national partnership for women & families

A Framework for Making Universal Health Coverage Meaningful for Women

Our Vision

Women should be at the forefront of every conversation about the future of our health care system. Access to quality care is essential not only to women's physical and mental well-being, but also their economic security and ability to participate fully in society. Women play an outsized role as health care decision-makers, paid and unpaid caregivers, a vital majority of the health workforce, and advocates for themselves and their loved ones. Women spend a disproportionate amount of their economic resources on health care, and women are central to the health care workforce.

We use the term "women" in this report, but we recognize that barriers to health care affect people of many gender identities – transgender, gender nonbinary and cisgender alike. Barriers to health care – especially reproductive health care – are often exacerbated for people in the LGBTQ community due in part to discrimination, stigma and a lack of cultural competency. The National Partnership works to remove barriers so that everyone is able to access the care they need. Quality, informed care for people of all genders must be covered under any universal coverage proposal.

NationalPartnership.org
@NPWF

1875 Connecticut Avenue, NW, Suite 650
Washington, DC 20009

info@NationalPartnership.org
202.986.2600

Nonetheless, women's perspectives and health care needs are too frequently ignored or excluded, with a variety of adverse health and economic consequences for them and their families.

WE BELIEVE THAT ALL WOMEN REGARDLESS OF RACE, INCOME LEVEL, IMMIGRATION STATUS, GENDER IDENTITY OR SEXUAL ORIENTATION, SHOULD HAVE ACCESS TO HIGH QUALITY, AFFORDABLE HEALTH COVERAGE THAT MEETS THEIR HEALTH CARE NEEDS THROUGHOUT THEIR LIFESPAN.

This framework outlines essential elements of universal coverage that any proposal must include to meet the needs of women, and in particular women of color, immigrant women, women with low incomes, and women with disabilities. Despite recent significant coverage gains, disparities in coverage still persist for these women. And even when women have coverage, it is increasingly difficult for them to afford the health care services they need.

We believe that all women regardless of race, income level, immigration status, disability, gender identity or sexual orientation should have access to high quality, affordable health coverage that meets their health care needs throughout their lifespan. Anything less should not be defined as universal coverage. And health care workers, the majority of whom are women, deserve to be paid a living wage, basic workplace protections, and the right to form a union. Elected officials and candidates who support women's equity should champion policies that are included in this framework. They must recognize that without such coverage women cannot achieve the well-being and economic security that is essential for them to be full and equal participants in our society.

There are many pathways to achieving universal coverage; some of those include creating a single payer system, offering a public option, or promoting more competition among health plans. Regardless of the path, any plan should include the communities most impacted as policy partners to co-create the plan and its rollout components, and should include ongoing implementation funding that ensures health care is actually accessible rather than just more widely available. It is particularly important that plan formulation, rollout and assessment include self-advocates from communities who are often sidelined in health care reform conversations (*e.g.* advocates for disability rights, mental and behavioral health, immigrants, LGBTQ people, low-income people, youth, and rural communities).

This framework is intended to provide a guide to the must-have elements of universal coverage regardless of the pathway to coverage. Moreover, achieving universal coverage is only one part of our overall vision for advancing health equity. This

framework does not specifically address other critical health care issues such as eliminating bias and discrimination in medical practice, increasing person-centeredness of care delivery or reducing the costs of health care services. Furthermore, while this framework does not address how universal coverage proposals should be financed, an essential part of financing meaningful, universal coverage is ensuring a progressive financing system where accrued savings go towards supporting coverage expansions and health care worker wages. Any universal coverage proposal should also minimize disruption to consumers and provide a reasonable and smooth transition from the current health care system to a universal coverage program.

Equitable Access to Health Coverage

Ensuring that every person living in the United States has access to coverage would have a significant impact on eliminating disparities in health care access and outcomes, and increase economic stability. For the first time in a decade, the number of people without health insurance increased in 2018, to a total of 28.6 million people – 10.8 million of whom are women.[1] Several of the most common reasons for being uninsured include the lack of knowledge about eligibility for Medicaid or subsidized insurance, falling into the Medicaid coverage gap, and immigration status.

