THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

May 2014

Women and Health Care in the Early Years of the Affordable Care Act

Key Findings from the 2013 Kaiser Women's Health Survey

Prepared by:

Alina Salganicoff, Usha Ranji, Adara Beamesderfer, and Nisha Kurani

Kaiser Family Foundation

Acknowledgements

The authors are grateful to many colleagues at the Kaiser Family Foundation and Princeton Survey Research Associates International who provided valuable contributions to this survey. In particular, the authors would like to thank Rachel Licata, formerly of the Kaiser Family Foundation, for her assistance with survey analysis.

Table of Contents

Executive Summary

The passage of the Affordable Care Act (ACA) in 2010 heralded a new era in health care coverage, with major implications for women's health and access to care. Provisions such as the mandatory inclusion of maternity care, coverage without cost sharing for preventive services such as contraceptives, and a prohibition on charging women more than men for the same plan were all designed to address gaps and inequities in women's health insurance. Some of these provisions were implemented shortly after the passage of the ACA, including the expansion of dependent coverage and the preventive services coverage rules. The requirement for mandatory insurance coverage and the expansion in Medicaid eligibility and state-based Marketplaces are just getting underway.

Understanding the law's myriad impacts on women's health and access to care will take many years, but it is important to have a baseline with which to compare future outcomes. The Kaiser Family Foundation undertook this survey to provide an initial look into the range of women's health and care experiences, especially those that are not typically addressed by most surveys nor often analyzed through a gender lens. The Kaiser Family Foundation conducted this nationally representative survey in the fall and early winter of 2013, just before the ACA's major coverage expansion began. The findings presented in this report examine women's coverage, access, and affordability to care, as well as their connections to health providers and use of preventive care based on an analysis of a nationally representative sample of 2,907 women ages 18 to 64. In addition, a shorter survey of 700 men ages 18 to 64 was also conducted and key findings are included in the text for the purposes of comparison. To provide the data for the analysis of women's use of reproductive and sexual health services, this report analyzes the responses of a nationally representative sample of 1,403 women ages 15 to 44.

This report addresses a wide range of topics that are at the heart of women's health care and changes that women may experience as a result of the ACA. It also highlights differences for uninsured, low-income, and minority women--groups of women that have been historically underserved –which is especially important in light of the characteristics of women in the U.S. today. Nearly one in three women ages 18 to 64 live in households that are below 200% of the federal poverty level (FPL) which was $19,530 for a family of three in 2013. One in three women identify as racial and ethnic minorities (13% Black, 14% Hispanic, and 9% Asian or Other) and half are in their childbearing years. A sizable minority of women also report that their health is fair or poor (15%) and over four in ten have a health condition that requires monitoring and treatment (43%). For these women in particular, access to health care is an essential and ongoing concern. Key findings from the survey include:

Coverage, Access and Affordability

The health coverage expansion will fill a major gap in coverage for women.

In the late fall and early winter of 2013, as the ACA's coverage expansion kicked into gear, approximately one in five women ages 18-64 were uninsured (18%). Employer-sponsored insurance (ESI) covered the majority of women (57%), with nearly half of that group covered as a dependent either through a spouse or parent. Just 7% of women were covered by individual insurance and about one in ten women (9%) had Medicaid, the nation's health program for low-income individuals. In the coming years, millions of uninsured women could gain access to coverage that includes a wide range of benefits that are important to their care.

Gaps in coverage are experienced by a disproportionately high share of low-income women and women of color.

For low-income women, the gaps in coverage are considerable, with 4 in 10 reporting that they were uninsured at the end of 2013. Nearly a quarter of Black (22%) and over one-third (36%) of Hispanic women were also uninsured. Eligibility for Medicaid and availability of subsidies in the form of tax credits will help many women gain access to coverage. While many may have enrolled in the state Marketplaces or in Medicaid during the open enrollment period, some of the poorest women do not qualify for assistance because they reside in a state that is not expanding Medicaid or are undocumented immigrants that are explicitly excluded from Medicaid and state Marketplace plans.

Coverage under a parent's plan is now the leading way that women under age 26 get their coverage, but few are aware that parents may get information about their care.

One of the earliest ACA provisions that took effect in September 2010 was the extension of dependent coverage to young people up to age 26, who had the highest uninsured rate of any age group at the time the law was passed. In 2013, over four in ten (45%) women ages 18 to 25 reported that they were covered on a parent's plan as a dependent. Because they are adult children, the extension of coverage has raised concerns about their ability to maintain privacy regarding the use of sensitive health services such as reproductive and sexual health care and mental health. The survey finds that less than four in ten young women (37%) are aware that private insurers typically send an explanation of benefits (EOB) documenting use of health care services to primary policy holders, often a parent. Yet, the vast majority (71%) of young women state that it is important to them that their use of health services be confidential.

Many women report they face cost-related barriers to health care, and many report that medical bills are a problem that force them to make difficult trade-offs.

One in four (26%) women have had to delay or forgo care in the past year due to cost compared to 20% of men. While health costs are a major barrier to care for nearly two-thirds (65%) of uninsured women, 16% of women with private insurance and 35% of women with Medicaid also said they delayed or went without care because they could not afford it. Nearly three in ten women have had problems paying medical bills in the past year (28%). Problems are, not surprisingly, more common among uninsured women (52%) and low-income women (44%), who have fewer resources to cover their bills. A substantial share of women with medical debt reported they either used up most of their savings, had difficulty paying for basic necessities, or had to borrow money from friends or relatives to pay for their bills.

Logistical barriers to care beyond coverage and affordability are challenges for many women.

Many women report they can't find the time (23%) or take time off work (19%) to get their care. Childcare (15%) and transportation problems (9%) also prevent some women from getting to care, and are more frequently reported among low-income women (19% and 18%, respectively). One-quarter of all women, regardless of income, reported that lack of time to go to the doctor was a reason they went without care. While the ACA and other reforms have the potential to help offset coverage gaps and assist with the burdens of costs, the survey finds that factors such as work place flexibility, sick leave, and child care also have implications for women's access to care.

Connections to Care

Coverage and delivery system reforms could result in more women having a stronger connection to health providers, but new models of care need to be gender sensitive.

The vast majority of women say they have a place to go when they need care (86%), have a doctor that they see regularly (81%) and have seen a provider in the past two years (91%). On average, a higher share of women than men report that they have an existing connection to a health care provider or place. Among women, however, those who are uninsured have considerably weaker connections to the health care system, reporting lower rates on all of these indicators. About seven in ten uninsured women (69%) have a regular site of care, but only half (50%) have a regular clinician, and three-quarters (75%) have had a recent provider visit. Women who are younger, Hispanic, low-income or uninsured are also more likely to lack these important connections to care. Women's care can also be complex because some see Obstetrician/Gynecologists for their reproductive needs and different providers for their other health needs. The ACA includes incentives to improve primary care and develop new models for patient centered medical homes. Given the importance of sexual and reproductive health for women, incorporating these sensitive services into new models of care will be a key consideration.

While most women get their care in a private doctor's office, community health centers and family planning clinics are sources of care for a sizable minority of women covered by Medicaid or without insurance.

Among women who identify a place where they usually seek care when they are sick or need medical advice, almost three in four (73%) go to a doctor's office or a health maintenance organization setting (HMO). While eight in ten women with private insurance (82%) go to a doctor's office for routine care, this share drops to two-thirds of women with Medicaid (66%) and less than half of uninsured women (45%). Medicaid beneficiaries (23%) and uninsured women (28%) have much higher reliance on clinics than privately-insured women (7%). Nearly one in six uninsured women (16%) say they get their routine care from an emergency room. While it is too soon to tell how safety net providers will fare as more people gain coverage and shift to private or Medicaid plans, many women will still rely on these providers for their care.

Preventive Services

The ACA rules that require private plans to cover preventive services without cost sharing may help boost use of preventive services, but awareness of the requirement and use of services are still lagging.

The ACA included new requirements for private plans to cover a wide range of recommended preventive screening and counseling services without cost sharing. Public awareness of these insurance reforms, however, is far from universal. Six in ten women know that plans must now cover well-woman visits and 57% know that mammograms and pap tests are covered without cost sharing. While most women report a recent checkup or well woman visit (82%), rates of specific preventive counseling and screenings are uneven. Most women report that they have discussed diet and nutrition (70%) with a provider in the past 3 years, but fewer than half of women have recently talked to a provider about smoking (44%), alcohol or drug use (31%), and mental health (41%). A deeper focus on the content of well woman visits, along with patient education, may be needed to broaden use of clinical preventive services for women.

Women enrolled in Medicaid use preventive care at rates that are similar or higher than women with private insurance.

Women enrolled in Medicaid, despite their lower incomes and constrained provider options, obtain preventive screening and counseling services at rates that are on par with women with private coverage. The ACA includes a small financial incentive for state Medicaid programs to provide coverage of all services recommended by the USPSTF without cost-sharing. Efforts to expand no-cost coverage under Medicaid to these recommended evidence-based services could further access to screening and counseling services for the millions of low-income women served by the program.

Reproductive and Sexual Health Services

There is considerable room for improvement in the rates of counseling on reproductive and sexual health topics.

Despite the high rates of sexually transmitted infections (STIs) and unintended pregnancy, counseling on these topics is not routine among women of reproductive age (15 to 44 years). While most reproductive age women have had recent conversations with a provider about contraception (60%), the rate is much lower regarding sexual history (50%), HIV (34%), other STIs (30%), and intimate partner violence (IPV) (23%). Furthermore, many women are incorrectly under the impression that HIV and STI tests are routinely included as part of their gynecological exams. While four in ten reproductive age women report that they have had a test for HIV (44%) or other STIs (40%) in the past two years—about half of these women mistakenly assumed this test was a routine part of an examination. Therefore, the actual screening rates are likely lower than the share of women who report being tested. This assumption clearly has implications for the treatment and the prevention of transmission of these infectious diseases.

A substantial share of sexually active women is not using any contraception and is at high risk for unintended pregnancy.

While the effectiveness of FDA approved contraceptives in preventing unintended pregnancy is widely known, an estimated one in five (19%) sexually active women ages 15 to 44 who do not want to get pregnant are at high risk for unintended pregnancy because they and their partner are not using contraceptives and have not had a sterilization procedure. Among women of reproductive age who have had sex in the past year, about half (51%) report that they or their partners used at least one contraceptive method, one in ten (10%) are pregnant or trying to conceive, and one in five (20%) women report that they or their partner have had a sterilization procedure or cannot become pregnant. Among sexually active women who have used contraceptives in the past year, nearly two-thirds (63%) report using male condoms and almost half have used birth control pills (48%).

A sizable minority of women using contraceptives now rely on long acting reversible contraceptives (LARCs).

LARCs, which include IUDs, sub-dermal implants and injections, are among the most effective methods of birth control. While condoms and oral contraceptives are the most common forms of birth control that women use, about one-third of women who have been sexually active in the past year and using a contraceptive say they used a LARC. About one in five (19%) say they have an intrauterine device (IUD), 6% report using an implant, and 7% report using hormonal injections as their contraceptive. LARCs, particularly IUDs, can have significant upfront costs and require provider insertion and follow up care. The ACA contraceptive coverage

provision may result in the increased adoption of these highly effective approaches by eliminating potential cost barriers associated with these contraceptives.

While awareness of emergency contraceptive pills is quite high, a small fraction of women say they have actually used or purchased them.

Emergency contraceptive (EC) pills can be taken after unprotected sex or as a backup method to prevent unintended pregnancy in cases of contraceptive failure. In 2009, the EC pills, Plan B®, became available without a prescription and in 2010, a new prescription formulation (ella®), was approved by the FDA. As with other contraceptives, private plans are required to cover prescriptions for EC without cost sharing under the ACA's preventive services policy. It has now been 15 years since EC pills were approved by the FDA and 86% of women ages 15 to 44 report that they have heard of them. However, a small percentage of women (5%) say they have used or bought EC pills, ranging from 12% of women ages 19 to 24 to 2% of both teens ages 15 to 18 and women ages 35 to 44.

One in three women with private insurance say their insurance covered the full cost of contraception.

The ACA includes provisions that require new plans to provide no-cost coverage for prescription FDA-approved contraceptive services and supplies for women (including insertion, removal and follow up care). While this provision only applies to "new" or "non-grandfathered" plans, over time it is anticipated that most women with private coverage will be enrolled in plans that offer this coverage. Nearly one and half years after the ACA contraceptive coverage rule took effect, insurance covered the full cost for one-third (35%) of women with private insurance. Another 41% reported that insurance covered part of the costs and about one in ten (13%) women with private insurance reported they did not have any coverage for birth control.

Family planning providers and community health centers play a major role in providing contraceptive care for uninsured women and women of color.

Most sexually active women who use birth control state that they receive contraceptives at a doctor's office or HMO (61%) and 16% obtain contraceptive care at a clinic-based setting. Established to provide care regardless of income, essential community providers finance contraceptive care largely through Title X (the federal planning program) and Medicaid. These clinics provide contraceptive care to substantial shares of uninsured (43%), Hispanic (37%), and Black women (23%). As care systems increasingly shift to private managed care plans, it will be important to monitor how care changes for the women who have been relying on these providers for their reproductive and sexual health care. In addition, because some low-income women will either not qualify for coverage or may not be able to afford to enroll in plans, many will still be reliant on these safety-net providers for their sexual and reproductive health care.

Introduction

For women, health care has long been a priority issue for reasons stemming from their own health needs and their central roles in managing their families' health. As such, many of the reforms in the Affordable Care Act (ACA) were developed to address the perceived shortcomings that were part of health insurance design before the passage of the law. The ACA includes a ban on gender rating, a policy that permitted plans in the individual insurance market to charge women more than men for the same coverage. The law eliminates pre-existing condition exclusions that affected women who were pregnant or victims of intimate partner violence or who had chronic medical conditions. It provides coverage without cost sharing for a wide range of recommended preventive services. These preventive benefits ultimately required coverage of contraceptives as well as seven other services specifically for women including well woman visits, screening for intimate partner violence, and breastfeeding support.

The impact of the law on women's access to coverage and care will take many years to assess. Will it make coverage and care more affordable for women? Will access be improved? Will the new coverage requirements improve the use of preventive services? How will contraceptive coverage affect the contraceptive choices that women make and where they get that care? And ultimately, will the changes in coverage improve health and provide stability of coverage for women? These questions will take time and will be difficult to answer.

While it is too early even to begin to answer these and other questions about the ACA, this survey was conducted to get a window into women's health care and coverage experiences at the early stage of the ACA's implementation. This survey builds on prior Kaiser Family Foundation surveys on women's health, conducted in 2001, 2004, and most recently in 2008 in the early days of the Great Recession. The survey was conducted in the fall and early winter of 2013 and reports on experiences related to health care coverage, access, affordability, providers, and preventive care among a nationally representative sample of women ages 18 to 64. It also reports on women's access to reproductive and sexual health services among a nationally representative sample of women ages 15 to 44. While most of the report presents findings for women ages 18 to 64, a shorter survey of men ages 18 to 64 was also conducted and key findings are included in the text for the purposes of comparison. All women and men were interviewed by telephone (landline and cell phone).

This report provides new data on women's health insurance coverage, their access to care and use of health care services, as well as health care affordability. This survey addresses topics that affect women across their lifespans, including the importance of the ACA for women's reproductive and sexual health care and establishes a useful baseline to help us understand and measure changes in women's health care experiences as health reform implementation moves forward over the coming years. We hope that these data will provide a useful lens through which to begin to gauge the impact of the ACA on women's health and their care.

Profile of Demographic and Health Characteristics of Women in the U.S.

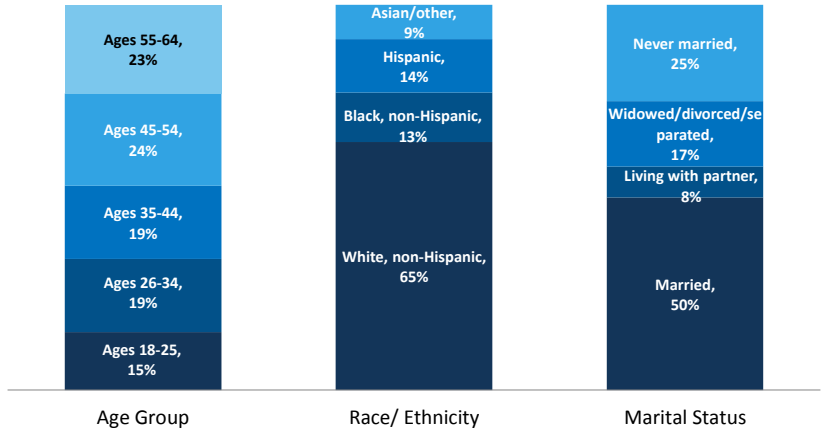
Health care is shaped by and intertwined with many aspects of women's lives. It is, therefore important to assess the demographic characteristics of the survey populations, non-elderly adult women ages 18 to 64 as well as reproductive age women, 15 to 44 years old.

Nonelderly adult women ages 18 to 64

Not surprisingly, the nation's women are a diverse population in many respects. Fifteen percent of women are in their early adult years, ages 18 to 25. Another 38% are ages 26 to 44 and almost half (47%) are in their middle years, ages 45 to 64. Almost two-thirds of women are White, non-Hispanic (referred to as White throughout this report), 13% are Black, non-Hispanic (referred to as Black throughout this report), 14% are Hispanic, and 9% are of another racial or ethnic group, including Asian, Pacific Islander, and other groups (**Figure 1**). Throughout this report, data are presented for White, Black, and Hispanic women. Data by other racial/ethnic groups are not presented because the sample sizes for these subgroups were not sufficient to provide reliable national estimates. The authors recognize that women of other races and ethnicities have important health needs and distinct health concerns; however, we were not able to report on these in this report. Half of women ages 18 to 64 are married (50%), nearly one in ten live with a partner (8%), 17% are widowed, divorced, or separated, and a quarter of women never married (25%).

