum differential based on age is 4 to 1). Health status: N.H. Rev. Stat. Ann. § 420-G:4(I)(d)(2) (2008) (imposing a rate band in which the maximum rating differential due to health status is 1.5 to 1).

New Jersey: 2008 N.J. Sess. Law Serv. Ch. 38, page nos. 12, 15 (Senate 1557) (West) (amending N.J. Stat. Ann. § 17B:27A-2 (West 2008) to define "modified community rating" as "a rating system in which the premium for all persons under a policy or a contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographic location or any other factor or characteristic of covered persons, other than age," and amending N.J. Stat. Ann. § 17B:27A-4 (West 2008) to require individual health benefits plans to "be offered on an open enrollment, modified community rated basis"). New Jersey law excludes bare-bones basic and essential plans from the modified community rating requirement. See N.J. Dept. of Banking & Ins., *N.J. Individual Health Coverage Program Buyer's Guide: How To Select a Health Plan – 2006 Ed.* (2006), http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcbuygd.html.

New Mexico: Gender: N.M. Stat. § 59A-18-13.1(A) (2008) (allowing gender rating); N.M. Stat. § 59A-18-13.1(B) (2008) (providing that "the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than twenty percent of the lower rate"). Age: N.M. Stat. § 59A-18-13.1(A) (2008) (allowing insurers to use age as a rating factor in the individual market). Health status: N.M. Stat. § 59A-18-13.1(C) (2008) (providing that insurers are not precluded from using health status as a rating factor).

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

North Carolina: Gender: 11 N.C. Admin. Code 4.0317(a) (2008) (excluding from definition of unfair discrimination gender rating when based on rate or premium differentials not prohibited under the chapter); see also NC Gen. Stat. Ann. §§ 58-3-1 to -4-25, 58-50-1 to -95 (West 2008), 11 NC Admin. Code 12.0101–.1804 (2008) (no statute or regulation restricts the use of gender as a rating factor in the individual market). Age and health status: N.C. Gen. Stat. Ann. §§ 58-3-1 to -4-25, 58-50-1 to -95 (West 2008), 11 N.C. Admin. Code 12.0101–.1804 (2008) (no statute or regulation restricts the use of age as a rating factor in the individual market).

North Dakota: Gender and age: N.D. Cent. Code § 26.1-36.4-06(1) (2008) (imposing a rate band under which age, industry, gender, and duration of coverage may not vary by a ratio of more than 5 to 1, but providing that "[g]ender and duration of coverage may not be used as a rating factor for policies issued after January 1, 1997"). Health status: N.D. Cent. Code § 26.1-36.4-06 (2008) (not explicitly prohibiting the use of health status as a rating factor in the individual market). Association health plans offered in North Dakota are not subject to these rating requirements. See N.D. Cent. Code § 26.1-36.4-02(1) (2008) (the definition of "insurer" does not include an association that offers health insurance coverage).

Ohio: Ohio Rev. Code Ann. § 3923.15 (West 2008) (prohibiting only unfairly discriminatory rates between individuals of substantially the same hazard). See also Ohio Rev. Code Ann. §§ 3923.01–.99 (West 2008), Ohio Admin. Code §§ 3901-1-01 to -7-04 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

Oklahoma: Gender: Okla. Admin. Code § 365:10-1-9(d)(1) (2008) ("The amount of benefits payable, or any term, conditions or type of coverage shall not be restricted, modified, excluded, or reduced solely on the basis of the sex or marital status of the insured or prospective insured except to the extent the amount of benefits, term, conditions or type of coverage vary as a result of the application of rate differentials permitted under the Oklahoma Insurance Code."). Age and health status: Okla. Stat. tit. 36, §§ 4401–4411 (2008), Okla. Admin. Code §§ 365:10-1-1 to :10-3-20, 365:10-5-1 to :15-5-2 (2008) (no statute or regulation restricts the use of age as a rating factor in the individual market).

Oregon: Or. Rev. Stat. § 743.767(2) (2008) ("The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age.").

