



HEALTH POLICY 101

Health Policy Issues in Women's Health

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[Medicare 101](#)

[Medicaid 101](#)

[The Affordable Care Act 101](#)

[Employer-Sponsored Health Insurance 101](#)

[The Uninsured Population and Health Coverage](#)

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Introduction

Health care is a central element of women's lives, shaping their ability to care for themselves and their families, to be productive members of their communities, to contribute to the workforce, and to build a base of economic security. Women's reproductive health care needs, their central roles managing family health as parents and as family caregivers, and their longer lifespans, albeit with greater rates of chronic health problems and functional limitations than men, all shape their relationships with the health care system. While women are major consumers of health care services and play a central role as health navigators and caregivers for their families, structural factors can challenge their ability to get the health care they need. Factors, including national and state policies that shape the health care delivery system to research priorities and discriminatory economic and societal forces, can deprioritize women's health concerns. Access challenges are greater for women who are in low-income households, who face structural and societal racism and discrimination, who struggle with complex or understudied medical conditions, or who live in states or communities that have enacted or invested in policies and programs that do not support their health needs.

In the United States, the women's health movement gained significant traction in the 1960s and 1970s as part of a larger grassroots women's rights movement that challenged long-standing inequities and discrimination that limited women's economic and social opportunities. The book, "[Our Bodies, Ourselves](#)," brought a wide range of women's health concerns, ranging from abortion and sexuality to menopause and cancer, into the mainstream. Over time, federal action also began to address many of the long-standing discriminatory sex and gender-based policies that were baked into our employment, health, and research policies. The 1973 U.S. Supreme Court ruling in *Roe v. Wade* decriminalized and protected the right to abortion care for nearly 50 years; the Pregnancy Discrimination Act of 1978 offered workplace and insurance protections to pregnant workers; the National Institutes of Health (NIH) Revitalization Act of 1993 mandated the inclusion of women in clinical research and formally established the NIH Office of Women's Health; and in 2010, the Affordable Care Act (ACA) banned many of the discriminatory practices that had shaped women's coverage of and access to care.

This primer focuses on some of the key areas disproportionately affecting women today that are shaped by national and state health policies. This includes health coverage and costs, reproductive health services, maternal health, mental health, and intimate partner violence. In addition, it highlights some of the structural factors and inequities that still impact women's health, particularly women of color and gender-expansive individuals such as those who are transgender or non-binary or otherwise gender fluid or non-conforming who are at risk of being marginalized or discriminated against by their health coverage or providers. We note that while we refer to "women" and "women's health" throughout this chapter, some persons assigned female sex at birth do not identify as women, such as transgender men, non-binary individuals, and otherwise gender-expansive individuals. Still, many of the issues discussed in this chapter also apply to them.

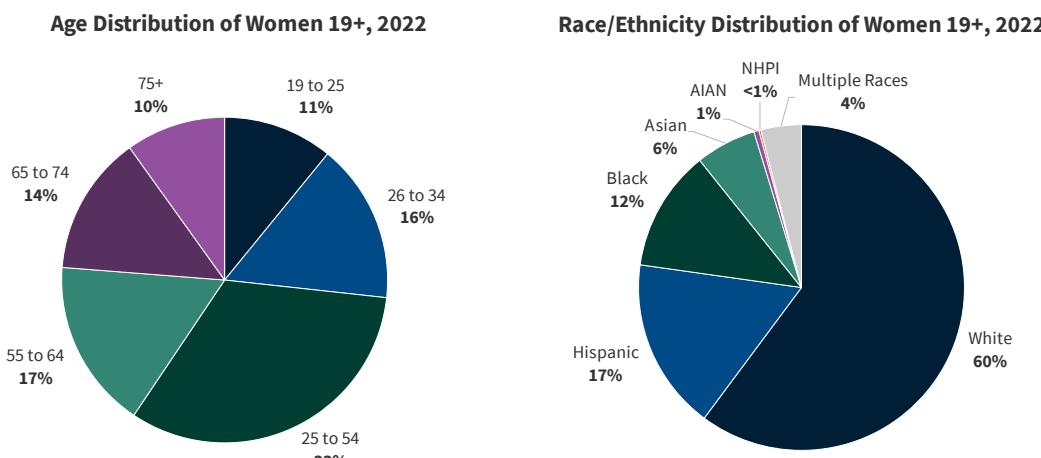
What Is the Demographic Profile of Women?

More than 128 million adult women over the age of 19 live in the U.S. today, with great diversity in many demographic characteristics. A third of adult women are between the ages of 35-54 (33%) and the majority are White (60%) (Figure 1). Nearly 1 in 5 (17%) women are Hispanic, 12% are Black and 6% are Asian.

Almost two-thirds (65%) of women live in a household with at least one full-time worker, while 1 in 10 (9%) live in a household with only part-time workers, and 25% of women live in households with no workers (data not shown). Given the important role of employment in shaping health coverage, workforce participation is a significant determinant of the type of health insurance that working women or women who live in households with full-time workers can obtain.

Figure 1

Age and Race/Ethnicity Distribution of Women Ages 19 and over, 2022



NOTES: AIAN refers to American Indian and Alaska Native; NHPI refers to Native Hawaiian or Pacific Islander. Percentages may not add up to 100% due to rounding.
SOURCE: KFF estimates based on 2022 American Community Survey, 1-Year estimates



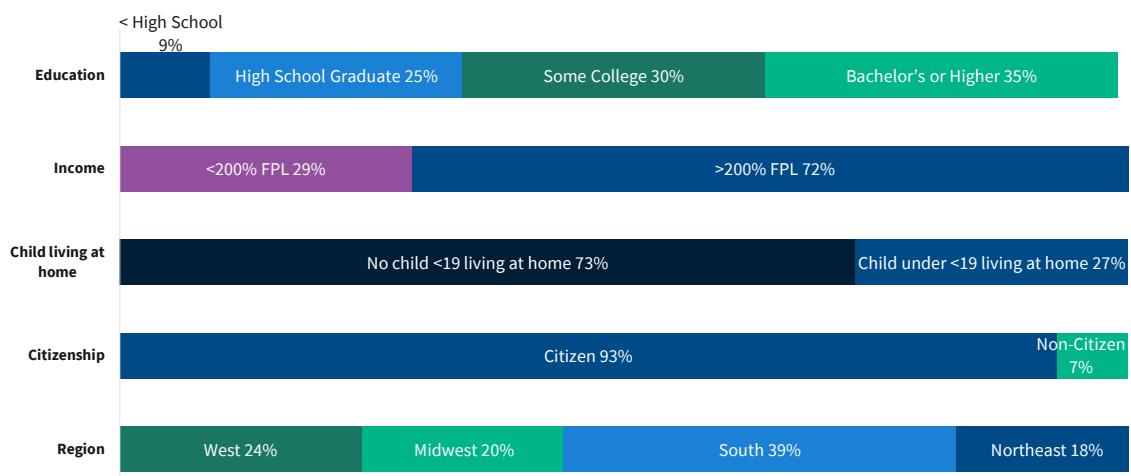
While most women in the U.S. report having good health, nearly 1 in 5 ([18%](#)) women 18 and older rate their health as “fair” or “poor” and [14%](#) report having a disability such as difficulty with vision, hearing, or walking. As women age, they are more likely to experience chronic health problems and declines in health status. These factors are highly predictive of their need for and use of health care services.

Income also plays a major role in health coverage and access to care. Income affects the resources that women have to pay for out-of-pocket health care costs and contribute to premium costs. Income also determines women’s eligibility for programs such as Medicaid or subsidies to secure coverage through the ACA Marketplace. Three in 10 (29%) adult women are part of households with low incomes (family income below 200% of the FPL was \$47,112 for a family of three in 2022). Almost 4 in 10 (35%) women have completed a bachelor’s degree or

higher, almost a third (27%) have a child under the age of 19 living at home, and 93% are U.S. citizens. Nearly 4 in 10 women live in the South (39%), almost a quarter (24%) live in the West, a fifth (20%) live in the Midwest, and 18% live in the Northeast (Figure 2).

Figure 2

The Population of Women in the U.S. is Diverse on Many Factors



NOTES: Among females 19 and older. Two-hundred percent (200%) of the Census Bureau Federal Poverty Level (FPL) was \$47,112 for a family of three in 2022. Percentages may not add up to 100% due to rounding.

