

Women and Health Care Reform in Massachusetts

POLICY BRIEF ~ SPRING 2008

Introductionⁱ

On April 12, 2006, Chapter 58—the Massachusetts health care reform bill—was signed into law. The purpose of Chapter 58 is to “redeploy current public funds to more effectively cover currently uninsured low-income populations, and [to] make quality health coverage more affordable for all residents of the Commonwealth. The bill promotes individual responsibility by creating a requirement that everyone who can afford health insurance obtain it, while also responding to concerns about barriers to health care access.”ⁱⁱ The Massachusetts reform, which builds upon the existing health care system, rapidly has become a model for other states seeking to address problems of health care access for uninsured residents.

This brief, exploring how the reform may affect women of diverse ages and income statuses, aims to raise awareness that will promote positive change in women’s health.

Why Women’s Health?

- Women make 58% more visits each year to primary care physicians than do men and are more likely than men to take at least one prescription drug on a daily basis.ⁱⁱⁱ
- Women have greater annual health care expenses than men (\$2,453 vs. \$2,316).^{iv}
- A greater proportion of women’s health care expenses are paid out-of-pocket (19% v. 16%).^v

However, women are less able than men to afford medical services and supplies. Primarily because of cost, uninsured women are nearly 20% more likely than uninsured men to have trouble obtaining health care.^{vi}

- Women earn less than men in every county in Massachusetts—earning an average of 77 cents for every dollar earned by a man.^{vii}
- The average weekly salary for a woman in Massachusetts is \$666, while a man’s is \$842.^{viii}
- Single-parent families headed by women represent 72% of the families living below the poverty line in Massachusetts.^{ix}

Massachusetts Health Care Reform

Chapter 58 establishes mandates requiring most Massachusetts residents to obtain health insurance or risk financial penalties. Measures to encourage health care coverage include modest expansion of Medicaid and the State Children’s Health Insurance Program (SCHIP), collectively called **MassHealth**, establishment of subsidized insurance plans for low-income residents (**Commonwealth Care**), and creation of the Commonwealth Connector to negotiate lower cost insurance plans (**Commonwealth Choice**). Chapter 58 also requires most employers to meet a “fair and reasonable” contribution to employees’ health insurance or pay an annual assessment of \$295 per uninsured employee. As of the end of 2007, the law is credited with covering an additional 300,000 Massachusetts residents.

As the reform moves into its second year, the experiences of the most vulnerable groups of women call for particular tracking efforts:

- Low-income women who have transitioned from Free Care to Commonwealth Care or Commonwealth Choice plans,
- Women whose incomes hover slightly above Commonwealth Care eligibility,
- Women at risk for being unable to afford to use their Commonwealth Choice insurance because of high deductibles,
- Young women who have purchased Young Adult Plans,
- Late–middle aged and near-elderly women,
- Women who are vulnerable to changes in family status,
- Women who are dependent upon a spouse’s health insurance,
- Minority women who traditionally face more obstacles to adequate health care, and
- Immigrant women.

Low-Income Women

Traditionally, Massachusetts women have been uninsured at lower rates than men, an advantage accounted for by women’s higher rates of MassHealth (Medicaid) enrollment. Since the reform, the estimated gender breakdown of new MassHealth enrollees favors men: 57% male versus 43% female (about 44,900 males and 33,800 females).^x This gap most likely reflects eligibility expansions; the raising of the enrollment cap in MassHealth Essential (a plan for very low-income, long-term unemployed adults) in particular may have brought in more men.

Massachusetts residents not eligible for Medicaid who earn less than three times the federal poverty line (FPL) are eligible for subsidized health care coverage through the newly created Commonwealth Care program. Based on income, residents are assigned to a “tier” that determines how much they pay out-of-pocket for premiums and co-pays (Commonwealth Care plans have no deductibles). Health care advocates as well as low-income women raise concerns regarding the premiums and cost-sharing required by Commonwealth Care. Indeed, enrollment rates have been slower for the tiers that require higher premiums.