Over half of all uninsured women are eligible for either Medicaid or subsidies under the Affordable Care Act (ACA) but may still struggle with affordability, lack awareness of their options, require targeted outreach to help them get covered or remain uninsured for other reasons.[2] Additionally 12 percent of uninsured women live in states that have not implemented Medicaid expansion and are stuck in a Medicaid coverage gap (their incomes are above Medicaid eligibility limits but too low for ACA Marketplace premium tax credits).[3] This coverage gap perpetuates geographic and racial disparities in coverage, as Black women are more likely to live in these states.[4]

Immigrant women also face barriers to obtaining coverage based solely on their immigration status. Many lawfully present immigrants are ineligible for Medicaid because of restrictions such as the Medicaid five-year bar, which only grants lawful permanent immigrants eligibility for Medicaid and the Children's Health Insurance Program (CHIP) after five years of residence. And immigrants without documentation are

ENSURING THAT EVERY PERSON LIVING IN THE UNITED STATES HAS ACCESS TO COVERAGE WOULD HAVE A SIGNIFICANT IMPACT ON ELIMINATING DISPARITIES IN HEALTH CARE ACCESS AND OUTCOMES, AND INCREASE ECONOMIC SECURITY.

completely prohibited from enrolling in Medicaid or purchasing insurance on the ACA Marketplaces in nearly all states. These restrictions and more recent administrative proposals, like the public charge rule, very clearly target immigrant women with low incomes and disproportionately affect immigrant women of color.

These barriers and many others to health insurance coverage have serious implications for women's health and access to care. Therefore, universal coverage proposals should make high quality, affordable health care equitably accessible to every person living in the United States regardless of national origin, immigration status, income, employment status or employer, race, ethnicity, language, sex, sexual orientation, gender identity, disability or age. Proposals should eliminate eligibility restrictions for immigrants without documentation, as well as the five-year bar for Medicaid and CHIP eligibility. Proposals should also provide adequate funding for targeted outreach to uninsured communities, a streamlined, simplified enrollment process, and adequate education and support for those who qualify for Medicaid or subsidy assistance. And finally, any universal coverage proposal should be consistent across all states and territories so that a woman's access to coverage does not depend on where she lives.

Cost and Affordability

The financial burden of health care and coverage is significant for many women, both for those who are uninsured as well as for those with coverage.

LACK OF AFFORDABLE COVERAGE EXACERBATES RACIAL WEALTH AND INCOME INEQUALITIES, A RESULT OF BOTH HISTORICAL AND ONGOING SYSTEMIC RACISM.

Affordability is the leading reason why more than a third of the remaining 10.8 million uninsured women still lack coverage.[5] In 2016 more than half (59 percent) of uninsured women delayed or skipped specialist care, a test, a prescription or a visit to the doctor due to costs.[6] At the same time, many women with coverage also face financial hardship that limits their access to care. This includes women with employer coverage and women in the Marketplace with or without subsidies. For example, more than one-third of women with employer insurance (34 percent) skipped a test or care because of the costs.[7]

Lack of affordable coverage exacerbates racial wealth and income inequalities, a result of both historical and ongoing systemic racism. High insurance premiums, co-payments and deductibles can be particularly burdensome for women of color who on average earn lower wages, have fewer financial assets, accumulate less wealth and have higher

rates of poverty than white women.[8] Accordingly, four in ten Black women had outstanding medical bills in 2017, compared to one in three white women.[9]

LACK OF INSURANCE COVERAGE FOR ABORTION CARE DISPROPORTIONATELY HARMS COMMUNITIES THAT ALREADY FACE BARRIERS TO HEALTH CARE, LIKE PEOPLE OF COLOR, YOUNG PEOPLE, PEOPLE WITH DISABILITIES AND PEOPLE WITH LOW INCOMES.

Women with lower incomes also experience cost-related barriers at twice the rate of their counterparts with higher incomes.[10] Even more concerning, people with lower incomes spend a greater percentage of their income on health care and often have to forgo health care in order to pay for other necessities, like rent or food. [11]

Universal coverage proposals should adequately protect women from high health care costs and financial hardship. At a minimum, proposals should cap premiums, out-of-pocket costs, including deductibles, co-pays and coinsurance, and out-of-network charges, based on an individual's income, as well as the cost of family coverage, and women with low and middle-incomes should contribute a lesser share than their counterparts. Additionally, to the extent that individuals are limited to a network, surprise medical billing should be prohibited. Universal coverage proposals should also ensure that prescription drugs are affordable for everyone by directly addressing the cost of prescription drugs and holding the pharmaceutical supply chain accountable. Finally, no woman should have to face cost barriers, including co-payments or other cost-sharing when seeking preventive services.