SOURCE: KFF estimates based on 2022 American Community Survey, 1-Year estimates



What Are the Sources of Health Insurance Coverage for Women?

While most adult women have some form of either private or public health insurance, the coverage profile for those who are under and over age 65 differs considerably. For those [who are under age 65](#), employer-sponsored coverage, individually purchased policies, and Medicaid—the state-federal program for people with low incomes—comprise the majority of coverage options. However, nearly 1 in 10 women in that age group are currently uninsured. Among women 65 years and older, the Medicare program plays a critical role covering nearly all seniors in the U.S., though often with considerable coverage gaps (such as hearing, vision and long-term services and supports) and cost-sharing burdens.

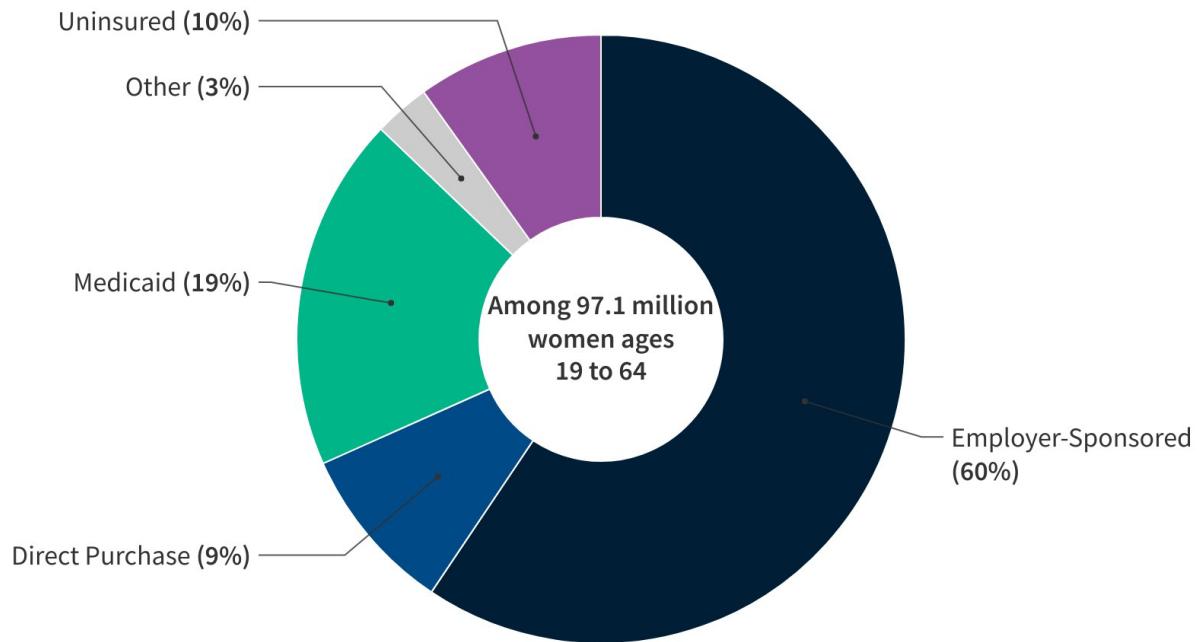
Employer-Sponsored Insurance

Approximately 58.3 million women aged 19-64 (60%) received their health coverage from employer-sponsored insurance in 2022 (Figure 3). Women in families with at least one full-time worker are more likely to have job-based coverage (70%) than women in families with only part-time workers (33%) or without any workers (17%).

Employer-sponsored insurance can come with substantial out-of-pocket costs based on premiums, deductibles, co-insurance, and co-payment levels. In 2022, [annual insurance premiums](#) for employer-sponsored insurance averaged \$7,911 for individuals and \$22,463 for families. On average, workers paid 17% of premiums for individual coverage and 28% for family coverage with the employers picking up the balance.

Figure 3

Women's Health Insurance Coverage, 2022



Note: Among women ages 19-64. "Other" includes those covered under the military or Veteran's Administration, as well as non-elderly Medicare enrollees.

Source: KFF estimates based on 2022 American Community Survey, 1-Year estimates



Non-Group Insurance

In 2022, about 9% of women ages 19 to 64 (approximately 8.3 million women) and 8% of their male counterparts purchased insurance in the non-group market. This includes individuals who purchased private policies from state-based Marketplaces established under the ACA, as well as those who purchased coverage from private insurers that operate outside of the ACA Marketplaces.

Most individuals who seek insurance policies in their state's Marketplace qualify for assistance with the coverage costs. Individuals with incomes below \$58,320 (400% of the Federal Poverty Level in 2023) can receive [federal tax credits](#) which lower premium costs.

The ACA set new standards for all individually purchased plans and eliminated many historically discriminatory practices that affected disadvantaged women in particular. Today, plans are prohibited from charging women higher premiums than men for the same level of coverage (gender rating) or from disqualifying women from coverage because they had certain [pre-existing](#) medical conditions, including pregnancy. All direct purchase plans must also cover certain “essential health benefits” ([EHBs](#)) that fall under 10 different categories, including maternity and newborn care, mental health, and a wide range of preventive health care services. Prior to the ACA, many individual plans excluded maternity care benefits or required policyholders to purchase costly riders to obtain maternity coverage.

Medicaid

Medicaid, the state-federal program for individuals with low incomes, covered 19% of adult women ages 19 to 64 in 2022, compared to 14% of men. 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, a person with a disability, or over 65. Women who didn’t fall into these categories typically were not eligible regardless of how low their incomes were. The ACA allowed states to broaden Medicaid eligibility to most individuals with incomes less than 138% of the FPL regardless of their family or disability status, effective January 2014. As of December 2023, 40 states and Washington, D.C. have [expanded](#) their Medicaid programs under the ACA, but 10 states have not and still base eligibility on historical categorical and income standards. For example, in Mississippi, the Medicaid income eligibility for parents is 28% of the FPL, which was approximately \$6,900 for a family of three in 2023. Therefore, parents in families of three in Mississippi with incomes above this amount do not qualify for Medicaid because their income exceeds the state’s eligibility level.

Medicaid covers the poorest segment of women in the U.S. Forty-three percent of women with incomes below 200% of the FPL and 52% of women with incomes below 100% of the FPL have Medicaid coverage. By federal law, all states must provide Medicaid coverage to pregnant women with incomes up to 133% of the FPL through 60 days postpartum. However, in recent years, there has been a growing interest in [expanding the length of the postpartum](#) coverage period and, as of March 2024, [nearly all](#) states have taken [steps](#) to extend postpartum Medicaid coverage to one year.

Medicaid covers many health services that are essential for women. Medicaid [financed](#) 41% of births in the U.S. in 2021 and accounts for [75%](#) of all publicly-funded family planning services. State Medicaid programs are prohibited from charging any cost-sharing for pregnancy-related care or family planning services. Over [half of states](#) have established programs that use Medicaid funds to cover the costs of family planning services for women with low incomes who remain uninsured, and most states have [limited scope Medicaid programs](#) to pay for breast and cervical cancer treatment for certain uninsured women with low incomes. Conversely, coverage for abortion is very limited under Medicaid as a result of the Hyde Amendment, a rider to federal appropriations that bans any federal funds from being used to pay for abortions unless the pregnancy is determined to be a result of rape or incest or poses a threat to the pregnant person’s life (more on abortion in the following section).

Uninsured Women

In 2022, approximately 10% of non-elderly women (9.5 million) were uninsured. This rate is slightly lower than that of men (13%) because, on average, women have lower incomes and have been more likely to qualify for Medicaid than men under one of Medicaid's eligibility categories: pregnant, parent of children under 18, disability, or over 65. The ACA opened the door for states to eliminate the categorical requirements, but the gender gap in the insured rates between men and women persists.

The disadvantage uninsured individuals experience in accessing care and health outcomes is well established. Compared to women with insurance, those who are uninsured 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, which is associated with better access to care and higher rates of use of recommended preventive services.

