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Realizing Health Reform's Potential

Oceans Apart: The Higher Health Costs of Women in the U.S. Compared to Other Nations, and How Reform Is Helping

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Abstract: An estimated 18.7 million U.S. women ages 19 to 64 were uninsured in 2010, up from 12.8 million in 2000. An additional 16.7 million women had health insurance but had such high out-of-pocket costs relative to their income that they were effectively underinsured in 2010. This issue brief examines the implications of poor coverage for women in the United States by comparing their experiences to those of women in 10 other industrialized nations, all of which have universal health insurance systems. The analysis finds that women in the United States—both with and without health insurance—are more likely to go without needed health care because of cost and have greater difficulty paying their medical bills than women in the 10 other countries. In 2014, the Affordable Care Act will substantially reduce health care cost exposure for all U.S. women by significantly expanding and improving health insurance coverage.



OVERVIEW

Compared with men, women use more health care services, especially during their childbearing years and, on average, have lower incomes. As a result, women are at greater risk of going without needed health care because of cost.¹ Women are also more likely than men to be insured through a spouse or partner's employer, leaving them vulnerable to losing health benefits in the event of a divorce, death, or a firm's decision to eliminate dependent coverage. Further, when women of childbearing age try to buy health insurance in the individual insurance market, they are charged higher premiums than men in most states and can rarely buy a plan that covers maternity care.²

Recognizing their unique health needs, the Affordable Care Act is ushering in a new era in health care for American women. The law now requires nongrandfathered insurance plans (i.e., those that were not in existence when the law was enacted in 2010) to cover recommended preventive services without cost-sharing. These include breast and cervical cancer screening, and beginning in August 2012, contraception. Beginning in 2014, women without health benefits through a job will have new affordable insurance options: they may be eligible for Medicaid or subsidized private health plans if they have incomes up to 400

percent of the federal poverty level (\$44,680 for a single person or \$92,200 for a family of four³). Insurance companies will be banned from charging women higher premiums than men and most health plans will cover maternity care.

Using data from three surveys—the federal Current Population Survey (2001–2011), the Commonwealth Fund Biennial Health Insurance Survey (2003, 2007, and 2010), and the Commonwealth Fund International Health Policy Survey (2010)—this issue brief shows why these changes in the U.S. health care system are critically important for women. The analysis finds that 18.7 million U.S. women went without insurance in 2010, and a further 16.7 million were underinsured; that is, they had insurance but were at risk of high out-of-pocket costs relative to their income. Uninsured rates varied across the country. They were highest in the southern and western states; in Texas 30.3 percent of women were uninsured in 2009–10, compared with 5.3 percent in Massachusetts.

Compared with women in 10 other industrialized countries, U.S. women had the highest rates of going without needed health care because of cost, having serious problems paying their medical bills,

high out-of-pocket health care spending, and experiencing problems with their health insurance. They also reported the lowest level of confidence in their ability to afford health care should they become seriously ill. Affordability problems were particularly acute for U.S. women who lacked health insurance, half of whom (51%) reported problems paying medical bills in 2009–10 and more than three quarters (77%) of whom reported going without needed care because of cost. Even women with insurance had high rates of medical bill and access problems compared with women in other countries.

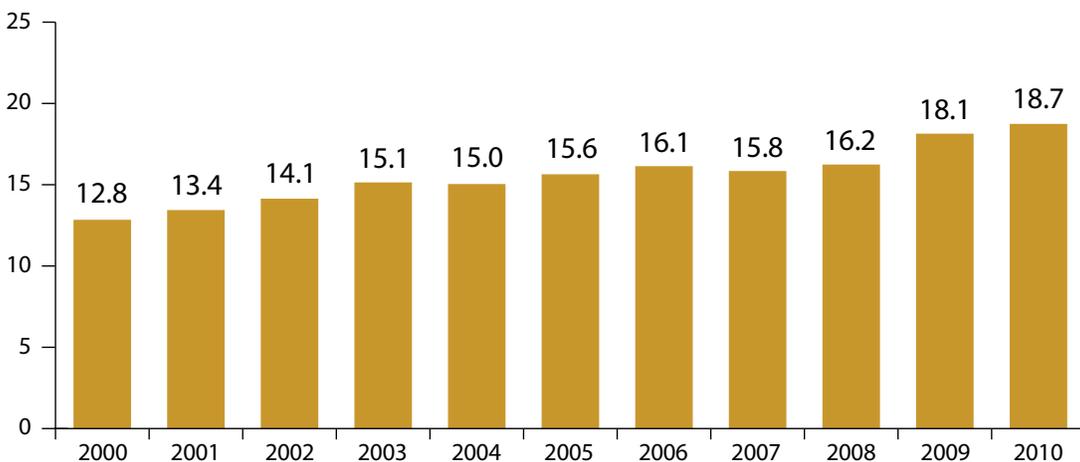
FINDINGS

The Number of Uninsured and Underinsured Women Has Climbed Over the Past Decade

The number of women without health insurance in the United States rose by nearly 6 million over the past decade to 18.7 million in 2010 (Exhibit 1). Half of that increase occurred over the last three years of the decade—job losses due to the recession likely contributed to 3 million women losing health insurance coverage. Nationally, 20 percent of women were uninsured in 2009–10, with the largest shares of uninsured women