Providing Benefits that Meet Women's Needs

Women need coverage that meets their specific health care needs across their lifespan. In this section, we highlight several key coverage areas that are of particular importance for women's health. These are benefits that are often first to get cut, attacked or entirely disregarded, and reflect high impact priorities that have emerged in our work to advance equality for all women. They are not intended to be inclusive of the full range of services that should be included in universal coverage proposals.

In addition, it is imperative that universal coverage proposals not weaken the existing coverage requirements in Medicare, Medicaid, Marketplace plans or any other plan that provides access to quality care.

Maternity Care

Despite requiring maternity care coverage in most insurance plans, dire and persistent disparities exist in access and outcomes. For example: Black women are three to four times more likely to experience a pregnancy-related death than white women.[12] Black women also experience higher rates of maternal health complications.[13] Rural women and American Indian and Alaska Native women similarly face high rates of maternal deaths.[14]

To help address these disparities, benefits for maternity care must be strengthened and must cover the services women need throughout pregnancy and in the postpartum period. Coverage should include routine and specialized prenatal visits, ultrasounds, home visiting, childbirth education, labor and birth, postpartum visits and support for one year after birth, and mental health screening and services. Additionally, coverage should include providers that can help women achieve optimal birth outcomes and experiences, including coverage of doulas, midwives, community-based providers and birth centers, in addition to hospital-based birth settings and providers.

Comprehensive Reproductive Health Care

Abortion

While nearly one in four women in the U.S. will have an abortion by age 45,[15] far too many people lack insurance coverage for abortion care because of where they live, how they are insured, how much they earn or their ability to pay. For many people, insurance coverage for abortion care means the difference between getting the health care they need and being denied that care. The impact of such a denial can have long-term, devastating effects on a woman's – and her family's – health and economic security.[16]

Lack of insurance coverage for abortion care disproportionately harms communities that already face barriers to health care, like people of color, young people, people with disabilities and people with low incomes. For example, people of color are more likely to live in poverty due to systemic barriers such as racism and discrimination. This means people of color are less likely to be able to afford to pay for abortion care, or other health care, out-of-pocket.[17]

Providing comprehensive insurance coverage for abortion care not only promotes the health and economic security of individuals and their families, it is also consistent with the reality that abortion is both basic health care and a fundamental

human right. Therefore, universal coverage proposals must include comprehensive coverage for abortion care for all enrollees. Medication abortion and abortion procedures, as well as all related pre-care and post-care, should be covered. This includes confidential access to care for young people, without mandated parental consent or notification, including confidentiality in billing and insurance claims processing procedures.

Contraception

Meaningful access to contraception through comprehensive insurance coverage improves women's health outcomes, as well as their economic security. Women's ability to plan and space their pregnancies through access to birth control is linked to greater educational and professional opportunities and increased lifetime earnings.[18] In addition, many women need birth control to manage medical conditions, such as treating menstrual disorders or reducing the risk of certain cancers.[19] Women also need access to the type of birth control that works best for them. No matter why someone uses contraception, insurance coverage means that they can get the method they need without having to worry about cost.

Despite expanded access to contraception under the ACA, more than 19 million women in the United States who are in need of publicly funded contraception currently live in contraceptive deserts, meaning that they lack reasonable access to a health center that offers the full range of contraception methods.[20] Furthermore, women with lower incomes and women of color are still less likely to have access to or use contraception.[21] This stems, in part, from historical and ongoing reproductive coercion and systemic racism within the health care system, which has impacted women of color, women with lower incomes, women with disabilities, young women, immigrant women, LGBTQ people and incarcerated women.[22]

Universal coverage proposals must ensure full coverage of all FDA-approved methods of contraception, including medication and devices, as well as over-the-counter methods and male-controlled methods. Coverage should also extend to comprehensive, non-directive, culturally relevant counseling so that people can make informed decisions about contraception use, insertion and removal of devices, and related follow-up care. There should be no age limits on contraceptive coverage – young people should be able to access contraception and related care without mandated parental notification or consent, and there should be confidentiality in billing and insurance claims processing procedures.

