ISSUE BRIEF
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How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care

Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016

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ABSTRACT

ISSUE: Prior to the Affordable Care Act (ACA), one-third of women who tried to buy a health plan on their own were either turned down, charged a higher premium because of their health, or had specific health problems excluded from their plans. Beginning in 2010, ACA consumer protections, particularly coverage for preventive care screenings with no cost-sharing and a ban on plan benefit limits, improved the quality of health insurance for women. In 2014, the law's major insurance reforms helped millions of women who did not have employer insurance to gain coverage through the ACA's marketplaces or through Medicaid.

GOALS: To examine the effects of ACA health reforms on women's coverage and access to care.

METHOD: Analysis of the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2016.

FINDINGS AND CONCLUSIONS: Women ages 19 to 64 who shopped for new coverage on their own found it significantly easier to find affordable plans in 2016 compared to 2010. The percentage of women who reported delaying or skipping needed care because of costs fell to an all-time low. Insured women were more likely than uninsured women to receive preventive screenings, including Pap tests and mammograms.

KEY TAKEAWAYS

- The number of U.S. working-age women lacking health insurance has fallen by nearly half since 2010, when the Affordable Care Act was enacted.
- Women are also finding it easier to find an affordable plan that fits their health needs.
- Fewer women are skipping or delaying needed care because of costs and fewer have medical bill problems.

The Commonwealth Fund

BACKGROUND

Compared with men, women on average have more interaction with the health care system over their lifetimes. Not only do women have relatively greater health care needs during their reproductive years, they also often serve as family caregivers and play a central role in coordinating the health care needs of multiple generations of family members, including children, spouses, and aging parents.[1]

Accessing health care became increasingly challenging for women in the decade prior to the passage of the Affordable Care Act (ACA), as increasing numbers lost insurance coverage. The percentage of adult women under age 65 without insurance climbed from 13 percent in 2001 to 20 percent in 2010 — from 11 million to 19 million women (Exhibit 1). Women who lost their employer coverage had few places to turn. In most states, Medicaid was available only to women who were pregnant, parents with very low incomes, or people with disabilities. In the individual insurance market in most states, women could be charged more for a health plan, or denied coverage altogether, based on a preexisting health condition.

To insurers, women's gender was, in effect, a preexisting condition that signaled the potential for higher health care use and higher costs. That is why in most states insurers selling plans in the individual market charged young women higher premiums than young men — to protect themselves from this greater risk. The U.S. Government Accountability Office found in 2013 that in 38 states, individual-market plans with the lowest premiums charged a nonsmoking 30-year-old single woman a higher premium than they charged her male counterpart.[2]

Insurers also protected themselves by excluding from coverage services that women would likely need, like maternity care. A 2012 study found only 12 percent of plans in the individual market offered maternity coverage, and only nine states required insurers to include this benefit.[3] Consequently, women with individual-market plans had less comprehensive policies, on average, than those with employer coverage. In 2012, the Commonwealth Fund Biennial Health Insurance Survey found only 44 percent of women with individual-market coverage had maternity benefits, compared to 81 percent of women in an employer plan (data not shown). And only one-third (34%) of privately insured women with individual policies had a plan that covered birth control or contraceptives, roughly half the rate for women (62%) with employer coverage.

The ACA brought about sweeping changes in insurance for women. Because of the law, women who buy coverage on their own are no longer charged higher premiums than men in their own age group, can no longer be denied coverage because of preexisting conditions, and must be covered for essential services like maternity care. Tax credits have helped make individual plans affordable for women with low or moderate incomes, and millions of women have become eligible for Medicaid. Young women, meanwhile, can stay covered on a parent's health plan until age 26. In addition, all private plans, including employer plans, cannot place limits on how much they will pay annually or over a lifetime, and most plans must cover preventive services, including contraception, without cost-sharing.[4,5] One 2015 study found the ACA collectively saved privately insured women about $1.4 billion per year on contraception.[6]

This analysis of the 2016 Commonwealth Fund Biennial Health Insurance Survey compares women's health insurance and health care experiences in the years before and after the ACA's major coverage expansions in 2014.

SURVEY FINDINGS

The Uninsured Rate for Women Is at an All-Time Low

By 2016, the number of working-age women (ages 19–64) lacking health insurance had fallen by almost half since 2010, from 19 million to 11 million, or from 20 percent to 11 percent of this population (Exhibit 1, Appendix 1). Women with low incomes have made particularly large gains: uninsured rates for those with incomes below 200 percent of the federal poverty level ($23,760 for an individual or $48,600 for a family of four), fell from 34 percent in 2010 to 18 percent in 2016 (Exhibit 2). The findings are similar for low-income women of all races and ethnicities.