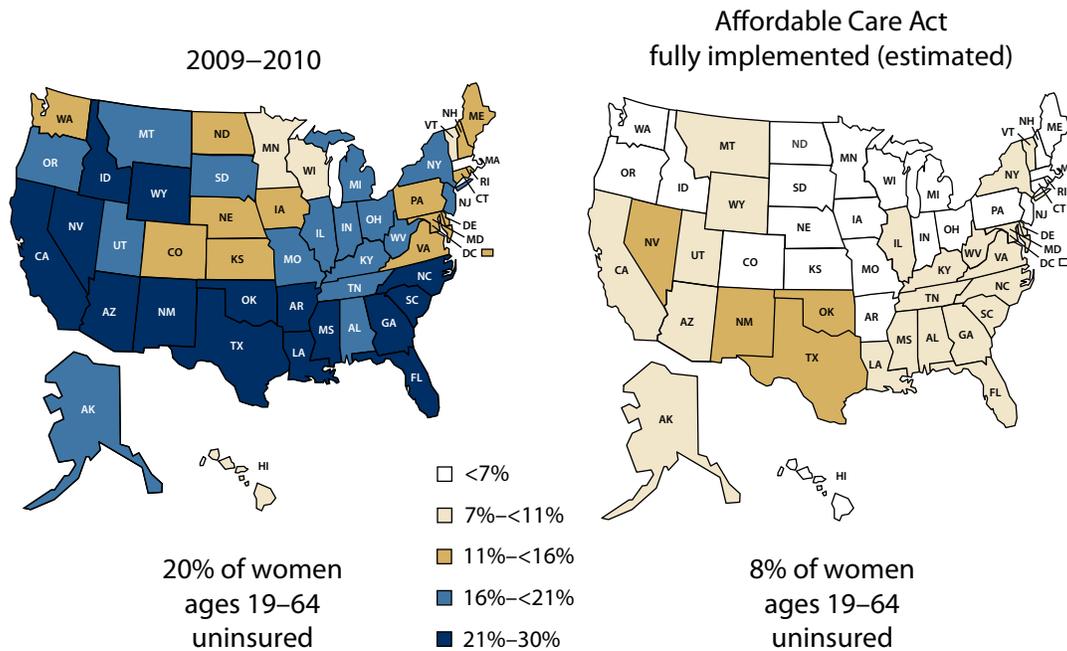
Exhibit 1. Nearly 19 Million U.S. Women Ages 19 to 64 Uninsured in 2010, Up 6 Million from 2000–2010

Millions of U.S. women ages 19–64



Source: Analysis of the March 2001–2010 Current Population Surveys by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.

Exhibit 2. Percent of Women Ages 19 to 64 Uninsured by State, 2009–2010 and Under the Affordable Care Act When Fully Implemented



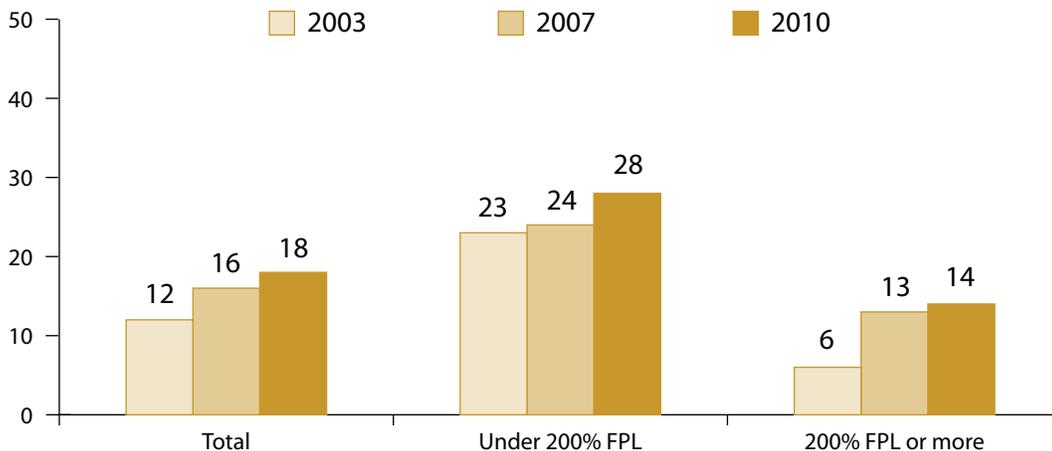
Sources: Analysis of the March 2011 and 2010 Current Population Surveys by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund; uninsured rates are two-year averages. Estimates for the Affordable Care Act when fully implemented by Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

in Texas (30.3%), Florida (26.2%) Arkansas (25.3%), New Mexico (25.3%), and Nevada (25.2%) (Exhibit 2). Massachusetts, which has had a law in place similar to the Affordable Care Act since 2006, has the lowest

rate of uninsured women at 5.3 percent. The state is followed by Hawaii (10.0%), Wisconsin (10.2%), Minnesota (10.2%), and Vermont (10.2%). Each has taken statewide action to ensure broader coverage rates

Exhibit 3. Across Income Groups, Increasing Numbers of U.S. Women Are Underinsured

Percent of U.S. women ages 19–64 who are underinsured*



* Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or per-person deductible equaled 5% or more of income. Note: FPL refers to federal poverty level.

Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2007, and 2010).

across its population in the form of more generous Medicaid eligibility levels for parents and childless adults, and an employer requirement to offer health insurance in Hawaii.⁴

Increasing numbers of women with health insurance are paying more for coverage and facing high cost-sharing. A Commonwealth Fund report found that employee premium contributions in employer plans climbed by 63 percent over 2003–2010, rising from an average annual employee contribution of \$2,283 to \$3,721.⁵ At the same time, nearly three-quarters of people with employer-based health insurance faced a deductible in 2010, up from about half in 2003.

Greater cost-sharing in insurance plans has left women increasingly exposed to health care costs. The percentage of women who were underinsured, or had out-of-pocket health care costs that were high relative to their income, climbed from 12 percent in 2003 to 18 percent in 2010, or an estimated 16.7 million women (Exhibit 3).⁶ Women with lower incomes were the most at risk for being underinsured: 28 percent of women in families with incomes under 200 percent of