Other Reproductive Health Care

Comprehensive reproductive health care should go beyond covering abortion and contraception services so that everyone has coverage for the full range of reproductive health care services they may need. This includes, but is not limited to, fertility care, such as sperm and egg donation, in vitro fertilization, and other assisted reproductive technologies without restrictions regarding the need to "prove" the absence of conception, which has a discriminatory impact on many people including many members of the LGBTQ community and some people with disabilities; menstrual supplies and care for menstruation-related pain, endometriosis, fibroids and polycystic ovary syndrome; care for sexual pleasure and dysfunction; gender-affirming health care; and other reproductive health care needs for all people.

Preventive Care

Preventive health care is an effective tool for improving the health and well-being of women.[23] Research shows that women generally need to use more preventive care than men due to reproductive and gender-specific conditions, but are also more likely than men to forgo preventive services such as cancer screenings and dental examinations because of cost.[24]

Despite huge improvements in the coverage of preventive services under the ACA, there are still significant gaps in women's screening and diagnosis. Although there are covered preventive screenings for breast and cervical cancer, women of color continue to fare worse than white women do.[25] This is in part due to gaps in access to care, but is also due to delays in screening, diagnosis and treatment which are a result of structural bias and discrimination in the health care system and clinical research.

Preventive services should be covered based on evidence-based recommendations including Health Resources and Services Administration (HRSA)-supported women's preventive services guidelines, United States Preventive Services Task Force (USPSTF) A and B recommendations, Bright Futures Project and the Advisory Committee on Immunization Practices recommendations. Specifically for women's preventive services, coverage should, at a minimum, include breast cancer screening for average-risk women, breastfeeding services and supplies, screening for cervical cancer, contraceptives and contraceptive counseling, screening for gestational diabetes, screening and brief counseling for interpersonal and domestic violence, counseling for sexually transmitted infections, and well-woman preventive visits.

Behavioral Health Care

Behavioral health care includes promoting women's well-being by preventing or treating mental conditions, such as depression or anxiety, as well as preventing or treating substance use disorders. State and federal laws promoting mental health parity and the ACA's essential health benefits have greatly expanded coverage of behavioral health services.

This is of particular importance for women as approximately 12 million women in the United States experience clinical depression each year and about one in eight women can expect to develop clinical depression during their lifetime.[26] Additionally, data show that for Black women, anxiety disorders (which are the most common mental health condition in the United States) are more chronic and the symptoms are more intense than for white women.[27]

Women are also disproportionately affected by the opioid crisis and its underlying issues. In rural areas, where the opioid crisis has been especially severe, pregnant women and women experiencing intimate partner violence are among populations with higher prevalence of misuse of prescription pain relievers.[28] Additionally, heroin use has also been increasing among women, and at rates faster than men.[29]

Behavioral health covered benefits should encompass integrated mental health care and treatment, such as psychotherapy and counseling, and inpatient services. Coverage should also include screening, early intervention and ongoing treatment as part of maternal health care and elder care, as well as for substance use disorders, including medication assisted treatment.

Long-term Services and Supports

Millions of women rely on long-term services and supports (LTSS) because women live longer, have higher rates of disability and have more chronic health problems than men. In fact, one in four women and about 42 percent of adults aged 65 years or older are living with a disability.[30] Unfortunately, the high-out of pocket costs for LTSS makes these critical services out of reach for most women, and places a high burden on unpaid family caregivers – 60 percent of whom are women.[31] Due to persistent income disparities between men and women, women also often lack the financial resources to pay for these additional years when they need more support and services.[32]

A national long-term services and supports system is an essential part of any universal coverage proposal, especially for older women and women with disabilities. It should promote optimal health by tailoring services to individual needs and preferences, supporting women's ability to live in their home or community as well as in institutional settings, and integrating care to address women's physical, mental and behavioral health. Coverage should prioritize services provided in the most community-integrated and least restrictive settings to maximize women's autonomy, well-being and economic security.

Hearing, Vision and Dental Care

Coverage of hearing, vision and dental care have often been purchased as separate insurance plans, or not covered at all, but are part of whole-person care and should be better integrated into routine health care.

Women are more likely to face vision issues as they age.[33] And, although women are less likely to suffer from loss of hearing, they are more likely to experience depression when they have impaired hearing.[34] Oral health is also important across women's lifespan: changing hormone levels during menstrual cycles, pregnancy and menopause can raise the risk of problems in women's mouth, teeth or gums.[35] Poor oral health can also have a harmful effect on pregnancy outcomes.[36] Additionally, there is new research suggesting a direct connection between poor oral health and negative impacts on mental health and cognitive issues.[37]

Universal coverage proposals should fully integrate coverage (including prevention, screening and treatment) for the hearing, vision and oral health care needs of women.

