

KAISER FAMILY FOUNDATION & WOMEN'S POLICY, INC.

EXPANDING ACCESS AND COVERAGE FOR WOMEN'S HEALTH SERVICES

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WASHINGTON, DC

DR. DIANE ROWLAND: I am Diane Rowland, the Executive Vice-President of Kaiser Family Foundation, and I am really pleased to be here and to have all of you here today, to launch our Capital Hill Briefing Series on Women's Health Policy.

The Kaiser Family Foundation is a nonpartisan philanthropy that serves a national role in trying to help inform the policy debates around health care issues. We are not affiliated with Kaiser Industries, or with the Kaiser Health Plan, although we share a common name in our founder and benefactor, Henry J. Kaiser. What our primary goal is, is to bring some information to help inform health policy debates, to both the media, and to policy makers, and to use the media and policy makers to help assure that public decisions are based on the very best information.

We sponsor a number of activities that you may be aware of, including the Kaiser Commission on Medicaid and the Uninsured. We have a Medicare Policy Project, we do a substantial amount of public opinion polling around health care issues, and we work on differentials in care by race and ethnicity. But I am especially pleased that we are also now moving much more aggressively into the area of women's health policy, under the direction of Dr. Alina Salganicoff, our head of Women's Health Policy, and her research associate Zoe Beckerman (?).

Today, we will be launching a series that we think will go on, hopefully with your support, for the coming year, so that we can bring a number of issues to The Hill and to you, and we will look forward to having your comments and your assistance in helping to shape what those issues are.

I am pleased to be doing this with the support and cooperation of The Women's Policy, Inc., and MS. HALL, and her staff. And I want to thank them for all of their support and their work on this event, and to turn it over to Cindy right now.

And we will look forward to hearing your comments about this session, and we also would like you to know that if you would like to re-watch it at any point, at the foundation we are in the process of launching the Kaiser

Network. It is at [www.kaisernetwork.org](http://www.kaisernetwork.org), and we will be HealthCasting various health events, including today's event, so you can watch them on the Web. Hearings and other health policy forums will also be part of our new HealthCast activities. So the camera in the room today and these microphones are for our CSPAN on the Web on health policy issues. Thank you. Cindy.

MS. CINDY HALL: Thanks so much, Diane, and we too, Women's Policy, Inc., are very pleased to be hosting this women's health series with The Kaiser Family Foundation, and very excited to be part of this HealthCast, too.

Before I forget, I would like to just make a note, there is a yellow evaluation form in your packet, and we do hope you'll take the time to fill it out before you leave, because we are doing a series of briefings, we would love to have your input for the future.

I also want to take this moment to acknowledge the sponsorship of this briefing by Senator Olympia Snow, and the Congressional Caucus for Women's Issues, and give our special thanks to the staff of Senator Snow, Congresswomen Maloney, Morton, Morella, and Kelly for all of their help, and also a note of thanks to The Center for Women's Policy Studies, Leslie Wolfe (?), Jennifer Tucker, and Cathleen Stole (?).

Just a brief mention about our organization, Women's Policy, Inc. was founded in 1995, after the elimination of funding for caucus groups on The Hill, including the Congressional Caucus for Women's Issues. We are a nonprofit, nonpartisan organization, and we conduct legislative research and follow issues in Congress affecting women and families. We are also a special affiliate of the George Washington University, at Mount Vernon College. And I want to let you know about our website [www.WomensPolicy.org](http://www.WomensPolicy.org), if you would like to learn more about our organization.

Our purpose for today's briefing is to review the current status of access and coverage for women's health services in the states, to hear about the challenges and opportunities facing the states in meeting those needs, and to examine how employers are addressing women's health needs.

After our speakers have made their presentations, we will have an open discussion, and I hope everyone will stay.

Before we proceed with our speakers, we want very much to open up with welcoming remarks by Congresswoman Connie Morella, recently reelected to

an eighth term, she represents Maryland's Eighth District. She currently chairs the Science Committee's Technology Subcommittee, and serves as Vice-Chair to the Government Reform Subcommittee in the District of Columbia. Congresswoman Morella was the Republican Co-Chair of the Congressional Caucus for Women's Issues during the

104<sup>th</sup> Congress, and has been a leader on such issues as scientific research and development, women's issues, education, and children's issues. Congresswoman Morella.

CONGRESSWOMAN CONNIE MORELLA (R-MD): Thank you.

Actually, when I was Co-Chair of the Women's Caucuses when Cindy Hall was my Legislative Director, and my Press Person was Mary Ann Larry (?), so I feel very close to Women's Policy, Inc., and all of the good people who are involved with it, as well as the Congressional Caucus for Women's Issues, Olympia Snow who has been a mentor of mine, and, of course, I want to thank The Henry J. Kaiser Family Foundation for sponsoring this.

And as I mentioned to you, that I think that having a woman Vice-President says something for Kaiser. So, I very much value that, and of course, our panelists who are here and I will mention them in just a moment.

But, as I was thinking about what you are doing, I know you are looking at: are states initiatives adequate? But I was thinking in general of the whole concept of women's health, and remembering in 1990 when we finally got an Office of Research in Women's Health at NIH, and the difference it has made, and I was thinking, you know, women are not little men, and sometimes they think that we really are, and I had a whole list of some of the ways that we differ. We know we differ in a lot of ways, but for instance, women wake up from anesthesia faster than men. Did you know that? OK. Women are affected by the HIV virus in a different way than men. I think you knew that. Eating disorders are 10 times more common in women than in men. Women are three to four times more likely than men to suffer from lupus or other autoimmune diseases. Women are susceptible to alcohol-related heart damage, at lower levels of alcohol consumption than men, and it goes on and on. I mean, heart disease, all of these things, we react differently. And as I see Sandy Nolenberg (?) here, I know that we must have a dietary luncheon here, since she is always after us for diet, as well as to exercise. At any rate, we are very proud to be here, and to know that we stand firmly for advancing women's health.

And today, for the forum which you are going to have, I want to thank Diane Rowland. Kaiser has been a leader in facing our nation's health deficiencies

head-on. Kaiser initiatives, such as the Children's Partnership and the Commission on Medicaid and the Uninsured, have encouraged dialogue, and demonstrated that access to quality healthcare must be a priority for our nation. And I think as lawmakers we need to be aware of the roadblocks some individuals face, and specifically how we can eliminate those barriers that block services from individuals in need.

And I am encouraged by the recent improvements in the School Lunch and Food Stamp Programs by the Agriculture Committee this year. These issues show wide bipartisan support, and I am optimistic that they'll be priorities for the 107<sup>th</sup> Congress, if we ever reach that point. Currently, we have 8 million uninsured children who are eligible, but who are not enrolled in Medicaid and in CHIP. We need to have the CHIP streamlining enrollment and improved outreach methods, improved in the states, and I think that Kaiser is a leader, and we thank you very much for all of that.

I also want to thank Dr. Alina Salganicoff, also from Kaiser, for being here to discuss coverage of women's health services in various states. I also want to thank Delegate Joan Stern, who represents a District in Montgomery County, Maryland, the Congressional District that I represent. She has been very active in the state in health coverage for women in Maryland. And we are both very proud that Maryland is the only state requiring equitable insurance coverage for contraception.