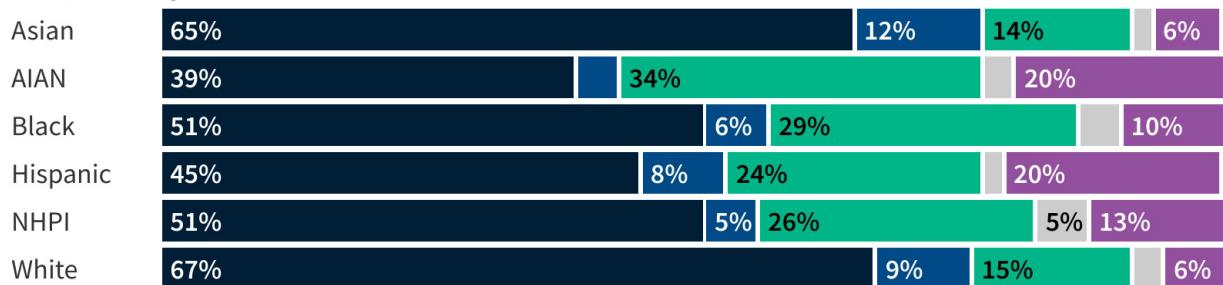
Women with lower incomes, women of color, and non-citizen women are at greater risk of being uninsured (Figure 4). One in 5 Hispanic (20%) and American Indian and Alaska Native (20%) women and 18% of women with incomes under 200% of the FPL are uninsured. A higher share of single mothers are uninsured (10%) than women in two-parent households (8%) (data not shown). Most 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 (data not shown).

Figure 4

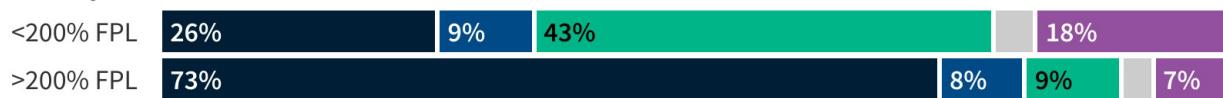
Health Insurance Coverage Among Non-Elderly Women by Selected Characteristics, 2022

■ Employer-Sponsored ■ Direct-Purchase ■ Medicaid ■ Other ■ Uninsured

Race/Ethnicity



Poverty Level



Citizenship



Note: Among women ages 19-64. AIAN refers to American Indian and Alaska Native; NHPI refers to Native Hawaiian or Pacific Islander. “Other” includes those covered under the military or Veterans Administration as well as nonelderly Medicare enrollees. Two-hundred percent (200%) of the Census Bureau Federal Poverty Level (FPL) was \$47,112 for a family of three in 2022. Percentages may not add up to 100% due to rounding.

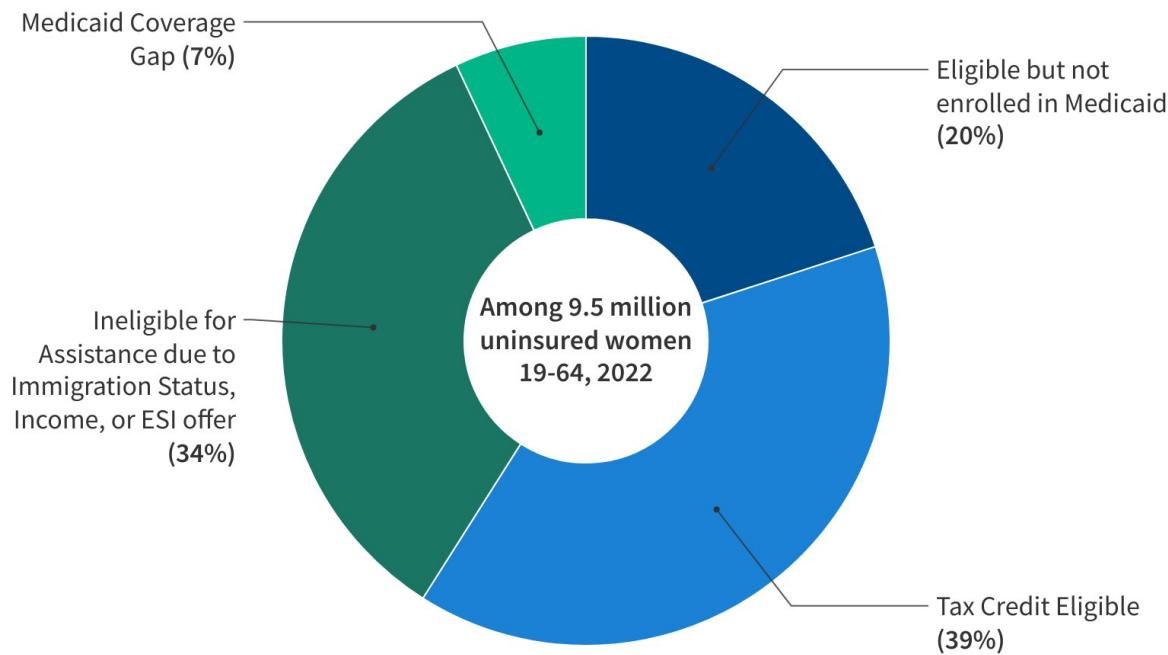
Source: KFF estimates based on 2022 American Community Survey, 1-Year Estimates



Many women who are uninsured are eligible for financial assistance with the costs of coverage. A fifth of uninsured women (20%) are eligible for Medicaid coverage but are not enrolled in the program (Figure 5). One in 4 uninsured women (39%), about 3.7 million women, qualify for subsidies to cover the premium costs and some of the out-of-pocket costs of Marketplace plans but may not be aware of coverage options or may face barriers to enrollment. However, 7% of uninsured women live in states that have not adopted the [ACA Medicaid expansion](#) and fall into a “[coverage gap](#)” because their incomes are above the thresholds to qualify for Medicaid but below the levels to qualify for Marketplace tax credits (below 100% of the FPL). Approximately 1 in 3 (34%) uninsured women are not eligible for any assistance with health coverage due to their immigration status, their income, or because they have an offer of coverage from their employer.

Figure 5

Eligibility for Assistance under the ACA Among Uninsured Women Ages 19-64, 2022



Note: Tax-credit eligible population in Minnesota & New York include uninsured adults who are eligible for coverage through the Basic Health Plan. This analysis does not account for any policy changes aimed at addressing the "family glitch," which limited access to Marketplace subsidies for dependents of workers with affordable offers of self-only employer coverage

Source: KFF estimates based on 2022 Census Bureau's American Community Survey

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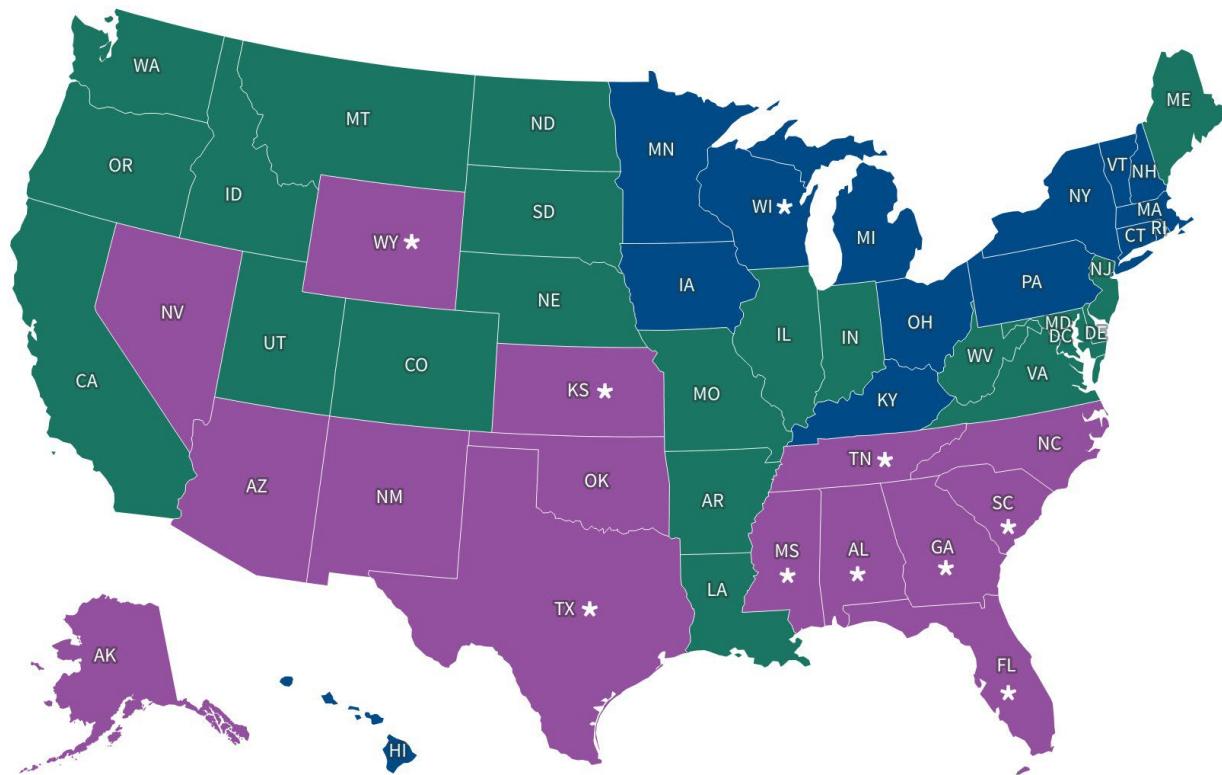
There is considerable state-level variation in uninsured rates across the nation, ranging from 21% of women in Texas to 3% of women in Washington D.C., Massachusetts, and Vermont (Figure 6). Of the 15 states with uninsured rates above the national average (10%), nine have not adopted the ACA Medicaid expansion.