Consumer Protections

Women must be able to access the care they need when they need it, without being subject to discrimination, political interference or intrusion in the patient-provider relationship.

WOMEN MUST BE ABLE TO ACCESS THE CARE THEY NEED WHEN THEY NEED IT, WITHOUT BEING SUBJECT TO DISCRIMINATION, POLITICAL INTERFERENCE OR INTRUSION IN THE PATIENT-PROVIDER RELATIONSHIP.

Nondiscrimination

All people should receive health care that is free of shame, stigma, bias and discrimination. Specifically, any health care entities involved in universal coverage

proposals should be prohibited from discriminating based on the patient's race, sex, gender identity, sexual orientation, ethnicity, national origin, immigration status, disability, age, income, and religion or health status.

Before the ACA, insurance companies routinely discriminated against women by charging them more than men for health coverage, refusing to cover essential women's health services (such as maternity care) and denying women coverage based on what they considered pre-existing conditions. The ACA included new protections in Section 1557, known as the Health Care Rights Law, which prohibits discrimination in health care on the basis of race, color, national origin, age, disability and sex. Universal coverage proposals should build on this groundbreaking nondiscrimination provision to ensure that all women can get the care they need.

Universal coverage proposals should expressly prohibit the use of religion to prevent women, LGBTQ individuals and their families from receiving the care, information or coverage they need, particularly in the context of reproductive and trans-related health care.

- **Providing high-quality care informed by the best science and evidence**

All patients deserve accurate information, high-quality care and the treatment options that best meet their needs. Health care providers should not be stymied by restrictions that limit or undermine the provision of care or be prohibited from offering the best available care options. Universal coverage proposals, therefore, should protect the patient-provider relationship, preserve patient autonomy and ensure that the course of care is guided by the best available science and evidence.[38]

Moreover, when creating and implementing universal coverage proposals, policy makers must use evidence-informed, peer-reviewed and medically accurate data and research that is as free of bias as possible to guide decision-making, specifically when related to eligibility and covered benefits.

Universal coverage proposals should ensure an extensive provider network, and women should be guaranteed choice of qualified, eligible providers that are accessible for their needs. Women should also be able to receive insurance coverage for all of the services a provider is qualified to offer.

For example, some insurers only reimburse for abortion care that is provided by a physician – this is despite evidence that advanced practice clinicians, such as nurse practitioners, certified nurse-midwives and physicians assistants, can safely and effectively provide abortion care.

- **Additional Protections**

Anti-discrimination protections should be vigorously enforced – universal coverage proposals must therefore include mechanisms to ensure compliance.

In cases where women face discrimination or cannot access the care they need, consumer protections, such as a right to due process, an appeals process or a private right of action, must be in place. In addition to a fair appeals process, consumer safeguards should include complete and consumer-friendly notice requirements; effective consumer outreach and education; and adequate protections pertaining to accessibility, privacy, confidentiality and data sharing.

Supporting the Health Care Workforce

A key component of quality health care is ensuring that our health care workforce – predominantly comprised of women – is strong and that their own health and economic needs are being met, including not only nurses and doctors but also home care workers, technicians, service workers and other support staff. Yet even though health care jobs are some of the fastest-growing occupations, they are often low-paid, offer few benefits and expose workers to harassment and violence in their workplaces, resulting in economic and health insecurity for workers and lower-quality care for consumers. This comes at a high cost to women both as consumers of health care and as health care workers. Women of color are central to the health care workforce and too often are overrepresented in many of the lowest-paid jobs.[39]

Universal coverage proposals should take steps to improve health care jobs and create an equitable future for health care workers. That includes ensuring all health care workers are paid at least $15 an hour and have basic protections including the right to form a union, paid sick days, paid family and medical leave and health insurance. Efforts to advance universal coverage should also support the expansion and enforcement of labor and employment protections for all health care workers many of whom were

historically excluded from these protections as a result of the racist and sexist underpinnings of our nation's labor laws.

