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Realizing Health Reform's Potential

Women at Risk: Why Increasing Numbers of Women Are Failing to Get the Health Care They Need and How the Affordable Care Act Will Help

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Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010

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Abstract: Women have greater health care needs than men, and generally play larger roles in the health care of family members. Rising health care costs combined with sluggish income growth has contributed to losses in health insurance among women and rising rates of problems gaining necessary health care and paying medical bills. Women who seek coverage in the individual insurance market face additional hurdles—few plans offer maternity coverage and, in most states, insurance carriers charge higher premium rates to young women than men of the same age. The Affordable Care Act is bringing change for women through required free coverage of preventive care services, small business tax credits, new affordable coverage options, and insurance market reforms, including bans on gender rating. When the law is fully implemented in 2014, nearly all the 27 million working-age women who went without health insurance in 2010 will gain affordable and comprehensive benefits.

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OVERVIEW

On average, women have far greater involvement with the health care system over their lifetimes than do men. They have relatively greater health care needs, especially during their reproductive years, and have historically played a central role in coordinating the health care needs of multiple generations of family members: children, spouses, and aging parents.[1] Rising health care costs combined with little to no real income growth over the past decade places the health and financial stability of many women at risk.[2]

Nearly one of three women ages 19 to 64—an estimated 27 million women—were uninsured during 2010, according to data gleaned from the Commonwealth Fund 2010 Biennial Health Insurance Survey (see Methodology). This brief finds cost-related problems in getting needed care and difficulties paying medical bills have worsened over the past decade: an estimated 42 million women, both with and without health insurance, reported medical bill problems

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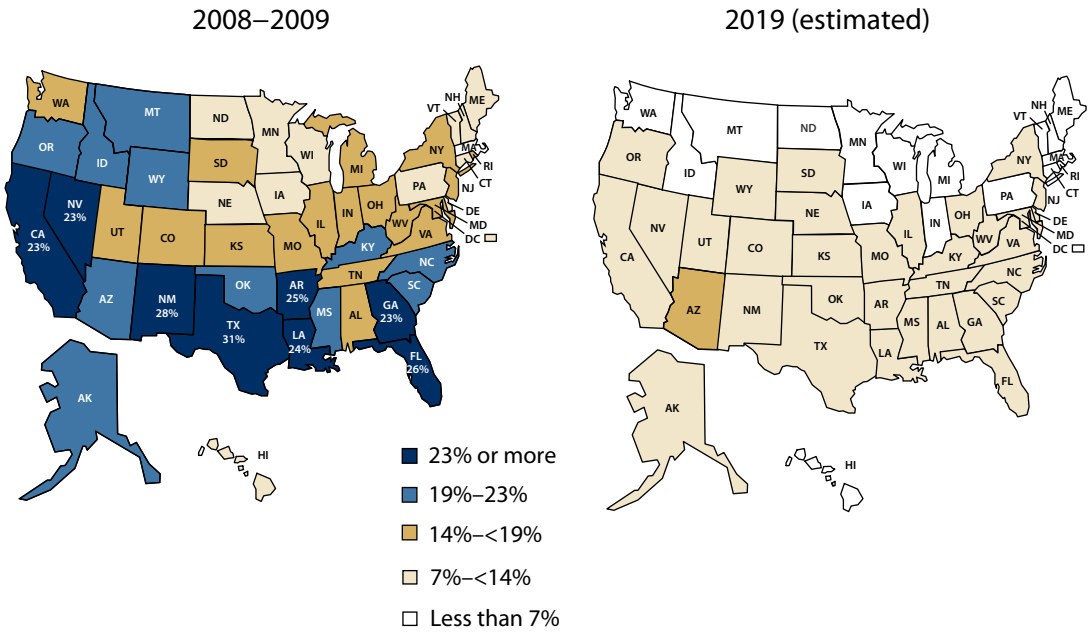
and 45 million said they delayed or avoided health care because of cost in 2010. Women who seek to purchase coverage in the individual insurance market face considerable challenges. Few plans offer maternity coverage and young women can face substantially higher premiums than men of the same age. Half of women who tried to buy a plan in the individual insurance market in the past three years never did so.

The pervasiveness of women's problems paying for health care—whether or not they have insurance—underscores the need for sweeping health reform. Several of the provisions in the Affordable Care Act have already gone into effect and are now benefitting women. These include requiring insurance companies to cover preventive care services like mammograms without cost-sharing, small business tax credits that could help more than 900,000 women-owned businesses provide health insurance to their employees, the ability to access obstetrics and gynecological services without a referral from a primary care provider, and requiring large employers to provide reasonable breaks for nursing women to express breast milk. But the law will have its most far-reaching consequences for women when it is fully implemented in 2014. Most uninsured women will gain affordable and comprehensive health insurance coverage that will include maternity coverage and consumer protections that ban insurance companies from rating women on the basis of their health or their gender itself. Women in the South and the West, where nearly a quarter or more of working-age women are uninsured in several states according to U.S. Census data, will make particularly large gains, with uninsurance rates estimated to plummet by more than half by 2019 (Exhibit 1).[3]

AN ESTIMATED 27 MILLION WOMEN SPENT SOME TIME UNINSURED IN 2010

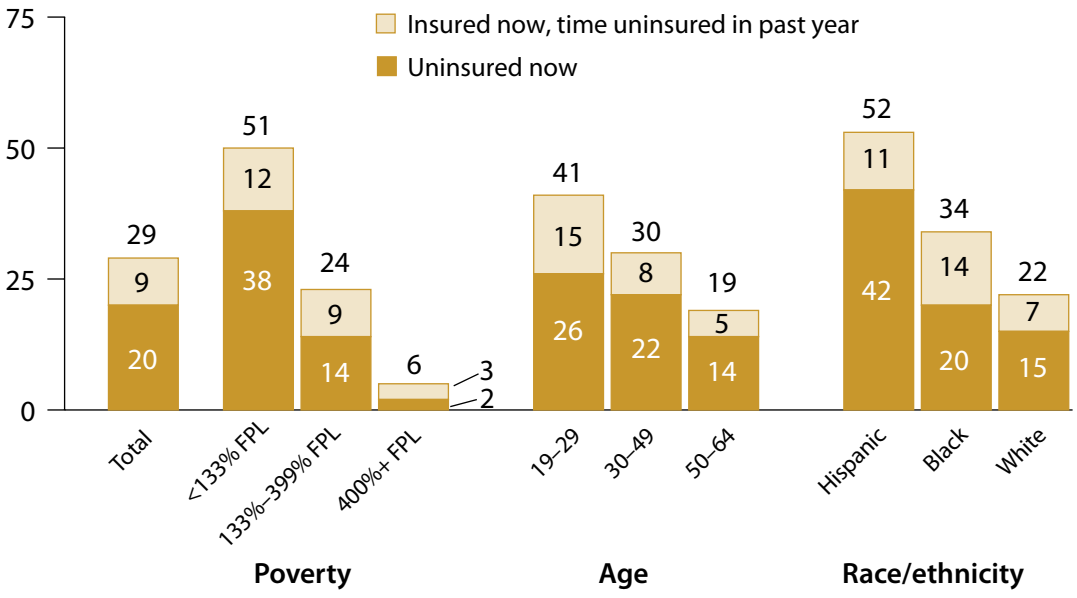
Nearly one of three (29%) working-age women—or an estimated 27 million—went without insurance for at least some part of the year in 2010 (Exhibit 2). This includes 20 percent who were uninsured at the time of the survey and an additional 9 percent who were insured when surveyed but had a time uninsured in the past year. Young and Hispanic women and those with

Exhibit 1. The Impact of Health Reform: Percent of Women Ages 19–64 Uninsured by State



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements), available at www.statehealthfacts.org, "Health Insurance Coverage of Women 19–64, states (2008–2009)."
Estimates for 2019 by Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

Exhibit 2. Uninsured Rates Are High Among Women with Low Incomes, Young Adults, and Hispanics in 2010



Subgroups may not sum to totals because of rounding.
Note: FPL refers to Federal Poverty Level.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

low and moderate incomes were the most likely to go without insurance (Exhibit 2). Half (51%) of those with incomes below 133 percent of the federal poverty level ($29,327 for a family of four) were uninsured during 2010, more than eight times the rate of women with incomes at 400 percent of poverty ($88,200 for a family of four). More than half (52%) of Hispanic women were uninsured, as were two of five (41%) young women ages 19 to 29, double the rates of white (22%) and older women ages 50 to 64 (19%).

