HEALTH SERVICES UTILIZATION

Availability of and access to quality health care services directly affect all aspects of women's health. Access to health care is critical to prevent the onset of disease, as well as to identify health issues early and prevent disease progression. Although health care is important for all women, it may be particularly important among women who have poor health status, chronic conditions, or disabilities. Appropriate utilization can be hampered by limited financial resources and lack of health insurance or comprehensive insurance, as well as language, transportation, and other barriers.

This section presents data on women's use of health services, including data on women's health insurance coverage, usual source of care, health care expenditures, and use of various services, such as preventive care, HIV testing, oral health care, and mental health services. A new topic within this section explores women's use of the internet for health information.

HEALTH INSURANCE

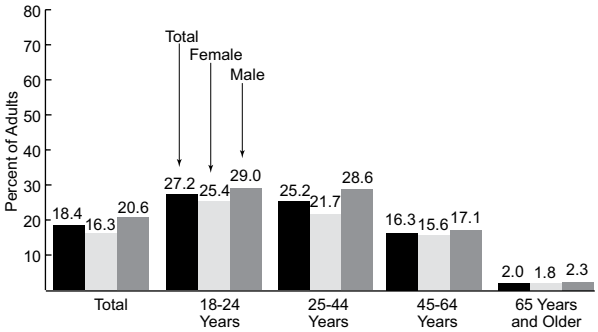
People who are uninsured face substantial financial barriers to health care, which can result in delayed diagnoses and poor health outcomes, including premature death.[1] In 2010, 42.6 million adults (18.4 percent) were uninsured, up from 37.5 million adults (16.7 percent) in 2007 (2007 data not shown). The recent rise in the uninsured population has been attributed to job loss and the economic recession.[1] The percentage of people who are uninsured varies considerably across a number of factors, including age, sex, marital status, race and ethnicity, income, and education.

Among adults in 2010, those aged 18–24 years were most likely to lack health insurance (27.2 percent). However, those aged 18–24 years were the only group to experience a significant decline in uninsurance between 2009 and 2010,[2] which is likely attributable to the Affordable Care Act provision allowing children to stay on their parents' insurance plan until age 26.[1] Men aged 18–64 years were more likely than women of the same age to be uninsured. The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage.

In 2010, 67.8 percent of women aged 18–64 years had private health insurance, 17.1 percent had public insurance, and 19.6 percent were uninsured. This distribution varied by marital status: women who were married and whose spouse was present were most likely to have private insurance coverage (77.8 percent) and least likely to be uninsured (14.2 percent). Conversely, women who were married, but whose spouse was absent or reported being separated were least likely to have private health insurance (48.7 and 47.2 percent, respectively) and most likely to be uninsured (32.2 and 30.3 percent, respectively). Women who were separated from their spouses or widowed were most likely to have public health insurance coverage (26.9 and 25.9 percent, respectively). [Respondents could report more than one type of coverage.]

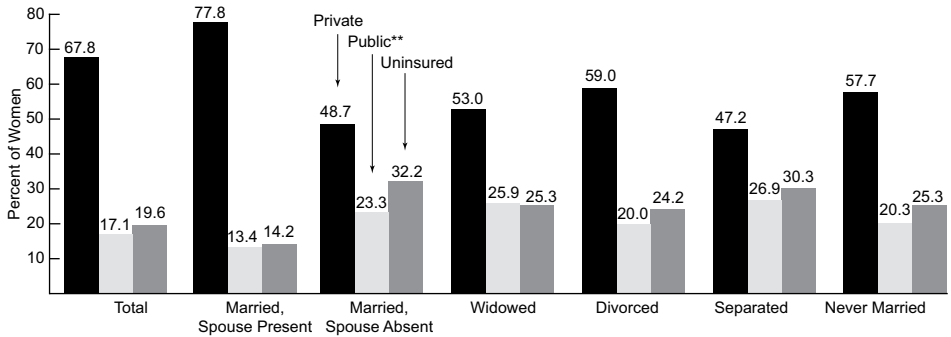
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2010

Source I.5: U.S. Census Bureau, Current Population Survey



Health Insurance Coverage of Women Aged 18–64, by Marital Status and Type of Coverage,* 2010

Source I.5: U.S. Census Bureau, Current Population Survey



**Percentages may add to more than 100 because it was possible to report more than one type of coverage. **Includes Medicaid, Medicare, military health care, and state health plans.*