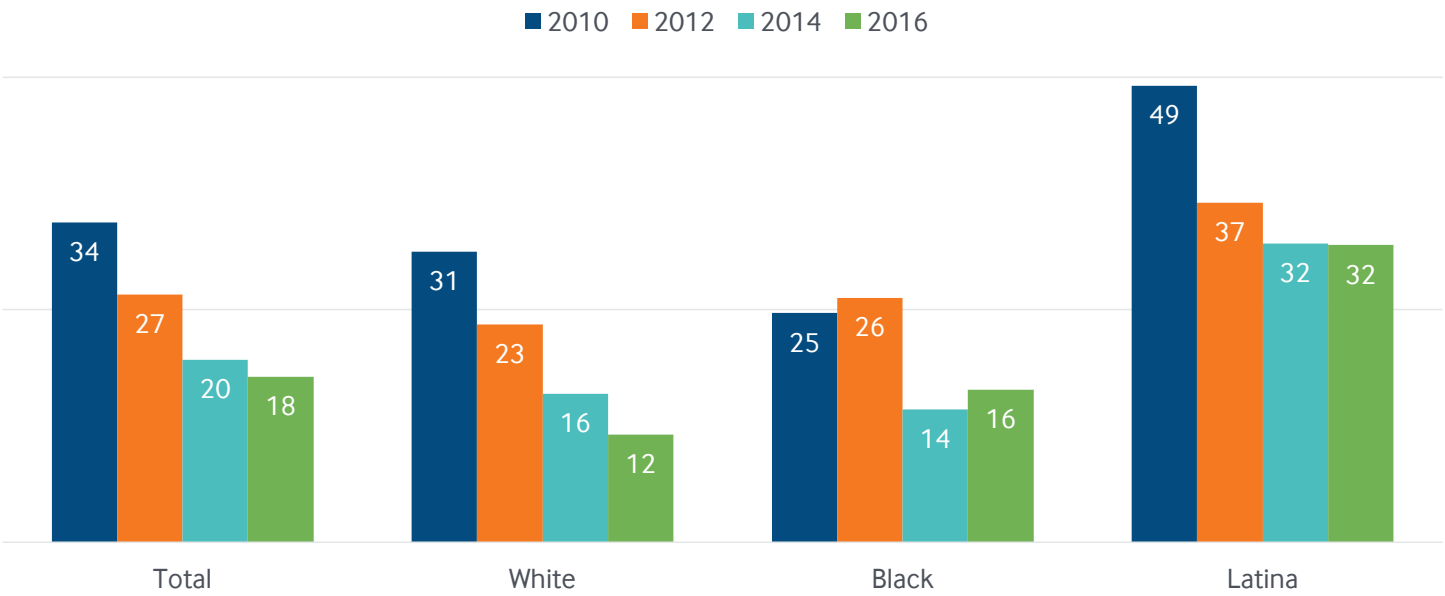
Exhibit 1. After Rising Steadily Through 2010, the Number of Uninsured Women in the U.S. Had Fallen by Nearly Half by 2016

Women ages 19–64	2001	2003	2005	2010	2012	2014	2016
Uninsured now	**13%** 11 million	**17%** 15 million	**18%** 17 million	**20%** 19 million	**17%** 16 million	**13%** 12 million	**11%** 11 million
Insured now, had a gap	**10%** 9 million	**9%** 8 million	**11%** 10 million	**9%** 8 million	**11%** 11 million	**13%** 12 million	**10%** 9 million
Continuously insured	**77%** 64 million	**74%** 66 million	**71%** 65 million	**71%** 67 million	**72%** 68 million	**74%** 70 million	**79%** 75 million

Notes: "Uninsured now" refers to women who reported being uninsured at the time of the survey; "Insured now, had a gap" refers to women who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Continuously insured" refers to women who were insured for the full year up to and on the survey field date.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, 2014, 2016).

Exhibit 2. Women with Low Incomes Have Made Gains in Coverage Across Race and Ethnic Groups

Percent of women ages 19–64 who are uninsured and earn less than 200% FPL



Notes: FPL refers to federal poverty level. Income levels are for a family of four in 2016. Rates are for those uninsured at the time of the survey.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2010, 2012, 2014, 2016).

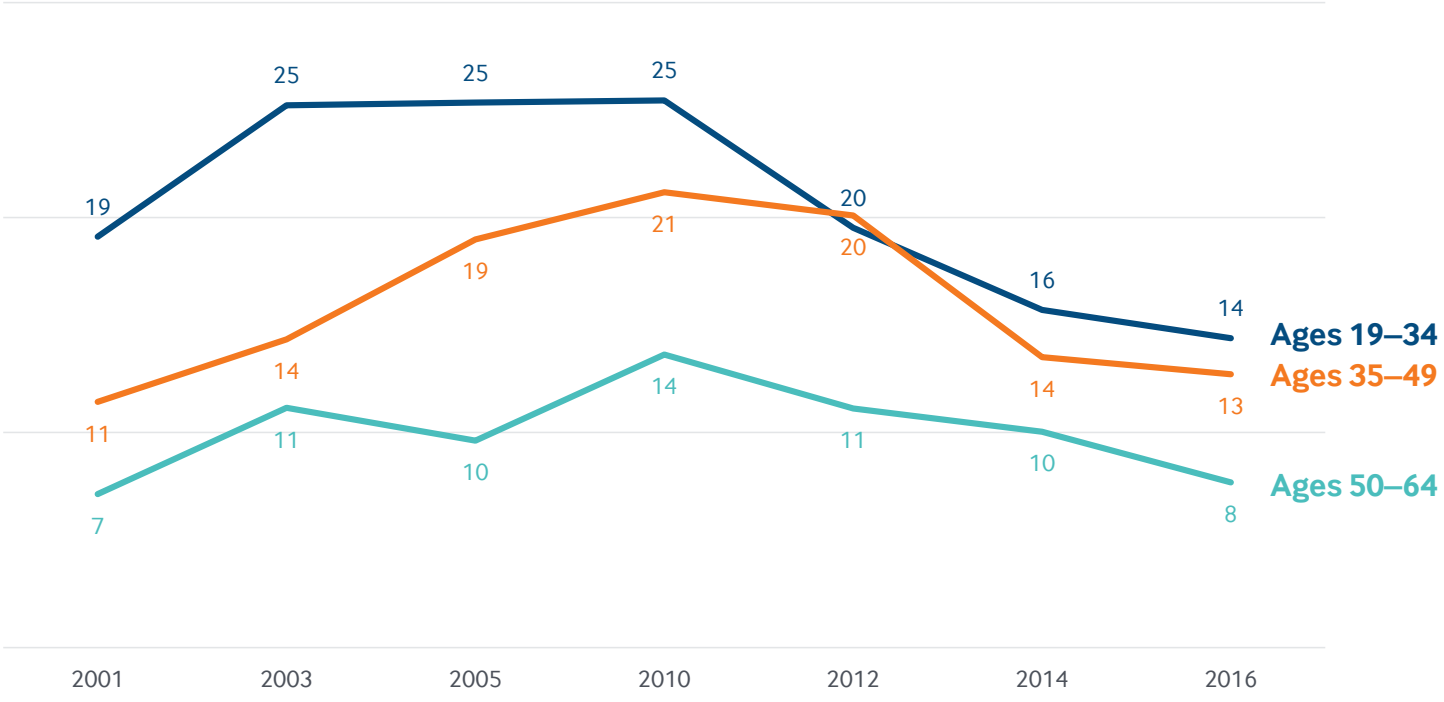
Of all age groups, women 19 to 34 have seen the greatest improvements in their coverage (Exhibit 3). In 2010, 25 percent of young women reported being uninsured, compared to 14 percent in 2016. The early improvements seen in 2012 reflected young adults' recent ability to stay on a parent's policy until age 26. After 2014, young women made further gains through the expansion of Medicaid eligibility, new subsidies for private coverage, and reforms of the individual market.

