

Chartpack

WOMEN AND HEALTH REFORM

HOW NATIONAL HEALTH CARE CAN ENHANCE COVERAGE,
AFFORDABILITY AND ACCESS FOR **WOMEN**

EXAMPLES FROM MASSACHUSETTS

THE WOMEN'S HEALTH POLICY AND
ADVOCACY PROGRAM

CONNORS CENTER FOR WOMEN'S HEALTH
AND GENDER BIOLOGY

OCTOBER 2011



BRIGHAM AND
WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School



EXECUTIVE SUMMARY

As national health reform implementation moves forward, states will likely encounter many of the same women's health challenges experienced in Massachusetts and outlined below. As key consumers, providers and coordinators of health care, women have been uniquely affected by Massachusetts health care reform. Massachusetts women have the highest rates of health insurance coverage in the nation, and access to care among women has improved across all demographic groups. However, important challenges persist. This chartpack presents crucial women's health examples from Massachusetts that state and national policymakers should consider as they work to implement health care reform at the state and federal levels.

6 KEY NATIONAL HEALTH REFORM OPPORTUNITIES FOR WOMEN'S HEALTH

1. Continuity of Coverage

- Women are more vulnerable to gaps in insurance coverage that negatively impact health and health systems. Therefore, Congress could establish a minimum eligibility period and streamlined enrollment systems.

2. Affordability

- Affordability remains a challenge for women in the wake of health reform. Congress could support regulations that include out-of-pocket costs in the national affordability standard and programs to help women navigate plan selection.

3. Access to Primary Care

- MA health reform exacerbated existing shortages in key women's health specialties. Congress could fund workforce programs and develop long-term solutions to alleviate primary care workforce shortages.

4. Long-Term Care

- As the major providers and consumers of long-term care (LTC), LTC issues disproportionately impact women. Congress could support programs such as the CLASS Act model or other strategies to ensure fair compensation of adequate coverage for women.

5. Health Equity

- MA improved access and coverage of minority women by investing in the public health infrastructure. Congress could protect key public health funding in the ACA to ensure similar gains among all minority women.

6. Assessing Impacts & Outcomes

- Collecting and stratifying data by sex and sex/race groups is essential. Congress could mandate comprehensive collection and reporting requirements for key health reform data.

INTRODUCTION

WHY FOCUS ON WOMEN'S HEALTH?

Health care reform is a priority for women. Because women tend to have lower incomes than men, use more medical services and spend more annually on care, they are more likely to face challenges affording and accessing care. Women are also more likely to transition through the workforce, have part-time jobs, and be insured as a dependent through a spouse's coverage, leaving them vulnerable to gaps in coverage and access to care. As women age, they are more likely to have multiple chronic illnesses, resulting in high associated costs and difficulties coordinating care.

WOMEN IN MASSACHUSETTS PRIOR TO HEALTH CARE REFORM

Even before Massachusetts passed its health care reform law, Chapter 58, in 2006, Massachusetts women enjoyed relatively good access to health insurance compared to women nationally. Massachusetts women also benefited from a comprehensive list of mandated services, including maternity care, family planning, and contraception, and strong consumer protections that prohibited practices such as gender-rating. Chapter 58 built on Massachusetts' commitment to providing equitable and comprehensive insurance coverage. The law expanded Massachusetts' Medicaid program to cover the state's neediest residents; instituted an individual mandate to ensure "shared responsibility" among all residents; and created a regulated health insurance exchange to provide individuals with quality and affordable health plans. To date, more than 98% of Massachusetts residents have health insurance.

THE IMPACT OF MASSACHUSETTS HEALTH CARE REFORM ON WOMEN

In 2009, nearly all women in Massachusetts reported having a usual source of health care. Additionally, the insurance rate among women ages 18-64 rose to 97% from 91% in 2006. Despite these gains, women still face problems accessing and affording.