Figure 6

Uninsured Rates Among Nonelderly Women, by State, 2022

Share of Uninsured Women, Ages 19-64

■ 3%-6% ■ 6%-10% ■ ≥11%



Note: Among women 19-64. * State has not adopted the ACA Medicaid expansion as of December 2023.

Source: KFF estimates based on 2022 American Community Survey; KFF. Status of State Medicaid Expansion Decisions: Interactive Map. December 1, 2023.

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Medicare

Medicare is the federal program that provides health coverage to virtually all people ages 65 and older as well as younger people with long-term disabilities. In 2020, Medicare covered 35 million women, including nearly 31 million ages 65 and older, and over 4 million under age 65 with long-term disabilities.

More than half (55%) of all Medicare beneficiaries are women and 45% are men. The population of women covered by Medicare is diverse, with varying social, economic, and health circumstances. Women live longer than men on average (79 years vs. 73 years life expectancy at birth in 2021), and many live with certain chronic illnesses, cognitive and mental impairments, and functional problems at higher rates than men. A higher share of older women than men also experience urinary incontinence, depression, osteoporosis, pulmonary disease, and Alzheimer's/dementia. Medicare plays a key role in supporting the health and well-being of women,

covering a broad range of essential services, including preventive, primary and specialty care, and prescription drugs. However, reflecting Medicare's original role as a program to serve the medical needs of older adults, coverage of services for enrollees of reproductive age may be more limited. For example, there is no federal requirement for Medicare to cover all contraceptive services and supplies for the purpose of preventing pregnancy for younger Medicare enrollees with permanent disabilities.

Another gap in the Medicare program is the absence of coverage for long-term care services and supports (LTSS), such as nursing home stays and home care services, which many older adults need and seek but are [expensive](#) and unaffordable for some. Compared with men, [women](#) are more likely to require these services because they have more chronic conditions, have higher rates of physical and cognitive impairments, and are more likely to live alone. Medicare only covers time-limited LTSS after a hospitalization and does not cover ongoing LTSS for those with chronic conditions or functional impairments. Some older women can qualify for Medicaid for LTSS, but only if they have low incomes and, in some cases, must spend down most of their assets. Just a small share of seniors have private [long-term care insurance](#) to help cover some of the costs of LTSS. As a result, unless they have incomes low enough to qualify for Medicaid, many older people do not have any coverage for LTSS and rely on unpaid caregiving provided by family, friends, or neighbors. The majority of [informal caregivers](#) are women, who are most commonly caring for aging parents and spouses.

Women with Medicare also tend to have more modest incomes than men—a consequence of smaller lifetime savings, lower retirement income, and divorce and widowhood that result in only one income. While Medicare covers many necessary health care services, gaps in benefits, cost-sharing requirements, and spending on premiums for Medicare and supplemental coverage can translate into high out-of-pocket expenses for some people in the program. In 2020, 13% of women and 11% of men with Medicare reported that they had faced [cost-related challenges](#) in the past 12 months, such as trouble getting care due to cost or problems paying medical bills. These challenges are more common among female Medicare enrollees who are Black (22%) and Hispanic (18%), do not have a bachelor's degree (15%), and those with annual incomes below \$20,000 (20%).

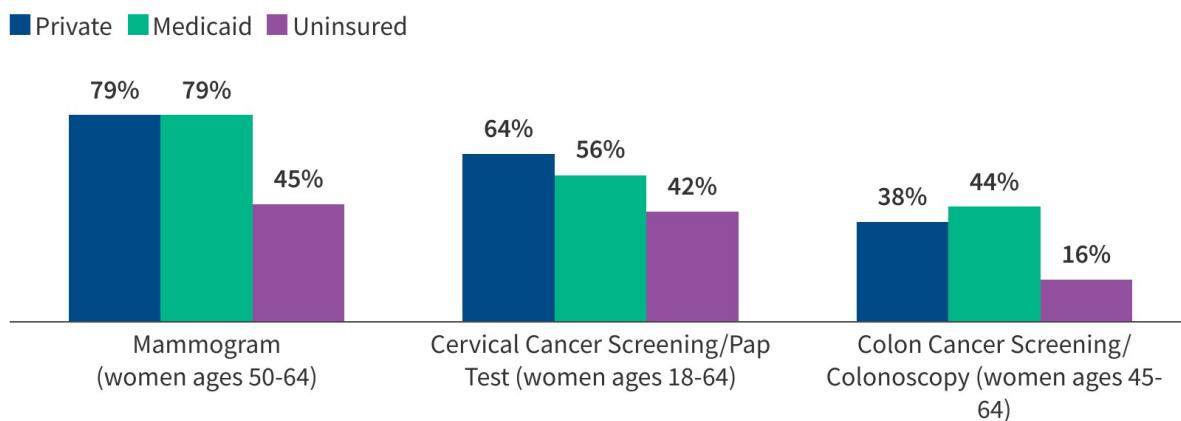
How Do Health Care Costs and Scope of Benefits Affect Women's Access to Care?

The ACA set national standards for the scope of benefits offered in private plans. As mentioned earlier, many insurance plans had adopted practices that discriminated against women that were addressed in the ACA. In addition to the broad categories of essential health benefits (EHBs) offered by Marketplace plans, all privately purchased plans must cover maternity care, which had been historically excluded from most individually purchased plans requiring the purchase of an expensive rider for that benefit to be covered. 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 services for sexually

transmitted infections (STI). [Higher shares](#) of women with private and Medicaid coverage report having had recommended preventive services such as mammograms, Pap screenings or colonoscopies compared to those who were uninsured (Figure 7).

Figure 7

Share of women who have had a mammogram, cervical cancer screening, or colon cancer screening in the past two years



Note: Two percent of women did not know if they had a cervical cancer screening/Pap test in the past two years; they are not included in these estimates. The USPSTF recommends routine mammograms every two years for women ages 50-74, and cervical cancer screenings for women ages 18-65 and colorectal cancer screenings for women ages 45-75, though the recommended frequencies vary by type of screening test.

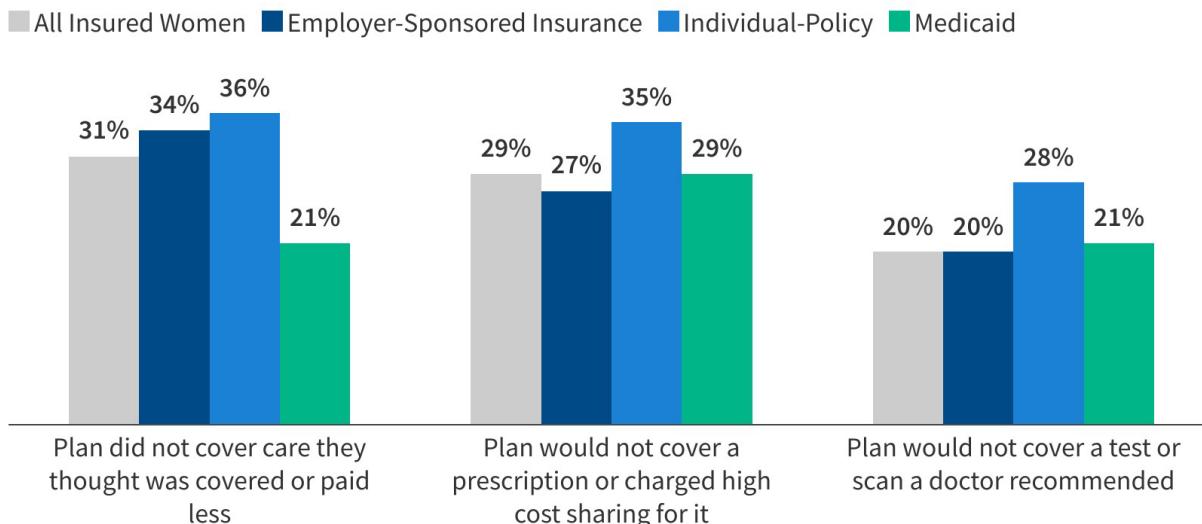
Source: KFF Women's Health Survey 2022

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Affordability of coverage 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 adults report that they have not obtained coverage is that it is [too expensive](#). Under employer-sponsored insurance, the major source of coverage for women, 61% of all covered workers with a general annual deductible have [deductibles](#) of at least \$1,000 for single coverage. Despite having coverage, many insured women (31%) report that their plans did not always cover all of their needed care or paid less than they expected (Figure 8).