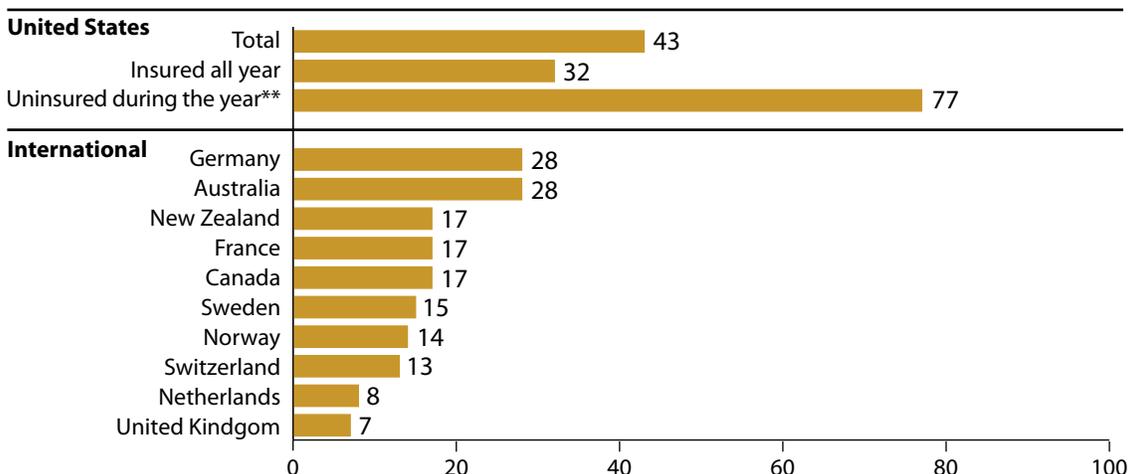
poverty (\$46,100 for a family of four) were underinsured in 2010, twice the rate of women in families with incomes of 200 percent of poverty or higher.

Compared with Women in Other Countries, U.S. Women Have Greater Difficulty Getting Needed Health Care

When seen from an international perspective, the high rates of uninsured and underinsured women in the U.S. are unique. All other industrialized nations provide universal health insurance, generally with comprehensive benefits.⁷ The failure to provide affordable and high-quality health insurance coverage in the U.S. has significant consequences. Forty-three percent of women in the U.S. reported they went without recommended care, did not see a doctor when sick, or failed to fill prescriptions because of costs in the past year. This was the highest rate among 11 countries. In the Netherlands and the U.K., only 8 percent and 7 percent of women, respectively, reported forgoing care because of cost (Exhibit 4, [Appendix Table 1](#)). Women in the U.S. without health insurance reported the highest rates for skipping needed care because of cost. More

Exhibit 4. Women in the U.S. Report Highest Rates of Not Getting Needed Care Because of Cost

Percent of women ages 19–64 who experienced any access problem because of cost in the past year*



* Experienced any of the following because of cost: did not fill a prescription for medicine or skipped doses; had a specific medical problem but did not visit a doctor; skipped or did not get a medical test, treatment, or follow-up that was recommended by a doctor.

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

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.

than three-fourths (77%) of women in the U.S. who had been uninsured during the previous year went without health care because of costs. However, these problems were not confined to the uninsured. Even women with health insurance in the U.S. reported high rates (32%) of cost-related access problems.

U.S. Women Have Higher Out-of-Pocket Costs than Women in Other Countries

High health care costs in the U.S. and greater exposure to the costs of health care even among insured families are imposing significant financial burdens on household budgets. Four of 10 (39%) U.S. women reported spending \$1,000 or more out-of-pocket for medical care in the past year, with rates similar for those with and without health insurance (Exhibit 5, Appendix Table 2). In comparison, about one of four women reported such high levels of out-of-pocket costs in Switzerland (24%) and Australia (23%), and fewer than one of six women in the other eight countries. Such expenses were extremely rare in Sweden (1%) and the U.K. (0%). In addition, one-fourth (26%) of women in the U.S. had a serious problem paying medical bills

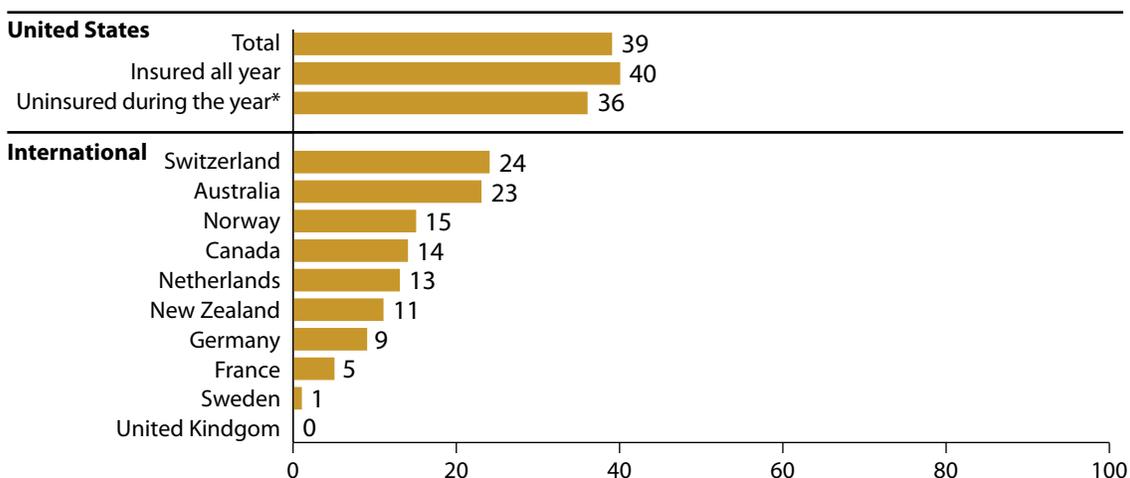
compared with 13 percent in Australia, 12 percent in France, 8 percent in Sweden and New Zealand, 4 percent in Germany, and 2 percent in the U.K. (Exhibit 6, Appendix Table 2). Uninsured women in the U.S. were particularly at risk, with more than half (51%) reporting serious problems paying or being unable to pay their medical bills. However, U.S. women with health insurance were still more likely to have medical bill problems (18%) than women in any other country.

Women in the U.S. were far more likely than those in the other 10 countries to have disputes with their insurers, or discover their insurance would not pay as they expected. In the U.S., one of three (31%) women who reported being insured all year said their insurer had either denied a claim or had not paid as much as expected, which was the highest rate among all countries surveyed (Appendix Table 2). In contrast, fewer than one of 15 women in New Zealand (6%), Norway (3%), Sweden (2%), and the U.K. (2%) reported these problems.