Pennsylvania: Gender: 31 Pa. Code § 145.1 (2008) (excluding from the definition of "unfair discrimination" when insurers "differentiat[e] in premium rates between sexes where there is sound actuarial justification"). Age: 40 Pa. Cons. Stat. § 1171.5(a)(7)(iii) (2008) (prohibiting unfair discrimination with regard to underwriting standards based on age, among other factors, but excluding the promulgation of rates based on age from the definition of unfair discrimination); see also 40 Pa. Cons. Stat. §§ 752–776.7 (2008), 31 Pa. Code §§ 88.1–.195 (2008) (no statute or regulation restricts the use of age as a rating factor in the individual market). Health status: 40 Pa. Cons. Stat. §§ 752–776.7 (2008), 31 Pa. Code §§ 88.1–.195 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Rhode Island: R.I. Gen. Laws § 27-18.5-3(f) (2008) ("nothing in this section shall be construed to create additional restrictions on the amount of premium rates that a carrier may charge an individual for health insurance coverage provided in the individual market"). See also RI Gen. Laws §§ 27-18-1 to -68 (2008), RI Code Ins., R. 23, Pts.VII & XI (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

South Carolina: Gender and age: S.C. Code Ann. § 38-71-325 (2008) ("Nothing contained in this section may be construed to prevent the use of age, sex, area, industry, occupational, and avocational factors or to prevent the use of different rates for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the person and are approved by the director or his designee."). Health status: S.C. Code Ann. §§ 38-71-310 to -680 (2008), S.C. Code Ann. Regs. 69-34 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

South Dakota: Gender: S.D. Codified Laws § 58-17-74(8) (2008) (expressly allowing the use of gender as a rating factor). Age: S.D. Codified Laws § 58-17-74(8) (2008) ("The maximum rating differential based solely on age may not exceed a factor of 5:1."). Health status: S.D. Admin. R 20:06:39:03 (2008) ("The application of rating factors based on health status or weight is limited to a 30 percent deviation from the index rate.").

Tennessee: Gender: Tenn. Comp. R. & Regs. 0780-1-34-.04(1) (2008) ("The amount of benefits payable, or any term, conditions or type of coverage shall not be restricted, modified, excluded, or reduced solely on the basis of the sex or marital status of the insured or prospective insured except to the extent the amount of benefits, term, conditions or type of coverage vary as a result of the application of rate differentials permitted under the Tennessee Insurance Code."). Gender and age: Tenn. Comp. R. & Regs. 0780-1-20-.06(1) (2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."). Health status: Tenn. Code Ann. §§ 56-26-101 to -133 (West 2008), Tenn. Comp. R. & Regs. 0780-1-20-.01 to -.09 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Texas: Gender: 28 Tex. Admin. Code § 21.406 (2008) ("When rates differ by sex or marital status, the insurer may be required to justify that the differential equitably reflects the difference in the risk assumed."). Age and health status: Tex. Ins. Code Ann. §§ 1201.001–1202.052 (Vernon 2008), 28 Tex. Admin. Code §§ 3.1–.128 (2008) (no statute or regulation restricts the use of age or health status as a rating factor in the individual market).

Utah: Gender and age: Utah Code Ann. § 31A-30-106(1)(h) (West 2008) (allowing the use of gender and age as rating factors). Health status: Utah Code Ann. § 31A-30-106(1)(b)(i) (West 2008) (providing that premium rates may vary from the index rate by no more than 30% of the index rate for individuals with "similar case characteristics").

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

Virginia: Gender and age: 14 Va. Admin. Code § 5-130-60(C)(7) (2008) (calculating the average annual premium per policy for individual health insurance policies based on "all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc."). Health status: Va. Code Ann. §§ 38.2-3430.1–.10, 38.2-3500 to -3520 (West 2008), 14 VA Admin. Code §§ 5-13-10 to -100 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

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

West Virginia: W. Va. Code § 33-15-1b(c) (2008) ("Nothing contained in this section may be construed to prevent the use of age, sex, area, industry, occupational, and avocational factors in setting premium rates or to prevent the use of different rates after approval by the commissioner for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the person.").

Wisconsin: Gender: Wis. Admin. Code Ins. § 6.55(5) (2008) (permitting insurers to differentiate rates on the basis of gender provided that such rates are based "on sound actuarial principles or a valid classification system and actual experience statistics"). Age: Wis. Admin. Code Ins. 3.13(6) (2008) (requiring individual accident and sickness insurers to file a "schedule of rates including policy fees or rate changes at renewal, if any, variations, if any, based upon age, sex, occupation, or other classification"). Health status: Wis. Stat. §§ 632.71–.899 (2008), Wis. Admin. Code Ins. §§ 3.13–.70 (2008) (no statute or regulation restricts the use of health status as a rating factor in the individual market).

Wyoming: Wyo. Stat. Ann. § 26-13-109(a) (2008) (prohibiting only rates that are unfairly discriminatory between individuals of the same class). See also Wyo. Stat. Ann. §§ 26-18-101 to -137 (2008), Wyo. Admin. Code Ins. Gen. ch. 1, § 1 to ch. 59, § 7 (2008) (no statute or regulation restricts the use of gender, age, or health status as a rating factor in the individual market).

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

11 Dupont Circle, NW, Suite 800
Washington, DC 20036
202.588.5180 • 202.588.5185 (fax)
www.nwlc.org