Figure 1

Selected Demographic Characteristics of Women, Ages 18-64

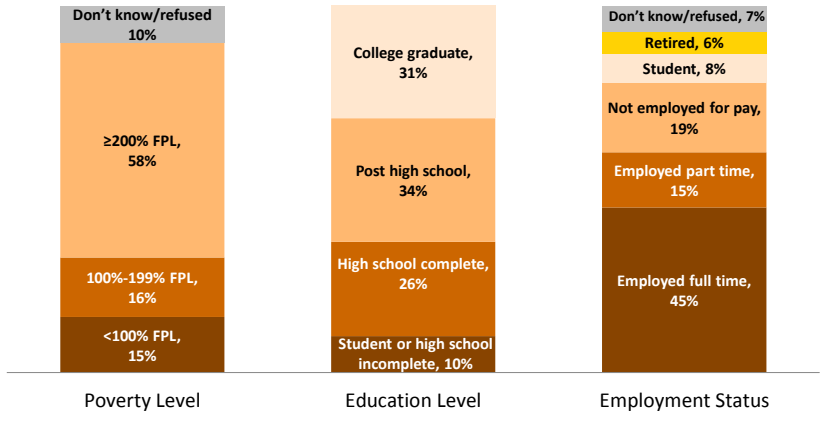


NOTE: Among women ages 18 to 64.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Many women face challenging economic circumstances **(Figure 2)**. Fifteen percent live below the poverty line, which was just under $20,000 for a family of three in 2013, when this survey was conducted. Another 16% of women have incomes between 100 and 199% of poverty. Together, 31% of women ages 18 to 64 have incomes under 200% of the federal poverty level, referred to as "low income," throughout this report. Almost six in ten women (58%) have incomes above this level and data are not available for 10% of women. About a third (36%) have a high school degree or less education. Most women work outside the home, either full-time (45%) or part-time (15%). About a third are not employed for pay (19%), students (8%), or retired (6%).

Figure 2

Selected Socio-Economic Characteristics of Women, Ages 18-64



NOTE: Among women ages 18 to 64. The Federal Poverty Level was $19,530 for a family of three in 2013.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Reproductive age women ages 15 to 44

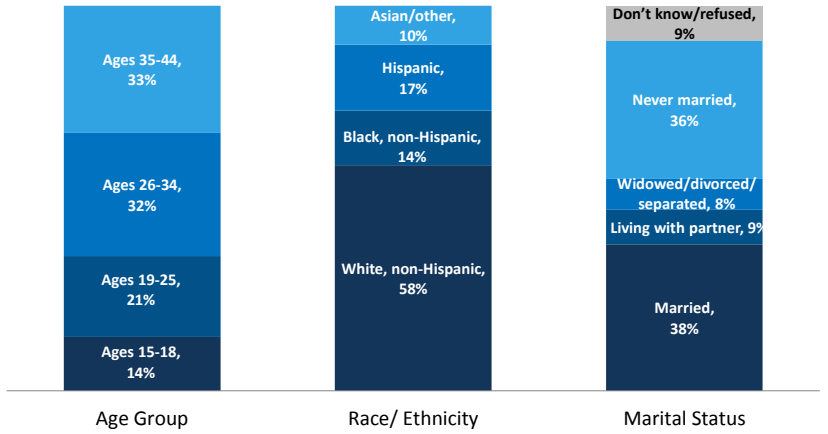
The survey also includes a sample of teen girls ages 15 to 17 as part of the reproductive age group. Although most females ages 15 to 17 are not yet sexually active, many are dating and reproductive and sexual health

services are an important component of health care for this age group. **Figures 3 and 4** present demographic characteristics of women ages 15 to 44, the population discussed in the section on reproductive and sexual health. About a third (35%) of this group are young adults through age 25 and the rest are 26 to 44. Almost six in ten are White (58%) and about four in ten (41%) are women of color. Not surprisingly, this group has a lower marriage rate (38%) than women 18 to 64, and more than a third (36%) have never been married. More than a third (37%) of reproductive age women are low-income, with incomes less than 200% of the poverty line, 18% are students or do not have a high school degree, and over half (56%) are working full or part time.

Throughout this report, data are presented to highlight the range of experiences that different subpopulations of women face when they use health care, particularly the challenges facing those who are at risk for poor access to care, those who are low-income, and women of color. These are the women who are most likely to benefit from the insurance and benefit reforms that are part of the ACA.

Figure 3

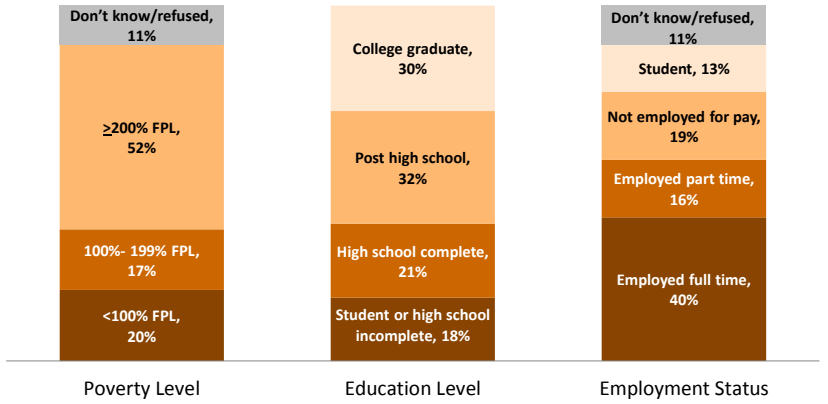
Selected Demographic Characteristics of Women, Ages 15-44



NOTE: Among women ages 15 to 44.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Figure 4

Selected Socio-Economic Characteristics of Women, Ages 15-44



NOTE: Among women ages 15 to 44. The Federal Poverty Level was $19,530 for a family of three in 2013.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Women's health status

In addition to diversity in demographic characteristics, women have a wide range of health needs, which set the framework for the care they need and seek. How women assess their health status is an important gauge of their overall health and medical care needs. Women who rate their health as "fair" or "poor" typically need and use more health care services than women reporting better health ("excellent," "very good" or "good"). In addition to the global measure of self-reported health status, the rates of chronic conditions and the impact of those conditions on women's ability to lead productive lives are important measures of women's health status and provide a window into their health needs over their lifetimes.

Overall, 15% of non-elderly adult women ages 18 to 64 rate their health as fair or poor (**Table 1**). This rate increases with age, from 12% of adult women in their reproductive years (ages 18 to 44) to nearly one in five women (19%) ages 45 to 64. Among Hispanic women, 28% report fair or poor health, also 12% of White and 16% of Black women. Fourteen percent of women report that they have a disability or chronic condition that

limits their daily activities. This is the case among 8% of women ages 18 to 44, but is reported by more than twice as many middle-aged and older women ages 45 to 64 (21%).

Table 1: Health problems reported by women, by age and race/ethnicity						
	All Women	Age Group		Race/Ethnicity		
Share of women reporting:		Ages 18-44	Ages 45-64	White	Black	Hispanic
Fair/poor health	15%	12%	19%	12%	16%	28%*
Have disability, handicap, or chronic disease that limits activity	14%	8%	21%*	15%	15%	14%
Have ongoing condition that requires regular monitoring, care, or medication	43%	32%	55%*	48%	38%*	35%*

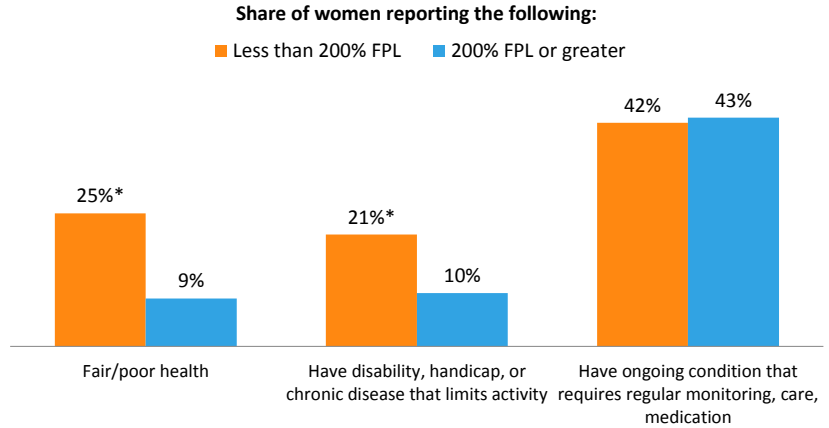
NOTE: Among women ages 18-64. *Indicates a statistically significant difference from Ages 18-44, White, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

A sizable minority of women (43%) say that they have an ongoing condition that requires regular monitoring, treatment, or medication. This is reported by about one-third of women ages 18 to 44 (32%) and rises to over half of older women (55%). In contrast to self-reported health status, White women (48%) report ongoing health conditions that require monitoring, care or medication at higher rates than both Black (38%) and Hispanic women (35%). This difference could be attributable, in part, to poorer access to care experienced by women of color. Women with more limited access may be more likely to have undiagnosed conditions that require care, but they are unaware of their presence.

The difference in health status between women of different poverty levels is also notable and of particular relevance, given the ACA's focus on health care costs and spending in addition to coverage. Low-income women report higher rates of health problems than more affluent women (**Figure 5**). One in four low-income women rate their health as fair or poor, which is over twice the rate of higher-income women (9%). Similarly, the rate of women reporting an activity-limiting disability or chronic disease is twice as high among low-income women (21%) than their higher income counterparts (10%). The lack of differences in the share reporting that they have a medical condition that requires ongoing care could be attributable to the poorer health care access experienced by many low-income women.

Figure 5

Poorer women have higher rates of fair/poor health and conditions resulting in activity limitations



NOTE: Among women ages 18 to 64. The Federal Poverty Level (FPL) was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Methods

The 2013 Kaiser Women's Health Survey obtained land line and cellular telephone interviews with a nationally representative sample of 3,015 women ages 15 to 64 living in the United States. The survey was conducted by Princeton Survey Research Associates International (PSRAI). Interviews were done in English and Spanish by Princeton Data Source LLC from September 19 to November 21, 2013. A combination of landline and cellular random digit dial (RDD) samples was used to represent all women ages 15 to 64 in the United States who have access to either a landline or cellular telephone. Both samples were provided by Survey Sampling International, LLC (SSI) according to PSRAI specifications.

For the landline sample, interviewers first asked to speak with the youngest female adult ages 18 to 64 who was at home. Once an eligible adult respondent was on the phone, interviewers determined if any eligible teens ages 15 to 17 lived in the household. If the household contained both an eligible adult and an eligible teen, one was chosen to interview, but priority was given to the teen interviews in recognition of the challenges of obtaining those interviews. Cell phone interviews started by first determining whether the person who answered the phone was eligible for the adult interview. If not, the interview was coded as ineligible and terminated. If the cell phone respondent was eligible for the adult interview, it was then determined whether or not they were the parent or guardian of any girls ages 15 to 17. Parental consent was obtained for all teen interviews and households where a teen interview was completed were sent $50 for their participation.

The samples were disproportionately-stratified to reach more low-income women and to increase the incidence of African American and Latina respondents. The data were weighted in the analysis to remove the disproportion from the selection rates by stratum and to make the data fully representative of women ages 15 to 64 living in the United States, as well as to compensate for patterns of nonresponse that might bias results. The weighting was accomplished in multiple stages to account for [a] the disproportionately-stratified samples, [b] the overlapping landline and cell sample frames, [c] household composition and [d] differential non-response associated with sample demographics.

A shorter companion survey of men was conducted via telephone (landline and cell phone) interviews with a nationally representative sample of 700 men ages 18 to 64 living in the United States to examine differences between women and men on a range of measures. Limited amounts of data on men are presented in this report and more detailed findings on men will be the subject of another forthcoming paper.

The margin of sampling error for the complete set of weighted data and for age subgroups of women as well as the full sample of men are shown in **Table 2** below. When possible, statistically significant at $p<.05$, differences are noted in the tables and graphics included in the report.

Table 2: Survey sample size and margin of error

	Sample Size	Margin of Error
Total sample of women ages 15-64	3,015	2.9 percentage points
Women ages 18-64	2,907	3.0 percentage points
Women ages 15-44	1,403	4.1 percentage points
Total sample of men 18-64	700	4.3 percentage points

Coverage, Access, and Affordability

Health insurance coverage is a critical factor in making health care accessible and affordable to women. Women with health coverage are more likely to obtain needed preventive, primary, and specialty care services, and have better access to new advances in women's health. The primary goal of the ACA was to expand coverage to millions of uninsured across the country and to make reforms so that coverage is stable, affordable, and comprehensive. The law requires that most individuals have health insurance coverage in 2014 or pay a tax penalty. To facilitate access to coverage, the law includes a major expansion of Medicaid to many low-income individuals and establishes new Marketplaces in each state where most uninsured individuals who do not qualify for Medicaid can purchase a private insurance policy. While the law's primary focus is on expanding coverage and reducing the number of uninsured, it also makes a number of other changes designed to make care more affordable and accessible.

Coverage

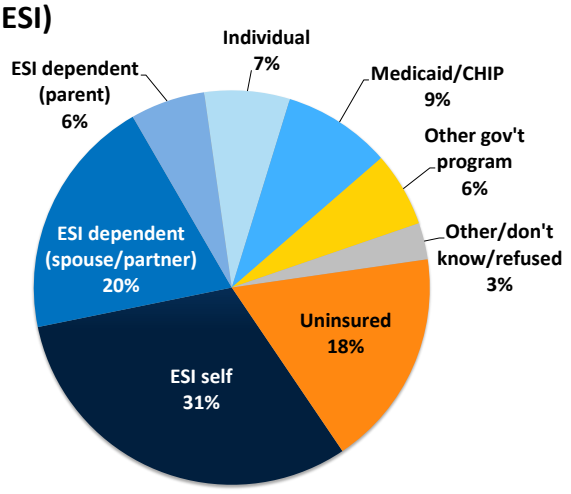
The ACA extends coverage to uninsured individuals through a combination of changes in private and public coverage. The ACA was designed to expand eligibility for Medicaid to the poorest individuals (less than 138% of the federal poverty level) and to make to make coverage more affordable and available to individuals with incomes between 100% and 400% of poverty by establishing state-based Marketplaces where individual can obtain coverage and receive assistance with premium costs through a graduated system of tax credit subsidies. However, because of a 2012 Supreme Court ruling, the Medicaid expansion is now optional for states; about half have decided not to expand their programs at this time. In the states that have not expanded Medicaid, this choice has had the consequence of limiting access to affordable coverage for the poorest uninsured residents and lowering the number of people who qualify for coverage under the program.

As the major part of the ACA's coverage expansion begins, almost one in five women are uninsured.

Most women (82%) have health coverage, but nearly one in five women (18%) between the ages of 18 and 64 are uninsured (**Figure 6**). Men, however, are uninsured at a higher rate (23%) than women. Employer-sponsored insurance (ESI) covers the majority of women (57%), with nearly half of that group covered as a dependent either through a spouse or parent. One in four women are covered as dependents (26%) and can be more vulnerable to losing their insurance should they become widowed or divorced, their spouse or parent loses a job, or if their spouse's or parent's employer drops family coverage. Just 7% of women are covered

Figure 6

Majority of women are covered by employer-sponsored insurance (ESI)



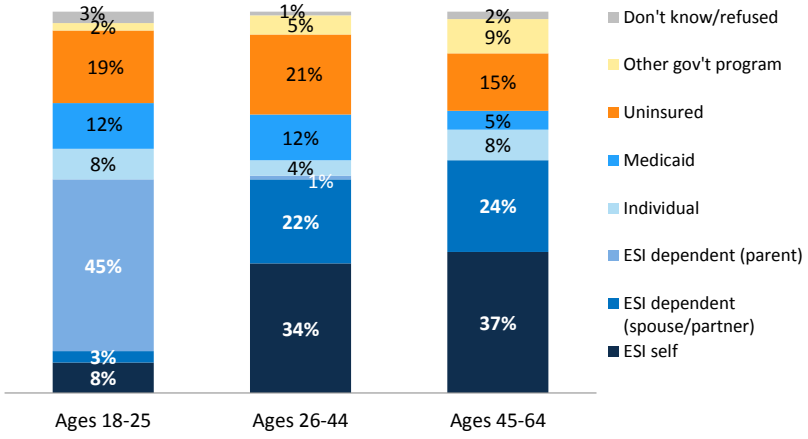
NOTE: Among women ages 18-64. "Other gov't program" includes Medicare and Tricare.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

by private individually purchased insurance, with that proportion expected to change, as many turn to state-based marketplaces to obtain their coverage under the ACA. Currently, Medicaid, the nation's coverage program for low-income individuals, covers about one in ten women (9%). Before the ACA was enacted, eligibility for Medicaid in most states was limited to women with dependent children, those who were pregnant and those with a disability. The ACA's coverage expansion was designed to broaden Medicaid to many more low-income individuals and offer a new coverage pathway to poor adults without children who were largely ineligible before the law was passed. Although not all states are expanding Medicaid, the program's enrollment is expected to grow significantly in the coming years.