Women in the U.S. were most likely (21%) to report they had spent “a lot of time” in the previous year on paperwork or disputes related to medical bills,

Exhibit 5. Women in the U.S. Report Highest Rates of Spending \$1,000 or More on Out-of-Pocket Medical Expenses

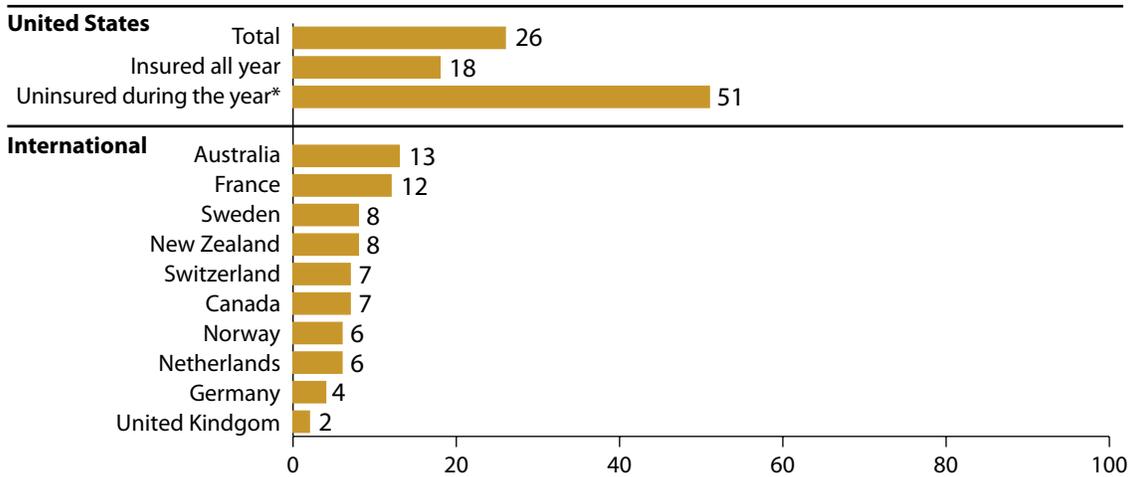
Percent of women ages 19–64 who had out-of-pocket medical expenses of \$1,000 or more in the past year



* Combines “Insured now, time uninsured in past year” and “Uninsured now”.
Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.

Exhibit 6. Women in the U.S. Report Problems Paying Medical Bills at More Than Double the Rate of Women in Ten Other Countries

Percent of women ages 19–64 who had a serious problem paying or were unable to pay medical bills in the past year



* Combines "Insured now, time uninsured in past year" and "Uninsured now".
Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.

most likely reflecting the complexity of how services are billed and paid for in the U.S. The rate in Germany was also high (18%). Women in the United States who had been without health insurance during the year were particularly likely (30%) to report spending a lot of time on paperwork or disputes ([Appendix Table 2](#)).

Half of U.S. Women Unsure They Could Afford Needed Care if They Became Seriously Ill

The survey asked respondents how confident they were that if they were to become seriously ill, they would be able to afford the care they needed. Only half (52%) of women in the U.S. felt confident or very confident they could afford needed care, which was the lowest rate among all countries. More than three of four (77%) women in the Netherlands and nine of ten (91%) women in the U.K. reported being confident they would be able to afford care ([Exhibit 7](#)).

Uninsured women in the U.S. were particularly apprehensive, with only one of four (24%) believing they would be able to afford needed care if they fell ill. Insured women in the U.S. were more confident they could afford care, at more than twice that rate (61%).

HOW THE AFFORDABLE CARE ACT IS HELPING WOMEN IN THE UNITED STATES GET AFFORDABLE, HIGH-QUALITY HEALTH CARE

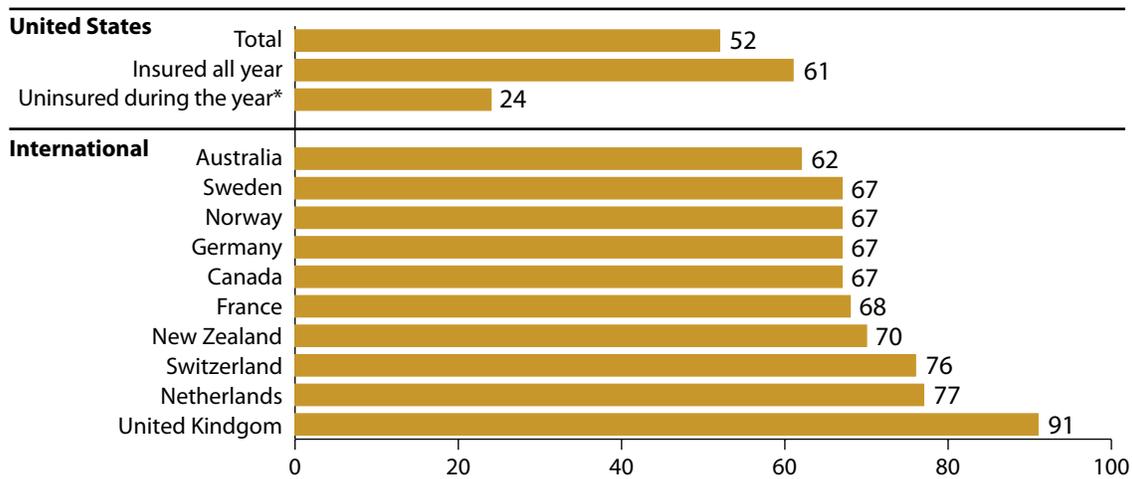
The Affordable Care Act will dramatically reduce women's exposure to high health care costs and eliminate many of their cost burdens and barriers to care. While the major insurance expansion provisions in the law begin in 2014, many early reforms are already helping women gain timely access to affordable care.