Coverage rates were similar for men and women (Table 1), although differences in sources of coverage make women more vulnerable to losing their insurance. Women are more likely than men to be insured through a spouse or partner's employer: 39 percent of women with employer-sponsored insurance compared with 16 percent of men were insured as a dependent (Table 1). Dependent coverage is less secure because it relies on a partner keeping his or her job and an employer continuing to cover dependents, a benefit which fewer employers are offering.[4] Dependent coverage is also vulnerable if a woman becomes divorced or widowed, or if the spouse becomes eligible for Medicare.

Most Americans are insured through their employers, but going without health insurance is not a problem confined to the unemployed. Of the 27 million women who were uninsured at some point during 2010, half (49%) were in families with at least one full-time worker, and two of five (18%) were in families with part-time workers (data not shown). One-third (33%) of uninsured women were in families in which no one had a job.

Women working for small firms were the most likely to be uninsured. Small firms pay on average higher health insurance premiums than do large firms. As a result, decreasing numbers of small companies offer health benefits to their workers.[5] One-third (32%) of women employed full or part time worked for companies with 2 to 99 employees, but almost half (47%) of those who went without insurance during the year worked for firms of that size (data not shown). In contrast, 44 percent of women employed full or part time worked for companies with 500 or more employees and

just over one-quarter (27%) of those without insurance worked in these large firms.

THE JOB MARKET SLUMP HAS LEFT MANY WOMEN WITHOUT INSURANCE

The U.S. economy is struggling to emerge from the recession and millions have been touched by its devastating effect on the job market. According to the Commonwealth Fund Biennial Health Insurance Survey, one-quarter (24%) of adults ages 19 to 64 reported they or their spouse had lost their job in the past two years.[6] Among workers who lost a job with health benefits in the past two years, three of five (57%) said they became uninsured, one-quarter (25%) were able to go on a spouse's insurance policy or found coverage through another source, and 14 percent continued employer coverage through the government's COBRA program.[7] There were few differences between the experiences of women and men (data not shown).

WOMEN FACE DIFFICULTIES BUYING INSURANCE IN THE INDIVIDUAL MARKET

People who lose employer benefits have few places to turn for coverage other than the individual insurance market. Only a small percentage of adults buy insurance in this market, and for women it is particularly difficult to find affordable coverage. In most states, insurance carriers will charge higher premiums or deny coverage on the basis of gender, age, and health status. Rating on the basis of gender is currently permitted in 42 states.[8] This means that women (especially younger women) can pay premiums that are as much as 84 percent higher than men for identical coverage.[9] Moreover, maternity benefits are rarely included in the plans offered. The survey included a set of questions which explored respondents' experiences of looking for insurance in the individual market. The results show that nearly half (46%) of women who had tried to buy coverage in the individual market in the past three years said they found it difficult or impossible to find a plan that offered the coverage they needed, and three of five (60%) found it difficult or impossible to find coverage they could afford (Exhibit 3). A third (33%) of women who looked for a plan were turned down, charged a higher price because of health, or had a health problem excluded from coverage. More than half (53%) of women who looked for coverage in the individual market never bought a plan.

Exhibit 3. Women Struggle to Find Affordable Coverage in the Individual Market

Women ages 19–64 with individual coverage* or who tried to buy it in past three years and:	Total	Health problem**	No health problem	<200% FPL	200%+ FPL
Found it very difficult or impossible to find coverage they needed	46%	55%	34%	47%	40%
Found it very difficult or impossible to find affordable coverage	60	74	44	64	54
Were turned down, charged a higher price because of health, or had a health problem excluded from coverage	33	44	21	39	30
Any of the above	71	85	55	77	65
Never bought a plan	53	64	39	64	40

Note: FPL refers to Federal Poverty Level.
* Bought in the past three years.
** Respondent rated health status as fair or poor, has a disability or chronic disease that keeps them from working full time or limits housework/other daily activities, or has any of the following chronic conditions: hypertension or high blood pressure; heart disease, including heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

MORE WOMEN SPENDING 10 PERCENT OR MORE OF INCOME ON HEALTH CARE

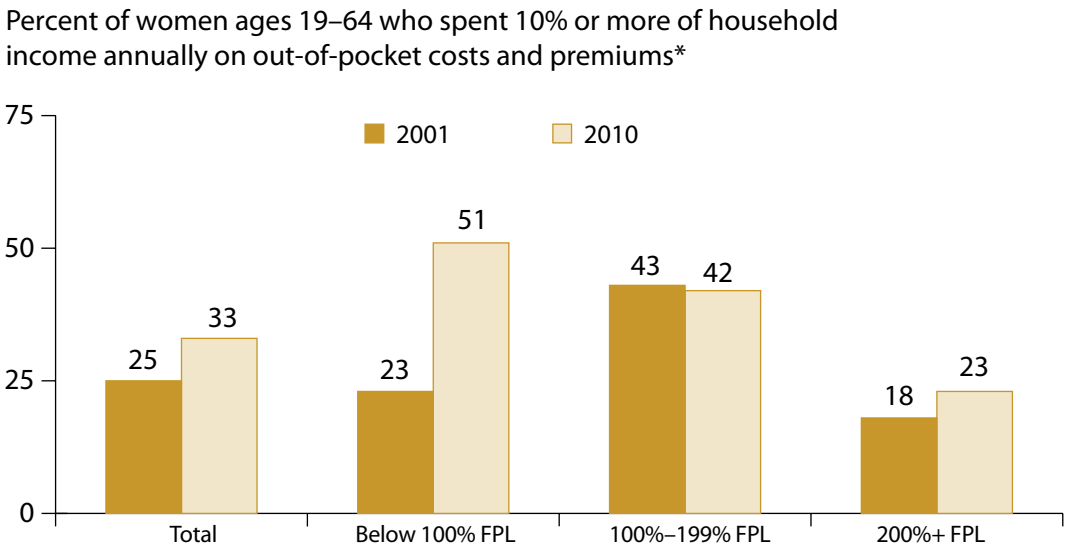
Over the past decade, increasing numbers of U.S. adults spent large shares of their income on health insurance and health care.[10] A third (33%) of working-age women—an estimated 26 million women—spent 10 percent or more of their income on premiums and out-of-pocket costs in 2010, up from 25 percent in 2001 (Exhibits 4 and 10). This is a result of rapidly rising health care costs and little or no growth in average family incomes. Health insurance premiums increased by 41 percent from 2003 to 2009, with changes in insurance plan design leaving enrollees facing higher deductibles and increased cost-sharing.[11] Incomes have not seen an equivalent rise. Real median family incomes were $2,000 lower in 2009 than in 2001, and women's incomes continue to lag behind men's.[12]

Women with low and moderate incomes have been particularly affected by these trends. In 2001, a quarter (23%) of women in households with incomes less than 100 percent of poverty ($22,050 for a family of four) spent 10 percent or more of their income on premiums and out-of-pocket costs (Exhibit 4). By the end of the decade, that rate had more than doubled to 51 percent. The financial burden of paying for health care was also felt by women higher up the income scale; almost one-quarter (23%) of those with incomes at or above 200 percent of poverty ($44,100 for a family of four) spent 10 percent or more of their income on health care costs, up from 18 percent in 2001.

INCREASING SHARES OF WOMEN REPORTING PROBLEMS PAYING MEDICAL BILLS AND PAYING OFF MEDICAL DEBT OVER TIME

High health care costs have left many women with financial difficulties which force trade-offs between paying off medical debt and other major life decisions, such as furthering education, making career changes, or starting a family. Reports of problems paying medical bills and paying off medical debt over time have increased over the past five years, particularly among women with low and moderate incomes.[13] Problems with medical bills include not being able to pay

Exhibit 4. The Share of Women Spending 10 Percent or More of Their Income on Health Care Climbed over the Past Decade, Especially for Women with Low Incomes



Note: FPL refers to Federal Poverty Level.
* Base: Women who specified income level and private insurance premium/out-of-pocket costs for combined individual/family medical expenses.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2001 and 2010).

medical bills, changing your way of life to pay bills, being contacted by a collection agency about unpaid bills, or paying off debt over time. In 2010, 44 percent of women—an estimated 42 million people—reported problems paying medical bills in the past year or said they were paying off medical debt over time, an increase from 38 percent in 2005 (Exhibits 5 and 10). Women were more likely than men to report problems, though men also experienced problems at high rates: one-third (35%) of men said they had a problem paying their medical bills or were paying off debt over time in 2010 (Table 2).