Currently there are under 10 states requiring a parity for private insurance coverage for women, and that is why casting the equity in prescription insurance coverage for contraception is such a priority for passage in the 107<sup>th</sup> Congress by those of us here on the Federal level. And we did have a big victory with the Lowey Amendment, in the 105<sup>th</sup> Congress, for women who were in that Federal Employee Health Benefits Program. I think we must extend this right to all women.

Many employers in the private sector have been actively engaged in dialogue to improve the health options for their employees. And I want to thank Dr. Julie Feldman, Director of Family Health, for being here to discuss employers perspectives on improving access to women's health services. Cindy, did I remember everybody who is here?

OK. Well, Women's Policy, Inc. has been in leadership in women's health issues, and I applaud those of you who are involved. I see Leslie Wolfe (?) is here, who are involved in the Board of Women's Policy, Inc. But to all of you also, who are on staff, I consider you very important. I have often said, "My rod and my staff they comfort me, and prepare the papers for me, in the presence of my constituents." But please know that you play a very,

very vital role in what happens with the members, when we get back into the 107<sup>th</sup> Congress. So, I thank you for allowing me to be here for welcoming comments and I welcome all of you!

MS. HALL: Thank you, Congresswoman Morella. We know we can always count on you to get a great event started.

I also want to make mention that Congresswoman Eleanor Holmes Norton had planned to be here, but a last minute glitch occurred and she was not able to be with us, but we did appreciate all of the help that came from her office.

Our first presenter will be Dr. Alina Salganicoff, who is Director of Women's Health Policy for The Henry J. Kaiser Family Foundation. She also serves as the Associate Director of the Kaiser Commission on Medicaid and the Uninsured, and has worked with the Medicaid Commission since its inception in 1991. Her work for the Commission and Foundation has focused on healthcare financing, access, and coverage issues for low-income women, Medicaid managed care, and state health reform. Alina will present new data on state policies affecting access and coverage for women's health services. Alina.

DR. SALGANICOFF: Thank you. It is a real pleasure to be here today, to launch the first Kaiser/Women's Policy, Inc., Women's Briefing Series. Before I get started though, I would like to extend a special thanks to Zoe Beckerman, my colleague, who has worked tirelessly to make sure that you have all the fabulous material there in the briefing packet, and I hope you will have a chance to take a look at them.

I also want to let you know that in your briefing packet is a chart packet that has all of the slides you are about to see that are here. So those of you who are at the table that it is kind of hard to see, over there, you can follow along with the chart pack.

While we here in Washington have been struggling to reach consensus on a number of health reforms, many of our colleagues at the states have been hard at work, particularly in the area of women's health. What I would like to today with my short time is summarize for you what has been going on some selected issues that are particularly important to women. That is, coverage and access to GYN services and contraceptions.

That is not to say that women don't have a wide range of health needs, as we heard earlier from Congresswoman Morella, but this is an issue that

really differentiates women's health needs from men's health needs. Much of what I am presenting here today is detailed in the folder.

I'm going to talk about reforms that are affecting women with private insurance, as well as progress that is being made expanding access to uninsured women. Before I go into the details of state policies, I wanted to remind you all of the importance of access to these services. The U.S. Preventive Services Task Force, as well as other notable professional associations, has agreed on a number of preventative services that are important to women.

While women can get these services from a family practitioner or an internist, research shows that OB-GYN physicians are the most likely to provide women with these services. And, in fact, women are more comfortable getting reproductive health services and counseling from OB-GYN providers. Again, this is an issue that really highlights how women and men use the health system differently. Women, unlike men, often split their routine care between a general practitioner and an OB-GYN.

The Division of Care really became an issue as managed care has become the prominent health delivery arrangement for America. In fact, now three-quarters of American women are enrolled in some type of managed care arrangement. One of the key features of managed care is that the patient typically selects a primary care provider who acts as a gatekeeper, managing their use of health services. In the early days of managed care, women either had to get their routine care through their primary care provider, or had to get a referral from their primary care provider to see an OB-GYN.

In recent years, patient preferences and growing concerns about the need for more preventative care specific to women, has led the healthcare industry and employers and legislators to facilitate access to OB-GYN care, OB-GYN's under managed care. These measures typically eliminate the requirement for a referral, often called direct access, and in some cases even allow women to select an OB-GYN provider as their primary care provider.

Some states have also enacted additional protection for those women in managed care. For example, 22 states and D.C. do not permit the plans to limit the number of OB visits a woman makes. Sixteen states with direct access laws also require insurance to notify women of this provision. And nine states bar health plans from imposing surcharges or added co-payments when they see an OB-GYN. The first state direct access law was also passed in Maryland in 1994. We are going to hear more about what

Maryland is doing in the future. Over the next six years, an additional 37 states and D.C. have approved similar policies. As you can see from the map here, these reforms have been sweeping the states.

However, not all plans in the states are subject to these laws. ERISA, the Employee Retirement Income Security Act of 1974, limits the impact of these regulations on the states. The details of ERISA are far beyond the scope of the presentation or my ability to discuss them, to be honest. So, what is important to know in this context, however, is that while states can regulate insurers, ERISA preempts them from regulating employers with self-insured plans, that is those the employers can bear the risk for insurance paying for care directly. It is estimated that from 48 to 72 million Americans receive coverage from a self-insured plan. Only a federal law that specifically amends ERISA would have jurisdiction over these types of plans.

Another area that has been gaining attention at the state level has been that of contraceptive equity, which would assure that insurance that covers prescription drugs also cover reversible contraception. A recent survey of employers by The Kaiser Family Foundation and HRET found that the rate at which contraception was covered was considerably lower than that of the basic prescription drug coverage provided by most insurers.

Adding the coverage of contraceptives, however, is not expensive. According to a study commissioned by the Alan Goodmaker (?) Institute, adding coverage for all five reversible birth control methods, including oral contraceptives, injectables, diaphragms, implants, and IUDs, would average \$21.40 per employee annually, just over \$17.00 of which would be paid by employers.

Contraceptive coverage legislation generally provides coverage for contraceptive services and supplies under the same terms and conditions as coverage for other prescription drugs. To date, 13 states now have enacted legislation to guarantee contraceptive insurance coverage of reversible contraception. In 1998, again Maryland became the first state to pass such a law. All of the states covered contraceptive drugs and devices and many states also explicitly mentioned that insurers must also include birth control related services, such as counseling, exams, and insertion and removal of devices where applicable. This is important, because these services actually typically cost more than the actual devices.

Some states have similar limited provisions on the books, such as laws or regulations which require that health plans, in some cases, just offer contraception. Others have requirements that only apply to the small group

or the individual market. One of the greatest issues of contention that you may have heard about in these legislative battles, has been whether or not to exempt employers and insurers whose religious beliefs or tenets conflict with the use of birth control. Of the 13 states with the contraceptive coverage measure, nine have a form of a religious exemption, which some call a conscientious clause, although the definition of what constitutes a religious employer or religious organization varies from state to state, but these employers and insurers are defined and they may opt out of providing birth control coverage.