The ACA also included a major reform that allows adult children to stay on their parents' health insurance policies up to the age of 26. This policy went into effect in 2010 and in 2013, many young adults were covered under their parents' employer sponsored plans. While the overall rate of ESI coverage is similar between women of different age groups, 45% of women ages 18 to 25 are covered through a parent's policy, accounting for the single largest segment of coverage in this age group (**Figure 7**). In prior years, this age group had the lowest coverage rates. Among women in older age groups, most women with ESI obtain coverage through their own job or through a spouse's job. Medicaid also plays a prominent role for women under age 45, insuring 12% in that age group, a rate that is over twice the rate of middle aged women ages 45 to 64.

Figure 7

Over four in ten young women are insured under a parent's plan



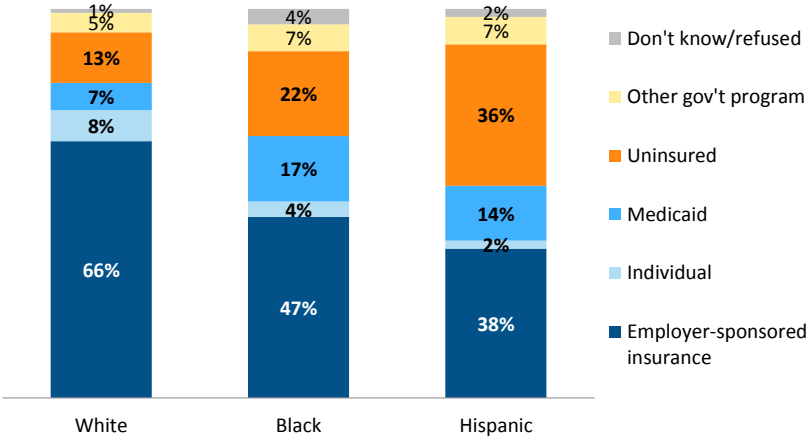
NOTE: Among women ages 18-64. "Other gov't program" includes Medicare and Tricare.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Lack of coverage is a problem facing a significant share of women of color.

Minority women have higher rates of uninsurance and lower rates of employer-sponsored insurance compared to White women (**Figure 8**). While two-thirds of White women (66%) have insurance through an employer, either their own or as a dependent, this is the case for less than half of Black (47%) and Hispanic women (38%). These differences in part reflect the fact that minority women and their spouses are more likely to work in low-wage jobs that do not provide access to employer-sponsored insurance and have fewer financial resources to purchase coverage on their own. The rate of

Figure 8

Women of color have lower rates of private coverage and higher rates of Medicaid or no insurance



NOTE: Among women ages 18-64. "Other gov't program" includes Medicare and Tricare.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

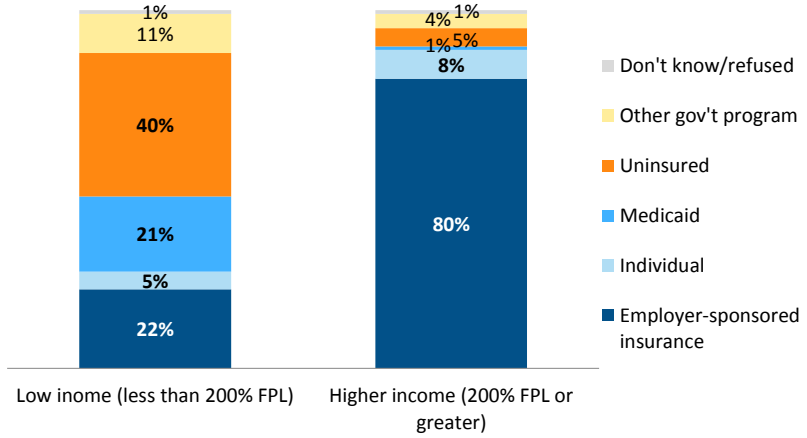
Medicaid coverage among Black (17%) and Hispanic women (14%) is double that of White women (7%), reflecting the lower average incomes and concentration of poverty among racial and ethnic minority women who may be more likely to qualify for the program. The highest uninsured rate is among Hispanic women (36%), followed by Black women (22%), compared to 13% of White women. However not all women have access to Medicaid or federal tax credit subsidies under the ACA. Most women who are recent immigrants (who on average have high rates of poverty) do not qualify for Medicaid for at least five years after entering the U.S. legally, as a matter of federal law. Undocumented individuals, however, do not have any avenue to coverage, as they are barred both from Medicaid eligibility and from purchasing a plan or receiving subsidies through the state-based Marketplaces.

Low-income women have much lower coverage rates, and even among those who are currently covered, some have been without insurance earlier in the year.

Four in ten low-income women (40%) are uninsured currently, compared to 5% among higher-income women (**Figure 9**). Not surprisingly, low-income women also have much higher rates of Medicaid coverage (21%) than their higher income counterparts (1%) due to Medicaid eligibility rules. They also have much lower rates of employer-sponsored insurance (22% vs. 80% respectively) than higher-income women largely due to the fact that they are more likely to work part-time or part-year, work in a low wage job that lacks health benefits, or live in a household without an attachment to the workplace.

Figure 9

Many low-income women are uninsured



NOTE: Among women ages 18-64. The Federal Poverty Level (FPL) was $19,530 for a family of three in 2013.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Even among women who have insurance, coverage is not always stable. Women can have spells of being uninsured as a result of job loss or change, premium prices becoming unaffordable, or in the case of dependent coverage, a spouse's job loss, or divorce or widowhood. While 82% of women report they had insurance at the time of the survey, a small share of that group report that there was a period in the prior when they were without insurance, which means that 77% were insured for the full year. Spells without insurance are more common among low-income women who have lower coverage rates to begin with. Only 53% of low-income women had coverage for a full year, compared to 90% of higher income women.

Access Challenges

While coverage plays a large role in accessing health care services, there are numerous factors that affect whether or not a woman actually obtains health care. These include health care costs, provider availability and capacity, as well as practical logistical issues such as transportation and finding time to make it to medical appointments. Some of these factors can be ameliorated by reforms in the ACA, such as the caps on out-of-

pocket costs and the coverage expansions, but others are systemic such as workplace benefits and flexibility, child care, transportation, and the availability of health care in communities where low-income women reside.

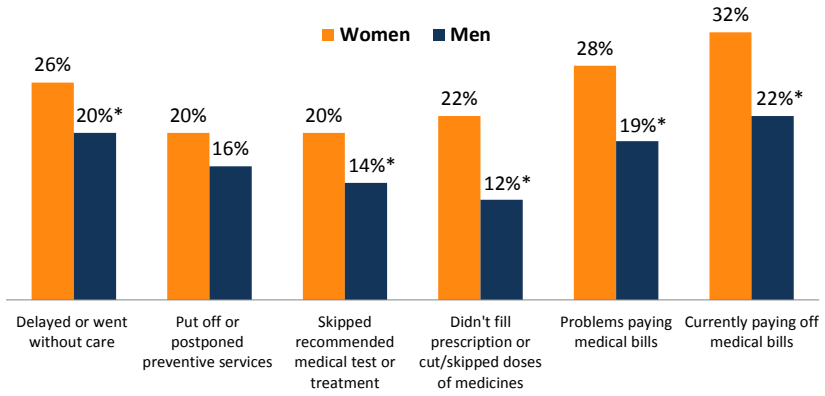
Out-of-pocket health costs are barriers to care for women and men, but are more common among women.

A higher share of women forgo health care needs due to cost compared to men. Insurance premiums, co-payments, deductibles, and services that are not covered by insurance can be expensive, potentially limiting access to care or jeopardizing a woman's and her family's financial health. While women and men both feel the impact of health costs, they are burdensome for a higher share of women, who on average earn lower wages, have fewer financial assets, accumulate less wealth, and have higher rates of poverty. This is compounded by women's greater health care needs, including reproductive health care services, and higher expenses throughout their lifespans.

Figure 10

A higher share of women than men forgo health care needs due to cost

Share reporting that in past 12 months they experienced following due to costs:



NOTE: Among women and men ages 18-64. *Indicates a statistically significant difference from Women, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey* and *2013 Kaiser Men's Health Survey*.

A sizable share of women report that health care costs impede their access to services, force them to make tradeoffs, or result in unpaid medical bills (**Figure 10**). Across the board, these problems are more common among women than men. One in four (26%) women and one in five men (20%) have had to delay or forego care in the past year due to cost. Because of costs, approximately one in five women have also postponed preventive care (20%), skipped a recommended test or treatment (20%), or made medication tradeoffs such as not filling a prescription or cutting dosages (22%). About three in ten women report that they have had problems paying medical bills (28%) in the prior year or are currently paying off medical bills (32%), compared to about one in five men who report problems paying bills (19%) or who are currently paying them off (22%).

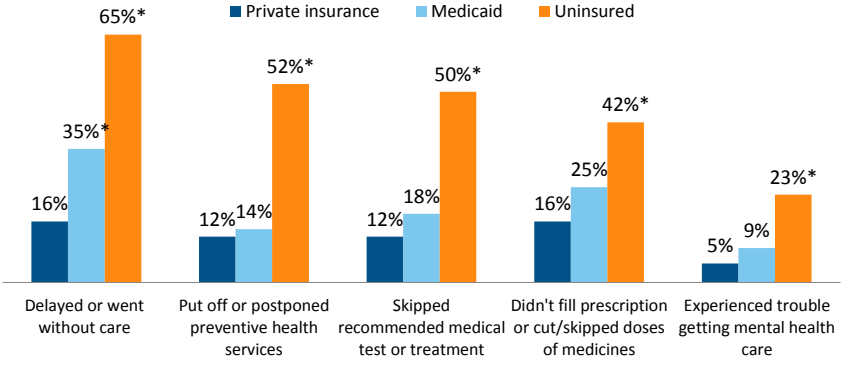
Costs are particularly burdensome for uninsured and low-income women.

For uninsured women, health costs can be a considerable barrier to care (**Figure 11**). Compared to women with private or public coverage, higher shares of uninsured women report that cost-related barriers to care. Almost two-thirds (65%) of uninsured women went without or delayed care because of the costs. Half

Figure 11

Health care costs are a barrier to care for uninsured women, but also for women with Medicaid and private coverage

Share of women reporting that in past 12 months they experienced following due to costs:



NOTE: Among women ages 18-64. *Indicates a statistically significant difference from Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

postponed preventive services (52%) and half skipped a recommended medical test or treatment (50%). Four in ten uninsured women either didn't fill a prescription or skipped or cut pills as a result of costs (42%) and about a quarter experienced problems obtaining mental health care (23%). However, it is important to recognize that even some women with coverage also experience affordability challenges that lower their access to health care. Sixteen percent of women with private insurance delayed or went without care because they could not afford it and many experienced other cost barriers as well. Although in some states Medicaid charges very nominal cost sharing amounts, this can still be an obstacle since women enrolled in the program have very low incomes by definition. One-third (35%) of women with Medicaid report postponing or going without care due to cost and many encountered other barriers too. One-quarter (25%) report that they made tradeoffs related to prescription drugs, which could be attributed to state policies that permit cost sharing or place caps on the number of prescriptions covered by their state Medicaid program.

Not surprisingly, low-income women report cost-related barriers at significantly higher rates than their higher income counterparts. One-third of low-income women report that cost was a reason they postponed preventive services (35%) or skipped medical tests and treatments (34%), a rate that was over twice as high among women with higher incomes (**Table 3**).

Table 3: Cost barriers to health care for women, by race/ethnicity and poverty level

	All Women	Race/Ethnicity			Poverty Level	
Share of women reporting they:		White	Black	Hispanic	Less than 200% FPL	200% FPL or greater
Put off or postponed preventive health services due to cost	20%	18%	23%	23%	35%*	13%
Skipped a recommended medical test or treatment due to cost	20%	19%	25%	21%	34%*	14%

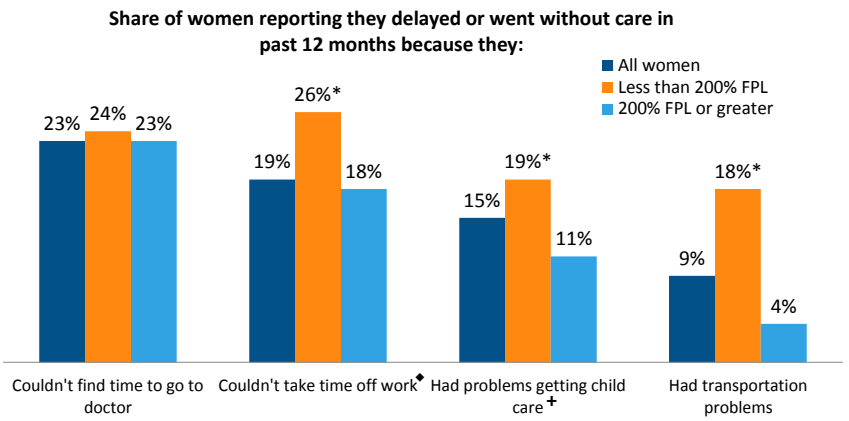
NOTE: Among women ages 18-64 reporting actions within past 12 months. *Indicates a statistically significant difference from White, 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

In addition to costs, women face logistical barriers to health care related to their roles as mothers and in the work place.

Costs and affordability are not the only barriers to health care for women. Lack of time and flexibility with work can pose a challenge in getting care for a sizable fraction of women. One in four women report that they did not obtain care they needed because they didn't have time (23%) and one in five delayed or went without care because could not take time off work (19%). These barriers affect women of all socio-economic statuses to different extents **(Figure 12)**. However, childcare and transportation problems are much more frequently reported among low-income women. Among women with children, one in ten (11%) with higher incomes report they delayed or couldn't obtain needed care because they had

Figure 12

Logistical problems pose barriers to health care for women, particularly low-income women



NOTE: Among women ages 18-64. ◆Among women employed full- or part-time. +Among women with children. *Indicates a statistically significant difference from 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

problems getting child care, but the rate is almost double among low-income women (19%). For many women, getting to a doctor can be a challenge, but nearly one in five low-income women cited transportation problems as a reason for going without care (18%).

Impact of Medical Bills

Many women and their family members face problems paying medical bills for a variety of reasons. While this problem is greater for women who are uninsured, women with Medicaid and with private insurance also have difficulties covering their out-of pocket medical costs. Medical bills can easily pile up given high cost sharing, charges associated with out of network use, coverage limits or exclusions, or high deductibles for women with insurance. Uninsured women are often charged "full price," a higher amount than the negotiated rate insurance plans pay for medical services, and do not have insurance to pay any of the costs of their care. Some women incur significant out-of-pocket medical expenses because of an unexpected health event such as a pregnancy, illness, or injury. These events may also limit a woman's ability to continue working and result in lost income, further limiting her ability to pay medical bills. Medical debt can have serious financial consequences. Prior research has found that it is the leading reason for personal bankruptcy, and can cause women to exhaust their savings, make tradeoffs with other needed expenses, or compromise their credit standing.[1] As more women gain coverage under the ACA, this should help alleviate the impact of medical bills but for some women, there could still be considerable costs associated with care, even among those gaining coverage.

Problems paying medical bills are reported by a sizable minority of women.

Approximately three in ten women have had problems paying medical bills in the past year (28%) compared to 19% of men. Nearly a third of women say they currently have medical bills that are unpaid or are in the process of paying them off (32%), also at a rate that is higher than for men (22%). Not surprisingly, uninsured women report problems paying medical bills in the prior year (52%) and having current outstanding bills (52%) at twice the rate of women with private insurance (21% and 26% respectively) (**Table 4**). This is however still a problem for a significant fraction of women with insurance. About one-third of women covered by Medicaid, who have very low incomes to use to pay off medical debt, also report having problems (37%) with medical bills or are currently paying them off (36%). These problems are also more common among younger women, who also tend to have lower earnings.

Table 4: Rates of unpaid medical bills, by age group, insurance status, and poverty level

	All Women	Age Group		Insurance Status			Poverty Level	
Share of women reporting:		Ages 18-44	Ages 45-64	Private insurance	Medicaid	Uninsured	Less than 200% FPL	200% FPL or greater
They or family member had trouble paying medical bills in past 12 months	28%	31%	26%	21%	37%*	52%*	44%*	21%
They currently have unpaid medical bills or bills currently being paid off	32%	35%	28%*	26%	36%	52%*	46%*	25%

NOTE: Among women ages 18-64. *Indicates a statistically significant difference from Ages 18-44, Private insurance, 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

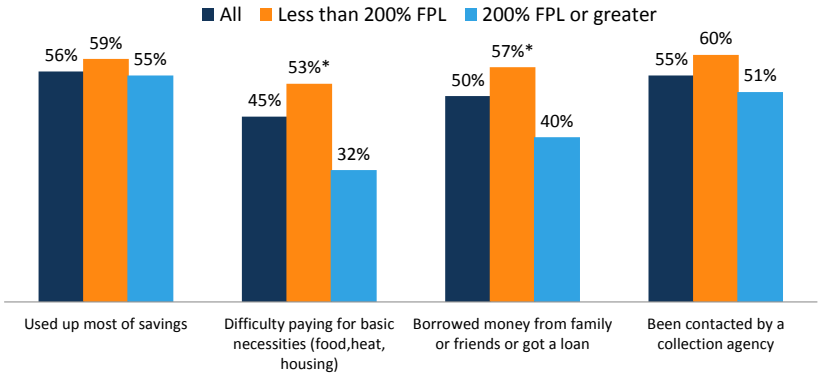
Medical bills have serious consequences for women's finances and can force women to make difficult tradeoffs.