Women have enrolled in Commonwealth Care plans at higher rates than men.^{xi} This trend reflects two factors:

- Women are poorer than men and thus are more likely to qualify for subsidized coverage.
- Women may be more concerned than men with accessing health care for themselves and for their families.

Table 1: Commonwealth Care Enrollees (as of December 2007)

PLAN TYPE	FEMALE	MALE	TOTAL
<100% FPL	39,765	41,091	80,856
100%–200% FPL	36,661	25,787	62,448
200%–300% FPL	8,392	6,481	14,873
Total	84,818	73,359	158,177

Table provided by Commonwealth Connector Insurance Authority

Commonwealth Care enrollees earning over 150% of the FPL and who formerly received medical services through the Uncompensated Care Pool (free care) in Massachusetts hospitals and community health centers may find that they now have higher out-of-pocket health care expenses. For some low-income women, these expenses are prohibitive.

KK is a type-1 diabetic working full-time as a pharmacy technician. A former free care recipient, she now is covered by Commonwealth Care. Based on her weekly net income of \$339, she is eligible for the Tier 3 subsidy. Her current premium is \$70 a month. Her out-of-pocket medical expenses for her diabetes medications are \$10 for generic and \$20 for name brand until her annual cap of \$500 is reached for prescription drug co-pays. Until she reaches that cap, she picks and chooses which medications to purchase, sometimes skipping one or two prescriptions if her income is insufficient. Given her low income, KK would like to work overtime whenever possible. However, she needs to be careful not to earn enough to push her Commonwealth Care level to Tier 4, which would result in higher co-pays than she can afford. KK worries that if her income increases by even a relatively small sum, she will lose her Commonwealth Care eligibility and will be required to find much more expensive alternatives.

Residents who earn slightly too much to qualify for Commonwealth Care, but who are not required to purchase individual insurance because it is unaffordable at their income level, may fall through the cracks of the reform. Because women earn less than men overall, it is likely that more women than men will fall into this category. Some of these women used free care services in the past and now express concern regarding bureaucratic difficulties in signing up for the new Health Safety Net as well as uncertainty over the future of those safety net services as the Commonwealth’s funding priorities have switched to the reform-mandated programs. As of May 2007, the last month for which figures were available, women made up approximately 62% of free-care users.^{xii}

Moderate-Income Women and High-Deductible Plans

A quasi-public regulatory body, the Commonwealth Connector, has been created to negotiate more affordable insurance options for Massachusetts residents via Commonwealth Choice insurance plans. The Commonwealth Choice plans are designed for people earning over 300% of the FPL (for an adult living alone, that means more than \$30,630 according to the 2007 Health and Human Services Poverty Guideline.)

As the name suggests, Commonwealth Choice plans include a range of options regarding premiums, deductibles, co-pays, and maximum benefits. Each of six insurance companies offers four levels of plans—Bronze, Silver, Gold, and Young Adults Plans. The main differences among the plans regard enrollee contributions: Bronze and Young Adults Plans have lower premiums but higher co-pays and deductibles; Silver and Gold Plans have larger premiums and lower co-pays and deductibles. All Commonwealth Choice plans offer a certain number of preventative care visits without a deductible.

Moderate-income residents may find that the high deductibles of many of the new Commonwealth Choice plans present unexpected problems. There are two categories

of high-risk profiles under this reform umbrella: (1) individuals who choose the plan with the lowest premium—and the highest deductibles—without any practical understanding of the plan’s actual costs; and (2) individuals who have unforeseen medical events that result in high co-pays or co-insurance.