As you can see, this issue is really again also taking root across the nation. It is worth noting that employers that are excluded by religious exemptions are not the only ones potentially exempted by the legislation. ERISA also exempts self-insured employers from contraceptive coverage provisions, as it does from the OB-GYN direct access mandate.

I am going to shift gears a little bit now, and I am going to be talking about what is going on with respect to improving coverage and access to GYN care and contraceptives for uninsured women. As I am sure you know, a significant share of Americans lack insurance coverage. Today, nearly one in five women between 18 and 64 is uninsured. This issue is considerably more striking for low-income women, where we have one-third of poor women and one-quarter of near poor women, that is women between 100 and 199 percent of poverty, who have no insurance.

Coverage of low-income women actually deteriorated with the passage of the 1996 Welfare Law, which de-linked Medicaid and cash assistance. Many women who left welfare for the workplace, lost their Medicaid coverage, and were not able to replace it with employer-based coverage, and were not enrolled in transitional Medicaid assistance for which they were typically eligible.

And we know that this is a problem, because women who are uninsured experience significantly more barriers to care, and are refused--received fewer services. These differences are even more magnified for uninsured, low-income women, who lack the resources to get healthcare, will often postpone care until they are very ill. However, there is hope that recent developments in Medicaid policy will begin to improve coverage for low-income women.

As you probably know, Medicaid is a very important program for low-income women. However, Medicaid eligibility is very limited. It is limited to women who are either low income and pregnant, and that coverage typically ends 60 days postpartum; very poor women with children; those who are over

65; or those who list disabilities and are eligible for SSI. However, for those women, Medicaid covers a broad range of services from physician care all the way through long-term care, and nursing care, and has been shown to improve access and to provide levels of care that are on par with private coverage, for low income women.

Since 1993, some states have used Medicaid as a vehicle to provide family planning benefits to low income and uninsured women. To do this, states, however, must obtain a waiver from the Health Care Financing Administration, the Federal agency that oversees Medicaid. These waivers, called Section 1115 Research and Demonstration Waivers, allow states to experiment with Medicaid, but must not cost the Federal Government anymore than it would have otherwise spent on Medicaid. Because the Federal Government matches family planning services at a 90 percent match, the Medicaid expansion is a relatively inexpensive way for states to improve access for this limited range of services. This approach may be even more attractive to the states in the wake of the '96 Federal Welfare Law, which provides added incentives for reducing the number of unintended pregnancies, including monetary bonuses to the state.

To date, 12 states have received approval to implement Medicaid expansion for family planning; six of these made services available to women who lost Medicaid coverage at the end of the postpartum period and extends the coverage from two to five years. Unless a woman, as I said before, qualifies for another category, she loses that coverage after the 60 days.

One state makes Family Planning services available for two years to women who leave Medicaid for any reason, and finally, five states have gone a step further, basing eligibility solely on income, rather than on previous Medicaid enrollment. And there is a correction from the chart pack; it says women losing Medicaid for income, but it is in fact, women don't need to have Medicaid coverage to have eligibility for this new program. An additional six states are now awaiting HCFA approval for their own family planning expansion. Some states have actually gone beyond family planning, and include services such as exams and counseling, sterilization, screening of STDs and HIV, treatment for STDs, and over-the-counter contraceptive supplies.

While expanding coverage for family planning services is important, we all know that women have a broad range of health needs, and require coverage for much more. States are now increasing latitude to expand coverage to populations that have not been traditionally eligible for Medicaid because they did not either meet Medicaid's restrictive income test or did not fit into one of the Medicaid categories.

Throughout the 1990's, a number of states expanded Medicaid using the same 1115 Labor Authority that the states used to expand family planning programs. This approach, however, does have some limitations. First of all, the changes, as I mentioned earlier, must be budget neutral. Furthermore, expanding coverage is often difficult to do without increasing state outlay, and probably as many of us know, and we'll probably hear from Joan, states are often reluctant to spend additional funds.

Secondly, HCFA approval process has often been complicated and this may have deterred some states from applying for expansion. Ten states, however, have expanded coverage to at least all of their poor, regardless of whether or not they meet Medicaid's categorical test.

Now, also a new option exists with the passage of the 1996 Welfare Law, a new eligibility category was created in Section 1931 of the Social Security Act. This category allows states to extend coverage to families with children without a waiver. They can choose to cover all parents, regardless of whether or not they have received public assistance through CANA (?). States can also set higher income levels, than cash assisted standards, which we know are very, very low, averaging 42 percent of the poverty level across the country.

Seven states have now adopted plans to extend eligibility to poor parents under the Section 1931. However, this coverage is only available to families with children, leaving a large number of poor, childless women and men ineligible and still uninsured.

As you can see, some states have made some very important expansions in covering low-income parents and adults. Some states though even considerably higher than the poverty level, but then they charge premiums and co-payments to those higher-income persons. However, many states, as you can see, still have very restrictive assets tests, that limit eligibility for those who own homes, for example, or even own cars.

Extending coverage to parents of low-income children is an important first step that states are considering in many cases and now beginning to adopt. If all states were to take advantage of 1931 eligibility, they could assist many women, often women living in single parent households. But many would be left out. Those who are married or childless, or those who live alone will never meet the categorical criteria, no matter how poor they are.

Taking a conservative approach, if all states opted to expand coverage to poor women with children, they we would cover about 12 percent of

uninsured women. However, not all states are in a position to expand coverage, because they are either reluctant to increase outlays in the state budget or because they are concerned about expanding entitlements.

Realistically, if we are to make a significant reduction in the uninsured across the country, particularly the low-income uninsured, we will need Federal action to make that happen. It is worth noting that there is actually considerable public support for improvement in coverage for women. A recent Kaiser poll on health priorities for women in the 2000 election, found that helping the uninsured get coverage was rated as very important by nearly three-quarters of the public, closely followed by allowing women to see OB-GYNs without referral. There was also significant support for coverage of family planning programs for low-income women and broadening contraceptive coverage for all insured women.

So, in closing, state reforms have resulted in some important expansions and assets to coverage of OB-GYN care and contraceptive services for women. States have been able to move forward with reforms for insurers and employers have not been able or willing to fill the gap, and at this time we have had a very difficult time reaching consensus on the federal level in getting reforms enacted. However, state reforms do have limitations. There is different willingness from state-to-state to get these reforms enacted and states have vastly different resources from which to finance these reforms, particularly the expansions in coverage. And as we all well know, ERISA limits the reach of many of these state reforms. Even if the states make the changes, not all women in the states are effected by the improvements. On the state and federal level, those of us who want to improve coverage for women are all facing the same challenges. How do we assure that women in this country have access to meaningful coverage that meets the broad range of health services that they need? Thank you.

MS. HALL: Delegate Stern was elected to the Maryland House of Delegates in 1998. She serves on the Environmental Matters Committee and her Subcommittee assignments include the Health Subcommittee, the Agriculture, Environment, and Natural Resources Subcommittee, and Health and Public Utilities Subcommittee.

Delegate Stern was recently elected Regional Director for the National Order for Women State Legislators, and has served on the National Health Committee for Women in Government. As (inaudible) Maryland has been a leader of these coverage issues, and Delegate Stern will tell us what's next for Maryland.