Medical bills have tangible consequences for other areas of women's financial security. Among women reporting they had problems paying medical bills in the prior year, more than half report that they used up most of their savings (56%) or were contacted by a collection agency (55%) as a result of those bills. Many women also say they have had to borrow money from family or friends (50%), and or faced difficulties in paying for basic necessities such as food and electricity (45%) because of their medical bills. Not surprisingly, higher shares of low-income women face these difficult tradeoffs attributable to medical debt (**Figure 13**).

Figure 13

Medical bills affect many aspects of women's financial stability

Among women reporting they had trouble with medical bills in past 12 months, the share reporting they have experienced the following due to those medical bills:



NOTE: Among women ages 18-64. The Federal Poverty Level (FPL) was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Connections to Health Providers

Women have a broad range of health needs that evolve over the course of their lives. In their younger years, health concerns related to reproductive and sexual health are priorities. As they age, management of chronic health problems takes on a larger role. Women's health needs and connections to providers are major factors in how they use health care. The ACA includes a number of measures that affect the delivery of care, such as incentives to increase the supply of primary care providers, who are often a woman's main connection to the larger health system. However, in recent years, there has been much concern that the supply of primary care providers is already insufficient and that this problem will be exacerbated by the health care demands of the newly insured. The ACA also prioritizes the development and expansion of health care delivery models, such as medical homes and accountable care organizations, which include financial incentives for providers to work in partnerships. The goal is to provide a strong linkage to a primary care provider and integrate the wide array of clinicians that women may turn to for health care. The expectation is that this will result in better coordination and continuity of care, as well as enhanced access to the full range of services women may need.

Usual Sources of Care

Having a usual site of care and a doctor are markers of women's access to care and are associated with higher use of recommended preventive care and screening services. Having a regular place or provider helps with care coordination and can promote access and continuity. There is increased attention in the ACA to the concept of a "medical home." In the case of women, this would be a health care setting where women's health needs can be addressed and coordinated in a way that can promote the quality of care and reduce duplication in care. This is especially important for women, who are more likely than men to rely on at least two providers for their routine care.

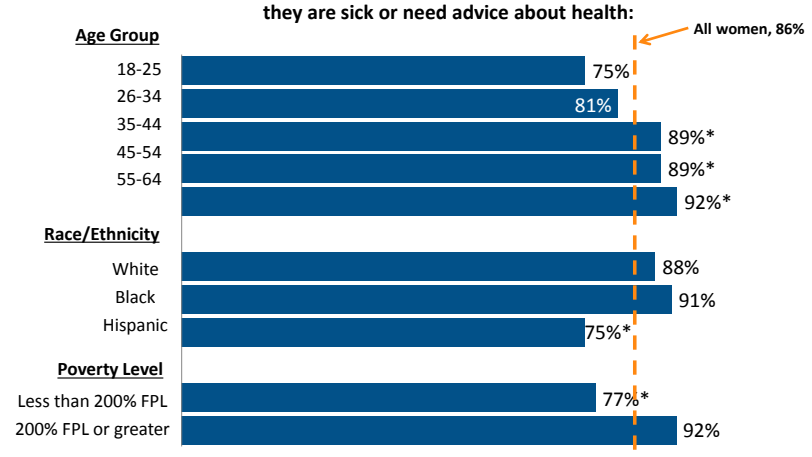
Most women have a place that they go for routine care, but it is less common among young, Hispanic, low-income and uninsured women to have a usual source of care.

Most women (86%) report they have a place to go for care when they are sick or need advice about their health (**Figure 14**). This rate is significantly higher than for men (72%). Among women, however, the rate is lowest among younger women, with 75% of women ages 18 to 25 and 81% of women 26 to 34 reporting they have a usual place to get their care, significantly lower than the rates for women who are older. Fewer Hispanic women (75%), low-income (77%) and uninsured women (69%) report they have a routine place to get their care.

Figure 14

Most women identify a place where they go for care

Share of women reporting they have a place that they usually go to when they are sick or need advice about health:

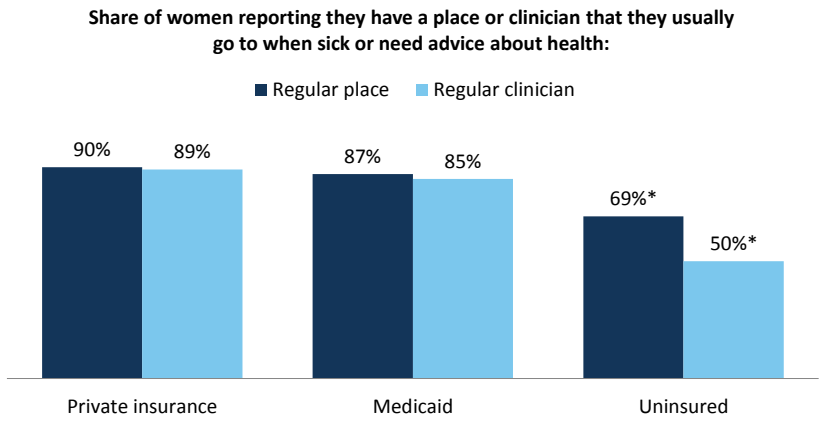


NOTE: Among women ages 18 to 64. The Federal Poverty Level (FPL) was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from Ages 18-25; White; 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

The vast majority of women also report that they have a specific clinician (doctor or other health provider) that they see for their routine care. Overall, more than eight in ten women report that they have a provider (81%) they use when they are sick or need routine care, compared to 68% of men. The rate is similar between privately insured women (89%) and those covered by Medicaid (85%) (**Figure 15**). For uninsured women, however, connections with individual providers are the most tenuous. While about two-thirds (69%) say they have a place they get their care, only half report that they have a specific clinician that they see for routine care (50%).

Figure 15

Most women identify a place or clinician they usually go to for care, but lower among uninsured women



NOTE: Among women ages 18 to 64. *Indicates a statistically significant difference from Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

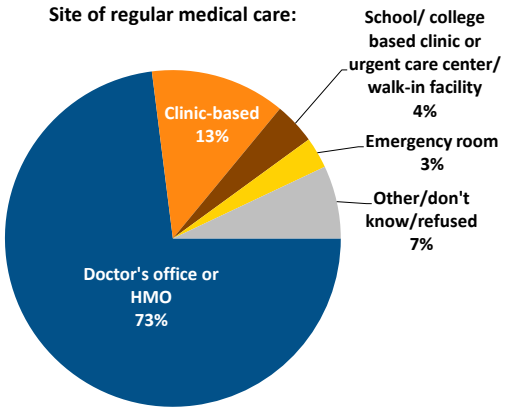
HEALTH CARE SETTINGS

Most women get their routine care from doctor's offices, but one in ten rely on clinic-based settings.

Among women who identify a routine setting, doctor's offices and HMOs are the most common site reported (**Figure 16**). Almost three in four women (73%) report that this is where they seek care. About one in ten women (13%) rely on a clinic setting and 3% report an emergency room as their routine source of care. A small fraction of women report that they rely on school based clinics or urgent care centers for their routine care. Women who use urgent centers and emergency rooms may be most at risk for receiving expensive, fragmented, and discontinuous care.

Figure 16

Doctors' offices are the most common setting where women receive care



NOTES: Among women ages 18-64 who have a usual source of care. "Clinic-based" includes family planning clinics , community health centers, and other clinics. "Other/don't know/refused" includes some other facility and all women who responded they do not know the site of care.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

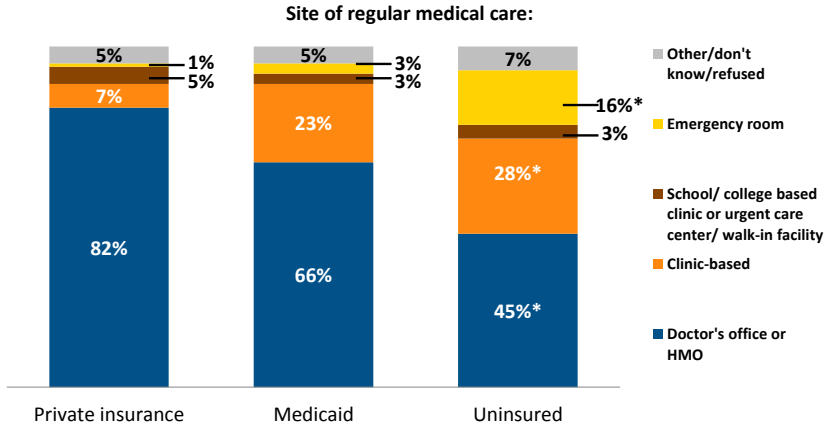
A sizable minority of women covered by Medicaid or who are uninsured rely on clinics for their care. For one in six uninsured women, emergency departments serve as their routine source of care.

Differences in the types of settings that women with various types of insurance coverage rely on are notable (**Figure 17**). This variation reflects the networks of providers available to women through their plans and the long-standing role that safety net providers have filled in serving uninsured and low-income patients. While eight in ten women with private insurance (82%) go to a doctor's office for routine care, this share drops to two-thirds of women with Medicaid coverage (66%) and less than half of uninsured women (45%). There have

been historical challenges with physician participation in the Medicaid program, which is due in part to low provider reimbursement rates under the program. Medicaid beneficiaries (23%) and uninsured women (28%) have much higher use of clinics than privately-insured women (7%). Community health centers and public clinics were established to help care for low-income and underserved populations and play a major role serving these women. Of particular concern though, is that 16% of uninsured women say they usually seek care when they are sick or need medical advice in an emergency room, a rate considerably higher than their counterparts with Medicaid (3%) or private coverage (1%). As more women gain coverage under the ACA, they may also have better access to primary care and it is hoped that reliance on emergency departments for non-urgent care will fall. It is also not clear at this point, however, whether the provider networks under plans offered by state Marketplaces will include traditional safety-net providers, such as community health centers and family planning clinics.

Figure 17

Clinics are important sources of care for women with Medicaid or who are uninsured



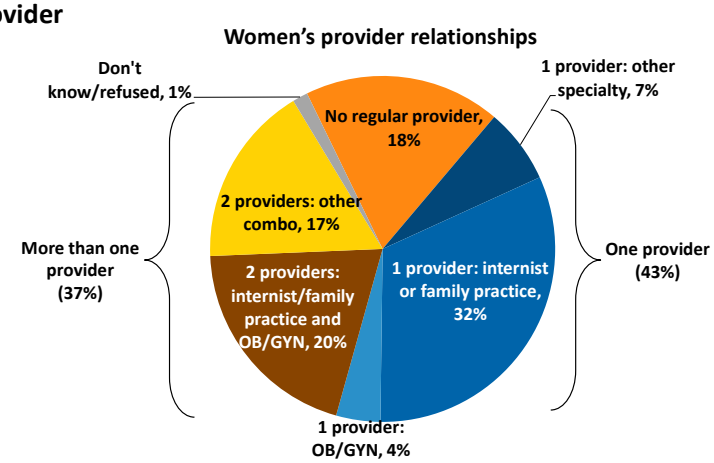
NOTES: Among women ages 18-64 who have a usual source of care. "Clinic-based" includes family planning clinics, community health centers, and other clinics. "Other/don't know/refused" includes some other facility and all women who responded they do not know the site of care. *Indicates a statistically significant difference from Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

One-third of women report that they see more than more than one clinician for their routine care.

Over four in ten women (43%) report they see one provider regularly and one-third of women (37%) say they have multiple providers to address their basic health needs (compared to 18% of men). Family practitioners and internists are the most common provider types, and among those with multiple providers, Obstetrician-Gynecologists (Ob/Gyns) are the most commonly identified second provider. This is not surprising given women's reproductive and sexual health needs. Almost one in five women (18%) do not have a regular provider of any type (**Figure 18**).

Figure 18

Over one-third of women have more than one provider they see for routine care, OB/GYN most likely to be identified as secondary provider



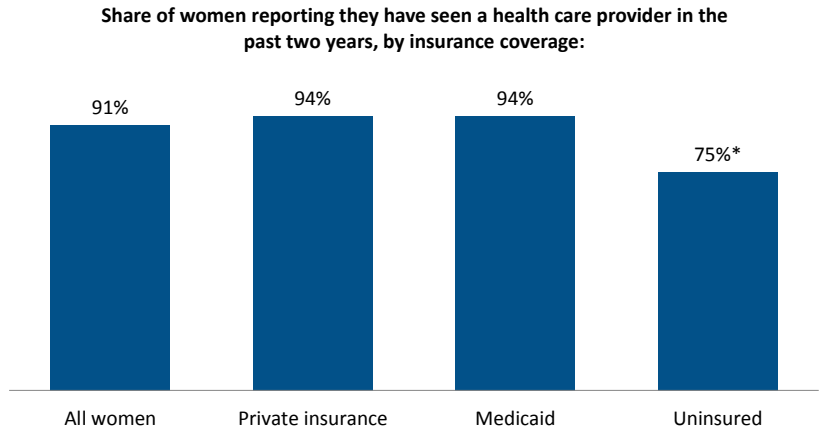
NOTE: Among women ages 18-64. Share of women who identified type of provider is among women who reported having a regular provider.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Most women have had a recent health provider visit in the past two years, but uninsured women have the lowest rates.

Nine in ten adult women (91%) have seen a health care provider in the past two years compared to 75% of men. Hispanic women (84%) have a significantly lower rate than Black (91%) or White (93%) women of having a provider visit in the past two years. The largest difference is between women who are uninsured (75%), who have a significantly lower rate than women with private insurance or Medicaid (**Figure 19**). Designing a medical home for women is complicated by the traditional division of care that many women experience, with reliance on Ob/Gyns for reproductive care as well as primary care providers for other types of care. Among women with more complex and multiple medical conditions, similar challenges will arise. In designing programs and systems that encourage stable and comprehensive medical homes, the distinct needs of women are important considerations.

Figure 19

Uninsured women have lower rates of recent provider visits



NOTES: Among women ages 18-64. *Indicates a statistically significant difference from Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Most women use at least one prescription medication on an ongoing basis, and nearly one in ten take six or more medications on a regular basis.

Another important health access issue relates to women's use of prescription drugs. Over half of women (56%) take at least one prescription medicine on a regular basis compared to just over one-third of men (37%). Three in ten women say they take one or two prescription medications (31%), while nearly one in ten women (9%) report taking at least six different medicines on a regular basis. Use of prescription medications is driven in part by health needs as well as access to care. Use rises with age, partly due to the higher rates of chronic conditions among older women. Six in ten uninsured women report that they do not use a prescription medicine on a regular basis, compared to about four in ten women with private insurance (40%) and Medicaid (42%) (**Table 5**). This may be in part attributable to poorer access to care, undiagnosed conditions that could be managed with medication, and poorer ability to pay for medications since they do not have insurance. Almost one in five women covered by Medicaid (19%) take at least 6 medications on an ongoing basis, compared to 6% of women with private insurance. This difference may be explained by the poorer health status of women enrolled in Medicaid. Women with Medicaid coverage are disproportionately poor and some may qualify on the basis of their disability as well as their poverty status. Under the ACA, prescription medicines are one of the Essential Health Benefits (EHBs) that all new plans must now cover, but specific medicines and cost sharing requirements vary between plans.

Table 5: Prescription drug use by women, by age, race/ethnicity and insurance status									
	All Women	**Age Group**		**Race/Ethnicity**			**Insurance Status**		
Share of women reporting:		Ages 18-44	Ages 45-64	White	Black	Hispanic	Private	Medicaid	Uninsured
No Rx Use	44%	50%	37%*	39%	45%	60%*	40%	42%	61%*
1-2 Medicines	31%	36%	25%*	33%	28%	27%	36%	20%*	22%*
3-5 Medicines	16%	9%	23%*	18%	16%	8%*	17%	19%	8%*
6+ Medicines	9%	4%	15%*	10%	10%	5%	6%	19%*	7%

NOTE: Among women ages 18-64. *Indicates a statistically significant difference from ages 18-44, White, Private insurance, p<05.

SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Preventive Services

Clinical preventive care helps identify health problems earlier, allowing conditions to be treated or managed more effectively before they become more serious. The ACA prioritizes and promotes access to clinical preventive services by requiring that new private plans cover recommended clinical preventive services without cost sharing. The specific services that new plans must include are the ones that are recommended by:[2]

- the US Preventive Services Task Force (USPSTF), an independent body of clinicians and scientists that reviews the evidence of preventive health care services and develops recommendations for primary care providers and health care systems; services with grade A or B are covered under the ACA policy;[3]
- the Advisory Committee on Immunization Practices (ACIP), a group of medical and public health experts convened by the Centers for Disease Control and Prevention (CDC) that makes recommendations on vaccines for people of all ages;[4]
- the Health Resources and Services Administration's (HRSA) Bright Futures project for children, in partnership with the American Academy of Pediatrics provides recommendations to improve health of infants, children and adolescents;[5]
- the Health Resources and Services Administration, Office of Women's Health issued federal regulations for eight preventive care services for women based on recommendations from a committee of the Institute of Medicine (IOM).[6]

The combined roster of services recommended by these groups is extensive and can be classified into a few broad categories, including counseling and screening tests related to cancer, chronic conditions, mental health, health behaviors, and certain sexual and reproductive health services. For women, the law also requires no cost sharing for at least one annual "well woman" visit.