Women with low and moderate incomes reported particularly large increases in such problems over the past five years. In 2010, 57 percent of women with incomes below 100 percent of poverty ($22,050 for a family of four) and 64 percent of those earning from 100 percent to 199 percent of poverty ($44,100 for a family of four) reported medical bill or debt problems, up from 45 percent and 54 percent, respectively, in 2005 (Exhibit 5).

Women without health insurance were the most vulnerable, but even those with insurance reported they were struggling to pay bills. Two-thirds (64%) of women who were uninsured for a time experienced a bill or debt problem in the past year compared with one-third (36%) of those insured all year (Table 2).

Medical bill problems forced many women to cut back on essential household expenses or spend their savings to avoid getting into debt; others went bankrupt because of bills. Among women who had experienced at least one of the medical bill or debt problems described earlier, one-third (32%) said they were unable to pay for basic necessities such as food, heat, or rent because of medical bills (Table 2). Forty-one percent spent all their savings, 25 percent took on credit card debt, 12 percent took out a mortgage against their home or took out a loan, and 6 percent had to declare bankruptcy because of medical bills.

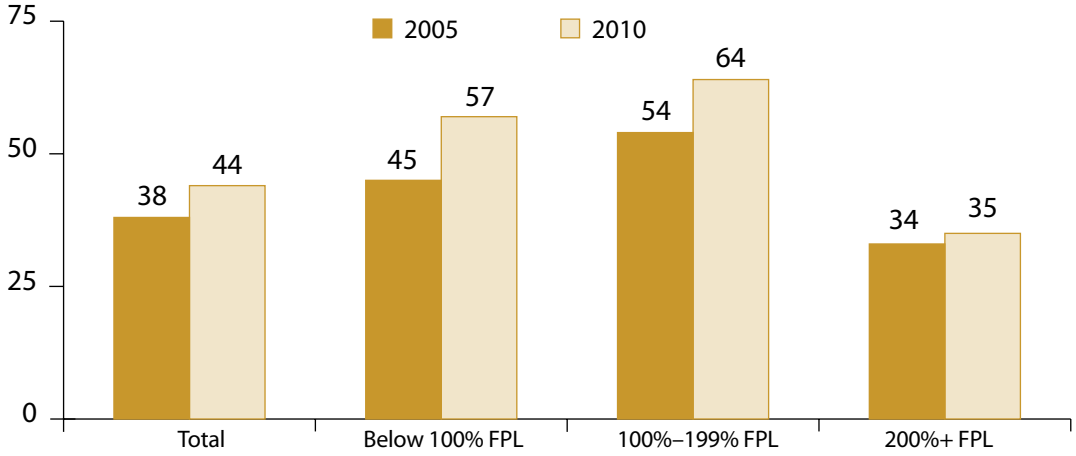
In 2010, 48 percent of working-age women—an estimated 45 million people—reported that because of cost they did not fill a prescription; skipped a recommended test, treatment, or follow-up; had a medical problem for which they did not visit the doctor; or did not see a specialist when needed—an increase from 34 percent in 2001.

INCREASING NUMBERS OF WOMEN REPORT AVOIDING OR DELAYING TIMELY CARE BECAUSE OF COST

The loss of jobs and health benefits, declining real incomes, and greater exposure to health care costs are creating barriers to care for increasing numbers of families. In 2010, 48 percent of working-age women—an estimated 45 million people—reported that because of cost they did not fill a prescription; skipped a recommended test, treatment, or follow-up; had a medical problem for which they did not visit the doctor; or did not see a specialist when needed—an increase from 34 percent in 2001 (Exhibit 6). Cost-related problems getting needed care increased substantially among women across the income spectrum, with those in low- and moderate-income households most affected. In 2010, more than three of five women with incomes below 200 percent of poverty reported cost-related problems getting needed care in the past year, up from just under half in 2001. For women earning more than 200 percent of poverty, two of five (38%) experienced problems, compared with one-quarter (26%) in 2001. Women are far more likely than men to report they had not received needed care because of cost, although men also reported problems at high rates: one-third (33%) of men reported cost-related access problems (Table 3).

Exhibit 5. Growing Numbers of Women Are Affected by Medical Bill and Debt Problems

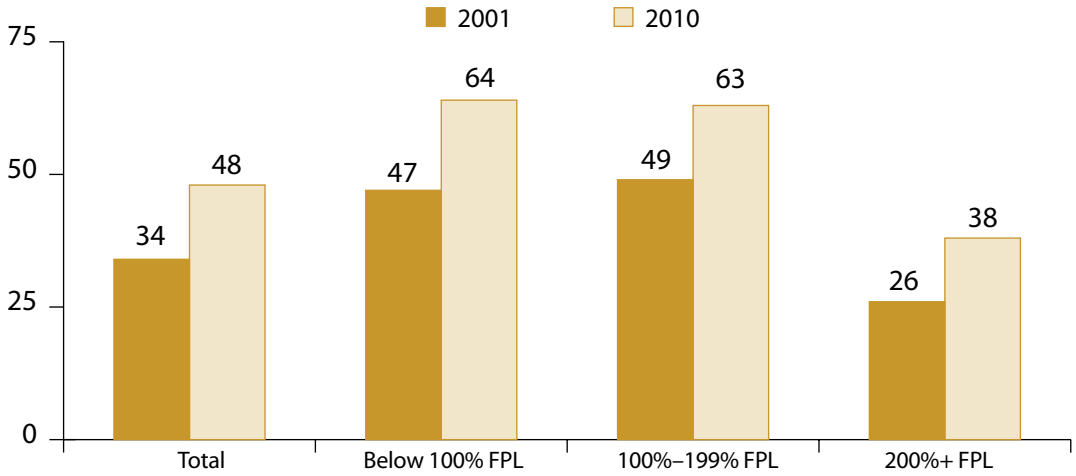
Percent of women ages 19–64 with medical bill problems or accrued medical debt*



Note: FPL refers to Federal Poverty Level.
*Had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2010).

Exhibit 6. Problems Accessing Needed Care Worsened for Women Across the Income Spectrum over the Past Decade

Percent of women ages 19–64 who had any of four access problems* in past year because of cost



Note: FPL refers to Federal Poverty Level.
*Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2001 and 2010).

The Affordable Care Act will dramatically improve women's ability to afford health insurance and get the timely health care they need. The law's sweeping reforms, many of which went into effect in 2010, will ease the growing health care cost burden plaguing so many women, particularly those in low- and moderate-income families.

These problems are greatest for women without health insurance. More than three-quarters (76%) of uninsured women went without care because of cost in the past year (Table 3). But even women with insurance reported problems: more than a third (37%) of women who were insured all year reported cost-related problems getting needed care, an increase from 26 percent in 2001 (Table 3, data not shown). Women who had health plans with high deductibles reported problems at higher rates than those without deductibles: among women in plans with deductibles of $1,000 or more, half (48%) reported a cost-related access problem in the past year, compared with a third (35%) of those whose plan had no deductible (data not shown).

Many people with chronic conditions take regular medications to manage their illness, keep them healthy, and avoid hospital visits. For these people in particular, forgoing care can have serious medical consequences. Adult women under age 65 are more likely than men to suffer from a set of chronic conditions including arthritis, depression, and asthma.[14] In the survey, more than a third (35%) of women suffered from hypertension or high blood pressure, heart disease, diabetes, asthma, emphysema, or lung disease. Among them, a third (31%) skipped a dose or had not filled a prescription for their condition because of cost, compared with one of five (19%) men (Table 3). Women without health insurance were particularly affected: 50 percent of uninsured women with a chronic health problem either skipped a dose or had not filled a prescription because of cost, twice the rate of women who were insured all year. Not maintaining their prescription drug regimen places these women at risk of worsening conditions and avoidable hospitalizations.