While men and women have signed up for Commonwealth Choice plans in relatively equal numbers, greater health care needs and expenses make women particularly vulnerable to high out-of-pocket costs. Based on data collected by the Agency for Health care Quality Research, Steffie

Woolhandler and David U. Himmelstein argue that high-deductible health plans are particularly onerous for women. “While only one third of insured men under 45 hit \$1,050 each year in medical costs, 55.6% of insured young women reached this figure. Similar cost disparities disadvantage insured women between ages 45 and 65, 74.2% of whom ‘consume’ \$1,050 or more in medical care annually.”^{xiii} Women’s health policy experts Elizabeth Ptachias and Judy Waxman conclude that “reforms that result in higher out-of-pocket expenses and limited benefits will not significantly improve the health and financial security of women.”^{xiv}

Table 2

Services and Procedures	Cost Billed to Insurance (AHRQ)	OUT-OF-POCKET EXPENSES			
		Young Adults Plan w/o Rx coverage* <i>Deductible is \$2,000, co-insurance is 20% after deductible, maximum out-of-pocket is \$5,000</i>	Bronze Plan with Rx coverage <i>Deductible is \$1,500, co-insurance is 20% after deductible, maximum out-of-pocket is \$5,000</i>	Silver Plan “Fallon” with Rx coverage <i>Deductible is \$500 and no co-insurance is charged</i>	Gold Plan <i>No deductible and small co-pays for office visits</i>
Yearly Premiums		\$1,494	\$2,588	\$3,504	\$5,234
Vaginal Delivery, No Complications ¹	\$6,200	\$2,840	\$2,440	\$500	\$0
Vaginal Delivery with Complications ¹	\$8,200	\$3,240	\$2,840	\$500	\$0
C-Section, No Complications ¹	\$11,500	\$3,900	\$3,500	\$500	\$0
C-Section with Complications ¹	\$15,500	\$4,700	\$4,300	\$500	\$0
Prenatal Care, No Complications ¹	\$1,500	\$1,275	\$1,275	\$315	\$150
Breast Surgery (Mastectomy) ²	\$16,704	\$4,940	\$4,540	\$500	\$0
Chemotherapy & Supportive Care for Ovarian Cancer ²	\$47,000	\$5,000	\$5,000	\$500	\$200
Chemotherapy for Colon Cancer ³	\$161,000	\$5,000	\$5,000	\$500	\$200
Hysterectomy ⁴	\$10,000	\$3,600	\$3,200	\$500	\$0
Uterine Fibroid Embolization ⁶	\$7,000	\$3,000	\$2,600	\$500	\$0
Lupus Testing and Treatment per Year ⁷	\$8,000	\$3,200	\$2,800	\$500	\$200
Emergency Contraception ⁵	\$90	\$90	\$90	\$90	\$0
Colposcopy (plus 2 Biopsies) ⁵	\$370	\$370	\$370	\$370	\$0
IUD Insert (Mirena) ⁵	\$750	\$750	\$750	\$500	\$10
Sterilization by Essure ⁵	\$3,300	\$2,260	\$1,860	\$500	\$0
1st Trimester Abortion (IV Sedation and Rhogham) ⁵	\$1,230	\$1,230	\$1,230	\$500	\$0
HPV Vaccine Series ⁵	\$959	\$790	\$790	\$500	\$30
Cryotherapy ⁵	\$270	\$270	\$270	\$270	\$0
CABG (Coronary Artery Bypass Graft) ¹	\$30,412	n/a	\$5,000	\$500	\$0

References: 1. Agency for Health care Research and Quality www.ahrq.gov ~ 2. Oxford Journals www.oxfordjournals.org/cgi/content/abstract/93/6/447 ~ 3. National Center for Policy Analysis www.ncpa.org ~ 4. Female-to-Male Guide www.ftmguide.org/hysto.html#risks ~ 5. Planned Parenthood League of MA Insurance Manual ~ 6. Journal of Vascular and Interventional Radiology, 2002 ~ 7. The Missouri Coalition for Life-Saving Cures www.missouricures.com/diseases_autoimmune.php

*Beginning in 2009, all plans must have prescription coverage.

Table 2 lays out the estimated annual out-of-pocket expenses for women’s common health problems. The total annual costs are calculated by adding premiums, co-payments, deductibles, and applicable co-insurances together for each separate component of a plan.