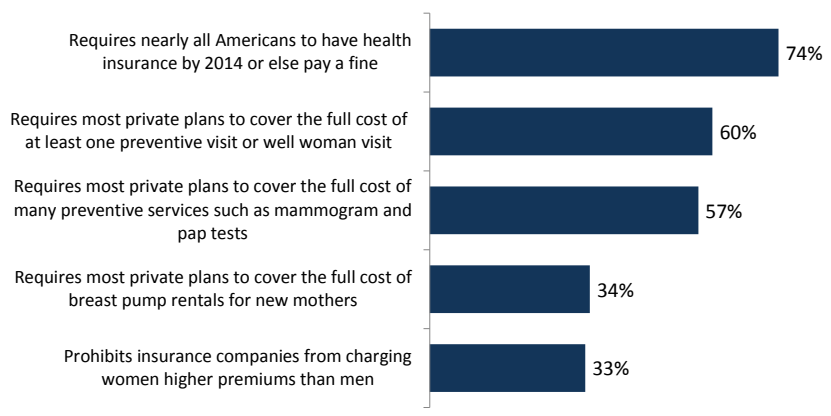
Knowledge and Understanding of the ACA Rules on Preventive Care

Women's awareness of the ACA requirements regarding no-cost coverage of preventive care is uneven.

Coverage for preventive services without cost sharing is required in all new private plans, including employer-sponsored plans, individual market plans, and those in the new state marketplaces. While millions of women could potentially reap these benefits, many are unaware of ACA's coverage for preventive services (**Figure 20**). A sizable majority (74%) of women are aware of the ACA's requirement that individuals carry insurance, but fewer

Figure 20

Women's knowledge about ACA coverage for preventive services



NOTE: Among women ages 18-64 except question on breast pump rentals among women ages 18-44.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

know that at least one preventive visit for women must be covered (60%), or of the no-cost coverage for preventive services such as mammograms (57%). Knowledge is quite low even among subgroups that are most directly affected. For example, only 34% of women of reproductive age (ages 18 to 44) know of the coverage for breastfeeding supports including breast pump rental. Awareness of other benefits of particular relavence to women, such as the prohibition on insurers charging higher premiums for women over men, known as gender rating, is also low.

General Checkups and Provider–Patient Counseling

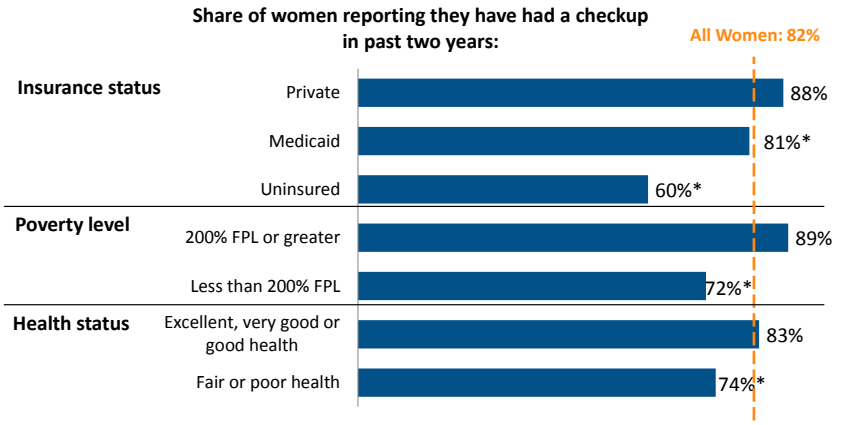
Provider visits can give women an opportunity to talk with clinicians about a broad range of issues, including preventing illness, the role of lifestyle factors, and management of chronic illnesses. Under the ACA, new plans must cover at least one annual "well woman visit," which the IOM Committee on Clinical Preventive Services for Women recommended could specifically cover a range of topics, such as assessment of diet and physical activity, history of pregnancy complications, mental health screenings for pregnant and post-partum women, screening for metabolic syndrome, preconception care, prenatal care, and screening for STIs.[7]

The majority of women have had a recent checkup with a provider.

Eight in ten women (82%) have had a general checkup in the past two years (**Figure 21**). However, it is less common among uninsured women (60%), women with incomes less than 200% FPL (72%), and those with poorer health (74%). Rates are similar between women of different racial and ethnic groups, with about eight in ten White (83%), Hispanic (79%), and Black (88%) women reporting they have had a recent well woman visit.

Figure 21

Eight in ten women have had a recent general check up, but rates are lower among some groups



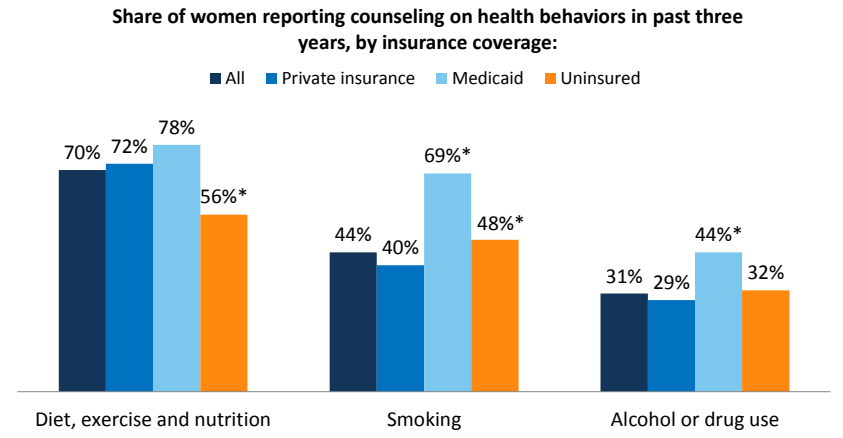
NOTE: Among women ages 18-64. The Federal Poverty Level (FPL) was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from Private insurance; 200% FPL or greater; Excellent, very good, good health, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

In general, rates of counseling on healthy lifestyles are highest for diet, exercise, and nutrition.

One component of preventive care that is now covered by plans without cost-sharing is provider counseling on health-related behaviors such as diet, smoking, and alcohol use, which have been shown to affect a wide range of health issues

Figure 22

Counseling on health behaviors is highest for diet, exercise and nutrition

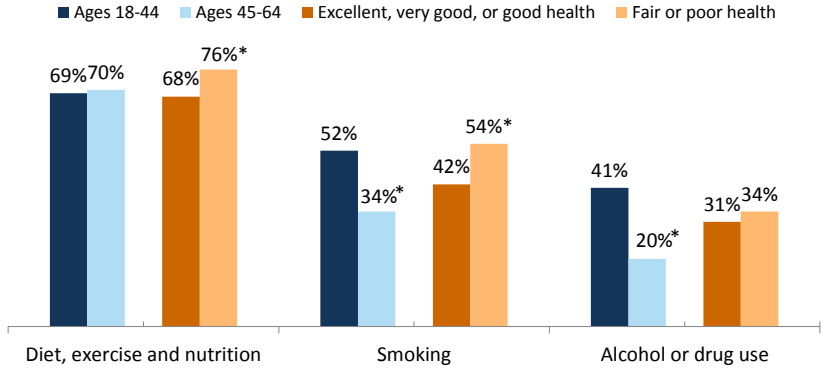


NOTE: Among women ages 18-64. *Indicates a statistically significant difference from Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

including a woman's risk for chronic diseases. Consistent with other national trends, the highest rate of preventive counseling is on diet and nutrition, which 70% of women have discussed with a provider in the past three years (**Figure 22**). However, fewer than half of women have recently talked to a provider about other risk factors for chronic illnesses, such as smoking (44%) and alcohol or drug use (31%). Across the board, women covered by Medicaid have the highest rates of counseling. In addition, younger women and those in poorer health have higher counseling rates compared to their counterparts **(Figure 23)**.

Figure 23

Higher rates of counseling on some topics among women who are younger or in poorer health



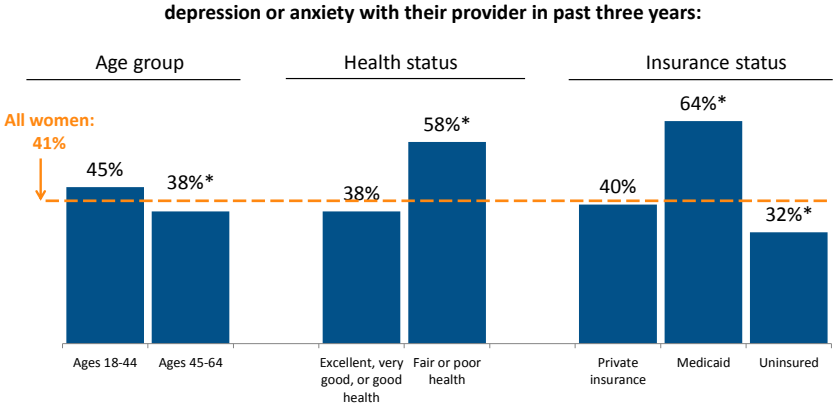
NOTE: Among women ages 18-64. *Indicates a statistically significant difference from Ages 18-44; Excellent, very good, or good health, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Fewer than half of women have talked recently with a provider about mental health issues.

It is estimated that 21% of adult women are affected by some form of mental illness, such as depression, anxiety, trauma, eating disorders, or dementia.[8] Under the ACA, mental health services have been included as one of the ten Essential Health Benefits,[9] meaning that all new plans must cover this category, although coverage for specific services varies between plans. Depression and anxiety in particular present challenges to a disproportionate share of women over their lifetimes, and in response, the USPSTF recommends routine screenings. Four in ten (41%) women report having discussed a mental health issue such as anxiety or depression with a provider in the past three years (**Figure 24**). Mental health screening rates are similar between women of different racial and ethnic groups, with about four in ten White (42%), Hispanic (42%), and Black (39%) women reporting discussing with a provider. As with other counseling topics, the rate is higher among women who are younger, sicker, or covered by Medicaid.

Figure 24

Four in ten women report speaking with their providers about mental health issues, rates higher among some groups



NOTE: Among women ages 18-64. *Indicates a statistically significant difference from Ages 18-44, Excellent, very good, or good; Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Screening Tests

Rates of preventive screening tests are higher among women with insurance.

Use of preventive services can lead to early identification of conditions when they are most responsive to early interventions. This is especially true for some types of cancers and cardiovascular conditions. For example,

routine mammograms and pap tests, which are used to identify breast and cervical cancers respectively, are recommended by the USPSTF as necessary preventive services. The USPSTF also recommends regular screenings for elevated blood pressure and cholesterol levels because they are considered markers for cardiovascular conditions, including stroke and heart disease. These services are all now covered by new private plans under the ACA's preventive services coverage requirements.

Most women have received cancer and cardiovascular screening tests in the past two years, including mammograms (73%), pap tests (70%), and cholesterol tests (67%), with some variation by age group (**Table 6**). The rate of blood cholesterol tests varies significantly between younger women (58% for women ages 18 to 44) and older women (78% for women ages 45 to 64). Cholesterol tests are recommended for women older than 20 who are at increased risk for heart disease.[10] Rates of screening for colon cancer within the past two years are lower, with about four in ten (39%) women 50 and older reporting a recent colorectal screening. The USPSTF recommends three different methods with different intervals that are equally effective screenings for women between age 50 and 75 years: 1) annual high-sensitivity fecal occult blood testing, 2) sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every 3 years, and 3) screening colonoscopy at intervals of 10 years.[11]

Table 6 : Rates of screening tests among women, by age and race/ethnicity

Preventive Screening	USPSTF Recommendation	Share of Women Reporting Screening Test in Past Two Years					
		All Women	Age Group		Race/Ethnicity		
			Ages 18-44	Ages 45-64	White	Black	Hispanic
Blood Pressure (Hypertension)	Screening for high blood pressure in adults age 18 and older.	92%	90%	94%*	94%	93%	83%*
Blood Cholesterol Test (Coronary Heart Disease)	Screening of women ages 20 and older who are at increased risk for coronary heart disease.	67%	58%	78%*	69%	66%	63%
Pap Test (Cervical Cancer)	A pap test every 3 years for women ages 21-65, or a combination of a pap test and HPV test every 5 years for women ages 30-65.	70%	72%	67%	71%	76%	72%
Mammogram (Breast Cancer)	Mammography screenings once every 1 to 2 years for women ages 40 and older.	73%	N/A	N/A	74%	79%	72%
Colonoscopy, Fecal Occult Blood test, Flexible Sigmoidoscopy (Colorectal Cancer)	1) Annual high-sensitivity fecal occult blood testing or 2) sigmoidoscopy every 5 years with high-sensitivity fecal occult blood testing every 3 years or 3) screening colonoscopy at 10 year intervals for adults ages 50 to 75.	39%	N/A	N/A	40%	35%	34%

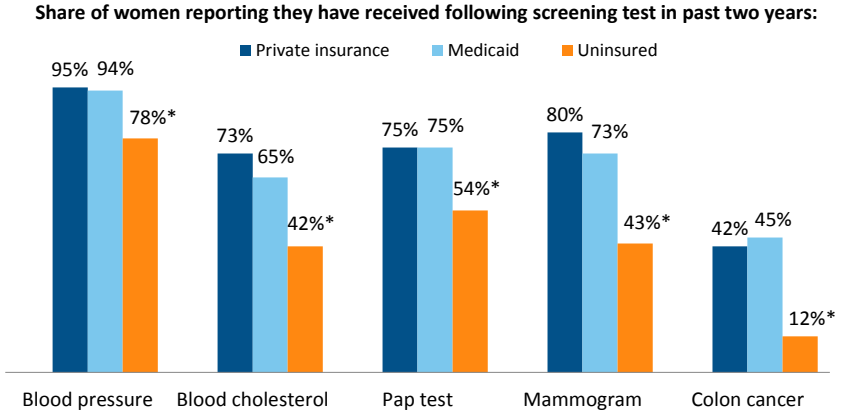
NOTES: Among women ages 18-64, except mammogram (ages 40-64), and colorectal cancer (ages 50-64). The ACA requires coverage of mammogram services based on the USPSTF 2002 recommendation on breast cancer screening, which recommended screening every 1-2 years beginning at age 40. *Indicates a statistically significant difference from ages 18-44, White, p<.05.
SOURCE: U.S. Preventive Services Task Force, USPSTF A and B Recommendations; Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Women who are uninsured have consistently lower use of all screening tests. While 95% of privately-insured women have had a blood pressure check in the past two years, the rate is 78% among uninsured women (**Figure 25**). Just over half of uninsured women have had a recent pap test, compared to three in four women with private insurance or Medicaid. The differences are even larger for mammography, cholesterol and colon cancer screenings, which typically require that patients go to a lab or other facility to have blood drawn or obtain other costly testing procedures. Women with Medicaid coverage receive screening tests on a par with women who are privately insured.

Over the past decade, self-reported rates of screening tests have been fairly level, except for a rise in the rate of cholesterol screenings and a decline in the rate of pap testing between 2001 and 2013 (**Figure 26**). The latter may be related to changes in the recommendations and guidelines for cervical cancer screening over that time period, which reduced the frequency and narrowed the age group for testing compared to earlier guidelines.[12]

Figure 25

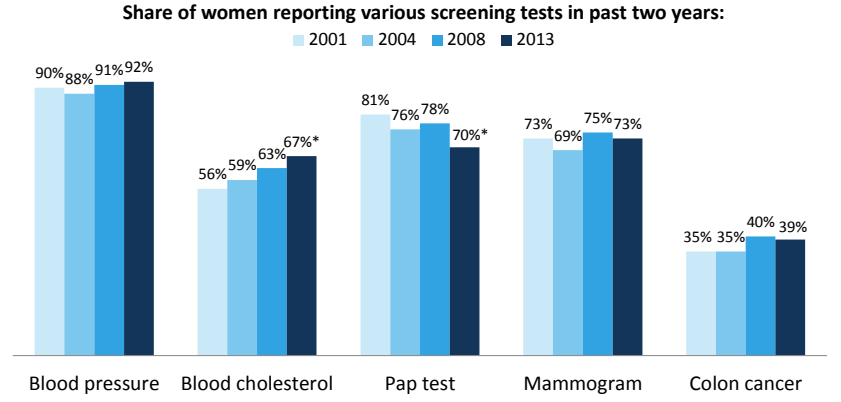
Lower utilization of screening tests among uninsured women



NOTE: Among women ages 18-64. Mammogram screenings among women ages 40-64. Colon cancer screening among women ages 50-64. *Indicates a statistically significant different from Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Figure 26

Rise in rate of cholesterol screenings between 2001 and 2013, rate of pap tests is falling



NOTE: Among women ages 18-64. Mammogram screenings among women ages 40-64. Colon cancer screening among women ages 50-64. *Indicates a statistically significant difference from 2001, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey, 2008 Kaiser Women's Health Survey, 2004 Kaiser Women's Health Survey, 2001 Kaiser Women's Health Survey.*

Reproductive and Sexual Health Services

Reproductive and sexual health is an integral component of women's general health and well-being. The ACA makes many reforms to insurance coverage that may improve access to these important services for insured women, in addition to broadening the availability of coverage to uninsured individuals. The ACA's requirement for preventive services coverage without cost sharing includes a number of counseling services, screening tests, and supplies that could affect women's access to reproductive and sexual health services, such as contraceptives, screening tests for sexually transmitted infections (STIs) and HIV, and the Human Papilloma Virus (HPV) vaccine. They also include pregnancy-related services such as prenatal visits, folic acid supplements, screening tests, tobacco cessation, and breastfeeding supports. Notably, the law includes maternity care as an Essential Health Benefit category that all new health plans must cover in their policies.

The ACA's large coverage expansion to the uninsured may also make changes in the types of settings that women, particularly those who are newly insured, will use to obtain their reproductive care. This change in coverage patterns may have a disproportionate effect on family planning clinics and community health centers, who have long served low-income women, but may not be part of the health care provider networks contracting with the Marketplace plans. The ACA's extension of dependent coverage up to age 26 also extends a new coverage option to women at a peak time in their lives when they typically seek reproductive and sexual health care. The fact, however, that these adult children are part of their parents' insurance during this period also raises questions about privacy and confidentiality around the services they use when the primary policy holders are their parents. This section reports survey findings among women of reproductive age, 15 to 44 years old.