A KEY COMPONENT OF QUALITY HEALTH CARE IS ENSURING OUR HEALTH CARE WORKFORCE – PREDOMINANTLY COMPRISED OF WOMEN – IS STRONG AND THAT THEIR OWN HEALTH AND ECONOMIC NEEDS ARE BEING MET, INCLUDING NOT ONLY NURSES AND DOCTORS BUT ALSO HOME CARE WORKERS, TECHNICIANS, SERVICE WORKERS AND OTHER SUPPORT STAFF.

Conclusion

We envision a world where all women have access to affordable, quality health care that is free of shame, stigma, bias and discrimination and where health care workers are treated with dignity and respect. All women in the United States should be eligible for and enrolled in insurance coverage that provides robust benefits that meet their needs across their lifespan at an affordable cost. Women's health care and coverage should be protected from political interference and discrimination to ensure they have access to the care they need from trusted providers.

Achieving universal coverage is one part of our overall vision for advancing health equity. Improving the health and well-being of all women will also require working to end discrimination in health care; providing more culturally sensitive, whole person-centered care; and an unrelenting focus on reducing racial and ethnic disparities. This includes multi-sector initiatives and health insurance coverage of services to address the non-medical factors (social determinants) that impede women's ability to achieve the best health outcomes, such as nonemergency transportation services, housing, nutrition and safety. Improving health care additionally requires policy change outside of the health care system, including increased funding for social services and supports to help address social determinants of health and remedy the negative health impacts of systemic discrimination, including discrimination based on race and gender.

Providing meaningful, universal coverage is a foundation for moving forward on many of these goals by ensuring that all women are connected with the health care system and will benefit from future progress and reforms.

[1] U.S. Census Bureau. (2019, September 26). *2018 American Community Survey. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2018*. Retrieved 5 November 2019, from https://www2.census.gov/programs-surveys/demo/tables/health-insurance/2019/acs-hi/hi05_acs.xls; U.S. Census Bureau. (n.d.) *American Community Survey. Health Insurance Coverage Status by Sex by Age*. Retrieved 5 November 2019, from https://data.census.gov/cedsci/table?q=&d=ACS%201-Year%20Estimates%20Detailed%20Tables&t=Health%20Insurance&table=B27001&tid=ACSDT1Y2018.B27001&lastDisplayedRow=56&g=

[2] Kaiser Family Foundation. (2018, December). *Women's Health Insurance Coverage*. Retrieved 1 November 2019, from https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/

[3] Ibid.

[4] Samantha Artiga, S., Orgera, K., & Damico, A. (2019, February). *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017*. Kaiser Family Foundation. Retrieved 1 November 2019, from http://files.kff.org/attachment/Issue-Brief-Changes-in-Health-Coverage-by-Race-and-Ethnicity-since-Implementation-of-the-ACA-2013-2017

[5] See note 3.

[6] The Commonwealth Fund. (2017, February 1). *2016 Biennial Health Insurance Survey*. Retrieved 1 November 2019, from https://www.commonwealthfund.org/biennial-explorer-interactive

[7] Ibid.

[8] National Partnership for Women & Families. (2019, September). *America's Women and the Wage Gap*. Retrieved 1 November 2019, from https://www.nationalpartnership.org/our-work/resources/economic-justice/fair-pay/americas-women-and-the-wage-gap.pdf; Hassani, H. (2018, March). *Women are building more wealth, but racial gaps persist*. The Urban Institute. Retrieved 1 November 2019, from https://www.urban.org/urban-wire/women-are-building-more-wealth-racial-gaps-persist; Fins, A. (2019, October). *National Snapshot: Poverty among Women & Families, 2019*. National Women' Law Center. Retrieved 1 November 2019, from https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2019/10/PovertySnapshot2019-1.pdf

[9] Kaiser Family Foundation. (2018, March). *Women's Coverage, Access, and Affordability: Key Findings from the 2017 Kaiser Women's Health Survey*. Retrieved 1 November 2019, from https://www.kff.org/womens-health-policy/issue-brief/womens-coverage-access-and-affordability-key-findings-from-the-2017-kaiser-womens-health-survey/

[10] Ibid.