- **Coverage:** 60,000 Massachusetts women still remain uninsured. The majority of the women who remained uninsured in 2009 had incomes below 300% of the federal poverty level (FPL), suggesting that they may be eligible for subsidized insurance. This indicates a need for more targeted outreach and enrollment.
- **Affordability:** Between 2006 and 2009, there was no significant decrease in the share of women who spent more than 5% of family income on out-of-pocket health care costs, had problems paying medical bills, or had medical debt they were paying off over time.
- **Access:** In 2009, more than one in five women reported going without needed health care, and over 20% of women reported difficulty finding a provider.

Massachusetts health care reform provides a guide for national efforts to expand coverage and improve access to care. Women's experiences in Massachusetts demonstrate the importance of prioritizing women's health as an integral element of national health care reform.

EXAMPLE ONE: CONTINUITY OF COVERAGE

THE CHALLENGE

As a result of health reform, Massachusetts has the highest rate of insurance coverage for women (97.1%) in the nation. Publically-subsidized insurance plans, rather than employer-sponsored coverage, accounted for the largest gains in coverage for women. As was the case pre-reform, women constitute a majority (76%) of the state's Medicaid beneficiaries. Particularly vulnerable subpopulations of women – low income; racial and ethnic minorities; non-elderly women ages 50-64, and women without dependent children – all experienced significant coverage gains.

TRANSITIONS BETWEEN COVERAGE PROGRAMS

Massachusetts achieved a 98% insurance coverage rate through a Medicaid expansion and new subsidized and unsubsidized insurance options. Although this approach achieved a high overall insurance coverage rate, certain populations lack continuous coverage. A significant number of low-income residents transition between Medicaid and subsidized insurance plans over the course of the year due to changes in eligibility status. About 17% of these enrollees experience a gap in coverage during their transition.

Enrollment volatility will also affect national health reform. In 2014, 28 million Americans under 200% FPL are expected to experience a shift in eligibility between Medicaid and subsidized plans.

THE IMPACT ON WOMEN

Women are disproportionately impacted by discontinuous coverage:

- Women are more likely than men to cycle in and out of the workforce and are less likely to be eligible for employer-sponsored health insurance.
- Women are more likely to have fluctuations in income, which is a key factor in determining insurance eligibility.
- Women are more likely to be dependents on someone else's health insurance plan.
- Life events such as pregnancy, marriage, divorce and death of a spouse affect health insurance eligibility.

CONSEQUENCES OF DISCONTINUOUS COVERAGE

- Individuals with discontinuous coverage are less likely to have a usual source of care and are more likely to report delaying care due to cost.
- Unstable coverage impacts disease management, which is a particular problem for women with chronic diseases.
- In 2010, the administrative expenses associated with transitions cost Massachusetts \$46 million dollars.

NATIONAL IMPLEMENTATION OPPORTUNITIES

CONTINUITY OF COVERAGE

LEGISLATIVE

Reduce churn due to income fluctuations

ACTION: Congress could create a minimum guaranteed eligibility period for Medicaid and state exchange plans. This change would reduce transitions and associated administrative costs.

ACTION: Congress could encourage states to use annual, rather than monthly, income as the standard for determining continued eligibility for insurance affordability programs.

REGULATORY

Reduce the burden on individuals already enrolled in insurance eligibility programs

ACTION: Support regulations that reduce or eliminate ongoing reporting burdens on enrolled individuals, such as monitoring available data sets to verify continued enrollee eligibility.

ACTION: Support regulations that improve the administrative efficiency of state exchanges in order to reduce the potential for coverage gaps.

WHAT MASSACHUSETTS IS DOING

Massachusetts continues to streamline the enrollment process for health plans for low-income residents, and to implement aggressive outreach campaigns designed to maintain and increase enrollment.

ELIMINATING TRANSITIONS BETWEEN COVERAGE PROGRAMS

Massachusetts has considered a statutory change that would provide 12 months of continuous eligibility for children and their eligible parents enrolled in the state's Medicaid program. This change would only affect women who are parents of eligible children and some women who are categorically eligible for Medicaid.