For office visits and procedures, Table 2 shows the price to be billed to insurance minus the deductible (if the billed amount was greater than or equal to the deductible). If there is a remainder, the co-insurance has been calculated. For office visits, once the deductible is met the remaining visits cost only the co-pay. Figures for procedures include the cost of the deductible plus any co-insurance. For procedures that involve co-payments, deductibles, and co-insurance (such as prenatal care and childbirth), each component is calculated and added together. For medication costs, the applicable co-payments are calculated depending on the plan (either a fixed amount or a percentage of the cost billed to insurance) and the tier (whether it is a generic drug, etc.). This co-payment is multiplied by whatever number is necessary to achieve a one-year supply based on dosage and quantity supplied at one purchase.

The calculations that comprise Table 2 are based on extensive research into the average costs of particular treatments, painstaking untangling of the structures of the various Choice plans, and complicated equations regarding how those costs would likely play out under the various plans. It is unlikely that most consumers would be able to make these calculations. Moreover, even the most careful research would not allow consumers to predict which illnesses may befall them in the future. In fact, the “choice” in Commonwealth Choice often turns out to be more of a gamble than an informed decision—a gamble made without even fully knowing the house rules.

Because women often serve as the health care representatives of their families, they are particularly likely to suffer from the burden of having to make insurance choices that may potentially result in their family members having to forego medical treatment or accumulating unexpected medical debt loads.

Young Women

Accessible, acceptable, and comprehensive physical and mental health care services are of the utmost importance as young women approach and then enter their childbearing years. However, possibly because they cannot afford higher premiums, possibly because they do not understand the actual out-of-pocket expenses of the various plans, young women may likely choose lower premium

plans but end up paying high deductibles and co-insurance. Of particular concern are certain Young Adult Plans that set a maximum annual benefit.

Table 2 shows the costs of common procedures for young women ranging from a colposcopy, a very common diagnostic test for young women, to the vaccine series for the human papilloma virus. Theoretically, an overall healthy young woman covered by a Young Adult Plan could need a colposcopy (\$370), cryotherapy (\$270), and an abortion (\$1,230) in one year and not reach her \$2,000 annual deductible; rather, she would pay \$1,970 out of pocket for these procedures. And, if the colposcopy were to indicate a precancerous condition or cancer, her out-of-pocket expenses would quickly reach her \$5,000 annual maximum (in addition to her annual premium of \$1,494).

LL is a young woman with overall good health who began to suffer from anxiety. She saw a psychotherapist for counseling and began taking Effexor. In addition to her co-payments for these visits, she also received a series of Gardasil vaccinations to protect against types of the human papilloma virus that can lead to cervical cancer. She also experienced a failure of her birth control method and found herself in need of an abortion. Referring back to Table 2, if she had chosen a Young Adult Plan (with prescription coverage), the total cost for these expenses, including the premium, would have been \$6,713 over one calendar year. If she had purchased a Bronze Plan with prescription coverage, her costs would have been \$4,844. With a Silver Plan, her costs would have been \$4,554. Her income is approximately \$35,000 annually.

Table 3

	YOUNG ADULT	BRONZE	SILVER
RX	\$1,532	\$600	\$300
OFFICE VISITS	\$1,125	\$1,125	\$500
HOSPITAL	\$1,230	\$1,230	\$250
DEDUCTIBLE REACHED	Co-Insurance on \$280 = \$56	Co-Insurance on \$780 = \$156	N/A
PREMIUMS	\$1,831	\$2,588	\$3,504
TOTAL ANNUAL COST	\$6,713	\$4,844	\$4,554