DELEGATE JOAN STERN: I want to thank you all for inviting me here today. I was afraid that I was going to be snowed in at North Carolina. I was at NCSL's National Leadership Forum for healthcare people, and we had a prediction of 12 inches of snow, so I called US Airways and said, I have to get out of here. I have to be back home on Monday. So, they put me on standby and I made it out, but I think that a lot of my colleagues are still snowed in in North Carolina. But, of course, if we got a foot of snow here, that wouldn't be a problem for us.

I don't have to tell you all about the unique healthcare needs of women. We know there is a difference and it is because of the efforts of people like Congresswoman Connie Morella and Senator Barbara Mikulski that we are seeing some differences in healthcare, that NIH now includes women in medical protocols, and that the medical community recognizes that women present different symptoms than men in many instances.

Two weeks ago, I was at a conference in New Orleans where I had an opportunity to talk about the Bill I am going to mention in a minute, and the wife of the Governor of a western state was there. And she went to her doctor with her husband for their annual checkup. He got an EKG, blood work, all kinds of tests, stress test, everything. The doctor didn't recommend any of those tests for her, and she said, "Why?" And he said, "Well, you are a wife, what stress are you under?" She was only, you know, the wife of the Governor.

And that happens all too often. So, one of the things that we are doing in Maryland, is creating an Office of Women's Health. This office is going to be proactive, it is going to be an advocate for women's health. It is going to provide a voice for women and the one thing we have said to our leadership, to the Governor and to everyone, is that we want a real office. We don't want something that is just going to look good on paper and make you all feel good and, you know, that you throw us a bone. We want a real office.

And when you set up offices in your state, that is something you need to be concerned about, because there are 22 states that have some type of an office, and when we looked at them we thought, no, this is not what we want for Maryland. We want the best in the nation. We want a model for the rest of the nation. And so, we took the best from those other bills and created our office.

We started working on it last May, and the initial focus is going to be on women over 45 and one reason we are doing that is this is the category of women that have been ignored. We do have a lot of programs in Maryland for pregnant women, for younger women, but we ignore women who are

postmenopausal women. We don't actually realize they are there again until they are in their 80's, they break a bone, and then they end up in the nursing home, and then we say, My God, what do we do with them? They're here. Most of the money that we spend on women is spent when they are pregnant or during the last two years of their lives, so if we can do something and you can sell this Bill as a cost effective measure to cut down on the cost in nursing homes, to keep women out of nursing homes for longer periods of time, we can save millions of dollars, both for the states and for the Federal government.

Recently I talked to two of my colleagues, who were in the House of Delegates, and to a delegate, well actually she is a newly elected Senator from Arkansas, only the sixth woman elected to the Senate in the history of Arkansas and all of these women take a medication that thins their bones. They are all in their 50's, they all have insurance, they all see doctors on a regular basis. None of them has had bone scans, none of them knew this medication thins bones. Now, why is that?

If we ask ourselves here, if we are not taking care of women who have health insurance, what are we doing for women who don't have health insurance? These are women who could potentially break a bone, end up in a nursing home, and there is a point in time where we could prevent that from happening. We could help them, but we are not doing it.

One of the things that we are doing with our office is creating a separate grant fund. The Health Department right now can solicit grants, but we are going to set up a special fund for this office and we are doing that for a couple of reasons. We have a very good osteoporosis program in Maryland, but it is not funded. I had a Maternal Mortality Bill last year, because a lot of women die within the first year of giving birth and we are trying to find out why. The Governor didn't fund that Bill either. This office will be able to write grants for programs like that. And also, for a lot of other special programs that they are going to focus on once they enlarge their staff. They are going to look at some nontraditional things, things like eating disorder, the lack of exercise, the effects of socioeconomic conditions on women, environmental factors. They are going to look at the total woman and how her life is effected, and what we can do to improve it. And so, they really need a separate grant fund to be able to do that, because otherwise all of the money will go into the traditional programs like cancer, heart disease, things like that.

I have been working closely with Dr. Georges Benjamin (?), who is wonderful. We are really very fortunate to have a great Health Department Director in Maryland. And when he knew I was bringing this legislation in,

he decided it would be wise to start working with me, and the Women's Caucus and not against us. So, he went one step further. He went out there and not only looked at the legislation, but he looked at health departments in other states, to see how the office fit in, how it interacted with their Health Department. And what he found was that California was the only other state in the nation that had an office, like this, that had a comparable health department.

So, that was very interesting to hear that, but in California, they have lots and lots of Deputy Secretaries, and so while they're office is under a Deputy Secretary, as ours will be, it can get lost in the maze out there. In Maryland, we have one Secretary, and three Deputies, and our office will be under one of the three Deputies, the Deputy for Public Health and our Executive Director will have direct access to the Secretary. So, it will be at a much higher level, it will be much more prominent than any of the offices in the country. And he worked with us to pull the best out of all the other bills, and create something that would serve as a model, because as you know, Maryland likes to be a national leader. We like to be a trendsetter in everything.

Initially because, you know, there are always funding issues and it looks like the great funding surplus is coming to an end. We are starting to see an end to that. We are going to start off with three people, an Executive Director, a professional staff person, and an administrative staff person, and the budget will start out at around \$320,000.00 and then we will expand from there.

The office is going to address services and programs for women at all socioeconomic levels, ages, race, and ethnic background in the various stages of their life. They are going to emphasize access, because we know great programs are worthless, unless you have access. They are going to disseminate information, especially to minority populations and populations that are not served.

Education and prevention are obviously two very important components. The office is going to prepare material. They are going to disseminate it. They are going to get the word out. They are going to be very proactive. They are also going to develop a strategic plan. You have to have a plan so you know where you are going and so you know how you are going to get there. And that is going to be one of the most important things that they are going to do, because if you look at the states today, they don't have a plan. Your Governor comes in, he's got a mission, he's only going to be there for four years, eight years, whatever. In many of the states you have term-limited legislatures, so they don't have time to develop long range

plans. We are very fortunate in Maryland. We have the time and the desire to develop a strategic plan.

They are also going to serve as a coordinating body and a clearinghouse body. We know there are lots of programs out there. We don't know what they are or where they are necessarily. It's going to be like one-stop shopping. You will contact this office, you will tell them what your problem is, whether it is diabetes or an eating disorder, cancer, and they should be able to refer you to the appropriate program. We are also going to have a library, so you can do some research.

They will also make recommendations for new programs and modifications in existing programs. One of the most important roles they are going to play is to maintain a database and that is something that is extremely important. This book actually is going to be your Bible. It was prepared by the National Women's Law Center and Elaina Tom (?) is here. It is called Making the Grade on Women's Health. They went in and looked at 50 states and D.C., and they evaluated them. And you can get this on the Internet. I will give you the Web page address. It is [www.nwlc.org](http://www.nwlc.org). It looked a number of different factors, and much to our horror we rank 25<sup>th</sup> in Maryland. California was 21. We thought we would be one, two, three; we were 25. None of the states passed. They all got failing marks. Maryland got some good marks in some areas, satisfactory in other areas, and we really went down with flying colors in some areas.

