October 2017 | Fact Sheet

Women's Health Insurance Coverage

Health insurance coverage is a critical factor in making health care affordable and accessible to women. Among the 98 million women ages 19 to 64 residing in the U.S., most had some form of coverage in 2016. However, gaps in private sector and publicly-funded programs left a little over one in ten women uninsured. The Affordable Care Act (ACA) requires that nearly everyone carry health insurance and expands access to coverage through a combination of Medicaid expansions, private insurance reforms, and premium tax credits. This factsheet reviews major sources of coverage for women residing in the U.S. in 2016, discusses the impact of the ACA on women's coverage, and the challenges in coverage that many women continue to face.

Sources of Health Insurance Coverage

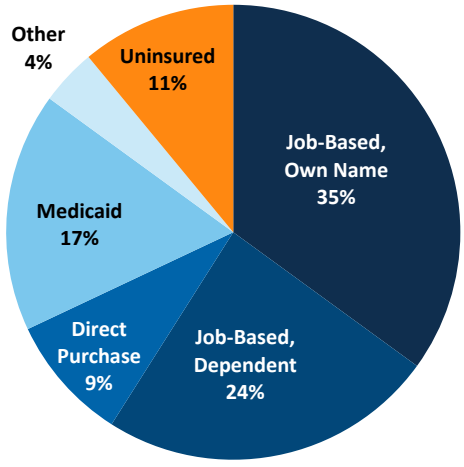
Employer-Sponsored Insurance:

Approximately 57.9 million women ages 19-64 (59%) received their health coverage from their own or their spouse's employer in 2016 (**Figure 1**). Women are less likely than men to be insured through their own job (35% vs. 44% respectively) and more likely to be covered as a dependent (24% vs. 15%).[1]

- Women in families with at least one full-time worker are more likely to have job-based coverage (69%) than women in families with only part-time workers (29%) or without any workers (16%).[2]
- Because women are more likely than men to be covered as dependents, a woman is at greater risk of losing her insurance if she becomes widowed or divorced, her spouse loses a job, or her spouse's employer drops family coverage or increases premium and out-of-pocket costs to unaffordable levels. The ACA also requires employer plans that offer dependent coverage to give workers the option of keeping adult children up to age 26 enrolled as dependents. An estimated 41% of women between the ages of 19 and 25 are covered as dependents under a parent's or a spouse's plan.[3]

Figure 1

Women's Health Insurance Coverage, 2016



Total = 98 Million Women Ages 19 to 64

NOTE: For non-elderly women, "other" includes women who are covered through the military or Medicare.
SOURCE: Kaiser Family Foundation analysis of 2017 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

- In 2017, annual insurance premiums for employer sponsored insurance averaged $6,690 for individuals and $18,764 for families, increasing by 55% over the last decade. On average, workers paid 18% of premiums for individual coverage and 31% for family coverage with the employers picking up the balance.[4]

Non-Group Insurance:

The ACA expanded access to the non-group or individually purchased insurance market by offering premium tax credits to help individuals purchase coverage in state-based health insurance Marketplaces. It also included many insurance reforms to alleviate some of the long-standing barriers to coverage in the non-group insurance market. In 2016, about 9% of non-elderly adult women (approximately 8.9 million women) purchased insurance on their own.[5] This includes women who purchased private policies from the ACA Marketplace in their state, as well as from private insurers that operate outside of Marketplaces.

- Most individuals who seek insurance policies in their state's Marketplace qualify for assistance with the costs of coverage. Those with incomes below 400% of the FPL can qualify for assistance in the form of federal tax credits which lower costs of premiums, and those with income below 250% FPL can purchase coverage that limits cost-sharing requirements.
- The ACA set new standards for all individually purchased plans, including plans available through the Marketplace as well as those that existed prior to the ACA. Historically, insurance carriers sold plans on the individual insurance market that placed women at a disadvantage, either by charging them higher premiums than men for the same level of coverage (gender rating) or disqualifying women from coverage because they had certain pre-existing medical conditions, including pregnancy. The ACA plans are barred from instituting these policies.
- Many of the pre-ACA individually purchased policies did not include coverage for services that are important to women, such as maternity care, prescription medications, or treatment for mental health conditions such as depression. As a result of the ACA, all direct purchase plans also must cover certain "essential health benefits" (EHBs) that fall under 10 different categories, including maternity and newborn care, mental health, and preventive care.