Free Preventive Care and Direct Access to Obstetrics and Gynecology Services for Women with Private Insurance

Since September 2010, all nongrandfathered private insurance plans (i.e., plans not in existence when the Affordable Care Act was signed into law in March 2010) sold in both the group and individual insurance markets have been required to cover preventive services rated as either "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) without copayment, coinsurance, or deductible. These services include screening for cervical and breast cancer; cholesterol checks; and osteoporosis and chlamydia screening for women in at-risk age groups.⁸ An estimated 20.4 million women

Exhibit 7. Women in the U.S. Report Lowest Rates of Confidence in Their Ability to Afford Needed Care

Percent of women ages 19–64 who felt confident or very confident in their ability to afford needed care if seriously ill



* Combines "Insured now, time uninsured in past year" and "Uninsured now."
Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.

ages 18 to 64 benefited from this provision in 2011.⁹ Women are also already benefiting from direct access to obstetrics and gynecological services without a referral from a primary care provider. Although these requirements apply only to nongrandfathered plans, most plans are expected to relinquish their grandfathered status over time and become subject to the requirement.¹⁰ Beginning in August 2012, an additional set of preventive services tailored specifically for women will be covered without cost-sharing, including all U.S. Food and Drug Administration–approved contraceptive methods and sterilization procedures.¹¹

Young Adults Stay on Parents Plans up to Age 26

In the past, uninsured rates for young women ages 19 to 29 were among the highest of any age group.¹² Since September 2010, young adults have been able to stay on or enroll in their parents' health plans until their 26th birthdays. The law applies to all private health plans that offer dependent coverage and to all adult children regardless of living situation, financial situation, or marital or student status. There is one restriction: young adults who are offered insurance by their

employer cannot join their parents' grandfathered plans until 2014. A recent survey by The Commonwealth Fund found that between November 2010 and November 2011, an estimated 6.6 million young adults ages 19 to 25, including 3.1 million women, stayed on or joined their parents' health plans, who likely would not have been able to do so prior to the passage of the law.¹³ A Department of Health and Human Services' analysis of the National Health Interview Survey found that insurance coverage of women ages 19 to 25 climbed from 71.2 to 77.5 percent between September 2010 and December 2011, likely as a result of the law.¹⁴

Insurance Plans for Women with Preexisting Conditions

Women who do not have an offer of employer coverage can struggle to find a health plan in the individual insurance market, particularly if they have health problems, are pregnant, previously had a cesarean section, or are survivors of domestic violence.¹⁵ Under the Affordable Care Act, Pre-Existing Condition Insurance Plans (PCIPs) are available in every state to cover people who have been uninsured for at least six months and who have a health problem that has made

it difficult for them to gain coverage.¹⁶ PCIPs cannot impose preexisting condition exclusions and premiums must reflect a standard population in the individual market with older enrollees charged no more than four times that of younger enrollees. The plans also limit annual out-of-pocket costs to \$5,950 for individual policies and \$11,900 for family policies. Nearly 62,000 people have enrolled in PCIPs, more than half of whom are women.¹⁷

New Market Rules

All private insurers in the individual and employer group markets are now prohibited from imposing lifetime limits on what their plans will pay out in benefits. The Department of Health and Human Services has estimated that 39.5 million women no longer have lifetime limits on their plans because of the law.¹⁸ The law also phases out annual benefit limits; by 2014, most health plans will be banned from imposing any limits on what they pay out in a given year. In addition, all health insurance plans are prohibited from rescinding coverage once an enrollee is covered under a plan, except in the case of intentional misrepresentation of fact.¹⁹

Support for Pregnant Women and New Mothers

The health reform law requires Medicaid to cover smoking-cessation support (including pharmacology and counseling services) for pregnant women and care provided by freestanding birth centers. The law also makes it easier for states to expand their Medicaid family planning services to women whose incomes are too high for Medicaid by greatly simplifying the process for gaining federal approval.²⁰ In 2011, the health reform law awarded \$224 million to states to fund home visits by nurses and social workers for families with children.²¹ In addition, the law also entitles all women who are nursing and employed by companies with 50 or more employees 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.

Improved Medicare Benefits for Older Women

Because of the Affordable Care Act, 24.7 million women who are covered by Medicare are also receiving additional preventive services without cost-sharing, including an annual wellness visit, a personalized prevention plan, mammograms, and bone-mass measurement for women at risk of osteoporosis.²² In addition, women with high prescription drug costs are benefiting from the law's phaseout of the Medicare prescription drug coverage gap, known as the "doughnut hole." More than 2 million women have saved \$1.2 billion on their prescription drugs as a result of rebates and discounts on brand-name drugs. The U.S. Department of Health and Human Services projects that 3 million women will save \$4.9 billion in 2021 when the hole is fully closed.

2014: NEAR-UNIVERSAL COVERAGE WITH CONSUMER PROTECTIONS

When fully implemented, the Affordable Care Act will ensure that nearly all American women have comprehensive, affordable health insurance. This will occur through a substantial expansion of the Medicaid program and the subsidized private health plans that will be sold through new state health insurance exchanges.²³

Although Medicaid is already an important source of insurance for pregnant women and parents in some states, most states cover parents with very low incomes only and few states insure adults without children at any income level.²⁴ In 2014, women with incomes up to 133 percent of the federal poverty level (\$30,657 for a family of four) will be eligible for coverage through Medicaid. For women with incomes up to 400 percent of poverty (\$92,200 for a family of four) who do not have an offer of an affordable plan through an employer, subsidies will be available to help them purchase private health plans from new state insurance exchanges. Refundable tax credits that are available in advance will cap what people spend on premiums on a sliding scale from 2 percent to 9.5 percent of their income. Cost-sharing subsidies will increase the cost protection of health plans for women with incomes

up to 250 percent of poverty; out-of-pocket limits will reduce out-of-pocket costs for those with incomes up to 400 percent of poverty.

Across all incomes, women purchasing health insurance on their own, whether through the exchanges or the individual insurance market, will be far more protected than they are in most states today. New consumer protections in the law require insurers to issue health plans to everyone who applies. Insurers will no longer be able to deny or restrict coverage based on preexisting health conditions, and will be prohibited from charging higher premiums based on health status or gender. This means that young women, whom insurers often charge considerably more for premiums than men, will face the same premiums as men in their age group.²⁵

In addition, starting in 2014, all plans sold through the exchanges and in the individual market will be required to include a new essential health benefit package similar to those offered in employer plans, which will include a full range of services including maternity coverage. An estimated 8.7 million people who currently purchase coverage in the individual market will gain maternity benefits starting in 2014 as a result of the law.²⁶

Some restrictions on women's access to abortion services in the individual market will remain. The law permits states to prohibit abortion coverage in the health plans offered through an insurance exchange if the state enacts a law that requires such a prohibition. As of July 2012, 19 states had passed legislation restricting abortion coverage in plans sold through their exchanges.²⁷ The exchanges are also required by law to follow strict payment and accounting procedures to ensure that the premium and cost-sharing tax credits are not used for abortion services, except as allowed by the Hyde Amendment.²⁸