LESS THAN HALF OF WOMEN ARE UP TO DATE ON RECOMMENDED PREVENTIVE CARE

Women are more frequent users of preventive care services than men, but many fail to get recommended levels of care.[15] The survey asked women whether they had received a set of recommended preventive screening tests: blood pressure, cholesterol, cervical cancer,

Exhibit 7. Less Than Half of Women Are Up to Date with Recommended Preventive Care*

Percent of women ages 19–64	Total	<133% FPL	133%–249% FPL	250%–399% FPL	400%+ FPL
Blood pressure checked	88%	82%	91%	91%	94%
Cholesterol checked	72	58	74	76	85
Received cervical cancer screening	74	64	73	80	86
Received colon cancer screening	46	36	30	54	54
Received mammogram	72	52	60	75	85
*Up-to-date with preventive care**	46	35	44	56	57

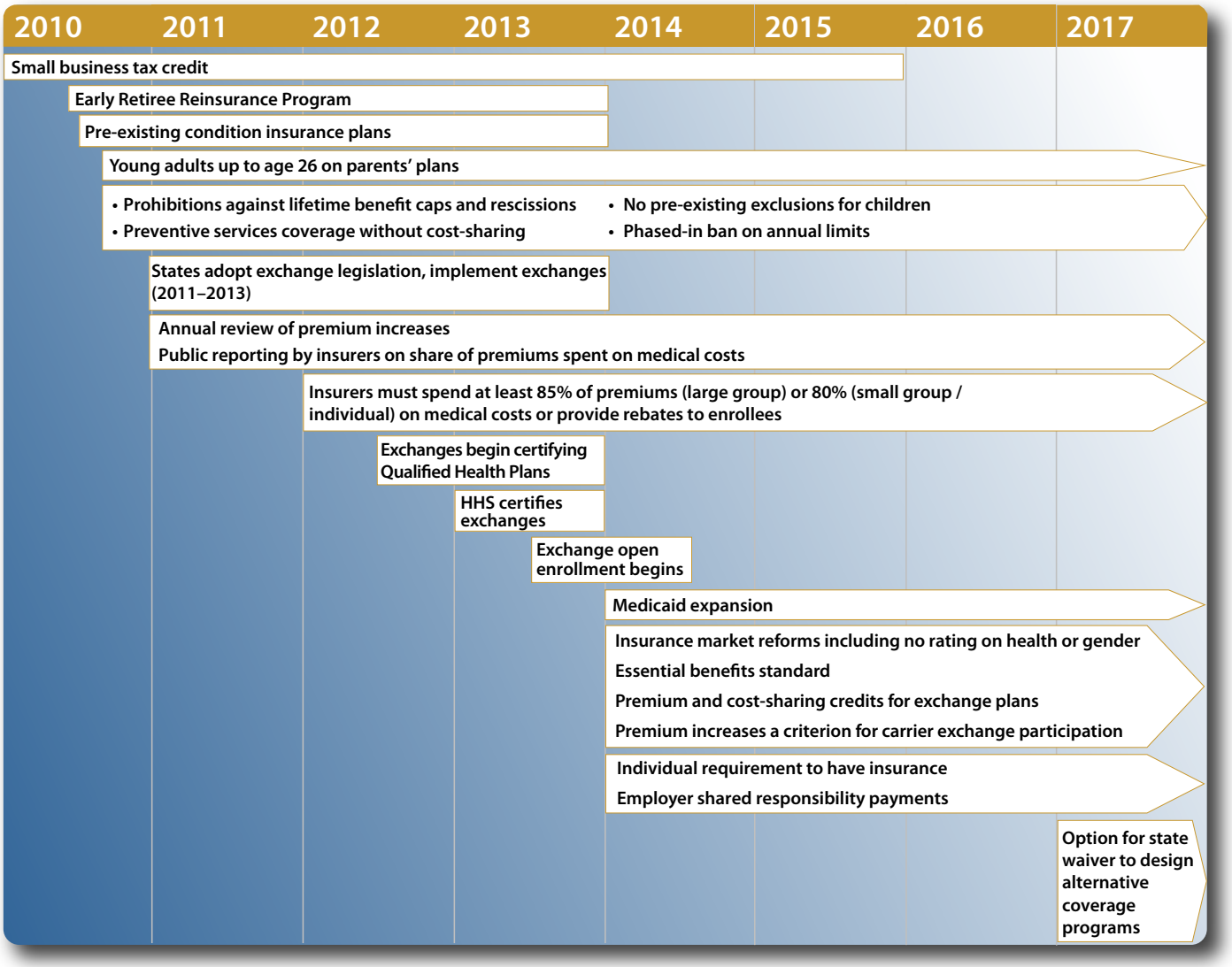
Note: FPL refers to Federal Poverty Level.
* Cervical screen in past year for females ages 19–29, past three years ages 30+; colon cancer screening in past five years for adults ages 50–64; and mammogram in past two years for ages 50–64; blood pressure checked in past year; cholesterol checked in past five years (in past year if has hypertension or heart disease).
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

colon cancer (for ages 50 to 64) and breast cancer (for ages 50 to 64) screens. Less than half (46%) of women were up to date on all these procedures and women with low incomes or those without health insurance were far less likely to have had all recommended preventive tests (Exhibit 7, Table 3). While 86 percent of women with incomes over 400 percent of poverty had received a cervical cancer screen in the recommended time frame, only 64 percent of those with incomes below 133 percent of poverty had received the test. Seventy-nine percent of women ages 50 to 64 who were insured all year had a mammogram in the past two years, compared with one-third (31%) of those uninsured at the time of the survey (Table 3).

HOW THE AFFORDABLE CARE ACT WILL LOWER WOMEN'S HEALTH CARE COSTS AND IMPROVE THEIR HEALTH

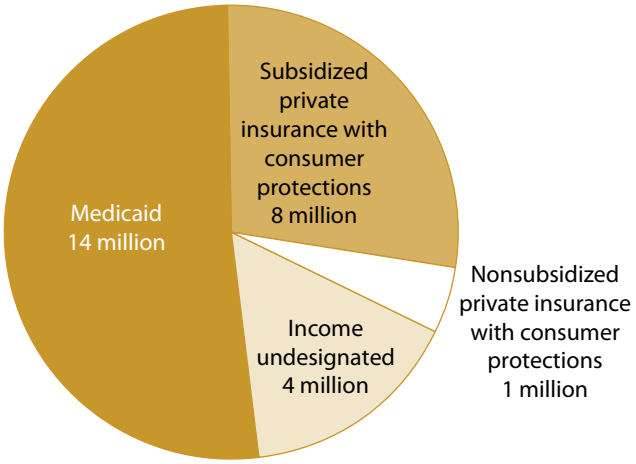
The Affordable Care Act will dramatically improve women's ability to afford health insurance and get the timely health care they need. The law's sweeping reforms, many of which went into effect in 2010, will ease the growing health care cost burden plaguing so many women, particularly those in low- and moderate-income families (Exhibit 8). Most of the 27 million working-age women who reported they went without coverage for a period of time last year will gain health insurance beginning in 2014 through substantial increases in Medicaid eligibility, subsidized private

Exhibit 8. Timeline for Health Reform Implementation: Coverage Provisions



Source: National Association of Insurance Commissioners; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111–148 and 111–152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

Exhibit 9. Most of the 27 Million Women Who Were Uninsured During 2010 Will Gain Coverage in 2014



27 million women ages 19–64 who were uninsured during the year in 2010

Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

health insurance in new state insurance exchanges, and insurance market reforms that ban underwriting on the basis of health or gender (Exhibit 9). Highlights of the Affordable Care Act that have substantial implications for women's health are discussed below in order of their implementation.