Medicaid:

The state-federal program for low-income individuals, Medicaid, covered 17% of non-elderly adult women in 2016. Historically, to qualify for Medicaid, women had to have very low incomes and be in one of Medicaid's eligibility categories: pregnant, mothers of children 18 and younger, disabled, or over 65. Women who didn't fall into these categories typically were not eligible regardless of how poor they were. The ACA allowed states to eliminate these categorical requirements and broaden Medicaid eligibility to most individuals with incomes less than 138% of the Federal Poverty Level (FPL) regardless of their family or disability status or age, effective January 2014. However, only 31 and DC states have taken up this option. In states that did not expand Medicaid, single women living under 138% FPL are not covered and pregnant women may not have coverage beyond 60 days postpartum depending on state eligibility criteria.

- Medicaid disproportionately covers the poorest and sickest population of women. Approximately 65% of non-elderly women with Medicaid had incomes below 200% of the FPL. More than one in four (27%) women covered by Medicaid rate their own health as fair or poor, compared to 6% of women covered by employer-sponsored insurance and 11% of uninsured women.[6]

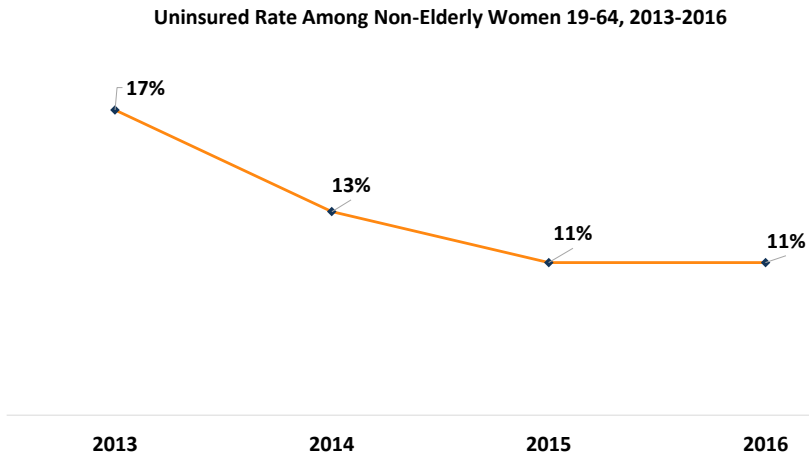
- Medicaid finances nearly half of all births in the U.S.,[7] accounts for 75% of all publicly-funded family planning services[8] and half (53%) of all long-term care spending, which is critical for many frail elderly women.[9]
- Half of the states (25 states)[10] have established programs that use Medicaid funds to cover the costs of family planning services for low-income women and most states have limited scope Medicaid programs to pay for breast and cervical cancer treatment for certain low-income uninsured women.[11]

Uninsured Women

Approximately 11% of women ages 19 to 64 (approximately 10.5 million women) were uninsured in 2016, a decline from a rate of 17% in 2013 (**Figure 2**). Uninsured women often have inadequate access to care, get a lower standard of care when they are in the health system, and have poorer health outcomes.[12] Compared to women with insurance, uninsured women have lower use of important preventive services such as mammograms, Pap tests, and timely blood pressure checks. They are also less likely to report having a regular doctor.[13]