Figure 8

Share of Insured Women 18-64 Who Experienced Problems Using their Health Insurance in the Past 12 Months



Source: KFF Women's Health Survey 2022

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What Are the Issues Affecting Women's Care and Access?

Reproductive Health

Pregnancy

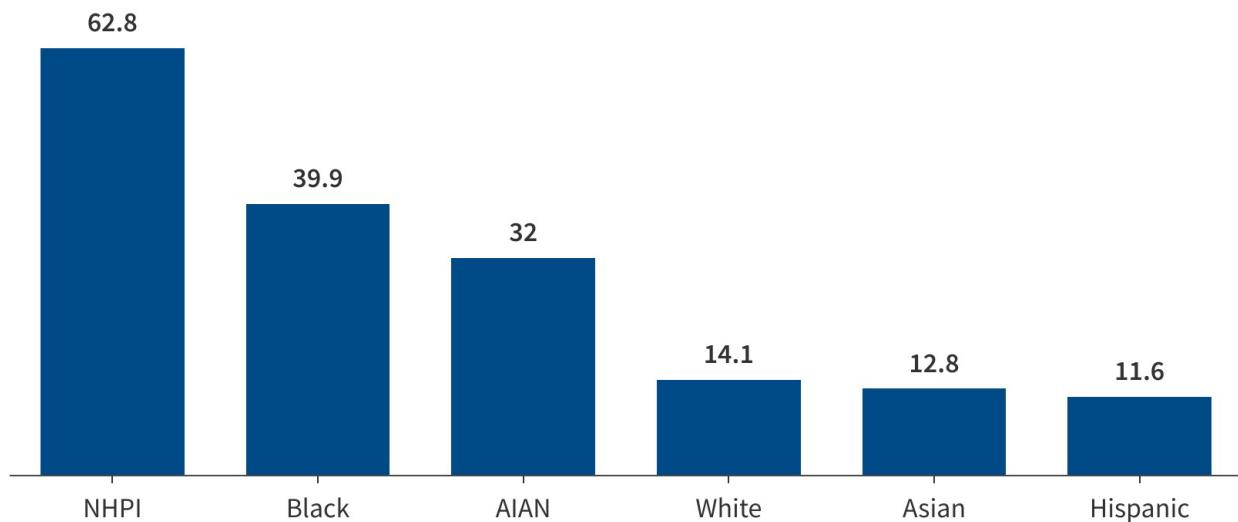
Maternity Care

In 2022, there were [approximately 3.6 million](#) births in the U.S. Childbirth is the leading reason for hospitalization, and most private insurance plans and the Medicaid program are required to cover care associated with childbirth. Medicaid covers [about 4 in 10](#) births nationally and, in some states, more than half. The Medicaid program prohibits plans from charging out-of-pocket charges for pregnancy-related care, and coverage lasts through one year postpartum in most, but not all, states. For people with private insurance, which finances just over half of births ([51%](#)), the federal [Pregnancy Discrimination Act](#) requires employer plans to cover maternity care benefits. However, even for those with private insurance, a pregnancy often comes with significant out-of-pocket health expenses that can reach [thousands of dollars](#). A [KFF analysis](#) estimated that women enrolled in large group plans pay around \$3,000 out-of-pocket for costs associated with pregnancy, childbirth, and post-partum care. On average, Caesarean section births, which account for [approximately one-third](#) of births in the U.S., are significantly more expensive than vaginal deliveries. The ACA also requires individual plans to cover maternity care and bans plans from implementing restrictions on coverage of pre-existing health conditions, including pregnancy.

In recent years, there has been growing attention to pregnancy-related quality of care and maternal health. [Maternal](#) and [infant mortality rates](#) in the U.S. are far higher than those in similarly large and developed countries, and people of color are at a considerably higher risk for poor maternal and infant health outcomes compared to their White peers. Despite continued advancements in medical care, rates of maternal mortality and morbidity and preterm birth have been rising in the U.S., characterized by stark racial disparities. Notably, rates of pregnancy-related death (deaths within one year of pregnancy) among Native Hawaiian or Pacific Islander (NHPI), Black, and American Indian and Alaska Native (AIAN) women are over four to two times higher, respectively, compared to the rate for White women (14.1 and 62.8 vs. 39.9 vs. 32 per 100,000 births) (Figure 9). The Centers for Disease Control (CDC) has determined that many of these pregnancy-related deaths were preventable, [caused](#) by cardiac-related conditions, infection, hemorrhage, and [mental health conditions](#), including substance use. Maternal death rates increased during the COVID-19 pandemic and racial disparities widened for Black women. Black, AIAN, and Native Hawaiian or Pacific Islander (NHPI) women also have higher shares of preterm births, low birthweight births, or births for which they received late or no prenatal care compared to White women. Infants born to Black, AIAN, and NHPI people have markedly higher mortality rates than those born to White women.

Figure 9

Pregnancy-Related Mortality (per 100,000 births) by Race/Ethnicity, 2017-2019



Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. AIAN refers to American Indian or Alaska Native. NHPI refers to Native Hawaiian or Pacific Islander.

Source: Centers for Disease Control and Prevention, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Pregnancy Mortality Surveillance System, Accessed January 18, 2024

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The disparities in maternal and infant health are symptoms of broader underlying social and economic inequities that are rooted in racism and discrimination. Differences in health insurance coverage and access to care play a role, but notably, disparities in maternal and infant health persist even when controlling for certain underlying social and economic factors, such as education and income, pointing to the roles racism and discrimination play in driving disparities. Moreover, with the [overturning of Roe v. Wade](#) and the numerous states that have enacted abortion bans across the nation, increased barriers to abortion for people of color may widen the already existing large disparities in maternal and infant health.

There have been efforts at the policy level and in clinical circles to improve maternal health and address disparities. The Biden Administration issued the [White House Blueprint for Addressing the Maternal Health Crisis](#), outlining policy priorities and strategies. These include funding to expand and diversify the perinatal workforce, enhancing training for clinicians to better listen to patient concerns, investing in maternal mental health care, and strengthening perinatal care in rural communities. At the state and local levels, multidisciplinary maternal mortality review committees and perinatal quality collaboratives have focused on data collection and reviewing the causes behind pregnancy-related deaths in their communities to try to prevent deaths in the future.

Fertility Assistance

Many people require fertility assistance to have children. These services include diagnostic services, treatment services, and fertility preservation. People seek fertility assistance for several reasons, such as if they or their partner has infertility, or because they are in a same-sex relationship or are single and desire children. Both female and male factors contribute to infertility, including problems with ovulation (when the ovary releases an egg), structural problems with the uterus or fallopian tubes, problems with sperm quality or motility, and hormonal factors. About 25% of the time, infertility is caused by more than one factor, and in about 10% of cases, infertility is unexplained. Infertility estimates, however, do not account for LGBTQ+ or single individuals who may also need fertility assistance for family building. Thus, there are varied reasons that may prompt individuals to seek fertility care.

Despite a need for fertility services, fertility care in the U.S. is inaccessible to many due to the cost. Fertility treatments are expensive and often are not covered by insurance. While some private insurance plans cover diagnostic services, there is very little coverage for costly treatment services such as intrauterine insemination, in vitro fertilization, and cryopreservation.