UNKNOWN FEMALE PARTICIPANT: Who got number one?

DELEGATE STERN: Who got one? That's an interest--who? Hawaii. OK. So, one of the problems is the lack of data. And that is what this office is going to do is maintain statistical data, so when we go in to fight for something, we can say, hey, this is why we need it.

There is also going to be an advisory council. Right now we do have an advisory council. It is called the Women's Health Promotional Council, and they will move over and work with this new office, help be an advocate. Go out--they are holding community forums right now, throughout Maryland, to ask women about their healthcare needs and what they think the state needs to do. And they will continue that role.

There is also a very important element in this still. We can pass wonderful legislation, and we are in session for 90 days, and then we go back home. The state does what it wants, the Governor does what it wants, and so we have a reporting requirement. Every year the Director, the Secretary of the Health Department, along with the Executive Director of this office, has to

some in and see us on environmental matters to tell us what they have been doing, how things are going, make a progress report to us, so that nothing will happen to this office when we are out of session.

We are lucky with this Bill because it is going to pass. The Women's Caucus decided that they wanted to take a very proactive role in supporting this Bill. It is the first time our caucus has really initiated legislation. And we went to the speaker and we said, we want this Bill. This Bill is important to us. And our speaker is a smart man and he saw some very stubborn and determined women and he looked at it and he said, "I can live with this. I like it." And then he came back and said, "You know what? I am going to make it a leadership Bill." And they had to pick me up off the floor because I couldn't believe he did that, but it's going to be-- we have about 2,300 bills introduced into the General Assembly every year and this will be one of ten that will be picked up by leadership. The Lieutenant Governor is supporting it. We have a meeting on January 8<sup>th</sup> with the Governor to try to get funding, but one of the reasons we were able to sell that Bill was because of this book, because I went to them and said, we rank number 25 in healthcare. We are the fifth wealthiest nation in the states. I have got people who are going to come in, in front of television cameras and say, "Maryland's healthcare stinks! I have an answer for you, I've got a solution." So, they said, "Sounds good to us." So, we are very fortunate, because we have documentation and we had a good Bill.

So, I want to thank you all. It has been a pleasure speaking to you and do invite me back again someday.

MS. HALL: Thank you very much, Delegate Stern. It is great to see your leadership on all these issues and to see that Maryland will truly continue to be a leader.

Our final presenter is Dr. Julie Gonen, Director of Family Health for the Washington Business Group on Health or also known as WBGH. WBGH represents employers in promoting performance-driven healthcare systems in competitive markets, that improve the health and productivity of companies and communities. The Business Group's Family Health Programs include initiatives relating to maternal and child health, women's health, and with life issues. Julie will discuss the employers perspectives on improving access to women's health services.

JULIE GONEN, PhD: Thanks, Cindy. Can everybody see those OK? I am sorry, but I was unable to get the slides in your packet ahead of time, but if anybody wants hard copies, I can either get them to you or we can probably manage to distribute them somehow.

I am pleased to be here today. Some of you, whom I know in the audience, know that the prior of joining WBGH, I was with the Jacobson Institute of Women's Health here in Washington and so I actually see a lot of old friends in the audience. So, it's very nice to be here and we be able to share some what I have been doing since I moved over to work with employers on some of these issues.

I should probably tell you just a little bit about what Washington Business Group on Health is. I am assuming that many of you here probably don't know, although I know I see a few folks in the audience that I have actually had some discussions with in the past. We are a membership association, basically of large employers. We are a 501(c)(3) non-profit, so sometimes people have a little difficulty getting their minds around that. We represent large for-profit companies when we are in fact non-profit. And although we sort of look like one, we are not really a trade association per se, we simply represent the interests of large employers around healthcare issues, specifically.

The way I look at it is we have sort of both an external role and an internal role. The external role is sort of representative by what I am doing here today, which is coming in and sort of explaining employers' view on various issues in different forums. But, I think almost more importantly is what I call our sort of internal role, which is to provide a forum for employers to really come together and work among the themselves on issues that have to deal with healthcare purchasing, revision of healthcare services in the workplace.

One of the best ways to influence an employer really is to get them to see what another employer is doing, and this is one of the most important function that I think we play, is that we provide a forum for employers to come to who sort of grapple with the issues that they are struggling with and hear from your peers about how they are being addressed.

So, we have about 165 members. We do represent exclusively large employers. I always have to sort of give that caveat, that I can speak only to what really large employers are doing and not so much to what the experiences of small and medium sized employers, who often, unfortunately, don't have the resources and the wherewithal to do some of the innovative programs that our large members do. When you add together the covered lives, that is the employees and the dependents of the folks that work for our members, it approaches 40 million people, so it's a good sector of those that are insured through private sector employers.

Although I should say also, that we don't only represent private sector employers anymore. Within the last few years we added to our ranks the Federal Office of Personnel Management and the US Postal Service, two very large employers who are in the public sector. So, we can claim now to represent large private and public sector employers.

Just to give you a quick snapshot who some of our more well-known members are, these are folks that you encounter every day and I probably failed a little bit in my equity agenda in that we have Pepsi up there but not Coke, we also have Coke, Cocoa Cola company membership. We have American Airlines and Delta. We have IBM and Dell. So this is, it's obviously not a place where competitors mind talking with each other around common issues that they share when it comes to healthcare.

Before explaining specifically sort of what employer's are thinking and doing around women's health, I want to just put up a couple of slides on what the landscape really looks like for employers now when it comes to health care issues. As many of you probably know, employers for a few years were enjoying relatively flat or lack of cost increases when it came to healthcare, largely because of the implementation of managed care. But the cost trend is going back up again and a big component of that is largely pharmacy costs, which becomes a little bit relevant when we talk about the issue of contraceptive coverage. Many of you also probably know that employers are beginning to take a sort of instead of a second, may it's a third or fourth look, at their role as a purchaser and provider of healthcare services for their employees. That is not to say that they are going to jump out of the game anytime real soon, but they are looking at what their role really should be as the healthcare delivery system evolves and the Internet actually becomes more an increasing factor or an element that they are looking at, just sort of help solve some of their problems.

This is why I have the third one up here about eHealth. This is something that our large employers are particularly intrigued with, the notion that the Internet can play an important role in helping employees actually become more involved in managing their own healthcare and even constructing packages of services that make sense for the individual.

Certainly, there are policy changes that our employers pay attention to. That is another one of the functions that we serve is kind of letting them know what is going on up here on The Hill and how that might effect their healthcare purchasing and their programs.

Now, my basic—I'm going to take a slightly different view than what Alina discussed earlier, and this probably won't surprise anybody, but employers

typically prefer not to have benefits mandated on them. They look at the benefits that they provide, whether it be health benefits or others, as voluntary benefits that they provide and they try to come up with the packaging that they think best serves the needs of their employees. Well, certainly, I know this doesn't surprise anybody, but they'd rather not have mandates handed down to tell them what, in fact, they should cover.