This broader availability of affordable insurance has led to striking changes in women's coverage. In 2010, just 5 percent of working-age women had coverage through the individual market and just 10 percent had Medicaid (Exhibit 4). By 2016, the share of women with individual coverage had doubled and the share with Medicaid had climbed to 15 percent.

But coverage options are more limited for women in the 19 states that have not yet expanded eligibility for Medicaid, and consequently uninsured rates are often much higher. In Texas, for example, women are uninsured at nearly five times the rate in New York and one and a half times the rate in California, both of which expanded Medicaid under the ACA (Exhibit 5). And women in Florida, which like Texas chose not to expand Medicaid, are also uninsured at much higher rates than those living in California and New York.

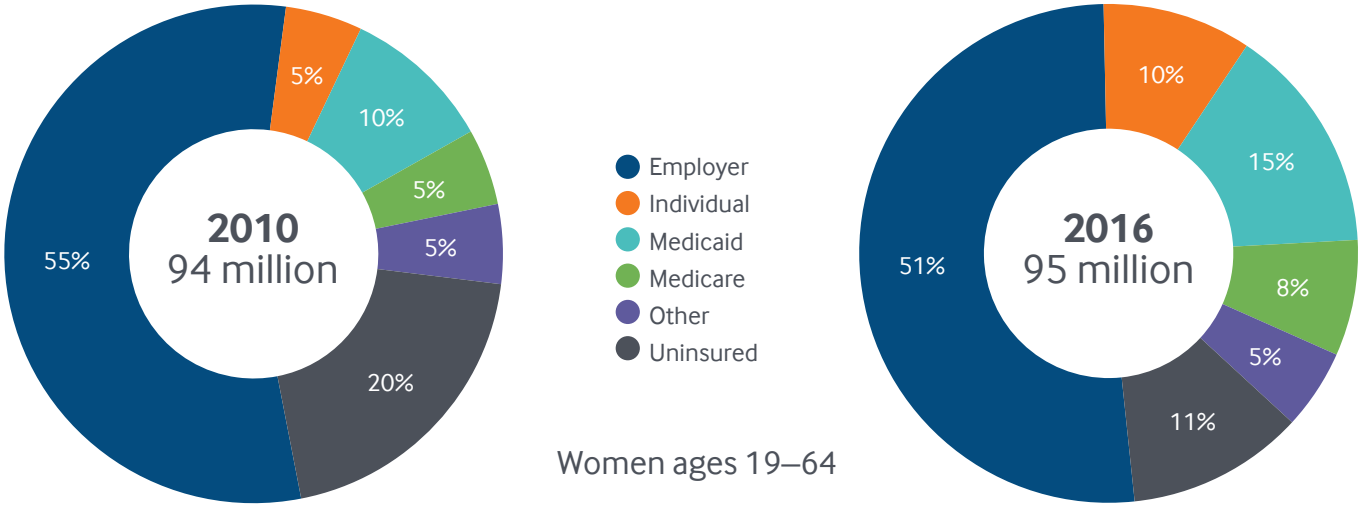
Exhibit 3. Young Women Have Made the Greatest Coverage Gains of Any Age Group Since 2010

Percent of women ages 19–64 who are uninsured



Data: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, 2014, 2016).

Exhibit 4. More Women Have Coverage Through Medicaid and the Individual Market Since the ACA's Passage

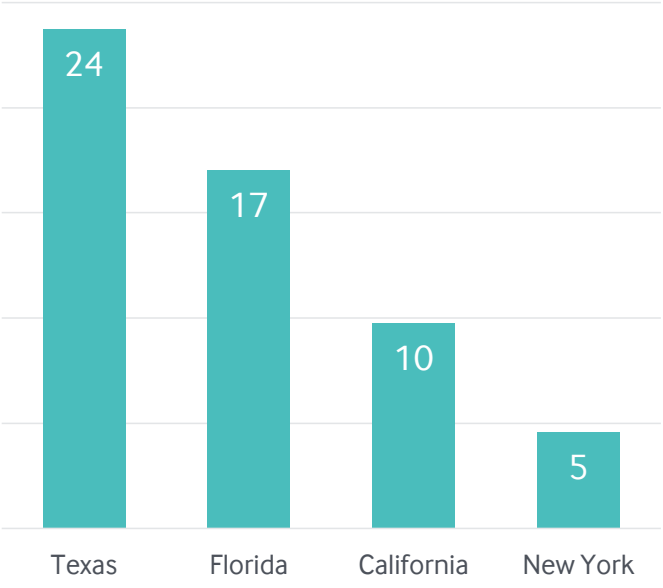


Note: Segments may not sum to 100 percent because of rounding. * Individual includes women who are enrolled in either marketplace plans or purchased directly from an insurance company.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2010 and 2016).