NEW COVERAGE OF PREVENTIVE HEALTH SERVICES WITH NO COST-SHARING: 2010

One of the most significant provisions in the law from the perspective of women's health is the requirement that health insurance companies cover preventive services without cost-sharing. The survey showed that fewer than half of adult women were up to date on a core set of preventive screening tests including cervical and breast cancer screens, colonoscopies, and blood pressure and cholesterol tests. Women without coverage reported the lowest rates of compliance but many women with coverage also were not up to date. Research shows that increasing preventive service utilization can save lives. For example, increasing the share of women age 40 and older who receive breast cancer screening every two years to 90 percent could save 3,700 lives annually. Increasing the number of young women receiving chlamydia screening to that level would save an estimated 30,000 lives annually.[16]

Both group and individual health insurance plans are now required to cover all preventive services that the U.S. Preventive Services Task Force has rated "A," or those where evidence shows a high certainty the net benefit of the services is substantial, or "B," or those with a high certainty that the net benefit is moderate.[17] (See box.) Though the requirement does not apply to grandfathered plans, or those in existence when the

Newly Covered Preventive Services Without Cost-Sharing Beneficial to Women

- breast cancer screening every one to two years for women age 40 and older
- cervical cancer screening
- chlamydia screening for women to age 25 and older women at increased risk
- anemia screening for pregnant women; folic acid supplementation
- osteoporosis screening for all women age 65 and older, and 60 and older for those at high risk
- colorectal cancer screening; blood pressure and cholesterol screening
- genetic counseling for the breast cancer (BRCA) gene

law went into effect, over time most health plans are expected to relinquish their grandfathered status and thus become subject to the requirement.[18]

In addition, the law also instructs the federal Health Resources and Services Administration to develop evidence-informed comprehensive guidelines for preventive care and services for women. To carry out this requirement, the department of Health and Human Services is currently sponsoring an Institute of Medicine expert committee to review the preventive services necessary for women's health and well-being and determine which services should be included in the guidelines.[19] In particular, the committee will examine the scope of preventive services for women that are not rated "A" and "B" by the Preventive Services Task Force. The new guidelines are expected to be released by August 2011, with health plans required to provide coverage of the new recommended services by August 2012.

YOUNG ADULTS UP TO AGE 26 CAN STAY ON OR JOIN THEIR PARENT'S HEALTH PLANS: 2010

Young women and men are the most likely of any age group to lack health insurance. In the survey, more than two of five (41%) women ages 19 to 29 were uninsured in 2010, compared with 30 percent of women ages 30 to 49 and 19 percent of women ages 50 to 64 (Exhibit 2). In the past, young adults have lost coverage under their parents' policies at age 19 or when they graduated from college. Or, if they were insured under Medicaid or the Children's Health Insurance Program, they aged off the program at age 19.[20] As new entrants to the labor market, young adults face significant challenges finding full-time employment with health benefits. The law requires all health plans that offer dependent coverage, including self-insured employer plans and grandfathered plans, to offer the same level of coverage at the same price to their enrollees' adult children up to the age of 26. The law applies to all adult children, regardless of marital or student status, degree of financial dependency, or whether they live at home.[21]

PRE-EXISTING CONDITION INSURANCE PLANS: 2010

Women with health problems who do not have coverage through an employer face substantial difficulties gaining coverage in the individual insurance market. In the survey, 85 percent of women with a health problem who tried to buy coverage in the individual market said that they either found it very difficult to find a plan that fit their needs or that they could afford, or that they had been turned down, charged a higher price, or had a preexisting condition excluded from coverage (Exhibit 3). Nearly two-thirds (64%) never bought a health plan. Going without coverage has the most far-reaching consequences for those with health problems. The survey found that among women who took regular medications for a chronic health condition who lacked health insurance, half said they had skipped a dose or had not filled a prescription for their health condition because of cost (Table 3).

The coverage expansions under the Affordable Care Act that go into effect in 2014 will ensure that no one with a health problem will be denied coverage, charged a higher premium, or have a condition excluded based on health status. Nor will women be rated up or denied coverage solely on the basis of gender. Millions of women who have not been able to afford health insurance on their own will gain coverage under Medicaid or private subsidized plans through the new insurance exchanges, all of which will come with maternity coverage, even when a pregnancy is considered high risk.

In the years prior to 2014, women with chronic health problems who have been uninsured for at least six months can gain coverage through new state pre-existing condition insurance plans (PCIPs) available in all 50 states.[22] PCIPs cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. Premiums are set for a standard population in the individual insurance market and cannot vary by more than a factor of four based on age. The PCIPs are required to cover at least 65 percent of medical costs on average and must limit annual out-of-pocket spending to $5,950 for individuals. They

also cannot impose preexisting condition exclusions or waiting periods.

SMALL BUSINESS TAX CREDITS: 2010

There are nearly 1 million woman-owned businesses in the United States with payrolls, the majority of which (86 percent) employ from 1 to 50 employees.[23] Eighty-one percent of woman-owned businesses have fewer than 20 employees. Compared with large companies, small businesses face enormous challenges buying health insurance for their employees.[24] On average, small firms pay up to 18 percent more in premiums than do large firms for the same health insurance policy.[25] The substantial differential in costs between large and small firms is driven by higher administrative costs, greater per-employee costs of offering coverage, and underwriting in many states that can lead to more costly premiums for sicker, older, or female-dominated workforces.[26] In these plans, a higher share of the premiums is used for administration, marketing, insurance broker commissions, underwriting, and other overhead costs of the insurance carrier.

In addition, to the extent that woman-owned businesses also have predominantly female workforces, policies can currently be underwritten on the basis of gender in 38 states.[27] As a result, companies with predominantly female workforces can pay substantially higher premiums than those with predominantly male workforces. New regulations against underwriting on the basis of gender and health under the Affordable Care Act will ban this practice in all states starting in 2014.

To reduce costs of health insurance for small businesses, the Affordable Care Act provides tax credits to employers with fewer than 25 workers and average payrolls of less than $50,000. The full credit is available to companies with 10 or fewer employees and average wages of $25,000, phasing out for larger firms. Eligible businesses must contribute at least 50 percent of their employees' premiums. From 2010 to 2013, the full credit covers 35 percent of a company's premium contribution. Beginning in 2014, the full credit will cover 50 percent of that contribution for up to a two-year period for plans purchased through the new state insurance exchanges. Tax-exempt organizations are eligible to receive the tax credits, though the credits are somewhat lower: 25 percent of the employer's contribution to premiums from 2010 to 2013 and 35 percent beginning in 2014.

ADDITIONAL PROVISIONS TO ENHANCE WOMEN'S HEALTH: 2010–2014

Additional provisions in the Affordable Care Act introduce measures to improve access to women's health services and provide help for pregnant women and mothers, including:

- Women who are nursing and employed by companies with 50 or more employees are entitled to reasonable breaks from work to express breast milk; they must be provided with a private place in which to do this for the first year after their child's birth.
- Women in non-grandfathered health plans may now access obstetrics and gynecological services directly, without a referral from their primary care provider.
- Medicaid now covers smoking cessation support (including pharmacology and counseling services) for pregnant women. In addition, the law provides for increased reimbursement for Medicaid patients of nurse midwives, birth attendants, and freestanding birth centers.
- Medicare reimbursement of midwives increased in 2011 to 100 percent of the rate of physicians. Previously, the amount paid to midwives could not exceed 65 percent of the amount paid to physicians for the same services. Although Medicare covers few births, its rates are often used as a standard by many insurers.

UNIVERSAL COVERAGE: 2014

Beginning in 2014, nearly everyone will have access to affordable and comprehensive health insurance, regardless of employment status. Nearly all of the 27 million

working-age women who went without health insurance in 2010 will be covered in 2014, most with subsidized premiums and reduced cost-sharing.

New Coverage Under Medicaid

Beginning in 2014, the Affordable Care Act expands eligibility for Medicaid for all legal residents with incomes up to 133 percent of the federal poverty level—about $14,404 for a single adult or $29,327 for a family of four. This represents a substantial change in Medicaid's coverage of adults. Although several states have expanded eligibility for parents of dependent children, in most states income eligibility thresholds for parents are well below the federal poverty level.[28] In addition, adults who do not have children are not currently eligible for Medicaid, regardless of their income, in most states.

What it means for women. Of all the provisions in the law, the expansion in Medicaid eligibility will have the greatest effect on reducing the number of uninsured women: more than half (51%) of women under 133 percent of poverty, or 14 million, were uninsured for some time during 2010 (Exhibits 9 and 10). Women in this income range comprise nearly half of uninsured women nationwide.[29] In addition, because there will be little or no premium contribution or cost-sharing, the expansion will substantially reduce the costs of health insurance and health care for women in this income range, improve their access to health care, and reduce their incidence of medical bill and debt problems. Nearly half (48%) of women in this income range spent 10 percent or more of their income on premiums and out-of-pocket costs; nearly two-thirds (65%) said they had delayed or avoided needed care because of costs, and 58 percent reported a problem paying medical bills or said they were carrying medical debt over time.