As Alina mentioned, many of the state mandates that we are discussing here today, don't to a large extent, effect a lot of the employees that we represent because they are very large self-insured employers that don't do these (inaudible) mandates because of Employee Retirement Income Security Act or ERISA. One of the reasons that—it's not only that employers don't want to have somebody tell them what to do when it comes to putting together a benefits package, but it is because our employees are often multi-state. Some of them have employees in almost all states and to the extent that some of them also offer insured products alongside their self-insured products, it makes it obviously a lot more complex when administering benefits to have to respond to a number of different state mandates that are going to vary when they are trying to administer programs that are relatively uniform across their employee population.

I did have occasion recently to start speaking with some of our more active members around kind of what they think about women's health. We have had a program working on women's health for a number of years now which actually had been sort of a little bit on the back burner before I came to the business group a couple of years ago, so it's really not been since about 1996 or so that we had actively surveyed our members and started collecting best practices on women's health. So, I started to just chat with some of them again about how did they view women's health, and somebody says women's health, kind of as an employer, what does it mean. And I got sort of varied responses. Some of them said that they look at it very generally, any health issue that effects women across the life span. Some of them gave more traditional responses in that they think first of reproductive health issues. And to some extent, this isn't surprising because employers, you know, pay very close attention to where the costs are. And most of them know that pregnancy related costs are always at the top of their lists when it comes to inpatient costs, etc., they know where the dollars go. So, reproductive health issues are going to appear at the top of their agenda.

But we also do and it sort of depends on who we speak with as well. We work with them at—a wide array of folks within companies. Sometimes we deal with medical directors, companies who are a little bit older who still have on-site medical programs. And so those folks who have a clinical

background are going to have a little bit different perspective than somebody who is a pure benefits manager type. And we have—we work with all of those types of corporate executives. So, it depends on sort of where they sit, how they view women's health.

But some of them did give what I would call more sophisticated answers to how they view women's health. They did mention some of the same things that some of you who work in women's health every day would say. That in looking at conditions that are common to both sexes, but that manifest differently in women. Or health issues that are, in fact, unique to women but aren't necessarily reproductive in nature. So, really the responses I got were sort of across the board.

And the other thing that will effect your response, of course, is the demographics of that particular employer's workforce. If it happens to be a bank that employs a number of women, many of whom are in their childbearing years, again, the reproductive issues are going to be very prominent. I talked to a Board Member from Union Pacific Railroad, those issues aren't going to be quite as prominent for him because he has an almost entirely male workforce. And usually I try to come back at them with well, you know, you are insuring the dependents, you know, most of the men are married or have wives or daughters. Well, yes, that is true, but those issues don't tend to rise quite as high, it's not those that they see at the workforce every day.

So in the course of these conversations, we also talk about why would you, as an employer, focus on women's health? And some of the answers really aren't very different than why they were focused on health issues generally. Certainly, productivity is a really big driver for employers providing healthcare and looking at their healthcare benefits. They obviously want their employees to be healthy so that they can be at work and to be productive while they are, in fact, at work. They want fewer sick days. They want fewer long and short-term disability absences, in case you were wondering on what STD stood for. I know this is an audience where you might sort of had a "bill" understanding of that term. This is something that I had to get used to when I came to the business group because it is to me something quite different for me as well.

And employers do recognize, of course, that individual health does lead to (inaudible) health. If the employees are not there, if they are sick or if they are at work, but they are not feeling well or they're trying to deal with claims issues or health issues for members or their family, that they are not going to be highly productive. So, employers want to do, what it's going to take to make sure that they're employees are healthy and productive.

They certainly want to maintain health over the life span and this is becoming increasingly important as the workforce ages and employers are becoming more and more aware of it, that they can't only focus on the health needs of younger workers. That the population is aging, therefore, the workforce is aging and they need to be more cognizant of the health needs of women and men who are over 50.

Also, in this economy, where the labor market is very tight, they want to be the employer of choice. Now, that's a good thing when it comes to advocating what your benefits and additional programs that will help women and all employees because this is a good time, frankly, to be asking for them. This is when employers want to be adding things, so that they are the employer of choice, particularly in sort of the new economy of employers, where competition for workers is very fierce. So, this is a good time for benefits though. If the economy takes a different turn, it gets a little bit more worrisome about whether these things will stick. But, if we can show—sort of make a good business case, show a good return on investment, it makes the chances of them sticking around definitely improve.

What I wanted to talk a little bit about is sort of the, what I would call the constructive approach that we take to working with our employers. And personally, I agree with, you know, wanting employees to have access to contraceptive coverage and to obstetrician-gynecologists. Working with employers in the business group, we do it sort of a different way. Rather than going through a state or federal mandate, we try to work with our employers to let them really see why they should be doing it anyway. To what we call make the business case. To have a benefit or to change a benefit, to structure it differently so that employees can access it better.

Some of the ways we do this is by working with outside organizations. We are now in the 11<sup>th</sup> year of a cooperative agreement with the Federal Maternal and Child Health Bureau as part of the Health Resources and Services Administration. Through that arrangement, we are able to work with organizations like Healthy Mothers, Healthy Babies, the Association of Maternal and Child Health Programs, to bring information on best practices in maternal and child health to our employers. Because we find that if we tell them what it is they need to do and why it will ensure employees health, it's not that hard to get them to look at their benefits and sort of do the right thing. But they would rather do it health and productivity reasons than because of a public policy mandate and so this is sort of what we see our mission as being is bringing this information to them. This cooperative agreement is a dialog between the private and public sectors to bring this information to our employers and also the other way around. To help those

in the public sector understand how employers operate some of the constraints under which they work.

Some of you may have seen a publication that came out of this project called Business Babies and the Bottom Line. I wish I could take credit for that title, because I think it's excellent and really does kind of encapsulate what the mission of the program is. It's really to show employers how they can get their arms around the maternal and child health costs and how it would benefit both the employees and the company.

Part of our work through this project is really kind of helping to just raise employers awareness of basic data, such as the fact that seven percent of childbearing-aged women will give birth in a given year. So, this is something, as I said, employers are pretty well aware of because of the cost issues, but what are the needs that child-bearing women so that these costs can be reduced so that they have more of the \$6,400.00-type pregnancies as opposed to the upwards of \$1 million-type pregnancies. And so we try and get them to look at pregnancy on sort of a continuum approach as opposed to just the instance of childbirth, and what that inpatient cost is, but what do women need way prior to the actual pregnancy: preconception counseling, access to contraception, prenatal care, obviously labor and delivery, and a lot of patience and support even at the work site afterwards. So, we really try to get them to see it along the continuum as opposed to just discreet episodes in care and the dollars associated with them.

Through the project, we have been able to identify both what employers are doing and get them to start adding these programs. And I just wanted to throw up a couple of slides just as an example of some of the things that we've discovered in working with our employers through our maternal and child health initiatives. These are just some examples of things that employers are doing.

You have actually a briefing paper in your packet on contraceptive coverage. We had an issue prior to that that was specifically focused on peer support of breast-feeding employees, both at the work site and having access to lactation consultants, etc.

I'll just put up one more slide of some other examples of some of the things that our larger employers are doing. As far as today's issue of contraceptive coverage, as I mentioned, you have a briefing paper in your packet that sort of encapsulates, I think, the approach that we take when we talk about this issue with our employers, as I said, we definitely feel that this is something that employers should be offering their employees. And, to be honest, sometimes the existence of state-level mandates or the effect of a Federal

mandate can actually help to raise awareness of the issue and get employers to look at it, whereas they wouldn't be before, because we could say, you know, you can either do it now because we can help make the business go forward or you can wait until somebody tells you do it later on, and I think they would prefer to be doing it the former way.