Exhibit 5. Women in Texas and Florida Are More Likely to Report Being Uninsured Compared to Women in California and New York

Percent of women ages 19–64 who are uninsured



Notes: Rates are for those uninsured at the time of the survey.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

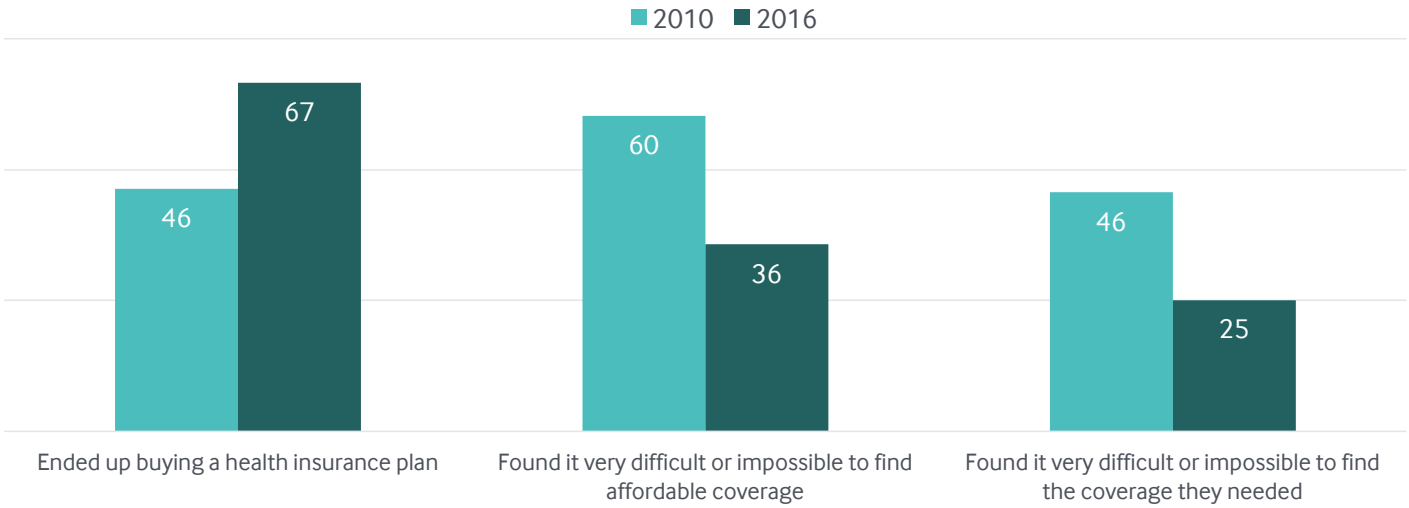
Reforms Have Made It Easier for Women to Buy Health Plans on Their Own

The ACA's consumer protections and subsidies for individual-market coverage have particularly benefited women. In 2010, one-third of women who had a health plan or tried to buy one in the individual market in the prior three years had either been turned down by an insurance company, charged a higher premium because of their health, or had a specific health problem excluded from coverage.[7] Among women with health problems, 46 percent reported one or more of these problems. In the end, fewer than half (46%) of women who had tried to buy a plan ended up enrolling (Exhibit 6).

By 2016, things had improved significantly. The proportion of women who had shopped for a plan in the individual market and ultimately enrolled in one climbed to more than two-thirds (67%) (Exhibit 6). And the proportion reporting difficulty finding an affordable plan fell by nearly half. There was similar improvement in the share of women experiencing trouble finding a plan that fit their needs. Women with health problems made particularly large gains (Appendix 2).

Exhibit 6. The ACA's Individual-Market Reforms and Subsidies Have Made It Easier for Women to Buy Health Plans on Their Own

Percent of women ages 19–64 with individual coverage or who tried to buy it in past three years***



Notes: * Bought in past three years. ** Base: In 2010, 13 million women ages 19–64 either had individual coverage or tried to buy it within the past three years. In 2016, this number increased to 24 million.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2010 and 2016).

Fewer Women Are Skipping or Delaying Needed Care Because of Costs

Gains in health insurance coverage have led to nationwide improvements in measures of health care access for women. In 2010, nearly half (48%) of women ages 19 to 64, or an estimated 45 million people, reported not getting needed care because of the cost, including they had not filled a prescription, not seen a specialist when needed, skipped a recommended medical test or treatment, or not gone to a doctor when sick (Exhibit 7, Appendix 3). By 2016, the share of women reporting any one of these cost-related problems getting needed care fell to 38 percent, or about 37 million people (Exhibit 7, Appendix 3, and Appendix 4).

Access to prescription drugs for women with health problems also significantly improved between 2010 and 2016. In 2010, 31 percent of women who reported having one of five chronic health problems or being in fair or poor health reported not filling a prescription for their condition because of costs (data not shown).[8] By 2016, this rate had fallen to 21 percent (Appendix 4).

Fewer Women Are Reporting Medical Bill Problems

Expanded coverage has also led to modest declines in medically related financial problems. In 2012, 47 percent of women, or 44 million, reported either having a problem paying a medical bill, being contacted by a collection agency for unpaid medical bills, having to change their way of life to pay medical bills, or that they were paying off medical debt over time (Exhibit 8, Appendix 3). In 2016, 42 percent of women, or 40 million, reported having a medical bill problem in the past year or medical debt (Exhibit 8, Appendix 3, and Appendix 5).

However, after substantial improvement on these indicators of financial stress in 2014, there was little improvement, and even erosion on some measures, in 2016. Most notably, the share of women who reported they were paying off medical debt over time rose significantly. Rates of medical debt in 2016 were highest among women with private insurance, both employer-based and individual-market, and among women with disabilities covered through Medicare. Rates were lowest for women with Medicaid coverage. As on all measures of medical bill problems, women are more likely than men to say they are paying off medical debt over time (data not shown).

Exhibit 7. Fewer Women Say They Are Not Getting Needed Care Because of Costs

Percentage of women ages 19–64 who reported any of the following cost-related access problems in the past year:	2003	2005	2010	2012	2014	2016
Did not fill prescription	29%	30%	32%	32%	22%	23%
Skipped recommended test, treatment, or follow-up	23%	24%	30%	31%	22%	22%
Had a medical problem, did not visit doctor or clinic	25%	27%	31%	32%	25%	21%
Did not get needed specialist care	15%	21%	21%	23%	14%	15%
Any of the above	**42%**	**43%**	**48%**	**49%**	**40%**	**38%**

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016).