[11] U.S. Bureau of Labor Statistics. (2018, September). *Consumer Expenditure Survey, 2017*. Retrieved 1 November 2019, from https://www.bls.gov/cex/2017/combined/decile.pdf

[12] Creanga, A.A., Syverson, C., Seek, K., & Callaghan, W.M. (2017). *Pregnancy-Related Mortality in the United States, 2011-2013*. Obstetrics & Gynecology, 130(2), 366-373. Retrieved 1 November 2019, from https://www.ncbi.nlm.nih.gov/pubmed/28697109

[13] National Partnership for Women & Families. (2018, April). *Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities*. Retrieved 1 November 2019, from https://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf

[14] Maron, D.F. (2017, February 15). Maternal Health Care Is Disappearing in Rural America. *Scientific American*. Retrieved 1 November 2019, from https://www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural-america/; Petersen, E.E., Davis, N.L., Goodman, D. et al. (2019, September). *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*. MMWR and Morbidity and Mortality Weekly Report; 68:762–765. The U.S. Department of Health and Human Services. Retrieved 5 November 2019, from http://dx.doi.org/10.15585/mmwr.mm6835a3

[15] Guttmacher Institute. (2017, October). *Abortion is a common experience for U.S. women, despite dramatic declines in rates*. [News release]. Retrieved 4 April 2019, from https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates

[16] Advancing New Standards In Reproductive Health. (2018, August). *Socioeconomic outcomes of women who receive and women who are denied wanted abortions.* Retrieved 5 November 2019, from https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf

[17] All* Above All, Ibis Reproductive Health. (2016, September). *The Impact of Out-of-Pocket Costs on Abortion Care Access*. Retrieved 5 November 2019, from https://allaboveall.org/wp/wp-content/uploads/2016/09/OutOfPocket-Impact.pdf

[18] Frost, J.J., & Lindberg, L.D. (2013, April). Reasons for using contraception: perspectives of US women seeking care at specialized family planning clinics. *Contraception, 87*(4):465-72. Retrieved 5 November 2019, from https://www.ncbi.nlm.nih.gov/pubmed/23021011; Sonfield, A., Hasstedt, K., Kavanaugh, M.L., & Anderson, M. (2013, March). *The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children*. Retrieved 5 November 2019 from Guttmacher Institute website: https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children

[19] The American College of Obstetricians and Gynecologists. (2010, January). ACOG Practice Bulletin No. 110: noncontraceptive uses of hormonal contraceptives. *Obstet Gynecol. 115*(1*):*206. Retrieved 5 November 2019, from https://journals.lww.com/greenjournal/Citation/2010/01000/Practice_Bulletin_No__110__Noncontraceptive_Uses.49.aspx