So we published a briefing paper earlier this year and then we had what we called business consultation with some of our employers, a couple of months ago actually, in mid-September of this year based on the ideas that were in that briefing paper. We brought together, basically we tried to provide what we call sort of a safe forum for employers to come and really grapple with this issue. And so we've had representatives from The Centers for Disease Control come, from The Division of Reproductive Health to discuss, taking again, that sort of continuum of approach or contextual approach to pregnancy and talk about why it's important to have access to contraceptive coverage, what the various methods are, and the importance of promoting healthy and planned pregnancies.

Part of our job really is to help sort of connect the dots for the employers, making the argument that, you know, you're paying for maternity benefits, but if you're not paying for contraception, you may, in fact, be paying for a number of untenable years. And she was able to say to our other employers in the room, it really hasn't done much as far as costs go, it hasn't broken the bank, it's been, if anything, pretty cost neutral. And that's a really important message for our employers to hear. I think that's a very important way and a very effective way of influencing employers to hear from another employer that they've done it, it's worked, it hasn't ruined anything, it hasn't made them go bankrupt, and that the employees are satisfied.

So, I just wanted to sort of share with you a little bit of what came out of that meeting. And as I said this is sort of a frank employer, almost employer only meeting on contraceptive coverage. And part of what we tried to elicit from them are what are some of the barriers to adding the contraceptive benefit, you know, if you're not doing it, why aren't you? And these are some of the things that they shared with us, I think, Alina mentioned sort of what the cost of that added benefit is. Some employers, I think, do have a bit of an exaggerated notion of what the cost would be. And one of the things we did at the meeting was we walked through a complex economic model for an employer and using sort of some default demographic data, showed them what it would cost to cover versus not cover. And we added in things, like replacement costs for employees who go out on pregnancy leave, including an assumption about a certain percentage who don't return, bringing in replacement workers, the cost of

the delivery, etc., and we can show almost every time that there is, in fact, a cost savings to covering contraception. So this is, again, an effective way of kind of reaching the employers. And we can even plug in their own workforce demographic data into this model and show them exactly what it will do to their own costs.

Another one of barriers that they mention was sort of the complexity of the administrating the benefit, because there is such a range of contraceptive methods. Some are in pill form, some are injectable, you know, where do you put it. It is in the medical benefit, is it in the pharmacy side, if you're using the PVM, how does that work, you know, how do you get Depo Provera, if you're using a mail-order pharmacy, you know, these are some of the issues that will need to be worked out. And so this is, you know, part of what we were trying to elicit from them, is what really are the barriers, and what kind of information can we get to you so that you can get around those barriers.

Sometimes the issues are not structural or financial. They can be, as Alina mentioned, conscious clauses. They can be, sort of a moral stumbling block of somebody who is a key decision maker in that company that needs to be guided along. And that's always a little bit trickier than being able to present numbers that show that it's going to save money.

So we asked them what kind of information could we give you that would help you kind of go through this and be able to add the benefit? As I said a model using for implementation: show me how another employer has done it and how it's been effective? Some discussion tools, so if they do encounter one of those internal decision-makers that is resisting, what kind of points can they make to them to try and sway them? More explicit information from the health plans that they contract with and what would be already covered. Sometimes they're not even sure if they are actually buying a product from an insured health plan, what exactly is covered. If they say we cover contraception, does that just mean the pill and is it just one brand of the pill or is it all, you know, 15 or however many FDA approved reversal methods that there are. And we're trying to ask them to ask these questions because saying we cover the pill is not the same thing as saying we have a comprehensive contraceptive benefit.

They need more information on the health impact. As I said before, they need to understand the connection between contraceptive coverage and unintended pregnancies and the health consequences of those unintended pregnancies. And actually, they said that they also wanted more information on the state laws that Alina was talking about earlier, because to the extent

that they do buy insured products across state lines, they need to know, you know, what those mandates are.

Points to emphasize when it comes to trying to work with an employer on making a case for contraceptive coverage is, as I mentioned before, to show that it is, in fact, pretty cost neutral when you add in both the direct and the indirect costs of having a benefit and then the cost of unintended pregnancy, that it comes out to be pretty neutral. Also again, especially in this tight labor market, employers want to be known as sort of the progressive employer of choice and this is one way that they can do that. Again, put in the context of healthy pregnancies, and as I mentioned before, we need to emphasize that one size does not fit all when it comes to contraception, that all methods really need to be covered.

Now just to sort of wrap up, employer goals in benefits, it's pretty obvious. They want to remain competitive and they want to enhance employee health and productivity, which helps to maintain their competitiveness and be the employer of choice. And, you know, at the Business Group, we want to be part, as Alina said, of meeting some of these challenges and providing access to women's health care services. So, we stand ready to work with any of you that want to, to work with us towards those ends. Thanks very much.

MS. HALL: Thank you, Julie, very much. It's great work you're doing encouraging employers to improve their coverage. It sounds like it's going well.

And this is the end of the formal presentation, so we do hope you'll stay for a brief discussion. And I want to remind you again about the evaluation forms, too. Please don't leave without filling those out.

But we are going to turn this over to a brief discussion, and I want to encourage any, particularly any staff members who are here with members that are particularly active on some of these issues. This is a great opportunity. And when you stand up please state your name and office.

MS. JENNIFER GRIFFITH (?): Hello, my name is Jennifer Griffith with Senator Smith's office. I wanted to make some shameless plugs for a couple of the bills we have out there. (Inaudible.) Anyway, if you don't have information on it and you need it, I'd be happy to provide some (inaudible).

MS. HALL: Anyone else?

MS. MICHELLE SWINDELL (?): Hi, my name is Michelle Swindell (?) and I have a question for you Dr. Salganicoff, I'm sorry--.

DR. SALGANICOFF: Alina is fine.

MS. SWINDELL: You talked a lot about different health forums, primarily with health coverage on a contraceptive level. And I was wondering what about mental health? And just knowing, you talked and mentioned a little bit about eating disorders. And that's a nice perception meaning the physical and the mental, because when you feel, I mean, that's the mental health issue which shows the highest death rate. And just because you talked about how women, or I'm sorry, who mentioned it? I think Congresswoman Morella mentioned that women suffer from eating disorders ten times more than men, whether there are any reforms in the mental health arena for women across these states?

DR. SALGANICOFF: I'm speaking into the microphone, but it doesn't work. I really have to plead ignorance on this issue. I really am not as familiar with the details of the different mental health bills that are moving across the country. I don't know whether in Maryland, you've addressed that, or-- we do have somebody who does know quite a bit about that.