Exhibit 8. There Has Been a Modest Reduction in Reports of Medical Bill Problems by Women

Percent of women ages 19–64 who reported any of following bill or medical debt problems in the past year:	2005	2010	2012	2014	2016
Had problems paying or unable to pay medical bills	26%	34%	34%	27%	26%
Contacted by a collection agency for unpaid medical bills	16%	19%	22%	18%	16%
Had to change way of life to pay bills	15%	19%	19%	17%	15%
Medical bills/debt being paid off over time	24%	27%	31%	23%	28%
Any of the above	**38%**	**44%**	**47%**	**38%**	**42%**

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, 2014, 2016).

Insured Women Are More Likely to Receive Preventive Care

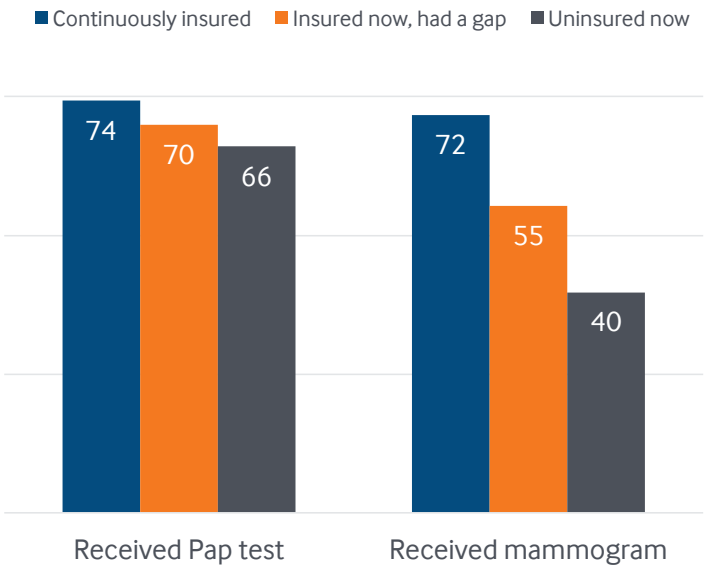
Research shows increased use of preventive services saves lives. For example, increasing the share of women 40 and older who receive breast cancer screening every two years to 90 percent could save 3,700 lives annually, while increasing the number of young women who receive chlamydia screening to that level would save an estimated 30,000 lives.[9] A 2015 study found that the ACA's dependent-coverage provision was associated with higher early detection of cervical cancer in young women ages 21 to 25.[10] Another recent study showed that early detection of breast cancer has also improved post-ACA.[11]

Our survey findings indicate the difference insurance makes in whether women receive timely preventive care and cancer screenings. Women ages 40 to 64 continuously insured for the full year were significantly more likely than uninsured women to have had a mammogram within the past two years (Exhibit 9, Appendix 4). And insured women 21 and older were somewhat more likely than uninsured women to have received a Pap test in the past three years. This narrower gap may be a result of women's widespread access to contraception and affordable cancer screening through clinics like those run by Planned Parenthood, where 79 percent of patients have incomes at or below 150 percent of poverty, and through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.[12] In 2014 alone, Planned Parenthood provided more than 270,000 Pap tests to women.[13]

Insurance also makes a difference in women's access to primary care and other preventive services. For example, insured women were more likely to report having a regular doctor and having their blood pressure and cholesterol checked in the recommended time frame (Exhibit 10, Appendix 4).

Exhibit 9. Insured Women Are More Likely to Receive Cancer Screenings Than Uninsured Women, 2016

Percent of women

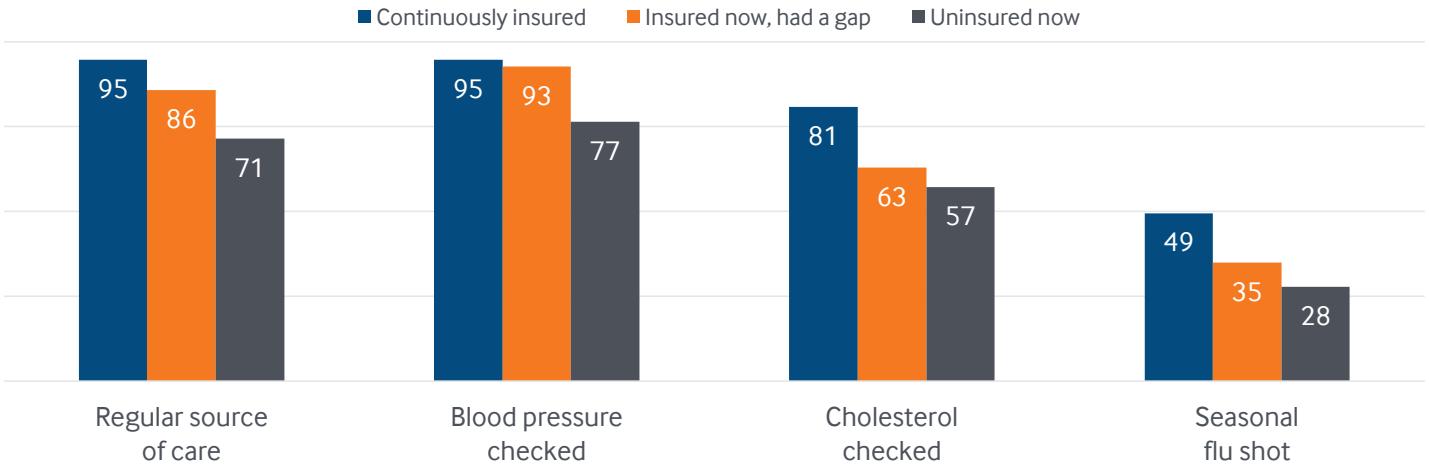


Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to women who reported being uninsured at the time of the survey. Respondents were asked if they: received a Pap test within the past three years for females ages 21–64 and received a mammogram within the past two years for females ages 40–64.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Exhibit 10. Insured Women Are More Likely to Have a Regular Source of Care and Receive Preventive Services

Percent of women ages 19–64



Notes: "Continuously insured" refers to women who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to women who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to women who reported being uninsured at the time of the survey. Respondents were asked if they: had their blood pressure checked within the past two years (in past year if has hypertension or high blood pressure); had their cholesterol checked in past five years (in past year if has hypertension, heart disease, or high cholesterol); and had their seasonal flu shot within the past 12 months.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

CONCLUSION

The Affordable Care Act has improved health care for women and their families through the law's insurance market reforms, mandatory coverage of free preventive care, and subsidized, comprehensive insurance options for people lacking access to affordable employer coverage.