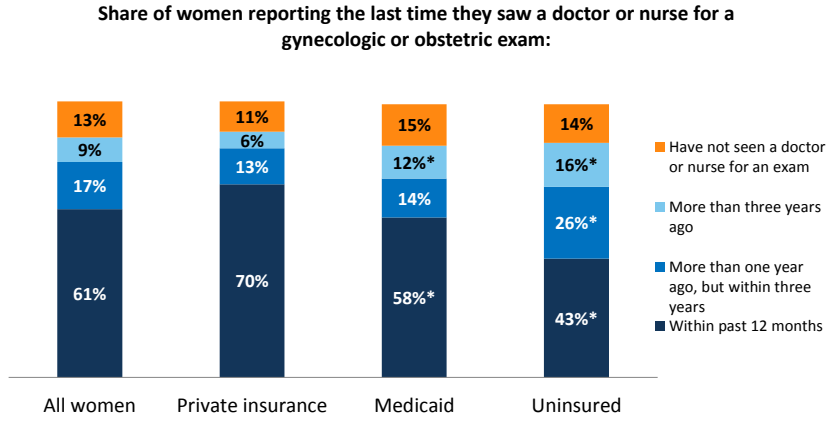
Use of Services

Most reproductive age women have had a gynecologic or obstetric visit in the past year.

The majority of women ages 15 to 44 report that they have had a gynecologic or obstetric visit in the past year (61%). Women with private insurance, however, have higher rates of a recent visit (within the past 12 months) for obstetric or gynecologic care (70%), compared to women with Medicaid (58%) and uninsured women (43%). A higher share of women covered by Medicaid (12%) and uninsured women (16%) reported that their last visit was over three years ago, more than twice the rate of women with private insurance (6%) (**Figure 27**). Just 13% of women ages 15 to 44 reported that they have never seen a provider for obstetric or gynecologic care and the rates were similar for all the insurance groups.

Figure 27

Most women have had a gynecologic or obstetric exam in the past year, except for women who are uninsured



NOTES: Among women ages 15-44. *Indicates a statistically significant difference from Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Most women (85%) report that their most recent sexual health visit was for gynecologic care and 14% report it was for prenatal care (**Table 7**). Almost one in four Hispanic women report that the reason was for pregnancy related care (23%), higher than for White (13%) and Black women (9%). Slightly more women ages 25 to 34 reported their most recent visit was for prenatal or pregnancy-related care (17%), and the shares of younger (12%) and older women (11%) were similar.

Table 7: Reason for most recent gynecologic visit, by age group, race/ethnicity, and poverty level

	All Women	Age Group			Race/Ethnicity			Poverty Level	
		15-24	25-34	35-44	White	Black	Hispanic	Less than 200% FPL	200% FPL or greater
Have had a gynecological or obstetric exam within the past year	61%	44%	74%*	64%	62%	70%	56%	56%*	68%
Reason for most recent visit									
Gynecologic care	85%	85%	82%	87%	86%	90%	75%*	79%*	90%
Prenatal/ Pregnancy Care	14%	12%	17%	11%	13%	9%	23%*	20%*	9%

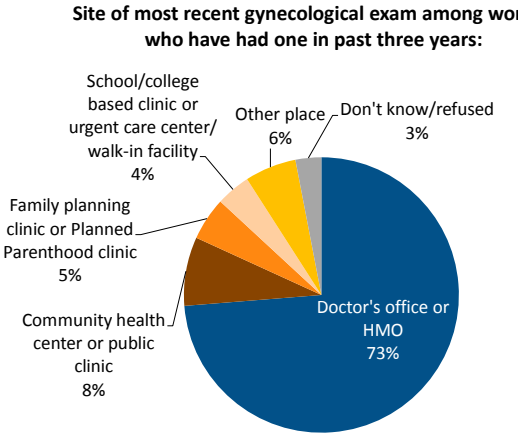
NOTE: Reason for most recent visit among women ages 15-44 who have *ever* had an obstetric or gynecologic exam. Federal Poverty Level was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from ages 15-24; White; 200% FPL or greater; p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Private doctors' offices and HMOs are the primary settings where women get gynecologic care, but family planning clinics and community health centers play a significant role for women who have Medicaid and women who are uninsured.

Among the group of women who said they have had a gynecologic exam (not for pregnancy related care) within the past three years, 73% report that their most recent exam was at a doctor's office or HMO (**Figure 28**). Among women who have a had a gynecologic exam in the past three years, nearly one in ten women (8%) report their most recent exam was at a community health center or public clinic. Fewer younger women sought care at a doctor's office or HMO (64%) than other women of reproductive age, with slightly more seeking care at school based clinics and urgent care centers/ walk-in facilities than other women **(Table 8)**. Not surprisingly, health care settings vary for women with different types of insurance coverage.

Figure 28

Most women obtain gynecologic exams at a doctor's office, but many also rely on clinics



NOTES: Among women ages 15-44 who had a gynecologic exam within the past three years. "Other place" includes emergency rooms and other unspecified sites.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Table 8: Site of most recent gynecologic exam among women, by age and insurance coverage							
	All Women	Age Group			Insurance Coverage		
Site of most recent visit		15-24	25-34	35-44	Private Insurance	Medicaid	Uninsured
Doctor's office or HMO	73%	64%	72%	82%	84%	57%*	53%*
Community health center or public clinic	8%	9%	8%	7%	4%	13%	16%*
Family planning clinic or Planned Parenthood	5%	6%	5%	4%	2%	5%	16%*
School/college based clinic or urgent care center/ walk-in facility	4%	9%	3%	1%	4%	5%	5%
Other place	6%	6%	7%	4%	4%	13%	5%
Don't know/refused	4%	3%	5%	2%	1%	7%	3%

NOTE: Among women ages 15-44 who have had an exam in the past three years. Other place includes other types of clinics and other locations such as emergency departments. *Indicates a statistically significant difference from ages 35-44; Private Insurance; p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Women with private insurance overwhelmingly get their gynecologic care from private doctor's offices or HMOs. While just over half of women enrolled in Medicaid and uninsured women obtain care from a doctor's office/HMO, community health centers, family planning clinics and school based clinics play an important role for these groups. A larger portion of women covered by Medicaid (13%) seek care in another location, which includes emergency departments, compared to women with private insurance and uninsured women. A sizable share of private physicians limits their participation in Medicaid, and safety net providers play an important role serving low-income and uninsured women. As more women gain coverage under the ACA, especially through the subsidized private plans available on state Marketplaces, many of the women using these safety net providers could shift to private settings because their existing providers may not be in-network providers.

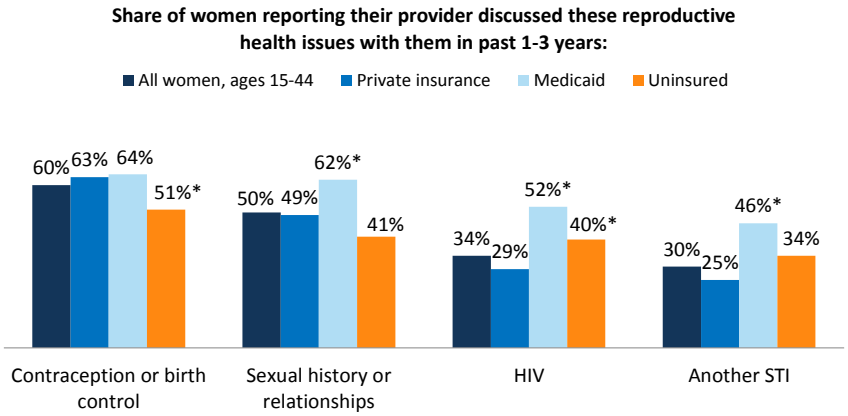
Counseling and Screening

Among reproductive health topics, counseling is more commonly reported for birth control than for other issues such as sexual history, sexually transmitted infections, and HIV.

An important aspect of reproductive and sexual health care is the counseling and education that health care clinicians can offer patients. Counseling allows clinicians to provide patient education, screen for high-risk behaviors, and identify the need

Figure 29

Provider counseling on contraception is more common than other sexual health topics, but there is variation by insurance status



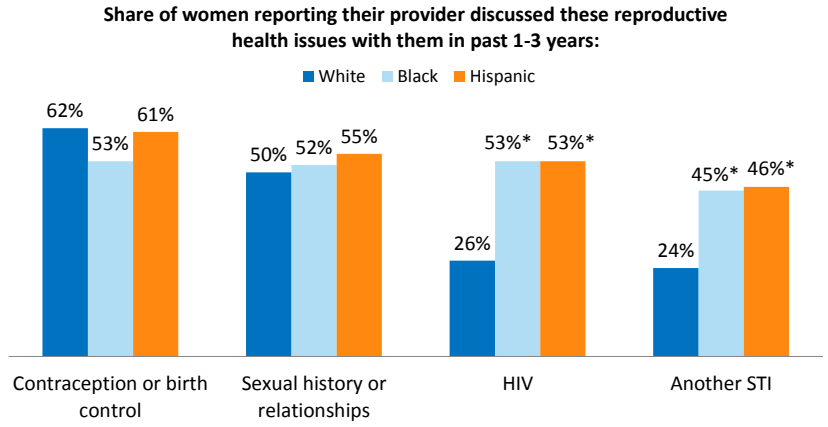
NOTE: Among women ages 15-44. For women ages 18+, have discussed within the past 3 years. For women ages 15-17, have discussed within past 12 months. *Indicates a statistically significant difference from Private insurance, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

for additional testing services. Providers can now be reimbursed when they provide counseling on a wide range of sexual health topics, because they are part of the preventive services that the ACA requires plans to cover without cost sharing. This is especially important because some of the health challenges women face during their reproductive years stem from sexual and reproductive health concerns. It is estimated that half of all pregnancies in the U.S. are unintended.[13] The CDC estimates approximately 19 million new cases of STIs, such as chlamydia, gonorrhea, and HPV, occur each year.[14] Approximately half of cases occur among young people ages 15 to 24, and disproportionately affect certain communities, with Black women at elevated risk for contracting an STI. Sex is also the major mode of transmission of HIV/AIDS among women, which has had a disproportionate impact on young women of color, particularly Black women.

Despite the high rates of STIs and unintended pregnancy, and the recommendations of professional groups, counseling on many of these topics is not routine among women of reproductive age (**Figure 29**). While most reproductive age women have had recent conversations with a provider about contraception (60%), the rate is much lower for other topics, including sexual history (50%), HIV (34%) and other STIs (30%). It is notable that women with Medicaid have significantly higher rates of counseling on most of these topics compared to women with private insurance. Women of color also report higher rates of counseling on HIV and other STIs, compared to White women (**Figure 30**). Women ages 19 to24 also have the highest rate of counseling from a health care provider on these topics (**Figure 31**).

Figure 30

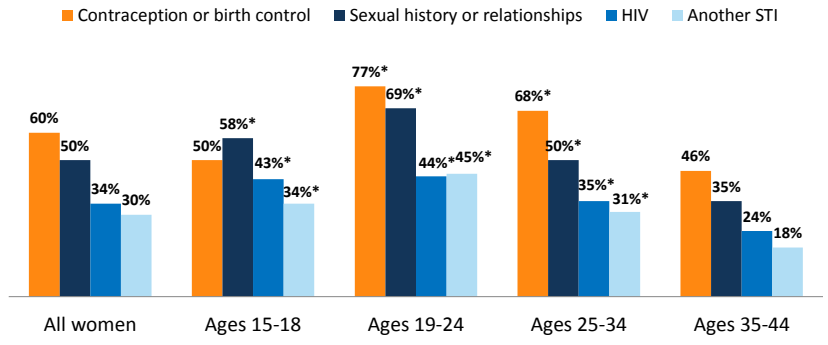
Counseling rates for STIs and HIV are higher among Black and Hispanic women compared to White women



NOTE: Among women ages 15-44. For women ages 18+, have discussed within the past 3 years. For women ages 15-17, have discussed within past 12 months. *Indicates a statistically significant difference from White, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Figure 31

Counseling on reproductive and sexual health is most frequently reported by women in their early twenties



NOTE: Among women ages 15-44. For women ages 18+, have discussed within the past 3 years. For women ages 15-17, have discussed within past 12 months. *Indicates a statistically significant difference from ages 35-44, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Despite the burden of sexual violence on women in the U.S., counseling on dating and domestic violence is particularly infrequent in a health setting.

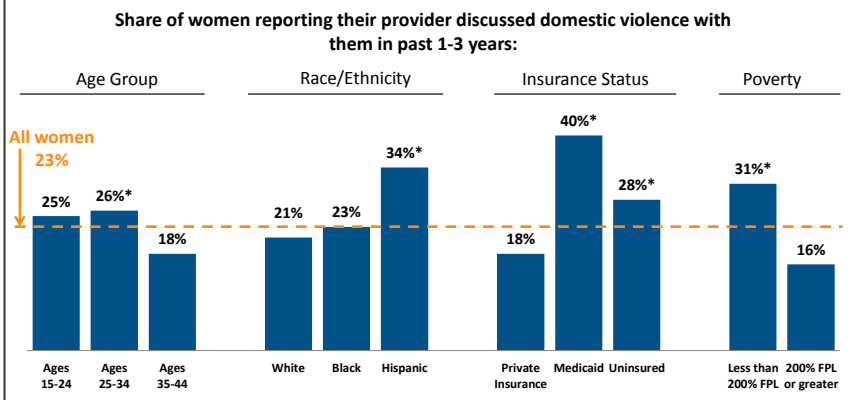
More than 1 in 3 adult women in the United States (36%) have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.[15] Intimate partner violence (IPV), also called domestic or dating violence, can affect women at any point in their lives, but rates are highest among women in their reproductive years.[16] IPV can take many forms, including sexual violence, physical violence, and psychological

and emotional abuse. It has long been recognized that clinicians can play an important role in the identification and treatment of women who have suffered from violence. As with other sexual and reproductive health topics, counseling on domestic violence is highly sensitive and requires training, including special protections for patients' privacy, and knowledge of referrals so patients receive safe and effective follow up care and are protected from retaliation by perpetrators.

One of the preventive services for women that the ACA covers without cost sharing is provider counseling on IPV. While there have been advances in the health care system's handling of IPV and newly developed screening tools for providers to use, it is still far from routine for providers to raise the issue of violence with women. Nearly one-quarter of women ages 15 to 44 (23%) have discussed dating or domestic violence with a provider in the past three years (**Figure 32**). Compared to older women, provider-patient conversations about IPV are more common among women in their twenties and early thirties, but it is still not the norm. Counseling rates for IPV are also higher among Hispanic women, those who are low-income, and those covered by Medicaid.

Figure 32

Approximately one-quarter of women have discussed domestic violence with their provider, but rates are higher among Hispanic women and those with Medicaid



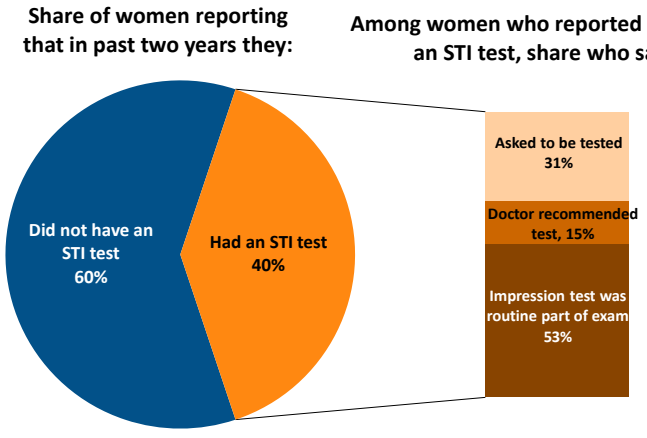
NOTE: Among women ages 15-44. For women ages 18+, have discussed dating or domestic violence within the past 3 years. For women ages 15-17, have discussed within past 12 months. The Federal Poverty Level (FPL) was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from Ages 35-44; White; Private insurance; 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Approximately four in ten women report recent screenings for HIV and other STIs, but many incorrectly assume they are being tested.

Several professional groups and government agencies, including the USPSTF, the Institute of Medicine, and the Centers for Disease Control and Prevention, recommend that women in their reproductive years be tested for sexually transmitted infections such as chlamydia, gonorrhea and HIV.[17,18,19] Knowing one's status is important to receive early treatment and prevent transmission to sexual partners. As with provider counseling, these tests are now covered without cost sharing in new private plans under the ACA's preventive services coverage requirements. They are also commonly included as part of family planning services under Medicaid.[20]

Figure 33

Many women incorrectly believe that STI testing is a routine part of an examination



NOTE: Among women ages 15-44.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Approximately four in ten women report that they have had a test for HIV (44%) or other STIs (40%) in the past two years;

however, approximately half of these women assumed this test was a routine part of an examination—which it is not (**Figure 33**). Therefore, the actual screening rate is likely lower than the share of women who report being tested. This perpetuates the gap in knowledge of HIV status and other STIs that has been reported in other research and may cause women to believe they do not have an STI when in fact they have not actually been tested.

Screening rates for HIV and STIs are higher among low-income, Medicaid, uninsured, and minority women, particularly Black women (**Table 9**). Notably, there is a higher rate among some of these groups of women reporting that they requested their provider to conduct these tests; however, among all these groups, a substantial share also still incorrectly assume the test is routinely included in a health exam.