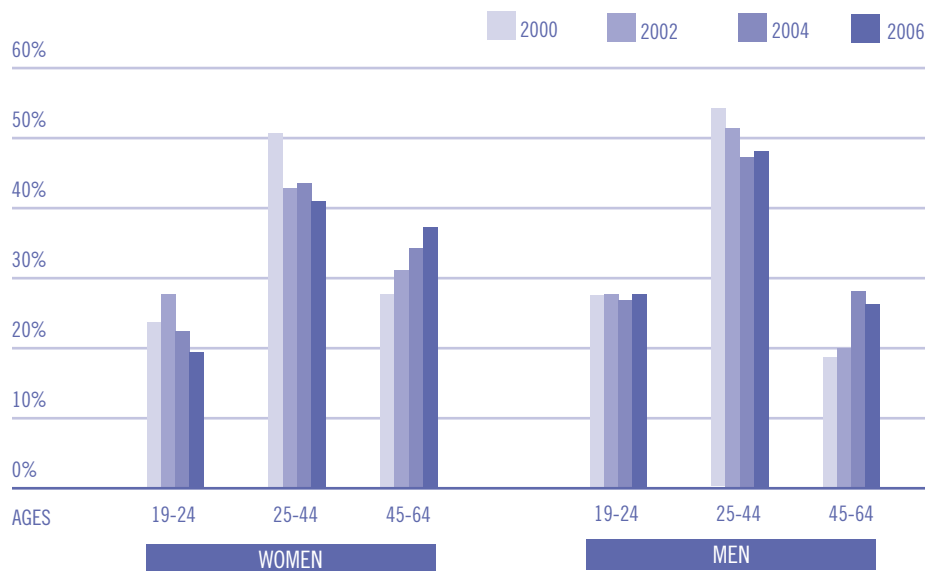
Middle-Aged and Near-Elderly Women

Middle-aged and near-elderly women are at increasing risk of chronic illnesses such as diabetes, osteoporosis, and cardiovascular disease, as well as breast and ovarian cancer. All of these illnesses are accompanied by extensive, ongoing medical costs.^{xv}

Chart 1 shows that the rate of uninsurance for Massachusetts women between the ages of 45 and 64 is rising faster than the rate of uninsurance for men of the same age cohort.

TT is a middle-aged woman who, during the past year, needed a bone scan, Fosamax (medication), a uterine fibroid embolization, and a hysterectomy—all fairly common procedures and treatments for middle-aged women. As Table 2 shows, if she had chosen a low premium Bronze Plan without prescription coverage, her out-of-pocket expenses for the year would have been \$7,822. If she had purchased a Bronze Plan with prescription coverage, her out-of-pocket expenses would have been \$7,754. If she had chosen a Silver Plan, her expenses would have been \$4,724. TT's annual income is approximately \$38,000.

Chart 1: Percent of Uninsured by Agegroups



Source: "Health Insurance Status of Massachusetts Residents, Fifth Edition" by the Massachusetts Division of Health Care Finance and Policy (December 2006), p. 5-6 (Study Findings). www.mass.gov/dhcfp

Several factors explain the rising number of uninsured middle-aged and near-elderly women:

- Because women often are younger than their husbands, 10% of women become uninsured when their husbands retire.^{xvi} (The retired husband is likely to be covered by Medicare.)
- As a result of cultural preferences for employing young women, middle-aged and near-elderly women may face discrimination when seeking employment.
- Middle-aged and near-elderly women are more likely than their younger counterparts to lack the technical skills required for many of the jobs that offer comprehensive health insurance packages.
- Many middle-aged and near-elderly women are forced to limit their workforce participation due to responsibilities in caring for elderly, frail parents and in-laws.

Women and Dependent Coverage

Women are more likely than men to rely on dependent coverage offered through their spouses' employers. Dependent status can put women at risk when marriages break up due to death or divorce. Even more problematic, the fear of losing health care coverage could put women at risk for staying in abusive marriages.

- In Massachusetts, only 44% of women have their own job-based insurance, compared to 59% of men.^{xvii}
- Among working-age women with group health insurance in Massachusetts, 57% are insured in their own name, compared to 74% of men.^{xviii}
- In Massachusetts, 29% of women have health insurance as dependents v. only 14% of men.^{xix}

MM is a 47-year-old cancer survivor who continues to require five daily medications. Recently divorced, she earns approximately \$12,000 annually as a day-care provider. Because her former husband's job provides her with insurance, she is not eligible for Commonwealth Care. However, she cannot afford the co-pays required by her husband's employer-based plan. She puts these payments on her credit card and has now amassed a staggering debt load.