Particularly important for young women and their families have been the requirements that insurers in the individual market offer a comprehensive benefit package with maternity coverage and that most private plans cover contraception. Some observers have claimed that maternity coverage has been a driver of higher premiums in the individual market, but research shows otherwise. Eibner and Whaley found that cutting maternity benefits from the ACA's essential benefit package would lower premiums by just 4 percent, but doing so would significantly increase costs to women having babies.[14] Without maternity coverage, a family's out-of-pocket costs would jump by roughly 1,000 percent to nearly 3,000 percent, depending on the complexity of a delivery.

But the Commonwealth Fund survey findings also suggest that more work needs to be done to make health care accessible and affordable for all U.S. women. First, an estimated 11 million working-age women remain uninsured. The 19 states that have yet to expand Medicaid eligibility could bring critical coverage to low-income women in their states by moving forward with expansion. State and federal outreach and enrollment efforts also have been shown to increase awareness of and enrollment in Medicaid or marketplace coverage among the remaining uninsured. And national immigration reform or a loosening of restrictions for undocumented immigrants' eligibility for Medicaid and marketplace plans would help to lower the much higher uninsured rates of Latinas.[15]

Second, although reforms to the individual market have made finding affordable health insurance coverage significantly easier, one-third of women still experience difficulty. One option to improve the affordability of plan premiums is to extend eligibility for tax credits to people earning more than 400 percent of poverty (about $50,000 for an individual and $98,000 for a family of four). This simple change could bring coverage to 1.2 million currently uninsured people, at a relatively modest annual federal cost of $6 billion.[16]

And while we have seen declines in cost-related obstacles to getting needed care and reductions in medical bill problems, rates remain very high. What is likely necessary is a fundamental redesign of private insurance, including employer plans, so that deductibles and cost-sharing encourage, rather than discourage, people to seek timely health care and do not leave people burdened with debt when they do seek care.

In the aftermath of Congress's failed effort to repeal and replace the ACA, the most immediate concern for policymakers is ensuring that the 17 million to 18 million people with marketplace coverage are able to enroll this fall. Congress could take three key modest steps toward this end:

1. A permanent appropriation for payments to insurers that, by law, must offer cost-sharing reductions for low-income enrollees in the marketplaces.
2. A fallback health plan option for the estimated 19 U.S. counties where consumers may not have a plan to choose from this fall.
3. Reinsurance to help carriers cover unexpectedly high claims costs.[17]

The Trump administration can also play an important role by signaling to insurers participating in the marketplaces that it will enforce the individual mandate. The administration also can help by affirming its commitment to ensuring that all eligible Americans have the tools they need to enroll in the coverage that is right for them.

HOW THIS STUDY WAS CONDUCTED

The Commonwealth Fund Biennial Health Insurance Survey, 2016, was conducted by Princeton Survey Research Associates International from July 12 to November 20, 2016. The survey consisted of 25-minute telephone interviews in English or Spanish conducted among a random, nationally representative sample of 6,005 adults age 19 and older living in the continental United States. A combination of landline and cellular phone random-digit dial samples was used to reach people. In all, 2,402 interviews were conducted with respondents on landline telephones and 3,603 interviews were conducted on cell phones, including 2,262 with respondents who live in households with no landline telephone access.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. This report limits the analysis to respondents ages 19 to 64 (n=4,186). Statistical results were weighted to correct for the stratified sample design, the overlapping landline and cell phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau's 2016 Annual Social and Economic Supplement.

The resulting weighted sample is representative of the approximately 187.4 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 14 percent response rate and the cell phone component achieved a 10 percent response rate.

We also report estimates from the 2001, 2003, 2005, 2010, 2012, and 2014 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy that was used in 2016, except the 2001, 2003, and 2005 surveys did not include a cell phone random-digit dial sample. In 2001, the survey was conducted from April 27 through July 29, 2001, and included 2,829 adults ages 19 to 64; in 2003, the survey was conducted from September 3, 2003, through January 4, 2004, and included 3,293 adults ages 19 to 64; in 2005, the survey was conducted from August 18, 2005, to January 5, 2006, among 3,352 adults ages 19 to 64; in 2010, the survey was conducted from July 14 to November 30, 2010, among 3,033 adults ages 19 to 64; in 2012, the survey was conducted from April 26 to August 19, 2012, among 3,393 adults ages 19 to 64; and in 2014, the survey was conducted from July 22 to December 14, 2014, among 4,251 adults ages 19 to 64.

NOTES

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

[2] U.S. Government Accountability Office, *Private Health Insurance: The Range of Base Premiums in the Individual Market by State in January 2013* (GAO, July 2013).

[3] D. Garrett, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act* (National Women's Law Center, March 2012).

[4] Religious employers, including churches, and certain religious organizations and employers are exempt from this requirement if they object to it on religious grounds.

[5] A. Sonfield, *What Is at Stake with the Federal Contraceptive Coverage Guarantee?* (Guttmacher Institute, Jan. 2017).

[6] N. V. Becker and D. Polsky, "Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing," *Health Affairs,* July 2015 34(7):1204–11.