The majority of newly insured women in 2014 will gain coverage through the Medicaid program. Studies show that women covered by Medicaid have better access to care than uninsured women, but still lag women with private insurance on important measures such as being up to date with essential preventive

Across all income levels, women purchasing health insurance on their own, whether through the exchanges or the individual insurance market, will be far more protected in 2014 than they are today in most states.

care.²⁹ To address this, the Affordable Care Act introduces measures to improve access to primary care for women with Medicaid and ensure their care is better coordinated.³⁰ Specifically, the law:

- temporarily increases Medicaid's reimbursement rates for primary care services to Medicare levels in 2013 and 2014, injecting an extra \$11 billion into the Medicaid primary care delivery system;³¹
- encourages Medicaid providers to cover USPSTF-recommended preventive services without cost-sharing by increasing federal matching payments to states that chose to do so, beginning 2013;
- allows states to pay higher reimbursement rates to health homes, a care model in which primary care providers and other health care professionals work together to improve patients' health care experiences across organizational boundaries;³²
- funds demonstration projects to test new models of care delivery, with medical homes and women's health selected as areas on which projects are encouraged to focus; and
- enhances primary care capacity through \$11 billion of new funding for community health centers, support for primary care physician training, and the establishment of new scholarship and student loan programs.

Together, once fully implemented, these reforms will provide near-universal health insurance coverage for women in the United States. Eight percent of

women are estimated to remain uninsured, compared with 20 percent who currently lack health insurance (Exhibit 2). Much of the cost burden and stress of paying for health care will be eliminated, and women—especially those with low incomes—will find it easier to get the essential health services that many struggle to access today.

CONCLUSION

A lack of comprehensive health insurance in the United States has exposed women to large financial risks during times of illness. In 2010, 18.7 million women between the ages of 19 and 64 were uninsured and an estimated 16.7 million had insurance that did not adequately protect them from high health care costs.

Comparing the experiences of women in the U.S. with women in other industrialized countries underscores the degree to which American women are disadvantaged by inadequate health insurance coverage. The U.S. stands out in terms of problems affording health care. Rates of going without needed health care because of its cost and of problems paying medical bills in the U.S. are the highest among all 11 countries included in the 2010 Commonwealth Fund International Health Policy Survey. Problems are particularly acute for women without insurance, half (51%) of whom reported problems paying medical bills in 2009 to 2010 and more than three-quarters (77%) of whom reported going without needed care because of cost. Although better off than their uninsured counterparts, women in the U.S. who are insured all year report health care affordability problems at higher rates than women in all other countries surveyed.

When fully implemented, the Affordable Care Act will correct much of the inequity in the U.S. system. A substantial expansion of affordable health insurance options is expected to reduce the percentage of uninsured working-age women from 20 percent to 8 percent (Exhibit 2). In the five states in which more than one-quarter of women lacked coverage in 2009–10, uninsured rates are estimated to fall below

Forty-three percent of women in the U.S. reported they went without recommended care, did not see a doctor when sick, or failed to fill prescriptions because of costs in the past year.

14 percent. In Texas, the uninsured rate is expected to drop from 30.3 percent in 2009–10 to 11.6 percent; in Florida, from 26.2 percent to 9.9 percent; in Arkansas, from 25.3 percent to 6.8 percent; in New Mexico, from 25.3 percent to 13.3 percent; and in Nevada, from 25.2 percent to 13.1 percent. In addition, women currently buying coverage on their own will experience significant expansions in benefits covered by their health plans and insurers will be prohibited from varying premiums based on health status and gender or excluding health problems from coverage.

Implementation of the insurance market reforms and the delivery system reforms in the law will be critical to closing the spending gap between the United States and other industrialized countries, and will also help lower the growth of premium costs. Data from the Organization for Economic Cooperation and Development (OECD) shows that health spending in the United States outstrips spending in all other industrialized countries.³³ In 2009, the United States spent 17.4 percent of its gross domestic product on health, while the OECD median was 9.5 percent, with no country spending more than 12 percent. The insurance market and health care delivery system reforms in the law will help lower U.S. health care cost growth and will move spending levels closer to those in other industrialized countries. The law is already changing the way in which hospitals, physicians, and insurers deliver care. New grants and incentives to providers and communities are helping to eliminate waste and accelerate the widespread adoption of innovative care delivery models—such as accountable care organizations

and patient-centered medical homes. These models aim to provide patients with care that is better coordinated around their needs, safer, and more efficient. The recent slowdown in national health spending to 3.9 percent in 2010 and 2011, from an average 6.8 percent annually in the 2000–2009 time period, is at least partly a reflection of these changes taking place across the country.³⁴

Continued implementation of the Affordable Care Act reforms will be essential to ensuring the future affordability of health care for women and

households. Furthermore, since research suggests that the differences in health spending between the U.S. and the rest of the world stem largely from higher prices rather than greater utilization, approaches to reducing prices must be explored.³⁵ Bringing health costs under control will be necessary to ensure that women can fully reap the benefits of the Affordable Care Act's insurance expansions and enjoy protection from the risk of catastrophic health care costs in the event of serious illness.

NOTES

¹ R. Robertson and S. R. Collins, *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* (New York: The Commonwealth Fund, May 2011); 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).

² National Women's Law Center, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act* (Washington, D.C.: NWLC, March 2012).

³ Federal poverty level income levels throughout the report are for 2012.

⁴ See Kaiser Family Foundation, *Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level (FPL) by Scope of Benefit Package*, Jan. 2012, available at <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>.

⁵ C. Schoen, A.-K. Fryer, S. R. Collins, and D. C. Radley, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs* (New York: The Commonwealth Fund, Nov. 2011).

⁶ Based on the Commonwealth Fund Biennial Health Insurance Survey, 2010, women are defined as underinsured if they were insured all year, but their annual out-of-pocket medical expenses (excluding premiums) were equivalent to 10 percent or more of their household income (5% for women with incomes below 200% of the federal poverty level), or their insurance plan included a per-person deductible equivalent to 5 percent or more of their household income. See C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs*, Sept. 2011 30(9):1762–71.