Immigrant Women

Throughout the country, Medicaid eligibility has become increasingly inaccessible for immigrants in the wake of residence requirements and heightened demands for documented citizenship. Immigrant advocacy groups express particular concern for women who have entered the United States on a fiancée or spouse visa and find that their fiancé or husband holds onto their immigration papers. These women may not be able to document their eligibility for services.

Provided they meet income guidelines, Massachusetts residents with legal immigration status may be eligible for Commonwealth Care.^{xx} Undocumented immigrants are not eligible for this program. Fearing deportation, hospital bills, and language barriers, undocumented immigrants may wait until they are extremely ill before seeking medical attention in hospital emergency departments. By federal law, emergency departments are required only to assess and stabilize emergent conditions, not to offer definitive treatment. This restriction raises particular problems for women. For example, while women in active labor must be admitted, women who lack health care coverage are unlikely to receive the pre-natal care that would facilitate a healthy pregnancy.

RR is in her late 50s. Separated from her husband, she works part-time as a janitor. (Part-time means that her employer keeps her right under the number of hours that would require him to offer insurance.) Her husband does have insurance through his employer but refuses to cover her on his policy. However, she is not eligible for Commonwealth Care because her husband's job—on principle—does make insurance available to her. According to the new law, a Massachusetts resident who is offered employer-based insurance must take it and is not eligible for subsidized coverage (Commonwealth Care).

Future Research: An Emphasis on Quality

Many officials in the public sphere express optimism regarding the reform's potential benefits for women. Dolores Mitchell, executive director of the Group Insurance Commission of the Commonwealth of Massachusetts and member of the Commonwealth Health Insurance Connector Authority Board, sees the individual mandate as empowering women. Carrying health insurance, according to Mitchell, enables a woman to pick up the phone and schedule an appointment for herself or her children instead of showing up in an emergency room to receive free care. In Mitchell's experience, newly enrolled women who had previously received free care from the state's Uncompensated Care Pool credit having a proper insurance card with preserving their dignity. Ultimately, she views the fact that more women and their families are buying health insurance plans as indicative of the reform's positive effect on women's health.

Other front-line health care professionals are not as confident. An office manager at a reproductive health facility notes that while the reform is "great for women in theory," it often fails to live up to its promises in reality. She has observed large numbers of women purchasing insurance that, due to exorbitant deductibles, they cannot afford to use. She feels that, as was the case before the reform, wealthier women receive higher quality care and more efficient services than lower-income women. The question she and many others have is, How has Chapter 58 affected the quality of care received?

Chapter 58 calls for a number of measures that have the potential to substantially improve the health of Massachusetts' women: medical error reduction, smoking cessation programs, and the creation of a health disparities council charged with addressing the needs of vulnerable populations. Measures specifically related to women's

health include calls for osteoporosis education and prevention, and ovarian cancer screening and education programs. At this early stage of reform implementation, data are not available for assessing the impact of these measures in terms of health outcomes. In the end, the success of the Massachusetts reform will need to be assessed not only in terms of reducing uninsurance but also in terms of bettering women's health.

Women's health advocates applaud efforts in Massachusetts to expand health care coverage. At the same time, they emphasize the importance of keeping sight of additional core principles of women's health care reform:

- Integrating reproductive services into women's overall health care programs,
 - Integrating comprehensive mental health services (not limited to drug therapy), as well as physical, speech, and occupational therapy into women's health care settings,
 - Providing resources that empower women to make truly informed and meaningful decisions regarding their own health and the health of family members,
 - Training clinicians in identifying and responding to patients' experiences of domestic and sexual violence.^{xxi}
- As the Massachusetts reform becomes fully established and (perhaps) serves as a model for reform in other parts of the country, it will be crucial to monitor the extent to which it:
- Results in improving health care access and quality for women with diverse needs, resources, and family statuses.
 - Ensures that women will not face unexpected and unaffordable costs because of high-deductible plans.
 - Leads to measurably positive health outcomes; that is, improved overall physical and mental health for women.