Table 9: Receipt of sexual health screening tests, by race/ethnicity, insurance status, poverty level

	All Women	Race/Ethnicity			Insurance Status			Poverty Level	
Reported having test in past 2 years		White	Black	Hispanic	Private	Medicaid	Uninsured	Less than 200% FPL	200% FPL or greater
HIV Test	**44%**	**35%**	**72%***	**60%***	**37%**	**59%***	**51%***	**54%***	**37%**
Thought test was routine part of Exam	56%	60%	48%	53%	56%	46%	61%	56%	55%
Doctor recommended test	14%	14%	7%	22%	16%	9%	13%	12%	18%
Asked to be tested	27%	23%	43%*	24%	27%	41%	22%	30%	26%
STI Test	**40%**	**33%**	**63%***	**50%***	**37%**	**55%***	**38%**	**47%***	**36%**
Thought test was routine part of exam	53%	55%	47%	54%	58%	35%	59%	50%	58%
Doctor recommended test	15%	11%	18%	21%	14%	15%	13%	14%	14%
Asked to be tested	31%	32%	35%	23%	28%	47%	27%	35%	27%

NOTE: Among women ages 15-44. Federal Poverty Level was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from White; Private insurance; 200% FPL or greater; p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Use of Contraceptives

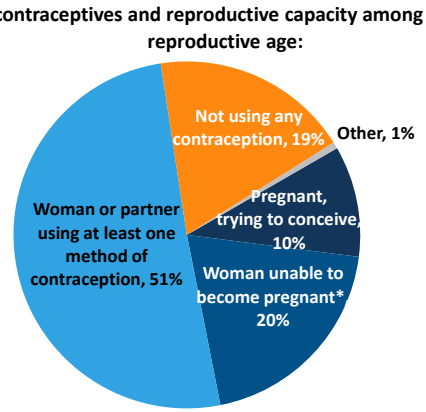
Nearly half of sexually active reproductive age women use at least one form of contraception, but approximately one in five sexually active women of reproductive age report that they do not use contraception despite reporting they do not want to get pregnant.

The vast majority of women who are of reproductive age (15 to 44 years) have been sexually active (81%) in the past year. Among sexually active women, one in ten are pregnant or trying to conceive, and one in five (20%) women report that they or their partners have had a sterilization procedure or cannot become pregnant. For women with reproductive capacity but who want to avoid an unintended pregnancy, contraception is an

essential health service. Some contraceptives also can reduce the risk of transmitting certain STIs (such as condoms) and in some cases can assist in managing other medical conditions (such as oral contraceptives). Among reproductive age women who have had sex in the past year, half (51%) report that they or their partners used at least one contraceptive method **(Figure 34)**. An estimated 19% of sexually active women ages 15 to 44 are at high risk for unintended pregnancy because they or their partners are not using contraception.

Figure 34

One in five sexually active women are at risk for unintended pregnancy because they are not using contraception



NOTES: Among women ages 15-44 who have had sex within the past 12 months. *Includes women who report that they or their partner have had a sterilization procedure or they have a medical condition that makes it impossible to get pregnant and are not using any contraception.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Condoms and birth control pills are the most commonly used forms of contraception.

While all forms of FDA approved contraception can reduce the risk of unintended pregnancy when used correctly, they vary in their use and effectiveness. Women are encouraged to consider a range of issues when choosing a contraceptive method in order to find the one that is most effective but also fits best within their beliefs and lifestyle. Condoms can protect against STIs and are widely available through many outlets without a prescription. Oral contraceptives, often referred to as the Pill, require prescriptions, are hormonal, and cannot be used or tolerated by all women. Other methods include injectables, implants, patches, and the vaginal ring, which deliver different doses of hormones. Intrauterine Devices (IUD) are devices that are inserted in a woman's uterus by a provider and some types also include hormones. They can last up to 5 years or longer and are among the most effective methods of reversible contraception but also have the highest up front cost. Under the ACA's preventive services provision, all new private plans are required to cover all FDA-approved methods of contraception as prescribed for women without cost sharing.

Table 10: Types of contraceptives used among sexually active women, by age and race/ethnicity

	All Women	Age Group			Race/Ethnicity		
Types of contraception used within the past 12 months		15-24	25-34	35-44	White	Black	Hispanic
Male condoms	63%	82%	60%*	41%	59%	78%*	59%
Oral contraceptives	48%	54%	44%	46%	53%	36%*	49%
IUD	19%	N/A	29%	22%	24%	10%*	17%
Injectables	7%	13%	6%	1%	3%	16%*	11%
Implants	6%	N/A	8%*	1%	6%	8%	8%
Other	12%	12%	14%	11%	12%	7%	17%

NOTES: Only includes women ages 15-44 who were sexually active in past year and used contraceptives in past year. Women may use more than one form of contraception. Oral contraceptives include birth control pills. IUD is an intrauterine device such as Mirena, Skyla, or Paragard. Injectables include Depo-Provera. Implants include Implanon or tubes in arm. Other methods include vaginal ring and the topical patch. N/A indicates data are not sufficient to meet criteria for statistical reliability. *Indicates a statistically significant difference from 35-44; White; p<.05.

SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

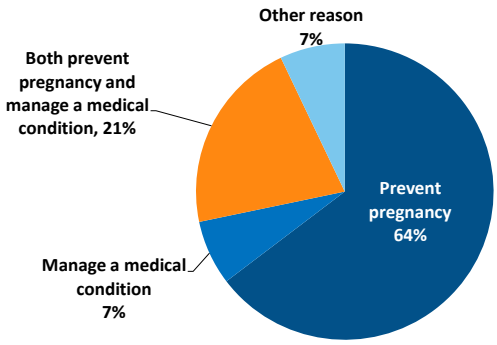
Among sexually active women who use contraception, just over half (54%) rely on one method and just under half (45%) use more than one method. Women most frequently report that they have used condoms and birth control pills in the past year (**Table 10**). Nearly two-thirds (63%) of sexually active women who have used contraceptives in the past year report using male condoms, almost half have used birth control pills (48%), and about one in five (19%) use an IUD. Nearly one in four White women (24%) report that they are using an IUD. A larger share of Black women than White or Hispanic women use condoms. Black women also have higher usage of injectables than White or Hispanic women.

While preventing pregnancy is the leading reason for contraceptive use, a sizable fraction of women also use them to manage a medical condition.

While contraceptives are essential for preventing and spacing pregnancies, they can also aid in the management of a wide range of medical conditions such as endometriosis, irregular periods, and fibroids.[21,22] Not surprisingly, preventing pregnancy is the main reason for using contraceptives (64%), but a fair share of women (21%) state they use it to prevent pregnancy and manage a medical condition (**Figure 35**). This factor likely affects women's choices in the types of contraceptives they select.

Figure 35

Many women use contraception to prevent pregnancy and manage medical conditions



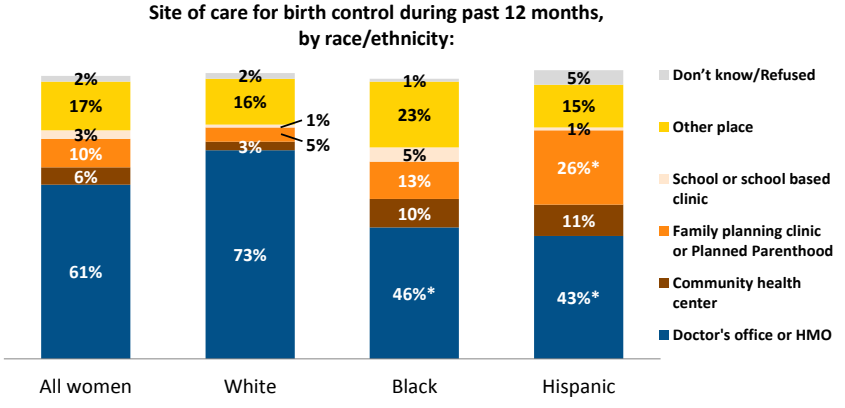
NOTES: Among women ages 15-44 who have had sex within the past 12 months and have used (or partner has used) contraception in past 12 months.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

While most women get their contraceptives from a private physician or HMO, a significant minority get their contraceptives from a clinic-based provider.

Six in ten sexually active women who are using birth control report that they obtain contraceptives at a doctor's office or HMO (61%), one in ten (10%) obtain it at a family planning clinic, such as Planned Parenthood, and 6% from a community health center (**Figure 36**). Higher shares of women of color go to clinics for contraceptives though. Nearly three-fourths of White women report they obtained contraceptive care at a doctor's office or HMO, compared to less than half of Black (46%) and Hispanic (43%) women. Conversely, reliance on family planning clinics and community health centers is more than twice as high among women of color as for White women. This is the case for more than a third (37%) of Hispanic women, who also have the

Figure 36

Women of color have higher reliance on clinics and health centers for contraceptive care

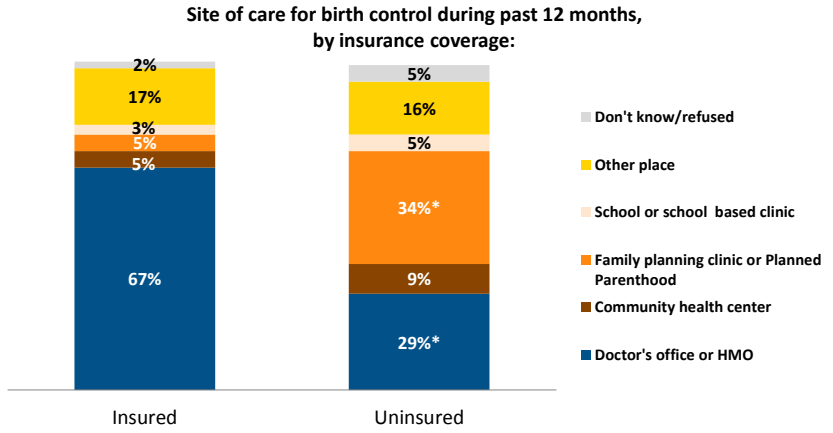


NOTES: Among women ages 15-44 who had sex and used any birth control within the past 12 months. "Other place" includes drugstores and other unspecified sites. *Indicates a statistically significant difference from White, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

highest uninsured rate. Some of the differences in site of care are likely related to insurance status, which means that over time there could be changes in where women obtain care for contraceptives as the ACA moves forward and more women gain coverage. It is important to note that 17% of all women state they received contraceptives at "some other place," such as a drugstore where condoms can be purchased.

Figure 37

One-third of uninsured women receive birth control from family planning clinics



NOTES: Among women ages 15-44 who have had sex and used any birth control within the past 12 months. "Other place" includes drugstores and other unspecified sites. *Indicates a statistically significant difference from Insured, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

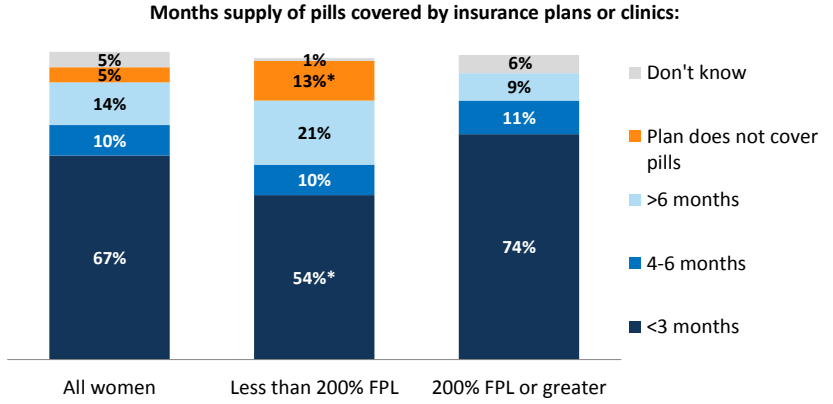
As with gynecologic exams, care seeking patterns differ between women with insurance and women who are uninsured, with uninsured women reporting much higher rates of obtaining contraceptives at family planning clinics such as Planned Parenthood (34%) compared to women with insurance (5%) (**Figure 37**). Only 29% of uninsured women receive birth control care from a doctor's office or HMO.

Among women who use oral contraceptives, most women typically receive 3 months' supply at a time.

Women who use oral contraceptives must take a pill every day; therefore having an adequate supply is important for consistent and effective use.[23] Nearly three in ten (28%) of those who take birth control pills report that they have missed a pill because they could not get next pack on time (data not shown). Among women who have used oral contraceptives in the past year, two-thirds (67%) reported their plan or clinic allows them to only get 3 months' supply or less at a time (**Figure 38**). A higher share of low-income women, however, say that their clinic or insurance covered a longer supply of oral contraceptives. At the same time though, more than one in ten low-income women (13%) also report that their plan did not cover birth control pills. The differences in dispensing patterns may be a result of differences in insurance coverage policies or practice variation between sites of care.

Figure 38

Most women receive a three months' supply of birth control pills, but one in four receive a longer term supply



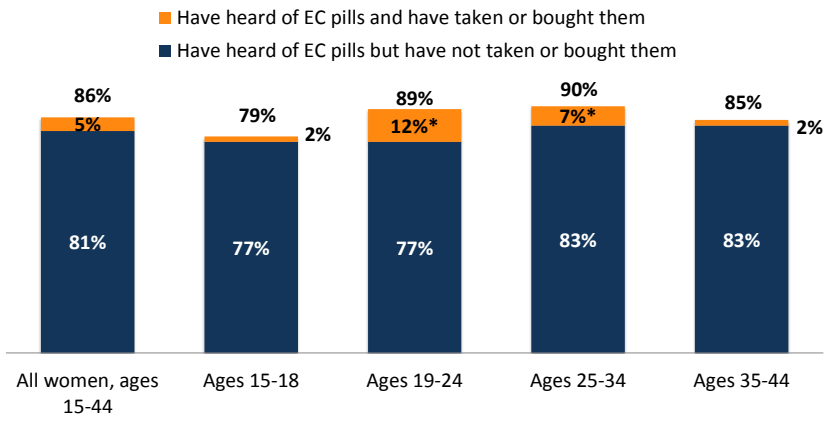
NOTES: Among women ages 15-44 who have had sex within the past 12 months, have used birth control pills within the past 12 months. The Federal Poverty Level (FPL) was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Awareness of the availability of emergency contraceptive (EC) pills is high, but only a fraction of women have purchased or used it.

Emergency contraception (EC), which is contraception that can be used after sex to prevent pregnancy, has been available in the U.S. since 1999. There are multiple forms, including the copper IUD, Plan B® pills, and more recently another form of EC pills, ella®, was approved by the FDA in 2010. Most forms require a prescription, except for Plan B®, which has been available without a prescription for women 17 and older since 2009. As with other contraceptives, new private plans are required to cover prescriptions for EC without cost sharing under the ACA's preventive services policy.

Figure 39

Most women have heard of emergency contraceptive (EC) pills, but few have used or purchased them



NOTES: Among women ages 15-44. Emergency contraception includes Plan B, Next Choice, and ella, as well as other generic versions. *Indicates a statistically significant difference from Ages 35-44, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

It has now been 15 years since EC pills were approved by the FDA and awareness of EC among women is very high. On average, 86% of women ages 15 to 44 report that they have heard of EC pills (**Figure 39**). Only a fraction of women (5%) have used or bought EC pills. Use is highest among women in their late teens and early twenties.

Contraceptive Coverage

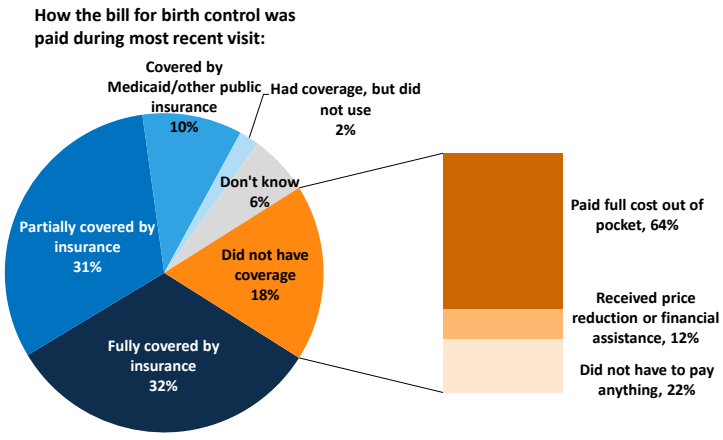
Among sexually active women who used contraception in the past year, three-quarters say that their insurance or Medicaid paid for some or all of the costs. However, nearly one in five say they had no coverage for their contraceptives, and most of these women paid the full cost out of pocket.

One of the most publicized and discussed of the ACA's preventive services benefits is the requirement that most new private plans cover without cost sharing prescription contraceptive services and supplies. This policy went into effect August 2012.