⁷ S. Thomson, R. Osborn, D. Squires, and S. J. Reed, *International Profiles of Health Care Systems, 2011* (New York: The Commonwealth Fund, Nov. 2011).

⁸ Robertson and Collins, *Women at Risk: Why Increasing Numbers*, 2011.

- ⁹ B. D. Sommers and L. Wilson, *Fifty-Four Million Additional Americans Are Receiving Preventive Services Coverage Without Cost-Sharing Under the Affordable Care Act* (Washington, D.C.: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Feb. 2012).
- ¹⁰ S. R. Collins, “Grandfathered vs. Non-Grandfathered Health Plans Under the Affordable Care Act: Striking the Right Balance,” *The Commonwealth Fund Blog*, June 2010.
- ¹¹ R. Robertson, “New Guidelines Mean Women with Insurance Will Get More Preventive Services Free,” *The Commonwealth Fund Blog*, Aug. 2011.
- ¹² Robertson and Collins, *Women at Risk: Why Increasing Numbers*, 2011.
- ¹³ S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Young, Uninsured, and in Debt: Why Young Adults Lack Health Insurance and How the Affordable Care Act Is Helping—Findings from the Commonwealth Fund Health Insurance Tracking Survey of Young Adults, 2011* (New York: The Commonwealth Fund, June 2012). New analysis of the 2011 Commonwealth Fund Health Insurance Tracking Survey of Young Adults was conducted to provide the estimate for women.
- ¹⁴ B. D. Sommers, *Number of Young Adults Gaining Insurance Due to Affordable Care Act Now Tops 3 Million* (Washington, D.C.: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, June 2012); S. R. Collins, T. Garber, and K. Davis, “Number of Uninsured in United States Grows to 49.9 Million; Young Adults Already Benefitting from the Affordable Care Act,” *The Commonwealth Fund Blog*, Sept. 2011.; B. D. Sommers and K. Schwartz, *2.5 Million Young Adults Gain Health Insurance Due to the Affordable Care Act* (Washington, D.C.: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Dec. 2011); A. Cuellar, A. Simmons, and K. Finegold, *The Affordable Care Act and Women* (Washington, D.C.: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 2012).
- ¹⁵ National Women’s Law Center, *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* (Washington, D.C.: NWLC, 2009).
- ¹⁶ J. P. Hall and J. Moore, *Realizing Health Reform’s Potential: Early Implementation of Pre-Existing Condition Insurance Plans: Providing an Interim Safety Net for the Uninsurable* (New York: The Commonwealth Fund, June 2011).
- ¹⁷ U.S. Department of Health and Human Services, “State by State Enrollment in the Pre-Existing Condition Insurance Plan, as of March 31, 2012,” HHS Press Release, May 18, 2012, available at <http://www.healthcare.gov/news/factsheets/2012/05/pcip05182012a.html>; Center for Consumer Information and Insurance Oversight (CCIIO), *Covering People with Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program*, available at <http://cciio.cms.gov/resources/files/Files2/02242012/pcip-report.pdf>.
- ¹⁸ T. D. Musco and B. D. Sommers, *Under the Affordable Care Act, 105 Million Americans No Longer Face Lifetime Limits on Health Benefits* (Washington, D.C.: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 2012), available at <http://aspe.hhs.gov/health/reports/2012/LifetimeLimits/ib.pdf>.
- ¹⁹ S. R. Collins, S. 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).
- ²⁰ Kaiser Family Foundation, *Medicaid’s Role for Women Across the Lifespan. Current Issues and the Impact of the Affordable Care Act* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Jan. 2012).
- ²¹ U.S. Department of Health and Human Services, “HHS Announces \$224 Million to Support Evidence-Based Home Visiting Programs to Help Parents and Children,” HHS Press Release, September 22, 2012, available at <http://www.hhs.gov/news/press/2011pres/09/20110922b.html>.
- ²² Cuellar, Simmons, and Finegold, *The Affordable Care Act and Women*, 2012.

- ²³ For more detail on the insurance provisions of the Affordable Care Act see, R. Robertson and S. R. Collins, *Women at Risk*, 2011; S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Gaps in Health Insurance: Why So Many Americans Experience Breaks in Coverage and How the Affordable Care Act Will Help* (New York: The Commonwealth Fund, April 2012); and The Commonwealth Fund's Health Reform Resource Center: What's In the Affordable Care Act? (Public Law 111-148 and 111-152), www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.
- ²⁴ The federal government requires state Medicaid programs to cover all pregnant women with incomes up to 133 percent of the federal poverty level during pregnancy and for up to 60 days after they have given birth. Some states extend coverage to pregnant women with incomes up to 300 percent of poverty.
- ²⁵ National Women's Law Center, *Turning to Fairness*, 2012.
- ²⁶ Cuellar, Simmons, and Finegold, *The Affordable Care Act and Women*, 2012.
- ²⁷ The 19 states restricting abortion coverage in the exchanges are: Arizona, Florida, Idaho, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, and Wisconsin. One additional state, Alabama, has a law restricting abortion coverage scheduled to go into effect later in 2012. See Guttmacher Institute, *State Policies in Brief: Restricting Insurance Coverage of Abortion* (New York: The Guttmacher Institute, July 1, 2012). Guttmacher Institute, July 2012, available at http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf.
- ²⁸ The Hyde Amendment is a long-standing federal law that prohibits federal funds being used for abortion services except in the case of rape, incest, or life endangerment. If receiving premiums paid for with tax credits, it is the responsibility of the health plan to segregate the part that is not subsidized with federal dollars into an account to be used exclusively for abortion services not allowed under the Hyde Amendment. For more detail see "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>. Restrictions on the use of federal funds for abortion services also apply to the expanded Medicaid program, the preexisting condition insurance plans, and the Community Health Center Fund.
- ²⁹ Kaiser Family Foundation, *Medicaid's Role for Women Across the Lifespan*, 2012.
- ³⁰ M. K. Abrams, R. Nuzum, S. Mika, and G. Lawlor, *Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers* (New York: The Commonwealth Fund, Jan. 2011); A. M. Audet and S. Patel, "The Care Coordination Imperative: Responding to the Needs of People with Chronic Diseases," *The Commonwealth Fund Blog*, Feb. 2012.
- ³¹ Centers for Medicare and Medicaid Services, Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program, Proposed Rule 42 CFR Parts 438, 441, and 447, *Federal Register*, available at <https://www.federalregister.gov/articles/2012/05/11/2012-11421/medicaid-program-payments-for-services-furnished-by-certain-primary-care-physicians-and-charges-for>.
- ³² Abrams, Nuzum, Mika, et al., *Realizing Health Reform's Potential*, 2011.
- ³³ D. Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality* (New York: The Commonwealth Fund, May 2012).
- ³⁴ S. P. Keehan, G. A. Cuckler, A. M. Sisko et al., "National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates," *Health Affairs*, July 2012 31(7):1600–12; K. Davis, "What's Working to Control Costs," *The Commonwealth Fund Blog*, June 2012; J. Tallon, "What Medicine Can Learn from Team Sports and Systems Science," *The Atlantic*, June 5, 2012; K. Davis, "Bending the Health Care Cost Curve: New Era in American Health Care?" *The Commonwealth Fund Blog*, Jan. 2012.
- ³⁵ Squires, *Explaining High Health Care Spending*, 2012.