SIMPLIFYING ENROLLMENT

The Massachusetts Virtual Gateway links consumers, providers and community organizations to a variety of health and social services including Medicaid and subsidized exchange plans. Through a series of questions, consumers determine eligibility and apply online for subsidized insurance plans. The Gateway also allows consumers to see the status of their insurance application, access important notices about their plan, and update important information like address and pregnancy status, minimizing the need to call or visit a Medicaid office. Some consumers can also renew their subsidized plan online, ensuring continuity of coverage.

EXAMPLE TWO: AFFORDABILITY

THE CHALLENGE

Health reform resulted in more affordable health care for many residents. However, despite strong gains in health insurance coverage since the implementation of health care reform, costs remain a challenge for many women. Affordability challenges disproportionately impact women because they have lower lifetime earnings, higher medical expenditures across their lifetimes, and higher out-of-pocket expenses. Between 2006 and 2009, the share of women spending 5% or more of family income on out-of-pocket health care costs did not change significantly. The share of women reporting problems paying medical bills or paying medical debt over time also did not decrease after health reform.

THE IMPACT ON WOMEN

CERTAIN GROUPS OF WOMEN MAY HAVE PARTICULAR DIFFICULTY AFFORDING CARE:

- Women with income just above the threshold of eligibility for subsidized health insurance;
- Women choosing low premium, high deductible health plans;
- Women enrolled in catastrophic coverage;
- Women ages 50-64, who have increasing health problems but are not yet eligible for Medicare; and
- Women who previously received care at little or no cost through safety net programs.

DEFINING AFFORDABILITY

Massachusetts determines affordability by comparing annual premium costs to annual income. This definition of affordability excludes out-of-pocket costs such as co-pays and deductibles. Thus, the affordability standard does not comprehensively account for the true costs of health care. Since women use more health services and spend more out of pocket on care than men, they are more likely to incur costs not accounted for in the state's definition of affordability.

UNSUBSIDIZED EXCHANGE PLANS

To extend comprehensive, affordable coverage to middle-income residents, Massachusetts health care reform created unsubsidized health insurance plans. These unsubsidized health plans have a range of deductibles, co-pays and maximum benefits, allowing residents to choose a health plan with the right balance of benefits and costs. Massachusetts' unsubsidized insurance options were designed to be affordable; however, what an individual pays for an unsubsidized plan is often **higher** than the average employee contribution for private employer-based coverage. This makes affording premiums for unsubsidized plans difficult for some moderate-income women.

Unsubsidized plans also may present unexpected problems for moderate-income women who lack a practical understanding of actual costs. For some health services, out-of-pocket costs plus premiums costs **more** for women with lower-premium plans than for women with high-premium, comprehensive plans. Women's greater health needs and the general unpredictability of health events makes picking appropriate coverage particularly challenging for moderate-income women.

NATIONAL IMPLEMENTATION OPPORTUNITIES AFFORDABILITY

LEGISLATIVE

Eligibility for Premium Tax Credits

ACA § 1401 ties eligibility for premium tax credits for working families to the annual cost of an individual plan despite the higher cost of family coverage.

ACTION: Congress could amend ACA § 1401 to refer to the cost of a family plan so that more families are eligible for exchange subsidies.

REGULATORY

Affordability Standard: The current definition of affordability does not include out-of-pocket costs.

ACTION: Support regulations that include out-of-pocket costs in the definition of affordability.

Consumer Protections: Proposed exchange regulations provide opportunities to strengthen women's ability to choose affordable insurance options.

ACTION: Support regulations that provide out-of-pocket costs in exchange Calculators. Support regulations that require Navigators to provide information to consumers about out-of-pocket costs.

WHAT MASSACHUSETTS IS DOING

Massachusetts already has several counseling mechanisms in place to help women make informed insurance choices, including a helpline and an interactive website operated by the Massachusetts health insurance exchange. States, with the help of Congress, will need to build similar resources to help educate and counsel women in the wake of national reform.