Among sexually active women who report using contraception in the last year, insurance covered the full cost for one-third (32%) of women (**Figure 40**). Almost another one-third of women (31%) reported that insurance covered part of the costs, which could be because they are

Figure 40

One in three women had full coverage for birth control, but one in five had no coverage for contraceptives



NOTES: Among women ages 15-44 who were sexually active and used any birth control within the past 12 months.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

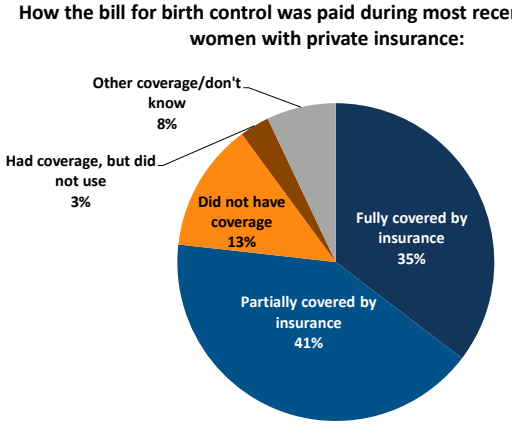
enrolled in an older private plan that is still "grandfathered" from ACA requirements or they used a particular contraceptive that is not covered by the requirement (such as condoms or a brand name drug), or they did not meet all the requirements (such as staying within the provider network). Family planning is a mandatory service under Medicaid and the program has covered contraceptives without cost sharing for decades. One in ten women who used birth control reported that Medicaid or another public program covered the costs of their contraceptives. Nearly one in five (18%) women reported they did not have any coverage for birth control, which could be due to lack of insurance or enrollment in a "grandfathered" plan (that does not have to cover preventive services). Among women without contraceptive coverage, nearly two-thirds (64%) paid the full cost out of pocket, 12% received a reduced price or financial assistance and 22% did not have to pay anything, presumably because they obtained free contraceptives at a clinic or through another assistance program.

About one in three women who use contraception and have private insurance say their plan covered the full cost of the contraceptives.

It is notable that by the end of 2013, just over one-third (35%) of sexually active women who use birth control reported that their insurance fully covered the cost of contraceptives. Another 41% of women who used contraceptives last year said that insurance covered part of the costs (**Figure 41**). Over one in ten (13%) report that they did not have any coverage for contraceptives under their insurance. Almost all women with insurance for contraceptives (97%, data not shown) report that they did not have trouble getting their insurance to cover the costs (fully or partially) for prescribed contraceptives. Only a small fraction of women (3%) had problems getting insurance to pay.

Figure 41

Among women with private insurance, one in three report plan paid for full cost of contraceptives



NOTES: Among women ages 15-44 who had sex and used any birth control within the past 12 months. "Other coverage/Don't know" includes coverage through Medicaid or other public insurance.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey.*

Insurance and Confidentiality

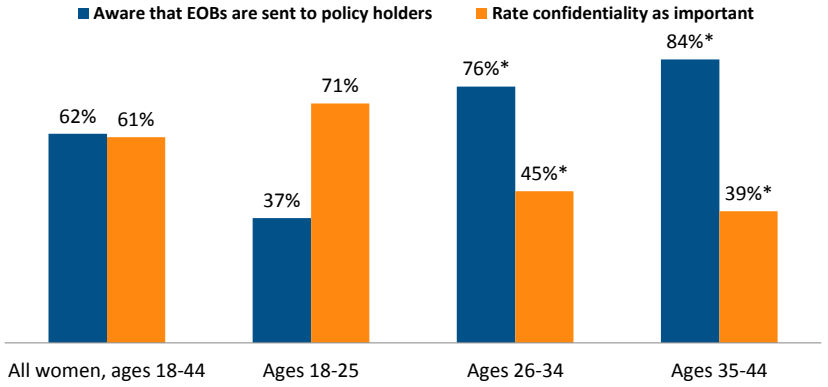
Women of all ages, but especially young women, value confidentiality. Many are not aware that private insurance plans can send documentation to the primary policy holder (such as a parent or spouse) that details the services they use.

Nearly half of women 18 to 25 (45%) with employer sponsored coverage are covered as dependents under their parents plan. Some of these women may have been able to obtain or keep private insurance through the ACA's extension of dependent coverage up to age 26. Because these individuals are adult children, the extension of coverage has raised concerns about maintaining privacy and confidentiality about use of health services. Overall, six in ten women 18 to 44 years old report that it is important to them that information about health care visits be kept confidential from a parent or spouse (**Figure 42**). However, it is a higher priority among young women, who also have the lowest awareness of the private insurance industry practice of sending documentation known as an explanation of benefits (EOB) with details about services and costs of services that were paid for by insurance to primary policy holders, often a parent or spouse. Among women 18 to 25, 71%

state that it is important to them that their use of health services, such as sexual or mental health care services, be kept confidential. Despite the importance of confidentiality, awareness of this practice was low among this age group, as only 37% of women knew that private insurers typically send an EOB to primary policy holders, often a parent. Awareness is even lower among teens ages 15 to 18, where only 24% reported knowing that EOBs were typically sent to the home (data not shown). Knowledge is considerably higher among women in older age groups, who likely have had greater experience with use of insurance plans.

Figure 42

Many young women place a high value on confidentiality, but are unaware that private plans can send EOBs to parents



NOTES: Includes women who are ages 18-25 and older women who are privately insured or are covered as a dependent.
EOB - Explanation of Benefits. Important includes Very and Somewhat Important. *Indicates a statistically significant difference from ages 18-25, p<.05
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Conclusions and Implications

The findings of this survey provide new information about the opportunities and ongoing challenges in women's health care and coverage in the early days of ACA implementation. The ACA includes reforms that could make coverage more affordable, accessible, and stable for many women in the years to come. The bans on pre-existing condition exclusions and gender-rating as well the requirement that plans now include maternity care and contraception could benefit many women, not just those who are uninsured. In the late fall and early winter of 2013 when this survey was conducted, there were still many gaps in coverage and access to care facing women. While the ACA can potentially fill some of these gaps, many challenges related to the law's implementation and other structural factors remain.

This report documents gaps in women access to care and identifies some of the barriers they experience including the need for affordable care and coverage options. It also highlights some of the distinct health concerns of women, especially the importance of reproductive and sexual health and the need for it to be addressed as part of women's basic care. Attention to these concerns will need to be part of the larger agenda to improve women's access to care and coverage, quality of care, and ultimately, their health and well-being.

Coverage

The health coverage expansion will affect many uninsured women. Gaps in coverage are experienced by a disproportionately high share of low-income women and women of color.

Uninsured women consistently reported barriers to care, lower use, and poorer access to care at much higher rates than women enrolled in Medicaid or private insurance. Millions of uninsured women could gain access to coverage that includes a wide range of benefits. The gaps in coverage are considerable for low-income women, with 4 in 10 reporting that they were uninsured at the end of 2013. The survey finds that Black and Hispanic women also bear a disproportionate burden of being uninsured. Eligibility for Medicaid and the subsidies in the form of tax credits are available to help many low-income women secure coverage under the ACA. While many may have enrolled in the state Marketplaces or in Medicaid during the open enrollment period, some of the poorest women will not qualify for assistance because they reside in a state that is not expanding Medicaid. Additionally, gaps will remain for some immigrant women because federal rules ban Medicaid coverage for new immigrants, and undocumented immigrants are not eligible for Medicaid and do not have access to the Marketplace plans.

Coverage under a parent's plan is now the leading way that women under age 26 get their coverage, highlighting the importance of confidentiality.

The ACA allows parents to keep their adult children enrolled in their plan until the age of 26. This age group had the highest uninsured rate of any age group before the law was passed. An issue related to this provision that has gotten less attention is confidentiality for this group. This stems from the practice of sending the Explanation of Benefits (EOB) to the principal policy holders, which in these cases is usually a parent of an adult child. The survey finds that most young women are not aware of this policy, but highly value their confidentiality. This is especially important when women see providers for sensitive services such as reproductive health and mental health care. While there are mechanisms available to protect confidentiality

and privacy in a health care setting, the receipt of an EOB signaling that an adult child has used services could violate that privacy.

Costs and Access

Many women, not just uninsured women, report they face cost related barriers to health care.

Between one-fifth and one-quarter of women report that they either postponed or went without care they felt they needed because of costs. While health costs are a major barrier to care for many uninsured women, women on Medicaid and privately insured women also report that out-of-pocket costs can limit access on a broad range of indicators. Out-of-pocket spending may still be a barrier to care for newly insured, low-income women despite the availability of subsidies and caps on spending under the ACA. A substantial share of women on Medicaid report that cost is a barrier, which could be attributable to Medicaid policy that permits nominal cost-sharing for some services and in some states limits on the number of visits, prescription drugs, or range of drugs the program will cover.

Medical bills are problems for nearly three in ten women and some are forced to make difficult trade-offs to meet these obligations.

Women report difficulties paying for medical bills at significantly higher rates than men. Not surprisingly, medical debt is a problem for a higher share of women who are low-income, uninsured, and even for women on Medicaid, who may also contend with bills for other family members who are uninsured. A substantial share of women with medical debt report they either used up most of their savings, had difficulty paying for basic necessities, or had to borrow money from friends or relatives to pay for their bills. The issue of medical debt could also be a consideration for women in the selection of a plan's metal tier available through the Marketplaces. Women choosing bronze plans with low premiums, but higher cost-sharing and deductibles could still face substantial out-of-pocket costs if they have a hospitalization, serious injury, or other medical condition that requires costly medical treatment.

Logistical barriers to care beyond coverage and affordability are challenges for many women.

Lack of flexibility at work, problems with childcare and difficulty securing transportation are reported by a sizable minority of women as a reason that they didn't get care they felt they needed in the past year. These challenges are more common among low-income women, but are also reported by some with higher incomes. Notably, one-quarter of all women, regardless of income, report that lack of time to go to the doctor is a reason they went without care. The survey suggests that factors such as work place flexibility, sick leave, and child care also could have implications for women's access to care.

Connections to Care

Expansions in coverage options and system reforms could result in more women having a stronger connection to health providers, but it is important that new models of care be gender sensitive.

While most women report that they have a specific place or provider for their routine care, a substantial share of women who are younger, Hispanic, low-income or uninsured lack this important connection to care. Sizable

shares of women also say they have more than one regular provider, typically a family physician/internist along with an Ob/Gyn. The ACA includes incentives to improve primary care and develop new models for patient centered medical homes. It will be important to examine how well these approaches address the diverse needs of women, including reproductive and sexual health care.

A network of safety-net clinics, including community health centers and family planning clinics, will still be needed by many women.

Safety-net providers including community health centers, public clinics, and family planning clinics play a significant role serving women, particularly those who are low-income, uninsured, or racial and ethnic minorities. While it is too soon to tell how these providers will fare as more people gain coverage and shift to private or Medicaid plans, many low-income women will remain reliant on these providers for their care.

Preventive Services

The ACA private plan coverage requirements may help improve the use of preventive services, yet awareness is still limited.

The new private plan coverage requirements in the ACA for well woman visits and for other preventive services could result in greater numbers of women receiving these services at recommended rates. However, public awareness of these insurance reforms is far from universal. In addition, while most women report a recent checkup or well woman visit, counseling and screening services are often not provided at recommended intervals. Gaps are especially notable among women who are low-income and uninsured.

Medicaid coverage of preventive services is an important benefit for low-income women.

Women with Medicaid coverage, despite their lower incomes and constrained provider options, obtain preventive screening and counseling services at rates that are on par with women with private coverage. The ACA includes a small financial incentive for state Medicaid programs to provide coverage of all services recommended by the USPSTF without cost sharing. In the coming years, we will track how many states take advantage of this option and broaden coverage of preventive care for women under Medicaid.

Sexual and Reproductive Health

There is considerable room for improvement in the rates of counseling on reproductive and sexual health services.

Among women of reproductive age, counseling rates fall far short of recommended levels. Screening rates for sensitive services are particularly low. Although nearly two-thirds of women have received some level of counseling for contraception, counseling on sexual history, HIV, and STIs is only provided to a fraction of reproductive age women. Many women are incorrectly under the impression that HIV and STI tests are routinely included as part of their gynecological exams. Therefore, the actual screening rate is likely lower than the share of women who report being tested. This mistaken assumption has implications for the treatment and prevention of transmission of these infectious diseases, especially given the high rates of STIs among young women and the disproportionate burden of HIV on Black women.

A substantial share of sexually active women is not using any contraception and consequently is at high risk for unintended pregnancy.

While the effectiveness of FDA approved contraceptives in preventing unintended pregnancy is widely known, many women are at very high risk for unintended pregnancy because they are not using any method. Among sexually active women who use reversible contraceptives, condoms are the most frequently reported followed by oral contraceptives, and a sizable share use more than one method. Condoms also offer important protection against certain STIs, but are not among the most effective methods for preventing pregnancy. It has now been 15 years since Plan B® emergency contraceptive (EC) pills were approved by the FDA and nearly 5 years since they became available without a prescription. Today, awareness of emergency contraceptive pills is quite high. However, a fraction of women report that they have used or purchased them to prevent unintended pregnancy in cases of contraceptive failure or as a backup method of contraception.

A sizable minority of women using contraception now rely on long acting reversible contraceptives (LARCs). Intrauterine devices (IUDs), sub-dermal implants and hormonal injections, considered to be LARCs, are among the most effective methods of birth control. The ACA includes provisions that require new plans to provide no-cost coverage for prescribed FDA-approved contraceptives and services for women (including insertion, removal and follow up care). This provision could expand access to highly effective and long lasting methods by eliminating costs as a barrier. In addition, coverage of family planning services without cost-sharing has long been a mandatory benefit under Medicaid. About half of the states also have special programs that provide coverage for family planning services to low-income women who do not qualify for full Medicaid, which has potentially expanded the pool of low-income women who can obtain LARCs without cost barriers. A recent study demonstrated that when financial barriers were removed, and women were counseled about all contraceptive methods, 75% of women chose LARCs. [24]

One in three women with private insurance report that their insurance plans covered the full cost of contraceptives.

Almost two years after the ACA contraceptive coverage rule took effect, among women with private insurance, one in three report that their insurance covered the costs of their contraceptive care in full. This provision only applies to "new" or "non-grandfathered" plans and over time it is anticipated that most women with private coverage will be enrolled in plans that offer this coverage. Still, four in ten say their insurance covered part of the costs and 13% reported that their plans did not cover contraceptives. While this provision has received much attention in the media, not all women are aware of this policy, which has the potential to broaden access to the most effective, but sometimes more costly, methods of contraceptives.

Family planning providers and community health centers play an important role providing contraceptive care for uninsured women and women of color.

Community health centers and family planning clinics were established to provide care to individuals regardless of their ability to pay. Title X, the federal planning program, and the Medicaid program are the leading sources of public funding for family planning services provided by clinics. As care systems under Medicaid increasingly shift to private managed care plans, and growing numbers of uninsured women are enrolled in private plans and Medicaid, it will be important to monitor how care changes for the women who have been relying on these clinics for their reproductive and sexual health care. In addition, there will still be gaps in coverage as many low-income women will either not qualify for coverage or may not be able to afford to

enroll. These low-income women will still need affordable sources of care if they are to have access to sexual and reproductive health services.

***

The findings of this survey provide new information about the opportunities and ongoing challenges in women's health care and coverage in the early days of ACA implementation. The ACA includes reforms that could make coverage more affordable, accessible, and stable for many women in the years to come. While the ACA can address some of these gaps, many challenges related to the law's implementation and other structural factors remain. Patient education, affordable care and coverage options, and integrated care systems that encompass the range of women's health needs, including reproductive and sexual health, will be critical issues to consider moving forward.

Endnotes

[1] Kaiser Family Foundation, Medical Debt Among People with Health Insurance, January 7, 2014.

[2] The Patient Protection and Affordable Care Act, Section 2713: Coverage of Preventive Health Services

[3] U.S. Preventive Services Task Force, USPSTF A and B Recommendations

[4] Centers for Disease Control and Prevention, Vaccine Recommendations of the ACIP

[5] Bright Futures and American Academy of Pediatrics, Recommendations for Preventive Pediatric Health Care

[6] Health Resources and Services Administration (HRSA), Women's Preventive Services Guidelines

[7] Health Resources and Services Administration, Women's Preventive Guidelines

[8] HHS, Substance Abuse and Mental Health Services Administration, Behavioral Health, United States, 2012

[9] HHS, Essential Health Benefits.

[10] U.S. Preventive Services Task Force, Screening for Lipid Disorders in Adults

[11] U.S. Preventive Services Task Force, Screening for Colorectal Cancer

[12] U.S. Preventive Services Task Force, Screening for Cervical Cancer

[13] Guttmacher Institute. (2013). Unintended Pregnancy in the United States.

[14] Centers for Disease Control and Prevention. (2013). Sexually Transmitted Infections Among Young Americans.

[15] Centers for Disease Control and Prevention. (2011). The National Intimate Partner and Sexual Violence Survey.

[16] Catalano, S. (2012). Intimate Partner Violence, 1993-2010. *U.S. Department of Justice, Office of Justice Programs.*

[17] U.S. Preventive Services Task Force. (2008). *Recommendations for STI Screening*.

[18] Centers for Disease Control and Prevention. (2014). Sexually Transmitted Diseases (STDs).

[19] The Institute of Medicine. (2011). Clinical Preventive Services for Women: Closing the Gaps.

[20] Kaiser Family Foundation. (2012). State Coverage of Preventive Services for Women under Medicaid: Findings from a State-Level Survey.

[21] The American Congress of Obstetricians and Gynecologists. (2009). Hormonal Contraceptives Offer Benefits Beyond Pregnancy Prevention.

[22] Dayal, M & Barnhart, KT. (2001). Noncontraceptive benefits and therapeutic uses of the oral contraceptive pill. *Seminars in Reproductive Medicine* 19(4).

[23] Foster, D, et al. (2011). Number of oral contraceptive pill packages dispensed and subsequent unintended pregnancies. *Obstetrics & Gynecology* 117(3).

[24] Peipert, J.F., et al. (2012). Preventing unintended pregnancies by providing no-cost contraception. *Obstetrics and Gynecology* 120 (6).

THE HENRY J. KAISER FAMILY FOUNDATION

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

This publication (#8590) is available on the Kaiser Family Foundation's website at www.kff.org.

Filling the need for trusted information on national health issues, *the Kaiser Family Foundation is a nonprofit organization based in Menlo Park, California.*