Figure 2

Uninsured Rate Among Women Has Dropped Since the Passage of the ACA



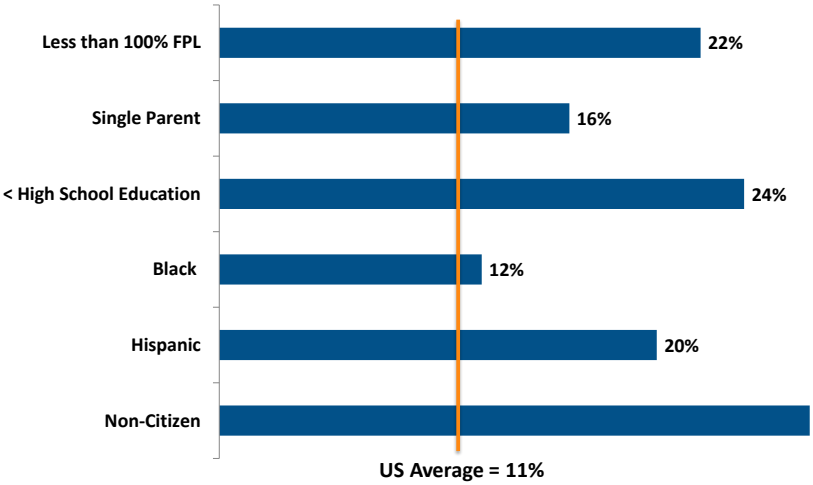
NOTES: Among women 19-64.
SOURCE: SOURCE: Kaiser Family Foundation analysis of 2017 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

Profile of Uninsured

- Low-income women, women of color, and immigrant women are at greater risk of being uninsured (**Figure 3**). Single mothers are more likely to be uninsured (16%) than women in two-parent households (9%).
- The majority of uninsured women live in a household where someone is working: 69% are in families with at least one adult working full-time and 82% are in families with at least one part-time or full-time worker.[14]
- There is considerable state-level variation in uninsured rates across the nation, ranging from 19% of women in Texas to 5% of women in Washington DC (**Table 1**).

Figure 3

Women at Greatest Risk for Being Uninsured, 2016



Note: The Federal Poverty Level (FPL) in 2016 was $12,486 for an individual under 65 years old.
SOURCE: Kaiser Family Foundation analysis of 2017 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

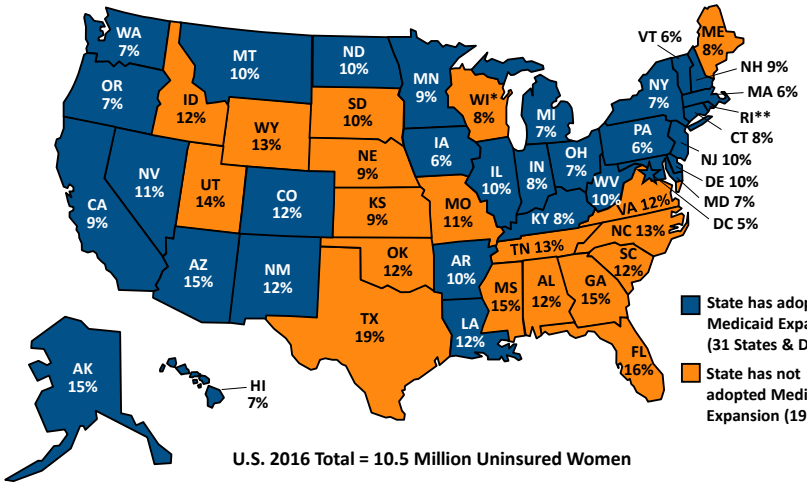
Eligibility for Coverage

Many women who are uninsured are potentially eligible for coverage, Medicaid or subsidies but are not enrolled. Some, however, still lack any pathway to affordable coverage.

- One in five uninsured women are currently eligible for Medicaid but are not enrolled and another third are income eligible for a subsidized Marketplace plan.
- Around 2.4 million women are uninsured but have an offer of employer-based insurance or are not eligible for a subsidy under the ACA because their income exceeds the thresholds for assistance.

Figure 4

Uninsured Rates Among Nonelderly Women, by State and Medicaid Expansion Status, 2016



NOTE: Uninsured rates among women ages 19-64. * Wisconsin covers adults up to 100% FPL in Medicaid under a waiver, but did not adopt the ACA Expansion. **RI estimate is n/a because point estimates do not meet the minimum standards for statistical reliability.
SOURCE: Kaiser Family Foundation analysis of 2016 ASEC Supplement to the Current Population Survey, U.S. Census Bureau. Kaiser Family Foundation State Health Facts, Status of State Action on the Medicaid Expansion Decision, as of October 14, 2016.