MEDICAID AND MEDICARE

Medicaid, jointly funded by Federal and State governments, provides medical coverage to certain categories of low-income people.[3] In 2009, Medicaid covered 62.2 million people including low-income pregnant women, children, parents, elderly individuals, and those with disabilities. Adults aged 19 and older accounted for about half of Medicaid enrollees (31.9 million), and women accounted for 68.2 percent of all adult enrollees. Medicaid serves as a critical safety net for those who might otherwise be uninsured; increasing enrollment has helped to offset declines in employer-sponsored coverage, but more notably for children than adults due to greater eligibility and expansions for children.[1]

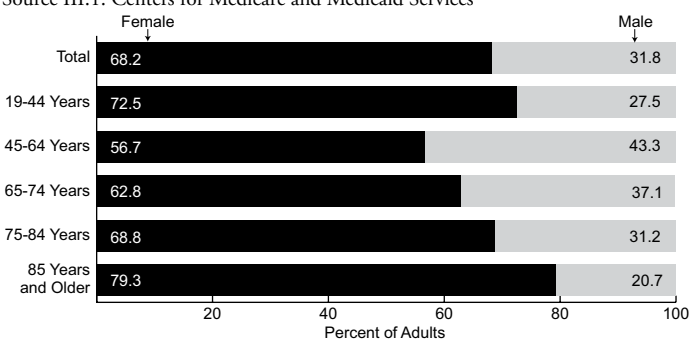
Women accounted for a larger proportion of adult Medicaid enrollees in every age group, most noticeably among those aged 19–44 and 85 years and older (72.5 and 79.3 percent, respectively). Nearly 13.5 million women, representing 62.0 percent of adult female Medicaid enrollees, were of childbearing age (data not shown). Because the Medicaid eligibility threshold is lowered in the postpartum period, 31 States have expanded family planning through a Federal waiver or State plan amendments to cover women who would not otherwise be eligible for Medicaid.[4]

Medicare is the Nation's health insurance program for people aged 65 years and older, some people under age 65 with disabilities, and those with end-stage renal disease (permanent kidney failure). Medicare has four components: Part A covers hospital, skilled nursing, home health, and hospice care; Part B covers physician services, outpatient services, and durable medical equipment; Part C (Medicare Advantage Plans) allows beneficiaries to purchase coverage through private insurers; and Part D allows for coverage of prescription drugs through private insurers.[3]

In 2010, 55.2 percent of Medicare's 47.7 million enrollees were female (data not shown). Due to age-related eligibility, those in older age groups accounted for a greater proportion of overall enrollment among both women and men. However, a greater proportion of male enrollees were under 65 compared to female enrollees (19.6 versus 14.6 percent, respectively). In contrast, adults aged 85 years and older comprised a greater proportion of female than male enrollees. (14.4 versus 8.5 percent, respectively), due to the longer life expectancy of women.

Adult Medicaid Enrollees Aged 19 and Older, by Age and Sex, 2009*

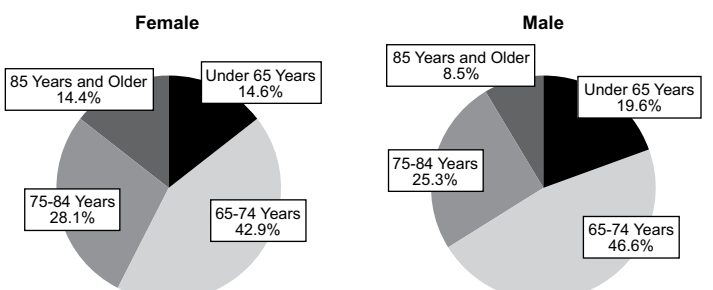
Source III.1: Centers for Medicare and Medicaid Services



*Based on Federal Fiscal Year (October to September); percentages may not add to 100 due to rounding.

Medicare Enrollees, by Sex and Age, 2010*

Source III.1: Centers for Medicare and Medicaid Services



*Enrolled as of July 1, 2010.

BARRIERS TO CARE AND UNMET NEED FOR CARE

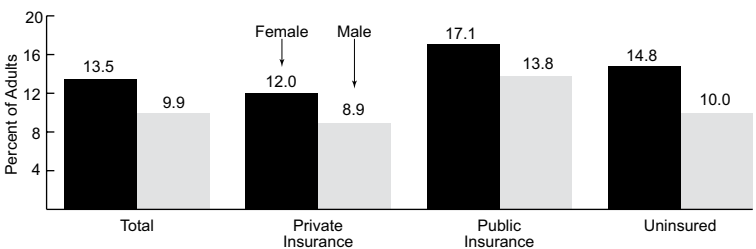
Barriers to receiving needed health care can include cost, language or knowledge barriers, and structural or logistical factors, such as long waiting times and not having transportation.[5] Barriers to care contribute to socioeconomic, racial and ethnic, and geographic differences in health care utilization and health status.