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Endnotes

- i Little statistical data regarding the reform's impact are yet available. This brief relies primarily on interviews with individuals involved in the creation and implementation of Chapter 58 as well as health care advocates, medical providers, and women who have enrolled in the new health care coverage programs. We particularly wish to thank Amy Agigian, Suffolk University; Christine Barber, Community Catalyst; Catherine DeLorey, Women's Universal Health Initiative; Linda Green, Division of Health Care Finance and Policy; Dolores Mitchell, Group Insurance Commission of the Commonwealth of Massachusetts and the Commonwealth Connector Board; Stephanie Anthony, Massachusetts Medicaid Office and the Center for Health Law and Economics at the University of Massachusetts Medical School; and Lisa Vinikoor, Greater Boston Interfaith Organization. Any errors in this brief are the responsibility of the authors alone.
- ii *Health Care Access and Affordability Conference Committee Report, 4/3/2006.* <http://www.mass.gov/legis/summary.pdf>
- iii Salganicoff, Alina and J. Zoe Beckerman et al, *Women's Health in the United States: Health Coverage and Access to Care*, Kaiser Family Foundation, May 2002. <http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14153>.
- iv Lambrew, Jeanne M., *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change*. Commonwealth Fund, August 2001. http://www.cmwf.org/publications/publications_show.htm?doc_id=221296.
- v Lambrew 2001.
- vi Lambrew 2001.
- vii Massachusetts Commission on the Status of Women. *State of Women: A County by County Report on Women and Girls in Massachusetts*, released Nov. 29, 2006.
- viii Massachusetts Commission 2006.
- ix Massachusetts Commission 2006.
- x Estimated numbers provided by MassHealth, February 2008.
- xi Commonwealth Connector News & Updates Webpage, <http://www.mahealth-connector.org/portal/site/connector/menuitem.4bab485e26865f535734db47e6468a0c/?fiShown=default>
- xii MassHealth officials helped us obtain these data from the Division of Health Care Finance and Policy.
- xiii Woolhandler, Steffie and David U. Himmelstein. 2007. "Consumer Directed Health care: Except for the Healthy and Wealthy It's Unwise." *Journal of General Internal Medicine* 22(6): 879-881.
- xiv Patchias, Elizabeth and Judy Waxman (2007). "Women and Health Coverage: The Affordability Gap." Commonwealth Fund. http://www.commonwealth-fund.org/usr_doc/1020_Patchias_women_hlt_coverage_affordability_gap.pdf?section=4039
- xv Sasser, Alicia D., Matthew D. Rousculp, Howard G. Birnbaum Emily F. Osters, Edward Lufkin and David Mallet et al., (2005). "Economic Burden of Osteoporosis, Breast Cancer, and Cardiovascular Disease among Postmenopausal Women in an Employed Population," *Women's Health Issues* 15:3, pp 97-108.
- xvi Lambrew 2001.
- xvii Amy Caiazza, *The Status of Women in Massachusetts*, Institute for Women's Policy Research, 2002.
- xviii Analysis of 2004 Current Population Survey Annual Social and Economic Supplement data.
- xix Caiazza 2002.
- xx Fact Sheet published by Health Care For All and the Massachusetts Law Reform Institute, Reviewed 4/30/07 http://www.masslegalservices.org/docs/NC-Health_Benefits_for_Non-citizens.pdf; Blue Cross Blue Shield Foundation of Massachusetts, "Ensuring the Success of Massachusetts Health Care Reform: What is needed for front line staff" July 5, 2006 http://www.bcbsmafoundation.org/foundationroot/en_US/documents/2006TAsessionandsurveyresults.pdf
- xxi Weisman, Carol. *Women's Health Care: Activist Traditions and Institutional Change*. Baltimore, MD: Johns Hopkins University Press, 1998.

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