Most people who use fertility services must pay out of pocket, with costs often reaching thousands of dollars depending on the services received. This means that in the absence of insurance coverage, fertility care is out of reach for many people. Few states require private insurance plans to cover fertility assistance services, but these only apply to a subset of insurance plans and beneficiaries. Additionally, even fewer states have any fertility coverage requirement under Medicaid, the health coverage program for people with low incomes.

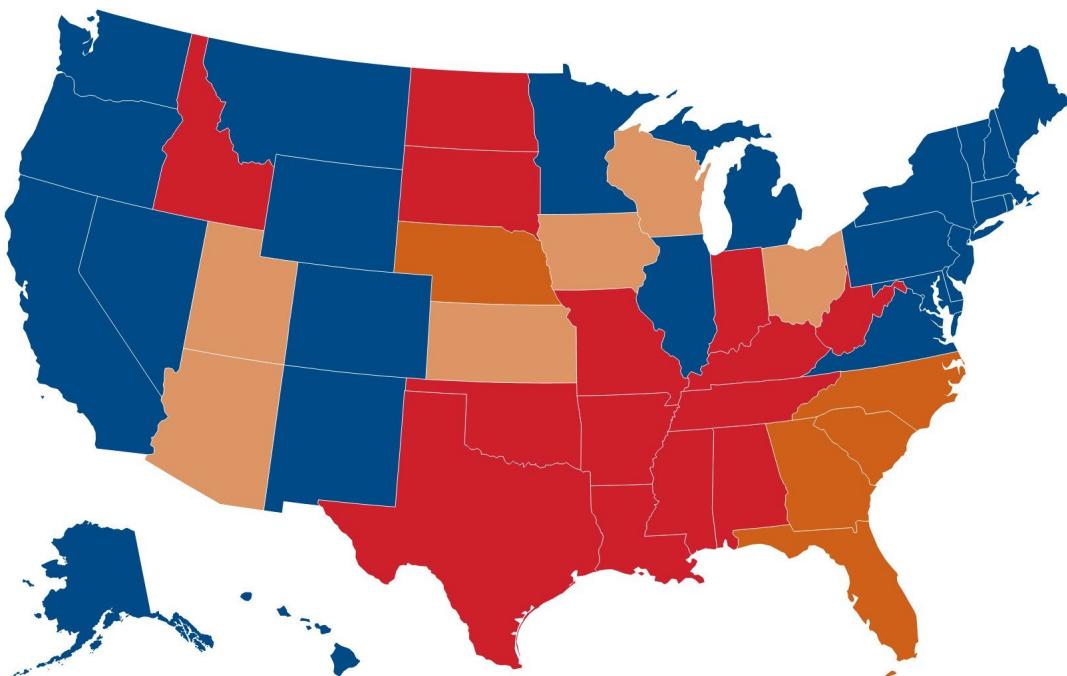
Abortion

Nearly 1 in 4 women in the U.S. have an abortion in their lifetime. Starting with the 1973 landmark Supreme Court ruling in *Roe v. Wade*, women in the U.S. had the right to abortion up until the point of viability, regardless of where they lived. On June 24, 2022, the Supreme Court issued a [ruling in *Dobbs v. Jackson Women's Health Organization*](#) that overturned the constitutional right to abortion as well as the federal standards of abortion access, established by prior decisions in the cases *Roe v. Wade* and *Planned Parenthood v. Casey*. The *Dobbs* decision allows states to set policies regarding the legality of abortions and establish gestational limits. Access to and availability of abortions vary widely between [states](#), with large swaths of the country banning or restricting almost all abortions, with few exceptions, and some states enshrining and protecting abortion rights (Figure 10).

Status of Abortion Bans in the United States as of June 28, 2024

Hover over state for more details

- Abortion Banned (14 states)
- Gestational limit between 6 and 12 weeks LMP (5 states)
- Gestational limit between 15 and 22 weeks LMP (6 states)
- Abortion legal beyond 22 weeks LMP (25 states & DC)



Note: LMP = Last Menstrual Period. For more information on state policies, please see our briefs on state actions to protect abortion, states without laws protecting or restricting abortion, our brief on the *Dobbs* case, our KFF State Health Facts page on abortion policies, our brief on legal challenges to state abortion bans, and our brief on abortion ban exceptions.

In 4 states (IA, OH, WI, and WY), laws banning or limiting abortion earlier in pregnancy are currently blocked by courts. However, on June 28, 2024, the Iowa Supreme Court ruled that the court order blocking on the state's 6-week LMP limit should be lifted. The earliest the order can be lifted (and the 6-week limit can go into effect) is July 18, 2024.

Source: KFF analysis of state policies and court decisions, as of June 28, 2024.

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Decades of research have shown that abortion is a very safe medical service. Still, despite its strong safety profile, abortion is the most highly regulated medical service in the country and is now banned or restricted to early gestational stages in many states. In addition to bans on abortion altogether, [many states](#) impose other limitations on abortion that are not medically indicated, including waiting periods, ultrasound requirements, and parental notification and consent requirements. These restrictions typically delay receipt of services and can increase costs associated with abortion care.

Paradoxically, the total [number of abortions](#) in the U.S. appears to have increased slightly following the *Dobbs* decision. This rise could be due to increased interstate travel for abortion access, expanded in-person and virtual/telehealth capacity to see patients, increased measures to protect and cover abortion care for residents and out-of-state patients, and the broader availability of low-cost abortion medication. However, these aggregated trends mask the sharp decline in abortions provided in states with total bans or severe restrictions as well as the hardships that many pregnant people experience in accessing abortion care.

Obtaining an abortion can be costly, with [median](#) costs exceeding \$500 in out-of-pocket expenses for patients who self-pay. On average, the costs are higher for abortions in the second trimester than in the first trimester. People may have to travel if abortions are prohibited or not available in their area, adding costs related to travel and lodging. Given abortion bans and Hyde Amendment restrictions on payment for abortions under Medicaid and state restrictions on insurance coverage of abortion services, many people pay for abortion services out of pocket. Some people are able to receive assistance from local abortion funds if they need financial support to obtain abortion services, particularly if they have to travel out of state or have low incomes and cannot afford the costs of the abortion. For some, however, the costs of abortion services and travel will put the service out of reach and force them to have a birth that is not desired or is a risk to their health or life.

Insurance coverage for abortion services is heavily restricted in some state-regulated private insurance plans and public programs, like Medicaid and Medicare. [Private insurance](#) covers most women of reproductive age, and states can choose whether abortion coverage is included or excluded in private plans that are not self-insured. Prior to the *Dobbs* ruling, about half of the [states](#) had enacted private plan restrictions and banned abortion coverage from ACA Marketplace plans. Since the *Dobbs* ruling, some of these states have also banned the provision of abortion services altogether. However, [10 states](#) have enacted laws that require private plans to cover abortion, typically without cost-sharing.

The [Hyde Amendment](#) has banned the use of federal funds for abortion unless the pregnancy is a result of rape, incest, or it endangers the woman's life. States may use non-federal state-only funds to pay for abortions under other circumstances for women covered by Medicaid, which [17 states](#) currently do. However, more than half ([56%](#)) of women covered by Medicaid live in states where they have no coverage for abortion, unless they qualify for an exception.

The impact of the *Dobbs* decision goes far beyond abortion care. It has also affected the provision of related health care services, including management of [miscarriages](#) and pregnancy-related emergencies, treatments for [cancer and other chronic illnesses](#), [contraceptive options](#), and much more. Women with low incomes, women of color, sexual/gender minorities, and other pregnant people have been disproportionately affected by the sweeping impacts of this ruling, as they are less likely to have the resources to travel potentially long distances to seek care.

Since the *Dobbs* ruling, there has been a constant stream of legal challenges, with a plethora of cases that seek to challenge abortion bans as well as block access to abortion medication or services. While most of the litigation is in state courts, in 2024 the Supreme Court considered a case involving the FDA's approved conditions for using mifepristone, one of the drugs used for [medication abortion](#), as well as a case about potential [conflict](#) between state-level abortion bans and [Emergency Medical Treatment and Labor Act](#) (EMTALA), the federal law that requires hospitals to provide care to stabilize patients experiencing medical emergencies. However, in June 2024, the Supreme Court did not rule on the merits of either of these cases, maintaining the status quo for now and allowing for litigation in the future.