In addition to existing consumer protection tools, Massachusetts lawmakers are also considering regulatory measures to address the rising costs of health care and premiums in the state.

EXAMPLE THREE: ACCESS TO PRIMARY CARE

THE CHALLENGE

Massachusetts health reform has provided women with improved access to primary care services. For example, Massachusetts women are more likely to have a usual source of care and are also more likely to have had a general doctor visit in the last 12 months. However, primary care access issues remain. Although Massachusetts' coverage expansions did not *cause* physician shortages; they exacerbated an existing problem in the health care system.

Increasingly, women are choosing careers in primary care, rather than medical subspecialties. This is a positive development as it may lead to increased access to primary care services.

THE IMPACT ON WOMEN

DIFFICULTY ACCESSING KEY WOMEN'S HEALTH SPECIALTIES

Women are disproportionately impacted by these shortages because women, as patients, have greater need for primary care across the lifespan. In Massachusetts, several medical specialties that are vitally important for women, including Family Medicine, Internal Medicine, Obstetrics and Gynecology (Ob/Gyn) and Psychiatry, continue to face severe labor shortages even after health care reform. Additionally, wait times for key women's health services have increased dramatically post health care reform, due in part to pent-up demand of previously uninsured residents. Despite these challenges, all women in Massachusetts, including vulnerable sub-populations such as low-income and minority women, saw some gains in access to care post-reform.

Wait times for new patients have increased dramatically since Massachusetts passed health care reform. In 2011, the average wait times for key women's health specialties including Family Medicine, Internal Medicine, and Ob/Gyn were 36, 48, and 41 days, respectively. Access to these key specialties is a particular problem for individuals enrolled in the state's subsidized exchange plans, with only about half of Family Medicine, Internal Medicine, and Pediatrics practices currently accepting new patients. Individuals with unsubsidized exchange plans fare even worse; only about 35 to 45% of these key specialties are accepting new patients with plans purchased through Massachusetts' health insurance exchange.

National pre-implementation data on women's physician utilization are broadly similar to Massachusetts' 2006 statistics. Similar gains in access are possible at the national level if the primary care workforce can accommodate the influx of new patients. As in Massachusetts prior to reform, national health care workforce stakeholders are predicting increasing physician shortages, due to a variety of demographic factors that extend beyond the ACA's expansion of insurance coverage to the uninsured. States in the south and west that already have very low primary care provider to patient ratios may also experience the largest expansions in Medicaid enrollment, further exacerbating problems with access to care.

NATIONAL IMPLEMENTATION OPPORTUNITIES ACCESS TO PRIMARY CARE

Assess the Primary Care Workforce: Determining the extent of provider shortages and implementing effective solutions are necessary to improve access to care.

ACA § 5101: Creates a National Health Care Workforce Commission that will coordinate improved access to primary care and administer state primary care workforce grants.

ACTION: Congress could appropriate funds to guarantee the future of the Commission.

Improve Primary Care Recruitment and Retention: Increasing the number of medical students choosing primary care residencies and encouraging physicians to work in underserved areas are crucial components of a strategy to improve access to primary care.

ACA § 5301: Establishes grants for primary care training of physicians and physician assistants. This program has been funded for 2010 and 2011.

ACTION: Congress could appropriate permanent funding for this program.

ACTION: Congress could provide for **future** funding for this program.

WHAT MASSACHUSETTS IS DOING

THE HEALTH CARE WORKFORCE CENTER AND A HEALTH CARE WORKFORCE ADVISORY COUNCIL

The Council was established in 2008 to assess the status of the primary care workforce in Massachusetts. To date, the Council has issued several reports on the state of primary care in Massachusetts.