- An estimated 1.1 million poor women in the so-called "Medicaid coverage gap" who live in states that have not expanded their Medicaid programs but who would qualify for Medicaid if their states would opt to expanded program eligibility to 138% of the federal poverty level as they are permitted to do under the ACA. States that have not expanded Medicaid typically have higher uninsured rates than those that have (**Figure 4**).
- Approximately 1.5 million undocumented women are uninsured yet ineligible for Medicaid, and in nearly all states prohibited from purchasing insurance on the Marketplaces.

Scope of Coverage and Affordability:

The ACA set national standards for the scope of benefits offered in private plans. In addition to the broad categories of essential health benefits (EHBs) offered by marketplace plans. All privately-purchased plans must cover maternity care and mental health which had been historically excluded from most those plans. In addition, most private plans must cover preventive services without co-payments or other cost sharing. This includes screenings for breast and cervical cancers, well woman visits (including prenatal visits), prescribed contraceptives, breastfeeding supplies and supports such as breast pumps, and several STI services. On October 6, 2017, the Trump Administration extended an exemption from the contraceptive coverage requirement broadening it to include any employer with religious or moral objections to contraception to contraception. Women who work for exempt employers and female dependents will no longer be entitled to contraceptive coverage.[15] Abortion services are explicitly prohibited from being included as EHBs, and 26 states have laws banning coverage of most abortions from the plans available through the state Marketplaces.[16]

Affordability of coverage and care continues to be a significant concern for many women, both for those who are uninsured as well as those with coverage. The leading reason why uninsured women report that they haven't obtained coverage is that it is too expensive. Under employer-sponsored insurance, the major source of coverage for women, half of all covered workers have deductibles of at least $1,000.[17] Similar affordability

challenges exist in the non-group market, which includes the ACA Marketplaces. Forty-seven percent report dissatisfaction with their plan's annual deductible, and 43% are dissatisfied with their monthly premium.[18]

Looking Forward

Health coverage matters for women. Those 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. Today, women can get coverage without worrying that they will be charged more for insurance than men, be assured that their insurance provides them with no-cost coverage for a wide range of recommended preventive services, and coverage for critical services for women such as maternity care and mental health. While there has been much progress in expanding coverage and reducing the number of uninsured women since the passage of the ACA, affordability continues to be a challenge for many women and 10.5 million women still lack coverage. About half of these uninsured women qualify for either Medicaid or subsidies to secure coverage through the health care exchanges but many still do not have a pathway to affordable coverage. Efforts to restructure or scale back Medicaid funding, make it more difficult or costly for individuals to enroll in Marketplace coverage, or destabilize the individual insurance market will likely erode the gains in coverage experienced by millions of women in recent years. Over the coming year, women will continue have much at stake in the outcomes of the health care debates that are being considered in Washington DC and in state capitols across the nation.