Contraception

Contraceptive care is an important component of overall health care for many women and people capable of becoming pregnant. Federal and state policies shape access to and the availability of contraceptive care, but factors such as provider characteristics, as well as individual preferences and experiences also impact contraceptive choices and use. For most people, private insurance coverage and Medicaid greatly reduce or eliminate financial barriers to contraceptive care. However, access is still limited in many parts of the U.S. with more than 19 million women living in [contraceptive deserts](#) where they may not have access to a health center offering the full range of contraceptive methods. There have been more efforts to broaden contraceptive availability outside of traditional clinical settings, including through [commercial apps](#) that use telehealth platforms, state efforts to allow [pharmacists](#) to prescribe birth control, and, most recently, [over-the-counter \(OTC\) access to contraceptives](#) without a traditional prescription.

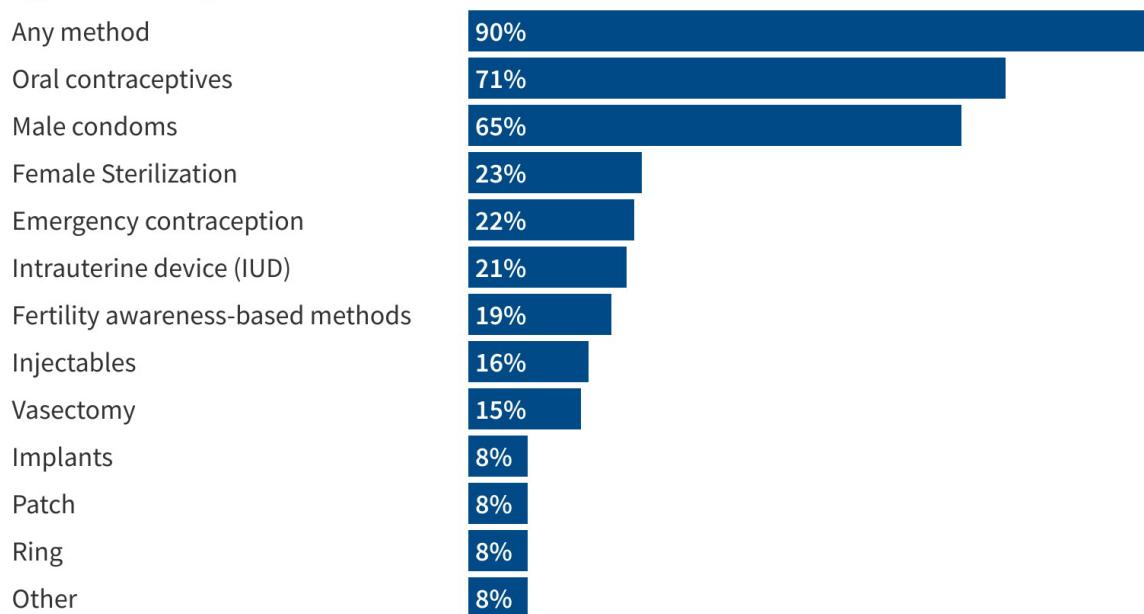
The importance and impact of contraceptives in women's lives are unquestionable. The [2022 KFF Women's Health Survey](#) highlighted that the majority of females 18 to 64 (90%) have used contraception at some point in their reproductive years, with most reporting they have used oral contraceptives and male condoms at some point in their lives (Figure 11). Many women have used more than one contraceptive method throughout their lifetime (76%), a reflection of changing needs and preferences across the lifespan.

Figure 11

Women's Use of Different Contraceptive Methods

Share of females ages 18-64 in the U.S who say they have used any of the following methods of contraception at some point in their lifetime

Type of contraception used in lifetime



Note: Respondents could respond with more than one contraceptive method.

Source: KFF Women's Health Survey 2022

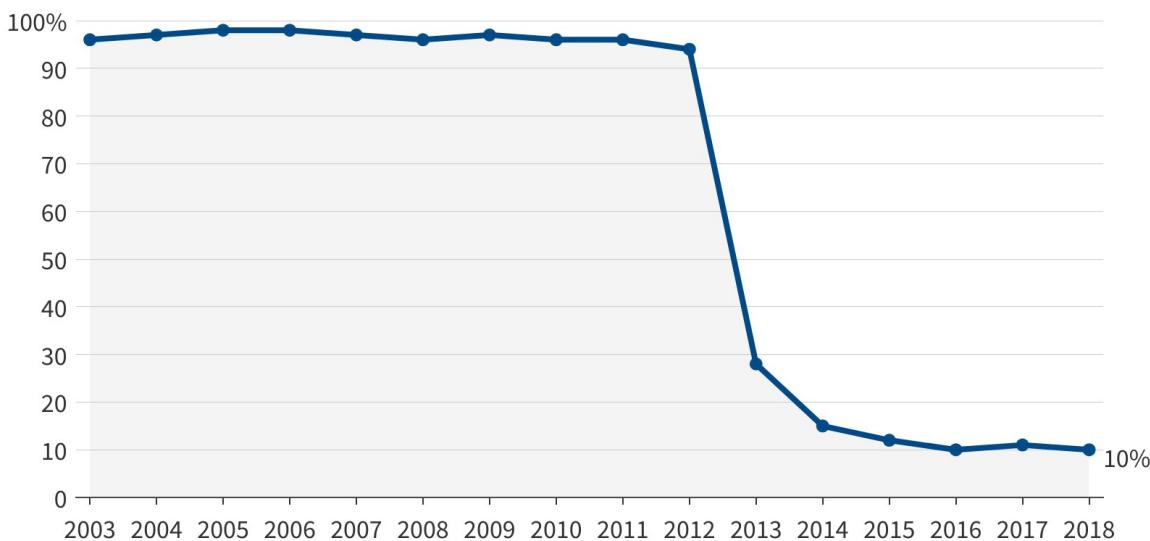
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The ACA requires that most private plans cover contraceptive services for females without cost-sharing – this includes patient education and counseling and FDA-approved methods of contraception with a prescription. This provision has [dramatically reduced cost-sharing](#) for contraception among females with private insurance plans, though some privately insured females who are eligible for no-cost coverage are still paying some of the cost of their contraceptives (Figure 12). Reasons include someone using a brand-name contraceptive that is not in the plan's formulary or consumers unaware of or not offered a generic alternative.

Figure 12

Decline in Out of Pocket Spending on Contraception Following Passage of ACA's Contraceptive Coverage Requirement

Share of oral contraceptive users with out-of-pocket spending by year, IBM MarketScan Commercial Claims and Encounters 2003–2018



Note: Respondents could respond with more than one contraceptive method.

Source: KFF analysis of IBM MarketScan Commercial Claims and Encounters Database, 2020

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Despite its far-reaching impact, the ACA's requirement for contraceptive coverage has been challenged in the courts on multiple occasions, with three cases reaching the Supreme Court. The earlier cases, *Burwell v. Hobby Lobby* (2014) and *Zubik v. Burwell* (2016), challenged the Obama Administration's regulations implementing the contraceptive coverage requirement, contending that the requirement violated some employers' religious rights. The most recent cases, *Little Sisters of the Poor v. Pennsylvania* (2020) and *Trump v. Pennsylvania* (2020), involved regulations issued by the Trump Administration, which currently exempt employers with religious objections from providing contraceptive coverage to their employees.

For people with lower incomes, the Medicaid [program](#) is the primary funding source for contraceptives. The federal Medicaid statute establishes minimum standards, and, for decades, has classified family planning as a [mandatory benefit category](#) that all state programs must cover. States may not charge any out-of-pocket costs for family planning services and must allow beneficiaries to see any Medicaid provider within their state for family planning care. Many [states](#) also have programs that provide Medicaid coverage just for family planning services to people who have lower incomes but do not qualify for full Medicaid benefits.

Additionally, the federal [Title X](#) family planning program, administered by the HHS Office of Population Affairs (OPA), is the only federal program specifically dedicated to supporting the delivery of family planning care for

individuals who are uninsured and have lower incomes. The program provides funding to more than 4,000 health clinics, public health departments, and nonprofit agencies across the country to deliver contraceptives and other family planning services to individuals with low incomes. Title X-funded providers must follow the program's requirements, which include offering a broad range of family planning methods for low or no cost and ensuring confidentiality for adolescents. Federal rules also require that participating clinics offer their patients non-directive pregnancy option counseling that includes abortion, adoption, and prenatal referral for those who seek those services.