LOAN REPAYMENT FOR PRIMARY CARE SPECIALTIES

In 2008, Massachusetts created a public-private partnership to fund an educational loan repayment program for medical school graduates in primary care specialties (Family Medicine, Internal Medicine, Pediatrics, Psychiatry and Ob/Gyn) and nursing school graduates practicing in underserved areas. The public-private partnership was highly successful. However, this year the state did not appropriate funding although private funding continues.

EXAMPLE FOUR: LONG-TERM CARE

THE CHALLENGE

Long-term caregiving will significantly affect the country's ability to contain health care costs and maintain the financial stability of Medicare and Medicaid as the baby boom generation ages. Massachusetts offers more comprehensive long-term caregiving coverage than most states. However, long-term care was not addressed in detail by the 2006 health care reform law or the state's current effort to contain costs. Since caregiving has not been a focus of Massachusetts health care reform, we present national data.

THE IMPACT ON WOMEN

Caregiving impacts women in several ways. Not only are women more likely to populate the professions responsible for long-term caregiving, they are also more likely to serve as informal caregivers for family and friends. In addition, because women live longer and are more likely to have multiple chronic conditions, women use more long-term care resources than men.

FORMAL CAREGIVERS

Allied health professionals comprise approximately 60% of the US health care workforce. Women make up the overwhelming majority of the allied health workforce, including nurses, nurse practitioners, physicians assistants, home health aides and residential, and nursing home workers. Both the allied health and nursing workforces face critical shortages due to the expense of training programs and the increased demand for health professionals as the baby boom generation ages.

INFORMAL CAREGIVERS

The majority of informal caregivers are women ages 45-64 who often hold full-time or part-time jobs in addition to their caregiving responsibilities. Caregivers often balance their caregiving, employment, and family responsibilities at the expense of their own health. Female caregivers are six times more likely to suffer symptoms of depressive and anxiety disorders.

Long-term care places a dual economic burden on informal caregivers. Not only are informal caregivers not compensated for their services, informal caregiving impacts the economic stability of caregivers themselves as they are often required to reduce work hours or give up employment altogether. Estimates for the value of the informal care that women provide range from \$148 billion to \$188 billion annually.

OLDER WOMEN AND LONG-TERM CARE

More women than men utilize long-term care because they live longer, suffer from more chronic diseases and are more likely to spend their later years alone. Because older women have an annual income equal to 72% of the income of older men and because they are more likely to live in poverty in old age, older women also have more difficulty affording long-term care.

NATIONAL IMPLEMENTATION OPPORTUNITIES

LONG-TERM CARE

Strengthen the Formal Caregiving Workforce

ACA § 5206: Establishes a \$60 million fund to expand loan repayment programs for allied health and public health professionals.

ACTION: Congress could appropriate funds to this program.

The Community Living Assistance Services and Support Act (CLASS Program)

ACA § 8002: Creates a long-term care insurance program designed to help adults with functional impairments access long-term care services. The CLASS program is a voluntary program which will be paid for by the premiums of its members and will provide individuals with a cash benefit that they can use to fund care, including payments to informal caregivers.

ACTION: Congress could support programs such as the CLASS Act model or other strategies that offer solutions to what is often an overwhelming financial and emotional burden for families.

WHAT MASSACHUSETTS IS DOING

THE MASSACHUSETTS LONG-TERM CARE FINANCING ADVISORY COMMITTEE

This Committee was convened to recommend strategies to improve and expand the options for financing Long-term Social Services (LTSS) for people with disabilities and elders within the Commonwealth. The Committee's vision is for universal access to basic financial protection for Massachusetts residents with LTSS needs. Universal access would ensure that individuals can use LTSS without impoverishing themselves and also relieve the state's growing financial burdens.

The Committee identified three strategies:

- Increase utilization of private LTSS financing mechanisms;
- Expand Medicaid coverage to achieve equity in access to LTSS;
- Promote the use of social insurance programs that allow all people to prepare for financing their LTSS needs.