[7] R. Robertson and S. R. Collins, *Women at Risk: Why Increasing Numbers of Women Are Failing to Get the Health Care They Need and How the Affordable Care Act Will Help* (The Commonwealth Fund, May 2011).

[8] Chronic health problems include: hypertension or high blood pressure; heart failure or heart attack; diabetes requiring insulin; asthma, emphysema, or lung disease; and high cholesterol.

[9] U.S. Departments of Treasury, Labor, and Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," *Federal Register,* 17242, July 19, 2010.

[10] A. S. Robbins, X. Han, and E. M. Ward, "Association Between the Affordable Care Act Dependent Coverage Expansion and Cervical Cancer Stage and Treatment in Young Women," *Journal of the American Medical Association,* Nov. 24, 2015 314(20):2189–91.

[11] N. Bakalar, "With Obamacare, More Breast Cancers Diagnosed at Earlier Stages," *New York Times,* June 27, 2017.

[12] *By the Numbers*, Fact Sheet (Planned Parenthood, Jan. 2014).

[13] *2014–2015 Annual Report* (Planned Parenthood Federation of America, 2015).

[14] C. Eibner and C. Whaley, "Loss of Maternity Care and Mental Health Coverage Would Burden Those in Greatest Need," *To the Point,* The Commonwealth Fund, June 19, 2017.

[15] M. M. Doty and S. R. Collins, "Millions More Latino Adults Are Insured Under the Affordable Care Act," *To the Point,* The Commonwealth Fund, Jan. 19, 2017.

[16] J. Liu and C. Eibner, *Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults* (The Commonwealth Fund, July 2017).

[17] D. Blumenthal and S. R. Collins, "In the Aftermath," *To the Point,* The Commonwealth Fund, July 28, 2017; and T. S. Jost, "Fixing Our Most Pressing Health Insurance Problems: A Bipartisan Path Forward," *To the Point,* The Commonwealth Fund, July 13, 2017.

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About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

Appendix 1. Insurance Status by Demographics, 2016

(base: women ages 19–64)

	Total (19–64)	Continuously insured	Insured now, had a gap	Uninsured now	Uninsured now or had a gap
Total (millions)	95.5	75.2	9.3	11.0	20.3
Percent distribution (%)	100%	79%	10%	11%	21%
Unweighted n	2,240	1,775	203	262	465
Age					
19–34	33	70	15	14	30
35–49	32	80	8	13	20
50–64	35	86	7	8	14
Race/Ethnicity					
Non-Hispanic White	59	86	7	7	14
Black	14	73	14	13	27
Latino	18	58	16	26	42
Asian/Pacific Islander	3	93	4	2	7
Other/Mixed	5	71	10	20	29
Poverty status					
Below 133% poverty	34	69	13	19	31
133%–249% poverty	19	76	10	14	24
250%–399% poverty	17	80	14	6	20
400% poverty or more	23	94	4	3	6
Below 200% poverty	49	71	12	18	29
200% poverty or more	44	87	8	4	13
Fair/Poor health status, or any chronic condition or disability*	48	76	11	13	24
Adult work status					
Full-time	44	84	9	7	16
Part-time	16	75	12	13	25
Not currently employed	39	74	9	16	26
Employer size**					
1–19 employees	23	77	7	16	23
20–49 employees	10	70	19	11	30
50–99 employees	7	71	15	15	29
100 or more employees	57	88	8	3	12

Note: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey; "Uninsured now or had a gap" refers to adults who were uninsured at any point during the year before the survey field date or on the survey field date.

* At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

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

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Appendix 2. Experiences Buying Health Plans in the Individual Market, by Health Status and Poverty

(base: women ages 19–64)

	Total		Health status*				Federal poverty level			
			Health problem		No health problem		Below 200% poverty		200% poverty or more	
	2010	2016	2010	2016	2010	2016	2010	2016	2010	2016
Women ages 19–64 with individual coverage or who tried to buy it in past three years										
Total (millions)	*12.5*	*23.6*	*6.3*	*11.5*	*6.3*	*12.1*	*6.1*	*13.9*	*5.1*	*8.5*
Percent distribution	*100%*	*100%*	*50%*	*49%*	*50%*	*51%*	*49%*	*59%*	*41%*	*36%*
Unweighted n	*242*	*543*	*135*	*297*	*107*	*246*	*112*	*316*	*105*	*197*
Found it very difficult or impossible to find affordable coverage	60	36	74	43	46	29	64	36	54	38
Found it very difficult or impossible to find coverage they needed	46	25	59	31	32	19	47	25	40	28
Has individual coverage or ended up buying a health insurance plan^	46	67	33	61	60	72	34	67	59	65

* Respondent rated their health status as fair or poor, or has any of the following chronic conditions: hypertension or high blood pressure; heart disease, including heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol.

^ Among those who ever tried buying health insurance on their own in the past three years.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2010 and 2016).

Appendix 3. Cost-Related Access Problems and Medical Bill Problems by Year

(base: women ages 19–64)

	Percent						Estimated millions					
	2003	2005	2010	2012	2014	2016	2003	2005	2010	2012	2014	2016
Total (adults ages 19–64)	100%	100%	100%	100%	100%	100%	89	91	94	95	94	95
Access problems in past year												
Went without needed care in past year because of costs:												
Did not fill prescription	29	30	32	32	22	23	26	28	31	31	21	22
Skipped recommended test, treatment, or follow-up	23	24	30	31	22	22	21	22	28	29	21	21
Had a medical problem, did not visit doctor or clinic	25	27	31	32	25	21	23	25	29	30	23	21
Did not get needed specialist care	15	21	21	23	14	15	13	19	20	21	13	15
At least one of four access problems because of cost	42	43	48	49	40	38	38	40	45	46	37	37
Delayed or did not get dental care	31	—	44	45	36	33	27	—	41	42	34	32
Medical bill problems in past year												
Had problems paying or unable to pay medical bills	28	26	34	34	27	26	25	24	32	32	25	25
Contacted by collection agency	26	23	26	26	24	24	23	21	24	25	22	23
Contacted by collection agency for unpaid medical bills	—	16	19	22	18	16	—	14	18	21	17	15
Contacted by collection agency because of billing mistake	—	7	5	4	5	5	—	6	5	3	4	5
Had to change way of life to pay bills	18	15	19	19	17	15	16	14	18	18	16	14
*Any bill problem**	—	31	39	39	33	32	—	29	36	37	32	31
Medical bills/debt being paid off over time	—	24	27	31	23	28	—	22	25	29	22	27
*Any bill problem or medical debt**	—	38	44	47	38	42	—	35	42	44	36	40

Note: — Data not collected for that year.