While there have been numerous over-the-counter contraceptive methods available (e.g. condoms, spermicides), in July 2023, the Food and Drug Administration (FDA) approved the first over-the-counter daily oral contraceptive pill, known as *Opill*. FDA's approval of *Opill* makes it the most effective form of contraception available OTC intended for regular use. Private insurers and Medicaid generally require a prescription to cover OTC products, so even though *Opill* and other OTC products are available without needing a prescription from a clinician, [coverage](#) without a prescription will be limited without federal or state action.

Mental Health

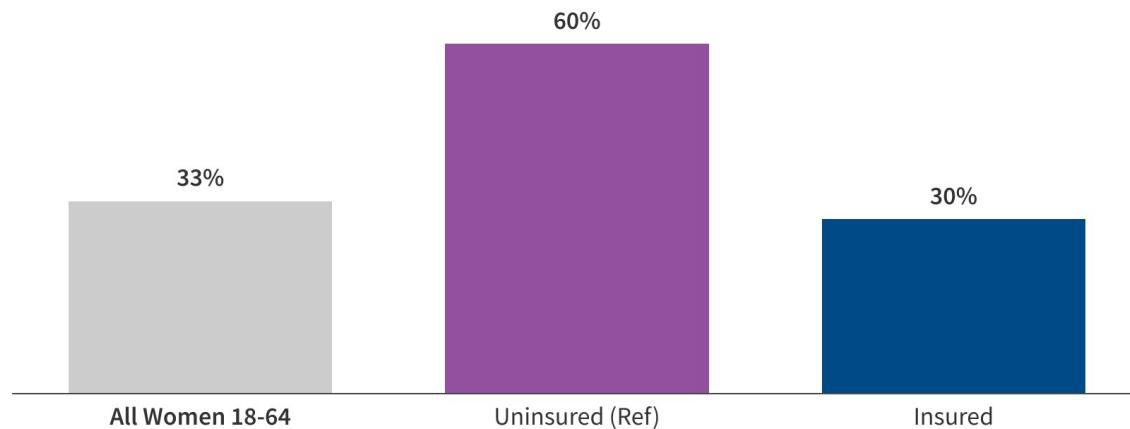
Mental health has emerged as a rapidly growing concern in recent years, with 90% of Americans saying there is a [mental health crisis](#) in a recent KFF-CNN poll. Women experience several mental health conditions such as anxiety, depression, and eating disorders more frequently than men, and some also experience mental health disorders that are [unique](#) to women, such as perinatal depression (including prenatal and postpartum depression) and premenstrual dysphoric disorders that may occur when hormone levels change.

A KFF survey found that in 2022, a significantly higher share of women (50%) than men (35%) thought they [needed](#) mental health services in the past two years. The rates were particularly higher among younger women (64% of women ages 18-25). However, barriers to accessing timely and affordable mental health services persist for many. Almost half of women who said they needed mental health services and tried to get care were able to get an appointment within a month, but more than one-third of women had to wait longer. Among those who could not get an appointment, women cite limited provider availability and cost as the main reasons they were unable to access mental health care. Significantly larger shares of women who are uninsured (60%) say they could not get an appointment due to affordability reasons, compared to those who have health insurance either through private plans (33%) or Medicaid (30%) (Figure 13).

Figure 13

Cost Barriers to Mental Health Services Among Women

Among women ages 18-64 who could not get mental health services in the past two years, share who say that cost is the main reason they did not get an appointment



Note: *Estimate is statistically different from reference (Ref) estimate within group ($p < 0.05$). Insured includes private insurance and Medicaid.

Source: KFF Women's Health Survey 2022

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Prior KFF [research](#) has documented the challenges some consumers with health insurance face when finding in-network mental health care. In fact, [2 in 10](#) privately insured women with a mental health care appointment in the past two years say their provider did not accept their insurance. The option is effectively not available to women who have low incomes or are on Medicaid and lack the financial resources to pay for out-of-network care.

Among the [COVID-19 pandemic](#) and the rise of [racist attacks](#), the ongoing [opioid epidemic](#) is a commonly cited stressor that has exacerbated long-standing mental health issues and prompted growing demand for mental health services in the past several years. Women face unique gender and sex-related differences when it comes to substance use, including greater physical, psychological, and social [harms](#) associated with drug use. Use of certain substances in women has been linked to increased rates of depression and anxiety disorders. [Studies](#) have also shown that women who use substances are at risk for issues related to [pregnancy](#), fertility, breastfeeding, menstrual cycle, and more. All of these factors also shape the availability of treatment and services accessible to women.

Intimate Partner Violence Against Women

Intimate partner violence (IPV), defined as sexual violence, stalking, physical violence, and psychological aggression perpetrated by a current or former intimate partner, affects nearly a [third of all Americans](#) at some point in their lives. Although IPV affects men and women of all ages, women experience IPV at higher rates. Rates are higher among some groups of women, particularly those who are young, Black, American Indian or Alaska Native, and LGBTQ. It is difficult to quantify the number of people who experience IPV, as many cases are not reported. Some studies have estimated [6.5 million women](#) in the U.S. experience sexual violence, physical violence, or stalking by an intimate partner in a single year. People who experience IPV are more likely to experience a [range](#) of health problems such as chronic pain, cardiovascular problems, and neurological problems. Both the CDC and U.S. Preventive Services Task Force (USPSTF) have identified IPV as a significant public health issue in the US.

Several federal programs and laws fund health care services and supports to survivors of IPV. The [Violence Against Women Act](#) (VAWA) has a broad scope, covering domestic violence, sexual harassment, stalking, and sexual assault. VAWA provides grants to states, local governments, and other organizations to establish their own violence-related programs and protocols. While some of the focus of VAWA and other public policies is prosecution of those who commit violence, provisions in VAWA also address health care coverage and costs for people who have experienced IPV.

It is well recognized that the health care system can serve as a site of IPV screening and support, and some professional medical [organizations](#) recommend that clinicians screen women for IPV. Under the ACA, IPV screening is considered a [preventive service](#) as screening is recommended by the USPSTF and Health Resources and Services Administration (HRSA) preventive services for women. When health care providers routinely screen patients for IPV, it helps identify cases and connect survivors to resources and supports. However, this can be challenging as a KFF survey of OBGYNs found that many [clinicians](#) say they do not have sufficient resources within their practices to provide follow-up services when cases of IPV are identified. Connections to community-based services are particularly important for clinicians to be able to care for patients who disclose IPV.

Future Outlook

Women's health has become one of the most politicized issues in society and health care. The overturning of *Roe v. Wade* in 2022 marked a seismic change in an important aspect of women's health care that has implications for all pregnancy-related care and women's economic future and well-being. The high and rising rates of maternal mortality and morbidity in the U.S. and the persistent gaps in mortality rates experienced by women of color highlight the need to address the roles that poverty, racism, and discrimination play in women's health. Some of the key challenges that remain to be addressed in women's health include:

- How to address and eliminate the persistent inequities in health coverage and outcomes experienced by women of color
- How to build a delivery system and develop coverage policies that is responsive to the reproductive and sexual health needs of women and other gender minorities to promote optimal health outcomes
- How to shape policies that protect women with low incomes from experiencing financial barriers to care
- Identifying and implementing policies that improve maternal health outcomes and also eliminate the structural and systemic barriers to care
- Providing access to comprehensive care to pregnant people who live in areas where abortion is unavailable due to state-level bans and restrictions
- How to provide care to women dealing with issues that are heavily stigmatized and marginalized, such as intimate partner violence and mental health challenges.

Resources

- [Abortion in the United States Dashboard](#)
- [State Profiles for Women's Health](#)
- [Women's Health Insurance Coverage](#)
- [Medicaid Coverage for Women | KFF](#)
- [State Health Facts Women's Health Indicators](#)
- [2022 Women's Health Survey reports](#)
- [State and Federal Reproductive Rights and Abortion Litigation Tracker](#)
- [Preventive Services Tracker](#)
- [A Focus on Contraception in the Wake of Dobbs](#)
- [Resources about the Title X National Family Planning Program](#)

This chapter was prepared by Usha Ranji, Karen Diep, Ivette Gomez, Laurie Sobel, and Alina Salganicoff and draws on existing KFF products.

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