EXAMPLE FIVE: HEALTH EQUITY

THE CHALLENGE

Massachusetts increased coverage and access among minority women by leveraging the state's public health infrastructure. Minorities not only have poorer overall health, they also face greater social and economic inequalities related to education, transportation, housing and employment. A population-based, public health approach is necessary to overcome these structural barriers to health.

Eliminating health disparities is an explicit goal of Massachusetts health care reform. Minority women experienced significant improvements in coverage, access and affordability post-reform. For example:

- **Health Insurance Coverage:** Rates of coverage increased significantly post-reform. In 2009, 95.5% of minority women had any insurance coverage, up from 89.5% in 2006. This increase is particularly noteworthy because minority women now have near-identical rates of insurance as white women. No other state has achieved a comparable result.
- **Access:** Preventive and general doctor visits among minority women rose significantly from 2006-2009. This suggests that Massachusetts' approach to universal coverage is an effective strategy for increasing access to care as well as insurance coverage for vulnerable sub-populations of women.

However, health care inequalities persist in Massachusetts despite near-universal coverage among minority women. For example, Hispanic women are more likely to be uninsured and having difficulty finding a provider. Additionally, residents who have problems paying medical bills are more likely to be female and African-American.

THE IMPACT ON WOMEN

Women of color in every state continue to fare worse than white women on a variety of measures of health, health care access and other social determinants of health. Nationally:

- African-American women are 67 percent more likely to die when diagnosed with breast cancer and have the highest rates of breast cancer mortality.
- Asian American and Pacific Islander women have low rates of cancer screening including mammograms and Pap tests.
- The prevalence rate of diabetes is 65% higher among African American women than white women.
- The obesity rate for African American women is 50% higher than white women.

NATIONAL IMPLEMENTATION OPPORTUNITIES

HEALTH EQUITY

The ACA establishes many new programs aimed at reducing health disparities among minorities:

ACA § 4002: The Prevention and Public Health Fund will expand and sustain the public health infrastructure through research, tracking and public health training.

ACA § 4001: The National Prevention, Health Promotion and Public Health Council will coordinate and promote health-related policies across multiple sectors and agencies at the federal level.

ACA § 4003: The Community Preventive Services Task Force (CPSTF) will develop topic areas for new preventive interventions and recommendations that consider social, economic and physical environments of communities.

ACTION: Congress could ensure that the above initiatives receive appropriations.

WHAT MASSACHUSETTS IS DOING

THE HEALTH DISPARITIES COUNCIL

Established by Massachusetts health reform, the Council makes recommendations to reduce and eliminate racial and ethnic disparities in access to quality health care and in health outcomes within the Commonwealth.

TARGETED OUTREACH AND ENROLLMENT

Targeted outreach and enrollment are necessary to increase insurance coverage among particularly vulnerable populations of women, including those with limited access to online resources. Massachusetts created several successful outreach programs that utilized bus advertisements, partnerships with local churches, community centers, and community health centers. Chapter 58 also set aside funding for community groups involved in enrollment outreach.

EXAMPLE SIX: ASSESSING IMPACTS & OUTCOMES

THE CHALLENGE

Despite strong gains by women under health reform, sex and racial/ethnic disparities persist in some measures of access, use and affordability. Yet Massachusetts does not have a specific commitment to stratifying critical health care reform indicators by sex and sex/race-ethnicity groups. As a result, key state agencies, as well as private organizations assessing health care reform, either do not record sex-specific data or do not stratify key measures of the impact of health care reform by sex. For example, the Massachusetts Department of Revenue, which monitors compliance with the state's individual mandate, does not require tax filers to denote sex, making it difficult to ascertain the differences by sex in the percent of residents who are exempted from the coverage requirement or penalized for non-compliance. The lack of data is a barrier to developing policies that address health disparities and the social determinants and community attributes that contribute to them.

THE IMPACT ON WOMEN

Understanding the experience of women as health care reform is implemented will be important in guiding future efforts to improve and implement Massachusetts and national health care reform, respectively. Failure to assess the impact of health care reform on women is a missed opportunity to improve population health.