[20] Power to Decide. (n.d.). *Birth Control Access.* Retrieved 5 November 2019, from https://powertodecide.org/what-we-do/access/access-birth-control
[21] Grady C.D., Dehlendorf, C, Cohen, E.D., Schwarz, E.B., Borrero S. Racial and ethnic differences in contraceptive use among women who desire no future children, 2006-2010 National Survey of Family Growth. *Contraception*, *92*(1):62–70. Retrieved 5 November 2019, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4468010/; Kossler, K., Kuroki L.M., Allsworth J.E., Secura G.M., Roehl K.A., Peipert J.F. Perceived racial, socioeconomic and gender discrimination and its impact on contraceptive choice. *Contraception*, *84*(3):273–279. Retrieved 5 November 2019, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3539813/
[22] McGrath, A. (2018, February 2). Racial Disparities in Contraceptive Use: The Role of Perceived Discrimination. Power to Decide Blog. Retrieved 5 November 2019, from https://powertodecide.org/news/medical-mistrust-leads-to-racial-disparities-in-contraceptive-use; See note 14.
[23] Institute of Medicine. (2011). Clinical Preventive Services for Women: Closing the Gaps. Washington, DC: The National Academies Press. Retrieved 5 November 2019, from https://www.nap.edu/read/13181/chapter/3#16
[24] Ibid.
[25] Planned Parenthood. (2016, August). *National Survey of Women's Knowledge of Recommended Screenings for Breast and Cervical Cancer.* Retrieved 5 November 2019, from
https://www.plannedparenthood.org/files/1314/7076/0158/cancer_survey_results_onepager_FINAL.pdf
[26] Mental Health America. (n.d.). *Depression In Women.* Retrieved 5 November 2019, from
http://www.mentalhealthamerica.net/conditions/depression-women
[27]Neal-Barnett, A. (n.d.). *To Be Female, Anxious and Black*. Anxiety and Depression Association of America. Retrieved 5 November 2019, from https://adaa.org/learn-from-us/from-the-experts/blog-posts/consumer/be-female-anxious-and-black
[28] U.S. Department of Health and Human Services, Office on Women's Health. (2017, July). *Final Report: Opioid Use, Misuse, and Overdose in Women*. Retrieved 5 November 2019, from https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf
26 U.S. Department of Health and Human Services, Center for Disease Control and Prevention. (2015, July 7). *Today's Heroin Epidemic: More people at risk, multiple drugs abused*. Retrieved 5 November 2019, from
https://www.cdc.gov/vitalsigns/heroin/index.html
[30] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. (n.d.) *Disability and Health Data System (DHDS) Data. 2017 Disability Status, Female*. Retrieved 10 December 2019, from
https://dhds.cdc.gov/LP?CategoryId=DISEST&IndicatorId=SEXIND&ShowFootnotes=true&View=Map&yearId=YR2&stratCatId1=DISSTAT&stratId1=DISABL&stratCatId2=&stratId2=&responseId=SEX02&dataValueTypeId=AGEADJPREV&MapClassifierId=quantile&MapClassifierCount=5; Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. (n.d.) *Disability and Health Data System (DHDS) Data. 2017 Disability Status, 65+*. Retrieved 10 December 2019, from
https://dhds.cdc.gov/LP?CategoryId=DISEST&IndicatorId=AGEIND&ShowFootnotes=true&View=Map&yearId=YR2&stratCatId1=DISSTAT&stratId1=DISABL&stratCatId2=&stratId2=&responseId=AGE03&dataValueTypeId=PREV&MapClassifierId=quantile&MapClassifierCount=5
[31] See AARP Public Policy Institute and National Alliance for Caregiving. (2015, June). *Caregiving in the U.S. 2015*. Retrieved 2 December 2019, from https://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf
[32] Houser, A. (2017, April). *Women and Long-Term Services and Supports.* Retrieved 5 November 2019 from AARP Public Policy Institute: https://www.aarp.org/content/dam/aarp/ppi/2017-01/women-and-long-term-services-and-supports.pdf
[33] Prevent Blindness America. (2012). *Vision Problems in the U.S.: Prevalence of Adult Vision Impairment and Age-Related Eye Disease in America*. Retrieved 5 November 2019, from http://www.visionproblemsus.org/introduction.html
[34] Li, C., Zhang, X., Hoffman, H.J., Cotch M.F., Themann C.L., Wilson M.R. (2014, April). Hearing Impairment Associated With Depression in US Adults, National Health and Nutrition Examination Survey 2005-2010. *JAMA Otolaryngol Head Neck Surg. 140*(4):293–302. Retrieved 5 November 2019, from https://jamanetwork.com/journals/jamaotolaryngology/fullarticle/1835392
[35] U.S. Department of Health and Human Services, Office on Women's Health. (2019, January). *Oral health.* Retrieved 5 November 2019, from https://www.womenshealth.gov/a-z-topics/oral-health
[36] U.S. Department of Health and Human Services, Center for Disease Control and Prevention. (2019, February 19). *Pregnancy and Oral Health*. Retrieved 5 November 2019, from https://www.cdc.gov/oralhealth/publications/features/pregnancy-and-oral-health.html
[37] Sahchez, D., Plotnick, D. (n.d.). *A Deep Dive into the Connections Between Oral and Behavioral Health*. Families USA. Retrieved 5 November 2019, from https://familiesusa.org/wp-content/uploads/2019/09/OH_Mental-and-Oral-Health_Fact-Sheet.pdf
[38] The American College of Obstetricians and Gynecologists. (2018, May 23). *Joint Principles for Protecting the Patient-Physician Relationship*. Retrieved 5 November 2019, from https://www.acog.org/About-ACOG/News-Room/News-Releases/2018/Joint-Principles-for-Protecting-the-Patient-Physician-Relationship?IsMobileSet=false
[39] See Hess, C., & Hegeswich, A. (2019, September 23). *The Future of Care Work: Improving the Quality of America's Fastest-Growing Jobs*. Retrieved 25 November 2019 from Institute for Women's Policy Research website: https://iwpr.org/publications/future-care-work-jobs/

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality, affordable health care and policies that help all people meet the dual demands of work and family. More information is available at NationalPartnership.org.