In 2008–2010, 11.8 percent or 26.4 million adults reported that they delayed getting medical care in the past year due to various logistical or structural factors, such as not being able to get an appointment soon enough and inconvenient office hours (data not shown). Women were more likely than men to report having delayed care due to logistical barriers in the past year (13.5 versus 9.9 percent, respectively). For both men and women, those with public insurance or no insurance were more likely to report having delayed care as a result of logistical factors than those with private coverage. For example, 12.0 percent of women with private health insurance reported having delayed care compared to 17.1 percent of women with public coverage and 14.8 percent of uninsured women. Non-Hispanic Black and Hispanic women also were more likely than non-Hispanic White women to report delayed care due to logistical barriers (16.3 and 16.7 versus 12.2 percent, respectively; data not shown).

Women were also slightly more likely than men to have forgone needed health care due to cost (13.0 versus 11.1 percent, respectively). For both women and men, the proportion who delayed needed care due to cost varied by poverty level. Among women, about one-fifth of those living in households with incomes less than 200 percent of poverty experienced an unmet need for health care due to cost, compared to 13.5 percent of those with household incomes of 200–399 percent of poverty and 6.5 percent of those with household incomes of 400 percent or more of poverty. The Affordable Care Act of 2010 helps to remove financial barriers to care by expanding Medicaid eligibility for more low-income people, mandating employer-sponsored coverage for large employers, establishing state-based insurance exchanges, and requiring insurance coverage of preventive services without copays.[6]

Adults Aged 18 and Older who Delayed Care Due to Logistical Barriers* in Past Year, by Type of Insurance, 2008–2010

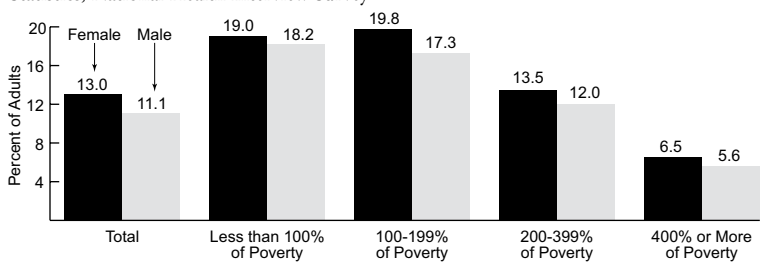
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that they delayed getting medical care in the past year due to any of five reasons: couldn't get through on phone, couldn't get appointment soon enough, office room wait too long, inconvenient office hours, no transportation.

Adults Aged 18 and Older with Unmet Need for Health Care* Due to Cost, by Poverty Status and Sex, 2008–2010**

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that they needed but did not get medical care because they could not afford it; excludes dental care. **Poverty level, defined by the U.S. Census Bureau, was $22,314 for a family of four in 2010.