It will be critically important to both collect and to report data by sex, race/ethnicity, sex/race groups, age and socio-economic status in order to understand the impact of the Affordable Care Act on specific populations of women. Given that women are disproportionately impacted by certain challenges related to affordability, transitions between coverage and being uninsured, examples of important data to collect and stratify include:

- Out-of-pocket medical spending in addition to premium costs in order to develop robust affordability standards.
- Measurement of the frequency and impact of transitions between coverage categories, such as subsidized exchange plans and Medicaid, so that insurance plans can be designed to reduce the likelihood of gaps in coverage.
- Use of IRS data in order to understand which groups are most likely to remain uninsured after the individual mandate goes into effect in 2014.
- Comprehensive data on health status and measurement of access to health services in order to understand the impact of the ACA on health outcomes.

NATIONAL IMPLEMENTATION OPPORTUNITIES ASSESSING IMPACTS & OUTCOMES

The ACA provides a unique opportunity to collect and report on women's access to health care and health insurance.

ACA § 4302: Requires federally conducted or federally supported health care or public health programs to create standards for collection of self-reported data including sex, race, ethnicity, primary language, and disability status, and to publicly report data on these indicators in addition to monitoring for sex and race/ethnic disparities in health outcomes.

ACTION: Congress could require that HHS routinely collect and report data on all aspects of implementation of the ACA stratified by sex and sex/race groups.

In addition, a bill currently under consideration expands on the potential to assess the impact of the ACA on women.

Health Equity and Accountability Act of 2011 (HR 2954): This bill includes enhancements to collection and analysis of data about health disparities. The bill includes an increase in resources for improved data collection and reporting on incidence rates of various diseases.

ACTION: By passing this bill, Congress could ensure the routine collection and reporting of data by sex and sex/ race groups.

WHAT MASSACHUSETTS IS DOING

THE MASSACHUSETTS HEALTH DISPARITIES COUNCIL (HDC)

The Council is working to adopt standards for race, ethnicity and language data collection across state programs and to collect and analyze race, ethnicity, and language data on all health professions. The Council analyzes claims data to determine health disparities on HEDIS and other measures through the all-payer claims database (APCD). The Council is also developing a Health Disparities Report Card that will provide Massachusetts with current health outcome data by race and ethnicity, highlight emerging trends, and inform policy recommendations.



BRIGHAM AND WOMEN'S HOSPITAL

A Teaching Affiliate of Harvard Medical School

The Women's Health Policy and Advocacy Program

Connors Center for Women's Health and
Gender Biology

Paula A. Johnson, MD, MPH
Chief, Women's Health
Executive Director, Connors
Center for Women's Health and
Gender Biology

Brigham and Women's Hospital
75 Francis Street Boston, MA
02155
(P): 617-732-8985
(F): 617-264-5191
(E): pajohnson@partners.org

Therese Fitzgerald, PhD, MSW
Director, Women's Health Policy
& Advocacy Program
Connors Center for Women's
Health & Gender Biology

Brigham and Women's Hospital
1620 Tremont Street OBC-3
Boston, MA 02120
(P): (617) 525-7516
(F): (617) 525-7746
(E): tfitzgerald1@partners.org

Laura Cohen
Health Policy Analyst,
Women's Health Policy &
Advocacy Program, Connors
Center for Women's Health &
Gender Biology

Brigham and Women's Hospital
1620 Tremont Street OBC-3
Boston, MA 02120
(P): (617) 525-6770
(F): (617) 525-7746
(E): lcohen12@partners.org

www.brighamandwomens.org/womenspolicy

The Women's Health Policy and Advocacy Program is a non-partisan program based at the world-renowned Brigham and Women's Hospital in Boston, MA. The Program is dedicated to improving health policy for women at the state and national level through policy analysis.

Special thanks to Katherine M. Sullivan, JD, MPH.