MS. HELENA HOOTEN: Hi, I'm Helena Hooten (?) for the National Women's Law Center. And first of all I just wanted to thank Joan for the (inaudible) support. And along those lines, we've looked at several different types of policies, and one of the policies that we addressed is actually (inaudible) policy that dealt with the mental health area and within that particular indicator we looked at coverage for eating disorders and incidences like that. I did bring a few extra copies of the report for those of you who don't have it, as well as order forms. And I just wanted to also encourage other people here, that in addition to doing our continued work on the report card for next year, one of the main goals of the report card was for a new system having with these tools within the states and we really like exactly the way it's being dealt with in Maryland and we'd like to offer technical assistance to any other legislative (inaudible).

LAURA (?): Hi, I'm Laura, (inaudible). I have first a general question for everybody, and maybe it's an unfair question, and I feel like (inaudible) wonderful presentations. (Inaudible) it seems like we know what the problem is and how to fix it and we did not fix it, we need to address it, but we still can't quite get there and even on a lot of things, you know, there's many things that, you know, are proven cost effective (inaudible). But what are we missing. Do we just need to keep doing it? Or is there a key thing

that we're missing, you know? Is there some big thing we're not doing or is it just to keep (inaudible).

UNIDENTIFIED SPEAKER: (inaudible).

DR. SALGANICOFF: Yeah, I think the other thing is that there are efforts underway and even though the progress feels very slow, I mean, if you look at what is happening in different states, there are some efforts, and I agree with Julie, I think we really do have to keep plugging away. That's why we're having this forum today. I think the more people that know that these things are not expensive, that they are very important, I think the more that we'll be able to kind of get the ball rolling. I think in the Federal case, you guys probably know better than we do where the obstacles have been and we're all hopeful that if we keep, again, keep moving forward and keep educating as many people as possible on the focus of these issues, that we will get some action.

UNIDENTIFIED SPEAKER: Well, two things that we are doing, I've talked to our Health Department Director a number of times (inaudible) he doesn't have the funding. He has now told me that there was a very inexpensive test that can be performed on low-income women, so he is looking around in his budget to see if he can find some funding for that.

The other thing I have done is come back to the medical society and some of the lobbyists for these groups, and I said to them, "Can you send out a letter to your physicians and ask them to start screening people who have insurance?" At a very minimum, these people should not be a problem. They've got health insurance, they've got prescription drug coverage, why aren't more people looking at this group of women? And so that is something that we're doing-- that we should be doing and we're not doing.

DR. SALGANICOFF: I would also add, I mean, I think everyone has already said this, but in terms of Federal mandates, it is a difficult thing. It can take a number of years and often the states taking the lead make a big difference. The more states that have done something, obviously, the much more likely that Federal government and Congress is going to say, well, you know, look at all these states that have done something. The laws aren't uniform. We need to make this coverage available for all women. And I think something like the Breast and Cervical Cancer Treatment Bill is a good example, where that actually came to pass, and I know--.

UNIDENTIFIED SPEAKER: (inaudible) that tailored the message and even in different groups that are (inaudible) that make the point. I think that's

really important. Of course, the business argument is really (inaudible) for a lot our more conservative.

MS. JOANN DUCETTE (?): I am Joann Ducette of the National Partnership for Women and Families. I have two questions, one for Julie and one for Alina. For Julie, did you—did the employer giving the benefit and make the argument that women will get contraceptives elsewhere and, you know, reconsidered trends and yet they didn't (inaudible) and yet they did, in fact, make that argument, what was there about the comeback. And for Alina, have you found that physical dispel the issue of access to health coverage as a women's issue because women are slightly more likely to be insured than men are(inaudible)? I mean the numbers are—all of these people, but, you know, men tend to have insurance on--.

MS. JULIE GONEN: Absolutely, we got our (inaudible) account money, money to buy birth control (inaudible) etc., etc. And to some extent, you know, the—well those are just as sort of frustrating, embedded in this is the idea that (inaudible) and so they must have been already been paying for it, but they're already getting contraception, it's just that if we're paying for it and to some extent that may be true, but the counter-argument is that what we hope is that they have coverage, and coverage of all methods, then they are more likely to get the appropriate method, the more accepted method. Prescription methods are more effective, so therefore, if they have coverage and can get access to those methods. They're still likely to utilize some savings through reduction of unintended pregnancy.

I wish I had access to better data on that. I think intuitively, you know, we all probably feel like that's the case, that if they have access to the prescription methods that are more effective, that the cost are going to go down, but that sort of replacement cost issue is definitely a wide one.

DR. SALGANICOFF: You know, I think your question is an interesting one because one of the things that I've been saying for a while is that insurance coverage is very much a woman's issue, and particularly when we are talking about the low-income women. You know, in the past, you know, since '97 when we had the new CHIP legislation, we've seen an tremendous expansion in interest and coverage of children. At the same time, the women who were assisted by Medicaid, we've seen a real decline, in particularly low income women.

And those are, in many cases, those are the very mothers of the children that we are expanding coverage to. So, even though women have the benefit of being more likely to be eligible for Medicaid because of the categorical requirements of Medicaid, I think that there is still a significant

problem with being uninsured for women, and I think that people don't think that. Many people don't even know that there is a difference, that women don't even know about Medicaid eligibility. But I think once you start scratching below the surface and you see that one-third of poor women, one-quarter of near poor women are uninsured, I think that there is still an important case to be made. And, actually, Medicaid, because of its categorical requirements and because of its linkages to children, would actually be a very good vehicle to start looking at that and expanding.

MS. GONEN: (Inaudible) when we began talking about women's health issues, we used to also just focus on many of the reproductive health issues, and I think that as insurance coverage has become a part of the overall women's health movement, that it's now going to have some visibility that it never had in the past, because it was never considered part of the discussion about women's health. And, as we broaden women's health to include more than just reproductive issues, I think it really changes the dynamic. It broadens the base and it helps to bring other people into the debate who wouldn't be there if it was only around reproductive health issues.

UNIDENTIFIED SPEAKER: (Inaudible) 70 percent of the health care budget (inaudible) women are between 35 and older and being the leading cause of death among women, is the first cost about that cost and if we're not preventing those costs to businesses, I am curious if you had any examples of stellar businesses. I've seen health companies now pushing through—like cooking, nutrition, and (inaudible) proactively, and that has to be a real shock from a low-income perspective (inaudible) and as an extension of the Breast and Cervical Cancer Program to provide one-stop shopping for women in the health arena. So, (inaudible) what we need to start looking at, with the cost issues (inaudible) we're going to get nailed later.

MS. GONEN: Actually, I mentioned earlier the cooperative agreement that we have with (inaudible) and part of that agenda, as you said, is to raise employer awareness of chronic disease issues. It's fair that—we'll start out next year with a business compensation on the effective (inaudible) the success of that program going into a three year sort of ongoing relationship, whereby we could do—actually the media (inaudible). But there are some challenges to make in the business sense where it comes across is, we think the employers who have a corporate time frame, you know, it's quarterly (inaudible) it can be a tough sell when there is a lot of employee turnover. That's not to say that we're not going to try, but we are—we are going to try.

MS. HALL: Thank you everybody for attending, we are going to still be around, but the formal part of the program is over. And I do want to also thank the WPI (?) staff Miriam Leery (?), our Executive Director, Jennifer Lopez Chivot (?) and Whitney Perry, our Senior Writer/Editors for all their help with this briefing. Thank you everyone.

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