Table 1: Health Insurance Coverage of Women Ages 19-64 in 2016, by State						
	Estimated Number of Women (Thousands)	Percent Distribution by Coverage Type				
		Employer Sponsored	Direct Purchase	Medicaid	Other	Uninsured
United States	**97,991**	**59%**	**9%**	**17%**	**4%**	**11%**
Alabama	1,513	57%	7%	17%	7%	12%
Alaska	213	56%	3%	18%	8%	15%
Arizona	2,032	54%	8%	18%	5%	15%
Arkansas	895	54%	13%	17%	6%	10%
California	12,030	55%	11%	23%	3%	9%
Colorado	1,660	63%	8%	13%	4%	12%
Connecticut	1,122	67%	6%	18%	N/A	8%
Delaware	299	58%	6%	21%	5%	10%
DC	241	59%	9%	25%	3%	5%
Florida	6,313	52%	14%	12%	5%	16%
Georgia	3,273	59%	10%	10%	6%	15%
Hawaii	415	65%	5%	14%	8%	7%
Idaho	481	59%	13%	12%	4%	12%
Illinois	3,846	62%	9%	16%	4%	10%
Indiana	1,997	61%	8%	19%	4%	8%
Iowa	941	65%	9%	17%	2%	6%
Kansas	822	65%	9%	12%	6%	9%
Kentucky	1,305	55%	13%	18%	6%	8%
Louisiana	1,426	51%	8%	23%	6%	12%
Maine	398	63%	5%	20%	4%	8%
Maryland	1,889	64%	10%	14%	5%	7%
Massachusetts	2,185	62%	7%	22%	3%	6%
Michigan	3,031	61%	6%	21%	4%	7%
Minnesota	1,621	65%	9%	13%	4%	9%
Mississippi	925	52%	8%	19%	7%	15%
Missouri	1,763	62%	12%	12%	4%	11%
Montana	294	56%	10%	19%	6%	10%
Nebraska	534	68%	10%	11%	3%	9%
Nevada	873	59%	6%	17%	6%	11%
New Hampshire	406	70%	7%	9%	5%	9%
New Jersey	2,718	63%	8%	15%	4%	10%
New Mexico	617	45%	7%	31%	5%	12%
New York	6,047	61%	8%	22%	2%	7%
North Carolina	3,138	55%	12%	13%	7%	13%
North Dakota	217	68%	8%	9%	5%	10%
Ohio	3,519	61%	7%	21%	3%	7%
Oklahoma	1,137	63%	6%	12%	7%	12%
Oregon	1,222	57%	10%	22%	3%	7%
Pennsylvania	3,860	64%	9%	17%	4%	6%
Rhode Island	329	62%	9%	20%	4%	N/A
South Carolina	1,515	56%	10%	14%	9%	12%
South Dakota	226	62%	10%	13%	5%	10%
Tennessee	2,051	56%	7%	19%	5%	13%
Texas	8,362	59%	8%	10%	4%	19%
Utah	865	68%	8%	8%	N/A	14%
Vermont	190	59%	11%	19%	5%	6%
Virginia	2,588	65%	7%	8%	8%	12%
Washington	2,230	60%	9%	21%	3%	7%
West Virginia	541	53%	5%	27%	5%	10%
Wisconsin	1,708	67%	7%	14%	3%	8%
Wyoming	167	62%	11%	10%	5%	13%

NOTES: Other category includes: Medicare coverage and military-related coverage. Percentages may not sum to 100% due to rounding. Some estimates are "N/A" because point estimates do not meet the minimum standards for statistical reliability.
SOURCE: Kaiser Family Foundation analysis of 2017 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

Endnotes

[1] Kaiser Family Foundation analysis of 2017 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

[2] Ibid.

[3] Ibid.

[4] Kaiser Family Foundation and Health Research & Education Trust. 2017 Employer Health Benefits Survey. September 19, 2017.

[5] Kaiser Family Foundation analysis of 2017 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

[6] Ibid.

[7] Markus A, Andres E, West KD, Garro N, & Pellegrini C. (2013). Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform. *Women's Health Issues*, 23(5), e273-e280.

[8] Hasstedt K, Sonfield A, & Gold RB. Public Funding for Family Planning and Abortion Services, FY 1980-2015. Guttmacher Institute. April 2017.

[9] Paradise J. 10 Things to Know About Medicaid: Setting the Facts Straight. Kaiser Family Foundation. May 2017.

[10] Guttmacher Institute. State Laws and Policies, Medicaid Family Planning Eligibility Expansions. As of October 1, 2017.

[11] Ranji U, Bair Y, & Salganicoff A. Medicaid and Family Planning: Background and Implications of the ACA. Kaiser Family Foundation. February 2016.

[12] Kaiser Commission on Medicaid and the Uninsured. The Uninsured: A Primer. October 2013.

[13] Gunja MZ, Collins SR, Doty MM, & Beutel S. How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care. The Commonwealth Fund. August 2017.

[14] Kaiser Family Foundation analysis of 2017 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

[15] Kaiser Family Foundation. New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women. October 2017.

[16] Kaiser Family Foundation. Interactive: How State Policies Shape Access to Abortion. September 21, 2017.

[17] Kaiser Family Foundation and Health Research & Education Trust. 2017 Employer Health Benefits Survey. September 19, 2017.

[18] Hamel L, Firth J, Levitt L, Claxton G, & Brodie M. Survey of Non-Group Health Insurance Enrollees, Wave 3. Kaiser Family Foundation. May 20, 2016.