METHODOLOGY

This issue brief includes data from three surveys conducted over multiple years: the Commonwealth Fund International Health Policy Survey of Adults in Eleven Countries (2010); the Commonwealth Fund Biennial Health Insurance Survey (2003, 2007, 2010); and the March Annual Social and Economic Supplement to the Current Population Survey (2001–2011).

The 2010 Commonwealth Fund International Health Policy Survey of Adults in Eleven Countries was conducted by Harris Interactive and country contractors in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the U.K., and the U.S. from March through June 2010. The survey was administered by telephone using a common questionnaire that was translated and adjusted for country-specific wording. Response rates ranged from 13 percent in Norway to 54 percent in Switzerland. The analysis weighted final samples to reflect the distribution of the adult population in each country, adjusting for age, sex, region, education, and additional variables consistent with country standards. This issue brief restricts the analysis to 8,197 women ages 19 to 64. Sample sizes for each country are included in [Appendix Table 1](#).

The 2010 Commonwealth Fund Biennial Health Insurance Survey was 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 Analysis in this issue brief is based on the responses of 1,671 women ages 19 to 64. 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

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>.

95 percent confidence level. We also report estimates from the 2003 and 2007 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 it did not include a cellular phone random-digit dial sample.² The 2003 survey was conducted from September 3, 2003, through January 4, 2004, and included 2,009 women ages 19 to 64; in 2007, the survey was conducted from June 6 through October 24 and included 1,675 women ages 19 to 64.

The Current Population Survey (CPS) is the primary source of information on U.S. labor force characteristics and is conducted monthly on a sample of about 60,000 households. The Annual Social and Economic Supplement to the CPS is conducted in March of each year with a sample of about 100,000 households. This brief uses data collected from 2000 through 2010 to analyze uninsured rates among women ages 19 to 64.

Commonwealth Fund staff analyzed the Commonwealth Fund International Health Policy Survey of Adults in Eleven Countries and the Commonwealth Fund Biennial Health Insurance Surveys. Nicholas Tilipman and Bhaven Sampat of Columbia University's Mailman School of Public Health provided analysis of the CPS data.

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.

Appendix Table 1. Cost-Related Access Problems in Past Year in Eleven Countries, Women Ages 19–64

In the past year, was there a time when you...	Did not fill a prescription for medicine or skipped doses because of cost?	Had a medical problem but did not visit a doctor because of cost?	Skipped a medical test, treatment, or follow-up that was recommended by a doctor because of cost?	Any access problem because of cost*
United States n=993	26%	30%	29%	43%
Insured all year n=805	18%	19%	20%	32%
Uninsured during the year** n=188	53%†	63%†	57%†	77%†
Australia n=1,544	16%^	17%^	18%^	28%^
Canada n=1,627	12%^	5%^	6%^	17%^
France n=614	8%^	8%^	8%^	17%^
Germany n=395	8%^	19%	12%^	28%^
Netherlands n=417	5%^	3%^	3%^	8%^
New Zealand n=409	9%^	12%^	10%^	17%^
Norway n=467	8%^	8%^	7%^	14%^
Sweden n=644	11%^	7%^	6%^	15%^
Switzerland n=474	5%^	9%^	4%^	13%^
United Kingdom n=613	2%^	2%^	3%^	7%^

* Respondent experienced at least one of the following access problems in the past year because of cost: did not fill a prescription for medicine or skipped doses; had a medical problem but did not visit a doctor; skipped a medical test, treatment or follow-up that was recommended by a doctor.

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

† Denotes significant difference from insured all year rate in United States ($p \leq 0.01$).

^ Denotes significant difference from United States rate for all women ages 19–64 ($p \leq 0.01$).

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.

Appendix Table 2. Problems with Medical Bills and Insurance Complexities in Eleven Countries, Women Ages 19–64

	Had out-of-pocket medical expenses of \$1,000 or more in the past year	Had a serious problem paying or unable to pay medical bills in the past year	Spent a lot of time on paperwork or disputes related to medical bills in the past year	Insurance denied payment for medical care or did not pay as much as expected in the past year*
United States	39%	26%	21%	31%
Insured all year	40%	18%	18%	31%
Uninsured during the year**	36%	51%†	30%†	n/a
Australia	23%^	13%^	8%^	15%^
Canada	14%^	7%^	8%^	16%^
France	5%^	12%^	12%^	24%^
Germany	9%^	4%^	18%	14%^
Netherlands	13%^	6%^	9%^	21%^
New Zealand	11%^	8%^	5%^	6%^
Norway	15%^	6%^	8%^	3%^
Sweden	1%^	8%^	3%^	2%^
Switzerland	24%^	7%^	8%^	13%^
United Kingdom	0%^	2%^	4%^	2%^

* Base: respondents insured all year.

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

† Denotes significant difference from insured all year rate in United States ($p < 0.01$).

^ Denotes significant difference from United States rate for all women ages 19–64 ($p < 0.01$).

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.

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