New Subsidized Private Health Plans with Consumer Protections

The law requires each state to establish by 2014 new health insurance exchanges for both people under age 65 without employer coverage or Medicaid and small businesses.[30] States can set up their own exchanges or

Exhibit 10. Under the Affordable Care Act, Women Will Benefit from Newly Subsidized Sources of Health Insurance

		Medicaid	Subsidized private insurance		Private insurance
Women ages 19–64	Total	<133% FPL	133%–249% FPL	250%–399% FPL	400%+ FPL
In the past 12 months:					
Uninsured anytime during the year	29% 27 million	51	30	18	6
Any bill problem or medical debt*	44% 42 million	58	66	43	21
Any cost-related access problem**	48% 45 million	65	59	44	28
Spent 10% or more of household income on premiums***	15% 7 million	43	24	10	6
Spent 10% or more of household income on premiums and total out-of-pocket costs****	33% 26 million	48	38	23	22

Note: FPL refers to Federal Poverty Level.
* Includes: had problems paying or unable to pay medical bills; contacted by collection agency for unpaid medical bills; had to change way of life to pay bills; medical bills being paid off over time.
** Includes any of the following because of cost: had a medical problem, did not visit doctor or clinic; did not fill a prescription; skipped recommended test, treatment, or follow-up; did not get needed specialist care.
*** Base: women who specified income level and premium for private insurance plan.
**** Base: women who specified income level and premium/out-of-pocket costs for combined individual/family medical expenses.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

the federal government will do it for them. The individual and small-group markets will continue to function outside the exchanges, but new insurance market regulations against underwriting on the basis of health or gender will apply to plans sold inside and outside the exchanges. Consequently, women who buy coverage on their own will no longer be charged a higher premium or denied coverage because of gender or health status. People with employer coverage who spend more than 9.5 percent of their income on premiums or those with plans that cover less than 60 percent, on average, of their medical costs also will be eligible to purchase coverage through the exchanges.

All health plans sold in the exchanges and in the individual and small-group markets will be required to provide an essential benefit package, similar in scope to a typical employer plan, including maternity coverage. Individuals and small businesses purchasing coverage may choose among health plans with the essential benefit package but with four different levels of cost-sharing: plans that cover an average 60 percent of an individual's total medical costs per year (bronze plan), 70 percent of medical costs (silver plan), 80 percent of medical costs (gold plan), and 90 percent of medical costs (platinum plan). Out-of-pocket costs are limited to $5,950 for single policies and $11,900 for family policies and are lower for people with lower incomes.

For the first time, women who buy coverage on their own will be eligible for a federal tax credit to help pay for the cost of premiums for plans sold through the exchanges. Premium credits will be tied to the silver plan and will cap contributions for individuals and families from 2 percent of income for those with incomes up to 133 percent of the federal poverty level ($14,404 for a single adult or $29,327 for a family of four) and gradually increase to 9.5 percent of income for those with incomes from 300 percent to 399 percent of the poverty level ($43,320 for a single person and $88,200 for a family of four).

People with low and moderate incomes will also benefit from cost-sharing credits that reduce out-of-pocket spending under the silver plan to an average 6 percent of total costs for those with incomes up to 149 percent of poverty ($16,245 for a single person and $33,075 for a family of four). Out-of-pocket costs will be reduced on average to a maximum of 13 percent of total costs for those with incomes up to 199 percent of poverty ($21,660 for a single person and $44,100 for a family of four) and 27 percent for those with incomes up to 249 percent of poverty ($27,075 for a single person and $55,125 for a family of four). In addition, out-of-pocket expenses will be capped for families earning between 100 percent and 399 percent of poverty from $1,983 for individuals and $3,967 for families up to $3,967 for individuals and $7,933 for families.

What it means for women. A large share of women in households earning from 133 percent to 249 percent of poverty ($29,327 to $55,125 for a family of four) will gain insurance coverage with substantial new protections against the cost of premiums and out-of-pocket costs. One of three (30%) women in this income range were uninsured for all or part of 2010 (Exhibit 10). Most will be eligible for coverage through the insurance exchanges with premium tax credits that will cap their premium costs at 3 percent to 8 percent of income. In the survey, one-quarter (24%) of women in this income range spent 10 percent or more of their income on premiums. Women in this income range who are enrolled in employer-based health plans who spend more than 9.5 percent of their income on premiums will also be eligible to purchase health insurance in the exchanges and receive the tax credit. In addition, women in this income range will receive cost-sharing tax credits and limits on out-of-pocket spending that will reduce their out-of-pocket costs. These protections, along with an essential benefit package, should reduce rates of cost-related problems getting needed care (59% of women in this income range) and medical bill problems (66%).

Women earning from 250 percent to 399 percent of poverty ($55,125 and 88,200 for a family of four) will also gain coverage and cost-protection. Eighteen percent of women in this income range spent a time uninsured in 2010. Most will be eligible for coverage through the exchanges with premium tax

credits that will cap their premium costs from 8 percent to 9.5 percent of their incomes; women in employer plans spending 9.5 percent or more of their income on premiums are also eligible for the tax credits for coverage through the exchange. In the survey, 10 percent of women in this income group spent 10 percent or more of their income on premiums. There are limits on out-of-pocket spending for women in this income range, but no cost-sharing tax credits.

Women earning 400 percent of poverty or more ($88,200 for family of four) will not be eligible for premium or cost-sharing tax credits. But their ability to purchase coverage on their own will be substantially improved. They will no longer be charged more on the basis of their health or gender, will have an essential benefit package with maternity benefits, and will have far greater information about covered services and out-of-pocket responsibilities than they do today.

RESTRICTIONS ON USE OF FEDERAL FUNDS FOR ABORTION SERVICES: 2014

The Affordable Care Act contains restrictions on the use of federal premium and cost-sharing subsidies for abortion services. In keeping with a longstanding federal law commonly known as the Hyde Amendment, the Affordable Care Act prohibits federal funds from being used for abortion services, except in the case of rape, incest, or when a woman's life is endangered.[31] The restrictions on federal funding apply to subsidized plans sold through the health insurance exchanges, the expansion of Medicaid eligibility, the preexisting condition insurance plans, and the Community Health Center Fund, which will provide additional federal funds for the federal community health center program.

The law requires that the exchanges follow strict payment and accounting procedures to ensure that premium and cost-sharing tax credits are not used for abortion services, except as allowed by the Hyde Amendment. People eligible for subsidies for plans sold through the exchanges will pay only one premium, but health plans must segregate part of the premium (that which is not subsidized with federal dollars) into an account to be used exclusively for abortion services not allowed under the Hyde Amendment. Insurers selling plans in the exchanges can decide whether they will offer any abortion services and are required to include in their benefit descriptions whether or not they cover abortion, as they will do for all other benefits. The allocation of the premium into its components will not be advertised or used in enrollment material. All applicants will see the same premium when they are choosing a plan.

The law also enables states considerable and unprecedented flexibility to place further restrictions on women's access to abortion services, even under private health coverage for which women would not receive a federal tax credit. The law permits states to prohibit abortion coverage in qualified health plans offered through an insurance exchange if the state enacts a law that requires such a prohibition. As of May 2011, 11 states have passed legislation banning abortion coverage in plans sold through their exchanges. Nine state passed laws in 2010–2011 and two passed legislation banning coverage in state-regulated health plans prior to that.[32]

CONCLUSION

Women have greater health care needs than men, and have historically played larger roles in the health care of family members. As a result, women are more exposed to the costs of health care than are men. The rapid acceleration in U.S. health care costs over the past decade, as family incomes barely budged and many women and their partners lost jobs and health benefits, has left millions of women at risk of medical debt or of forgoing necessary health care. The individual and small-group insurance markets have been especially hostile zones for women seeking health insurance, with health plans worried above all about risk and thus charging women and female-dominated businesses higher premiums on the basis of gender and excluding coverage of services that are intrinsic to family life. The Affordable Care Act is already bringing dramatic change for women and their families through required free coverage of preventive care services integral to

women's health, coverage of young adults on family plans, preexisting condition insurance plans, small business tax credits, and insurance market reforms including bans on lifetime benefit limits. But the heart of the health reform law—universal health insurance coverage—is yet to come and will bring relief to the estimated 27 million women who went without insurance coverage in 2010. The findings of this brief underscore why federal and state policymakers must continue their work implementing the Affordable Care Act over the next three years. Health reform's successful implementation will be critical to the future health and financial well-being of millions of women and their families.