* Does not include adults who reported being contacted by a collection agency because of a billing mistake.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016).

Appendix 4. Cost-Related Access Problems and Preventive Care by Insurance Continuity, Insurance Status, and Poverty

(base: women ages 19–64)

	Insurance status					Insurance type*				Federal poverty level			
	Total ages 19–64	Continuously insured	Insured now, had a gap	Uninsured now	Uninsured now or had a gap	Employer	Individual**	Medicaid	Medicare (under age 65, disabled)	Below 133% poverty	133%–249% poverty	250%–399% poverty	400% poverty or more
Total (millions)	95.5	75.2	9.3	11.0	20.3	49.0	9.2	14.1	7.2	32.8	18.4	15.8	21.8
Percent distribution	100%	79%	10%	11%	21%	51%	10%	15%	8%	34%	19%	17%	23%
Unweighted n	2,240	1,775	203	262	465	1,107	223	333	211	762	422	362	530
Access problems in past year													
Went without needed care in past year because of costs:													
Did not fill prescription	23	19	34	39	37	19	31	18	24	25	30	27	13
Skipped recommended test, treatment, or follow-up	22	18	28	41	35	21	30	11	18	21	26	27	17
Had a medical problem, did not visit doctor or clinic	21	16	32	47	40	18	31	11	20	23	30	27	12
Did not get needed specialist care	15	12	23	33	29	12	22	8	12	18	16	18	10
At least one of four access problems because of cost	38	33	56	60	58	35	52	28	37	39	49	43	27
Delayed or did not get dental care	33	27	53	59	56	27	47	33	27	38	42	40	17
Preventive care													
Regular source of care	91	95	86	71	78	95	90	92	96	88	90	93	95
Blood pressure checked in past two years ¥	92	95	93	77	84	97	90	90	90	88	89	98	99
Dental exam in past year	63	70	44	35	39	79	54	45	49	49	53	69	89
Received mammogram in past two years (females age 40+)	68	72	55	40	47	73	69	66	64	59	63	69	76
Received Pap test in past three years (females ages 21–64)	73	74	70	66	68	79	68	71	54	65	72	79	82
Received colon cancer screening in past five years (age 50+)	58	60	41	44	43	62	51	52	57	45	61	60	64
Cholesterol checked in past five years ¥¥	76	81	63	57	60	86	70	66	76	67	72	84	91
Seasonal flu shot in past 12 months	46	49	35	28	31	52	30	47	51	40	41	46	57
Access problems for people with health conditions													
Unweighted n	*1,266*	*1,019*	*118*	*129*	*247*	*582*	*114*	*204*	*179*	*462*	*261*	*205*	*263*
Stayed overnight in a hospital or visited the emergency room because of [this/any of these] problem[s]^	20	18	35	21	28	17	21	22	29	25	17	22	11
Skipped doses or not filled a prescription for medications for the health condition(s)^...?	21	16	29	50	40	15	23	15	26	24	22	29	9

Note: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey; "Uninsured now or had a gap" refers to adults who were uninsured at any point during the year before the survey field date or on the survey field date.

* Insurance type at time of survey.

** Individual includes adults who are enrolled in either marketplace plans or purchased directly from an insurance company.

¥ In past year if respondent has hypertension or high blood pressure.

¥¥ In past year if respondent has hypertension or high blood pressure, heart disease, or high cholesterol.

^ Base: Respondents with at least one of the following health problems: hypertension or high blood pressure, heart disease, diabetes, asthma, emphysema, lung disease, high cholester, depression, kidney disease, cancer, or stroke.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Appendix 5. Medical Bill Problems, by Insurance Continuity, Insurance Status, and Poverty

(base: women ages 19–64)

	Insurance status					Insurance type*				Federal poverty level			
	Total ages 19–64	Continuously insured	Insured now, had a gap	Uninsured now	Uninsured now or had a gap	Employer	Individual**	Medicaid	Medicare (under age 65, disabled)	Below 133% poverty	133%–249% poverty	250%–399% poverty	400% poverty or more
Total (millions)	95.5	75.2	9.3	11.0	20.3	49.0	9.2	14.1	7.2	32.8	18.4	15.8	21.8
Percent distribution	100%	79%	10%	11%	21%	51%	10%	15%	8%	34%	19%	17%	23%
Unweighted n	2,240	1,775	203	262	465	1,107	223	333	211	762	422	362	530
Medical bill problems in past year													
Had problems paying or unable to pay medical bills	26	21	49	46	48	22	29	23	38	32	37	32	8
Contacted by collection agency for unpaid medical bills	16	13	27	27	27	14	7	18	25	19	26	14	6
Had to change way of life to pay bills	15	12	25	26	26	12	19	10	19	18	20	16	6
Any bill problem	32	26	57	51	53	28	33	29	45	36	46	37	14
Medical bills/debt being paid off over time	28	27	42	22	32	32	32	15	37	25	37	34	24
Any bill problem or medical debt	42	37	64	56	60	41	45	32	54	44	54	47	30

Note: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey; "Uninsured now or had a gap" refers to adults who were uninsured at any point during the year before the survey field date or on the survey field date.

* Insurance type at time of survey.

** Individual includes adults who are enrolled in either marketplace plans or purchased directly from an insurance company.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

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