Notes

1 S. D. Rustgi, M. M. Doty, and S. R. Collins, *Women at Risk: Why Many Women Are Forgoing Needed Health Care* (New York: The Commonwealth Fund, May 2009); A. Ho, S. R. Collins, K. Davis, and M. M. Doty, *A Look at Working-Age Caregivers' Roles, Health Concerns, and Need for Support* (New York: The Commonwealth Fund, Aug. 2005).

2 S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (New York: The Commonwealth Fund, March 2011).

3 Kaiser Family Foundation, Health Insurance Coverage of Women 19–64, States (2008–2009), http://www.statehealthfacts.org/comparebar.jsp?ind=652&cat=3.

4 E. M. Patchias and J. Waxman, *Women and Health Coverage: The Affordability Gap* (New York: The Commonwealth Fund, April 2007).

5 M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Nicholson, *Out of Options: Why So Many Workers in Small Businesses Lack Affordable Health Insurance, and How Health Care Reform Can Help* (New York: The Commonwealth Fund, Sept. 2009).

6 Collins, Doty, Robertson, and Garber, *Help on the Horizon*, 2010.

7 Ibid; employees who lose their jobs may continue to be covered by their job-based health insurance policy through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if they pay the full cost of their premium (including the portion previously contributed by their employer), see M. M. Doty, S. D. Rustgi, C. Schoen, and S. R. Collins, *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (New York: The Commonwealth Fund, Jan. 2009).

8 National Women's Law Center, *Still Nowhere to Turn: Insurance Companies Treat Women Like a Preexisting Condition* (Washington, D.C.: National Women's Law Center, Oct. 2009).

[9] Ibid; S. R. Collins, S. B. Berkson, and D. A. Downey, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund, Jan. 2003).

[10] Collins, Doty, Robertson, and Garber, *Help on the Horizon*, 2010.

[11] In addition, deductibles increased by 71 percent from 2003 to 2009, see C. Schoen, K. Stremikis, S. K. H. How, and S. R. Collins, *State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits* (New York: The Commonwealth Fund, Dec. 2010).

[12] Council of Economic Advisors, "Economic Report of the President: 2011 Report Spreadsheet Tables," Feb. 2011, Table B–33, http://www.gpoaccess.gov/eop/tables11.html.

[13] 2005 was the first year in which the Commonwealth Fund Biennial Survey included a comparable question series on medical bill and debt problems.

[14] Office of Management and Budget, *Women in America: Indicators of Social and Economic Well-Being* (Washington, D.C.: White House Council for Women and Girls, March 2011), http://www.whitehouse.gov/administration/eop/cwg/data-on-women; women under age 65 (and at all ages) are more likely to have arthritis than men (data from 2007–09), http://www.cdc.gov/arthritis/data_statistics/national_nhis.htm#gender_specific; women ages 15 to 34 and 35 and older are more likely to have asthma than men, http://www.cdc.gov/nchs/data/nhis/earlyrelease/201103_15.pdf; adult women are more likely to suffer from depression than are men, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5938a2.htm#tab1.

[15] Office of Management and Budget, *Women in America* (Washington, D.C.: OMB, 2011).

[16] Departments of Labor, Treasury and Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," http://www.healthcare.gov/center/regulations/prevention/regs.html.

[17] Ibid.

[18] Under interim final regulations issued by the Departments of Health and Human Services, Labor, and Treasury in June 2010, health plans will lose their grandfathered status if they make significant reductions in coverage or increases in cost-sharing. The departments estimate that by 2013 from 49 percent to 80 percent of small employers (fewer than 100 employees), from 39 percent to 69 percent of large employers, and from 40 percent to 67 percent of individual-market plans will relinquish their grandfathered status. See S. R. Collins, "Grandfathered vs. Non-Grandfathered Health Plans Under the Affordable Care Act: Striking the Right Balance," Commonwealth Fund Blog, June 22, 2010; and Department of the Treasury, Department of Labor, and Department of Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," http://www.hhs.gov/ociio/regulations/grandfather/index.html.

[19] See Institute of Medicine, http://www8.nationalacademies.org/cp/projectview.aspx?key=IOM-BPH-10-13.

[20] S. R. Collins and J. L. Nicholson, *Realizing Health Reform's Potential: Young Adults and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Oct. 2010).

[21] There is one exception: prior to 2014, young adults may only be covered by their parents' grandfathered employer group health plans if they are not eligible to enroll in any other employer-sponsored plan (i.e., through their own employer or a spouse's employer).

[22] J. P. Hall and J. Moore, *Realizing Health Reform's Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Oct. 2010); J. Hall, "Improving Affordability of Coverage for People with Preexisting Conditions," Commonwealth Fund Blog, Dec. 7, 2010.

[23] U.S. Census Bureau, 2007 Survey of Business Owners, Dec. 7, 2010, http://www2.census.gov/econ/sbo/07/final/charts/women_chart3.pdf.

[24] S. R. Collins, K. Davis, J. L. Nicholson, and K. Stremikis, *Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Sept. 2010).

[25] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs,* May/June 2006 25(3):832–43.

[26] Kaiser Family Foundation, *State Variation and Health Reform: A Chartbook* (Menlo Park, Calif.: Kaiser Family Foundation, Oct. 2009); R. C. Chu and G. R. Trapnell, *Study of the Administrative Costs and Actuarial Values of Small Health Plans* (Annandale, Va.: Small Business Administration, Office of Advocacy, Jan. 2003), http://www.sba.gov/advo/research/rs224tot.pdf; M. A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs,* Mar./Apr. 2000 19(2):173–84; Executive Office of the President Council of Economic Advisors, *The Economic Effects of Health Care Reform on Small Businesses and Their Employees* (Washington, D.C.: Executive Office of the President of the United States, July 25, 2009); Gabel, McDevitt, Gandolfo et al., "Generosity and Adjusted Premiums," 2006.

[27] National Women's Law Center, *Still Nowhere to Turn* (Washington, D.C.: NWLC, 2009), http://action.nwlc.org/site/PageNavigator/nowheretoturn_Report.

[28] S. R. Collins and J. L. Nicholson, *Rite of Passage: Young Adults and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, May 2010).

[29] S. R. Collins, S. D. Rustgi, and M. M. Doty, *Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, July 2010).

[30] T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues* (New York: The Commonwealth Fund, Sept. 2010); T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).

[31] "Executive Order—Patient Protection and Affordable Care Act's Consistency with Longstanding Restrictions on the Use of Federal Funds for Abortion," The White House Office of the Press Secretary, March 24, 2010, available at http://www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst.

[32] The nine states with specific legislation passed in the past two years to prohibit abortion coverage in their exchanges are Arizona, Louisiana, Mississippi, Missouri, Tennessee, Idaho, Oklahoma, Utah, and Virginia. The Utah law will apply to all state-regulated insurance plans from 2014. There are five states (three of which also have exchange-specific legislation) that had prior laws banning abortion coverage by any state-regulated insurance plan: Idaho, Kentucky, Missouri, North Dakota, and Oklahoma. This legislation will extend to plans sold in the exchanges once they are established. In Rhode Island, a law of this type passed but has been enjoined for many years. There are some exceptions in these laws which vary by state; abortion coverage is sometimes permissible in cases such as incest, rape, and life endangerment. See Guttmacher Institute, *State Policies in Brief: Restricting Coverage of Abortion* (New York: Guttmacher Institute, April 2011); personal communication with Adam Sonfield, Senior Public Policy Associate at the Guttmacher Institute.

Table 1. Demographics and Insurance Coverage by Gender

	Total (ages 19–64)	Women	Men
Total (millions)	183.6	94.1	89.5
Percent distribution	100%	51%	49%
Unweighted n	3,033	1,671	1,362
Insurance status			
Insured all year	72%	71%	72%
Insured now, time uninsured in past year	8	9	8
Uninsured now	20	20	20
*Any time uninsured in past year**	28	29	28
Age			
19–29	24	23	25
30–49	44	43	44
50–64	33	34	31
Race/Ethnicity			
White	64	65	63
Black	12	14	11
Hispanic	16	15	17
Asian/Pacific Islander (n=87)	3	3	3
Other/Mixed (n=106)	3	3	4
Income			
Less than $20,000	26	27	26
$20,000–$39,999	20	18	21
$40,000–$59,999	14	13	15
$60,000 or more	29	28	30
Poverty status			
Below 133% FPL	27	29	26
133%–249%	18	17	19
250%–399%	19	18	21
400% FPL or more	25	24	26
Below 200% FPL	38	40	37
200% FPL or more	51	47	55
Any chronic condition or disability or fair/poor health status	50	51	49
Family status			
Married/LWP, no children	25	26	24
Married/LWP, children	37	38	36
Not married, no children	27	23	30
Not married, children	11	12	10

	Total (ages 19–64)	Women	Men
Adult work status			
Full-time	52	42	62
Part-time	12	15	10
Not currently employed	36	42	28
Family work status			
At least one full-time worker	68	68	68
Only part-time worker(s)	9	9	10
No worker in family	22	23	22
Employer size**			
Self-employed/1 employee	6	5	7
2–24 employees	20	17	23
25–99 employees	14	15	13
100–499 employees	15	16	15
500 or more employees	42	44	40
Insurance source***			
Employer-sponsored	73	72	75
Individual purchase	6	6	5
Public	15	15	14
Medicaid	8	9	7
Medicare	7	6	7
Other	6	7	5
Policy holder****			
Own name	67	56	78
Spouse's/Partner's name	27	39	16
Parent's name	4	3	4
Someone else's name	1	1	0

Notes: FPL refers to Federal Poverty Level; LWP refers to living with partner.

* Combines "Uninsured now" and "Insured now, time uninsured in the past year."

** Base: full- and part-time employed adults ages 19–64.

*** Base: adults insured all year.

**** Base: adults covered by employer-sponsored health insurance.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Table 2. Bill and Debt Problems by Gender, Insurance Continuity and Income

				Women							
	Total	Women	Men	Insured all year	Insured now, time uninsured in past year	Uninsured now	Uninsured during the year*	Below 133% FPL	133%–249% FPL	250%–399% FPL	400% FPL or more
Total (millions)	183.6	94.1	89.5	67.2	8.1	18.8	26.9	27.3	15.6	16.8	22.2
Percent distribution	100%	51%	49%	71%	9%	20	29%	29	17%	18%	24
Unweighted n	3033	1,671	1,362	1210	134	327	461	470	270	299	407
Medical Bill Problems in Past Year											
Had problems paying or unable to pay medical bills	29	34	23	25	52	57	55	49	53	30	10
Contacted by collection agency for unpaid medical bills	16	19	14	13	33	32	33	33	32	11	3
Had to change way of life to pay bills	17	19	14	15	26	31	30	25	34	16	7
Any bill problem	34	39	28	29	60	63	62	55	61	34	12
Medical bills/debt being paid off over time	24	27	20	25	32	30	30	31	43	30	15
Any bill problem or medical debt	40	44	35	36	65	64	64	58	66	43	21
Base: Any Bill Problem or Medical Debt											
Percent reporting that the following happened in the past 2 years because of medical bills:											
Unable to pay for basic necessities (food, heat, or rent)	31	32	29	29	—	37	36	42	38	16	—
Used up all of savings	40	41	38	37	—	50	47	42	44	42	—
Took out a mortgage against your home or took out a loan	10	12	8	12	—	9	12	12	12	7	—
Took on credit card debt	24	25	22	26	—	24	23	18	28	28	—
Had to declare bankruptcy	6	6	6	6	—	9	7	8	4	8	—
Insurance status of person/s at time care was provided											
Insured at time care was provided	59	60	57	83	—	21	27	42	68	79	—
Uninsured at time care was provided	35	34	37	11	60	73	69	53	27	15	10
Other insurance combination	2	2	1	3	0	1	1	1	3	4	0

FPL refers to Federal Poverty Level.

— Sample size too small to report results.

* Combines “Uninsured now” and “Insured now, time uninsured in the part year.”

Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Table 3. Access Problems and Preventive Care by Gender, Insurance Continuity and Income

				Women							
	Total	Women	Men	Insured all year	Insured now, time uninsured in past year	Uninsured now	Uninsured during the year*	Below 133% FPL	133%–249% FPL	250%–399% FPL	400% FPL or more
Total (millions)	183.6	94.1	89.5	67.2	8.1	18.8	26.9	27.3	15.6	16.8	22.2
Percent distribution	100%	51%	49%	71%	9%	20	29%	29	17%	18%	24
Unweighted n	3033	1,671	1,362	1210	134	327	461	470	270	299	407
Access Problems in Past Year											
Went without needed care in past year because of cost:											
Did not fill prescription	26	32	19	25	48	54	52	48	41	29	15
Skipped recommended test, treatment or follow-up	25	30	20	22	37	57	51	44	38	27	16
Had a medical problem, did not visit doctor or clinic	26	31	22	20	46	61	57	44	41	26	15
Did not get needed specialist care	18	21	15	14	30	45	41	32	27	20	10
At least one of four access problems because of cost	41	48	33	37	68	76	74	65	59	44	28
Delayed or did not get preventive care screening because of cost	18	21	14	12	29	50	44	32	29	12	10
Delayed or did not get dental care because of cost	38	44	31	35	54	70	65	57	55	45	25
Access Problems for People with Health Conditions											
Skipped doses or not filled a prescription for medications for health condition(s) because of the cost of the medicines**	25	31	19	25	—	50	—	45	45	—	7
Preventive Care											
Regular source of care	89	91	86	97	88	73	77	85	91	95	97
Blood pressure checked (past year)	85	88	82	93	84	72	76	82	91	91	94
Dental exam (past year)	59	61	56	71	49	33	38	43	52	67	86
Received mammogram in past 2 years (females age 50+)	72	72	na	79	—	31	42	52	60	75	85
Received cervical cancer screening in past year (females ages 19–29), in past 3 years (females age 30+)	74	74	na	80	72	55	60	64	73	80	86
Received colon cancer screening in past 5 years (age 50+)	54	46	62	50	—	26	30	36	30	54	54
Cholesterol checked in past 5 years	70	72	68	80	66	50	55	58	74	76	85
Seasonal flu shot in past 12 months	38	40	35	45	32	26	28	34	42	39	50

FPL refers to Federal Poverty Level.
— Sample size too small to report results.
* Combines "Uninsured now" and "Insured now, time uninsured in the part year."
** Base: Respondents who take prescription medication on a regular basis and have at least one of the following health problems: heart disase including heart attack, hypertension, high blood pressure, diabetes, asthma, emphaseyma, or lung disease.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Methodology

Data for this study were drawn from the Commonwealth Fund 2010 Biennial Health Insurance Survey, conducted by Princeton Survey Research Associates International from July 14 through November 30, 2010. The survey consisted of 25-minute telephone interviews in either English or Spanish with a random, national sample of 4,005 adults, age 19 and older, living in the continental United States. Because relying on landline-only samples leads to undercoverage of American households, a combination of landline and cell phone random-digit dial samples was used to reach people, regardless of the type of telephones they use.[1] This issue brief is based on the responses of 3,033 adults ages 19 to 64, including 1,362 males and 1,671 females. Data are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The landline portion of the survey achieved a 29 percent response rate and the cellular phone component achieved a 25 percent response rate. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level. We also report estimates from the 2001 and 2005 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy as was used in 2010, except they did not include a cellular phone random-digit dial sample.[2] In 2001 the survey was conducted from April to July 2001 and included 2,829 adults ages 19 to 64; in 2005 the survey was conducted from August 2005 to January 2006 among 3,353 adults ages 19 to 64.

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[1] According to the latest estimates from the 2008 National Health Interview Survey, 20 percent of U.S. households have only wireless telephones. S. J. Blumberg and J. V. Luke, "Wireless Substitution: Early Release of Estimates from the National Health Interview Survey, July–December 2008" (Atlanta: National Center for Health Statistics, May 2009), available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/wireless200905.htm.

[2] In 2005, only 7.2 percent of households in the United States did not have landline telephones. S. J. Blumberg and J. V. Luke, "Reevaluating the Need for Concern Regarding Noncoverage Bias in Landline Surveys," *American Journal of Public Health,* Oct. 2009 99(10):1806–10. Employing a landline-only sample in 2001 and 2005 did not result in undercoverage of American households.

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