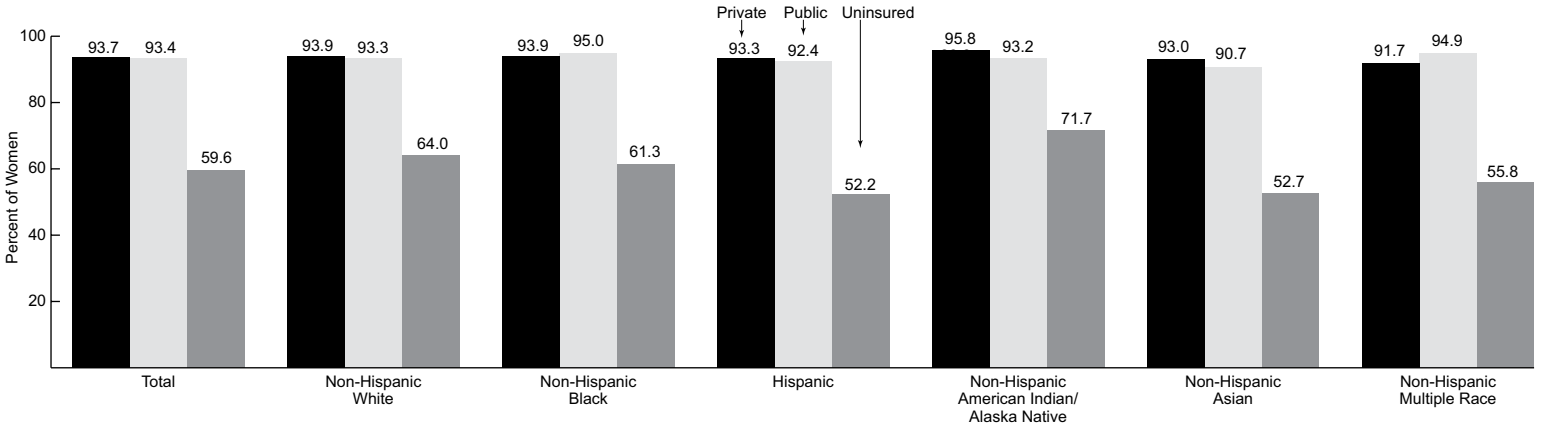
USUAL SOURCE OF CARE

In 2008–2010, 88.3 percent of women reported having a usual source of care (a place where one usually goes when sick, such as a physician's office or health center), compared to 79.0 percent of men (data not shown). Having a usual source of care is more common among older adults. For example, nearly all women aged 65 years and older (97.2 percent) had a usual source of care compared to 80.9 percent of women aged 18–34 years (data not shown). Having a usual source of care has been shown to improve care quality and the receipt of preventive services.[7]

Overall, non-Hispanic White women were most likely to report a usual source of care (90.1 percent), while Hispanic women were least likely to do so (80.8 percent; data not shown). The proportion of women of different races and ethnicities who have a usual source of care varied by health insurance coverage. Overall, approximately 94 percent of women with private or public insurance had a usual source of care compared to 59.6 percent of uninsured women. Among women with private or public insurance, those reporting a usual source of care exceeded 90 percent for all racial and ethnic groups. Women lacking health insurance were least likely to have a usual source of care, with significant variation by race and ethnicity. Among women without health insurance, non-Hispanic American Indian/Alaska Native, non-Hispanic White, and non-Hispanic Black women were most likely to report a usual source of care (71.7, 64.0, and 61.3 percent, respectively), while only about half of uninsured Hispanic, non-Hispanic women of multiple races, and non-Hispanic Asian women had a usual place to go when they were sick. Having both a usual source of care and health insurance coverage has been found to significantly reduce problems obtaining needed medical care and delaying or forgoing needed care.[8]

Women Aged 18 and Older with a Usual Source of Care,* by Health Insurance Status and Race/Ethnicity, 2008–2010**

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*All estimates are age-adjusted. **The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results.*

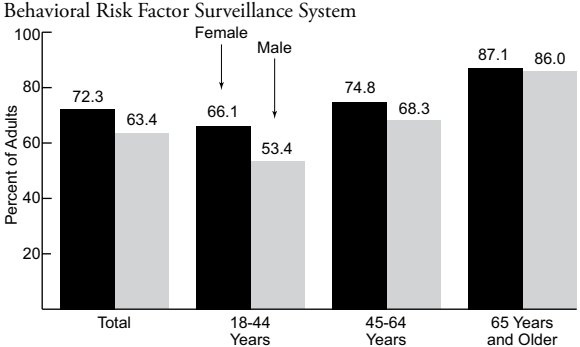
PREVENTIVE CARE

Preventive health care, including counseling, education, and screening, can help prevent or minimize the effects of many serious health conditions. In 2010, 72.3 percent of women reported that they had received a routine checkup or general physical exam that was not for a specific injury, illness, or condition, compared to 63.4 percent of men. For both men and women, the receipt of preventive health care increased with age and exceeded 85 percent among those aged 65 years and older. Among those aged 18–44 years, however, women were much more likely than men to have had a preventive checkup (66.1 versus 53.4 percent, respectively).

The U.S. Preventive Services Task Force recommends specific screening tests, counseling, immunizations, and preventive medications for a variety of diseases and conditions including several types of cancer, cardiovascular disease, injury, infectious diseases, mental health, and substance abuse.[9] For example, biennial breast cancer screenings (mammograms) are recommended for every woman aged 50–74 years and cervical cancer screenings (Pap smears) are recommended every 3 years for women aged 21–65 years. In 2010, 79.8 percent of women aged 50–74 years reported receiving a mammogram within the past 2 years and 84.5 percent of women aged 21–65 reported receiving a Pap smear within the past 3 years. Non-Hispanic American Indian/Alaska Native and non-Hispanic women of multiple races were less likely than women of other races and ethnicities to have met the mammogram guidelines (65.5 and 72.7 percent, respectively). Non-Hispanic Asian, non-Hispanic American Indian/Alaska Native, and women of multiple races were least likely to have met the Pap smear guidelines (74.6, 77.8, and 78.1 percent, respectively). The Affordable Care Act requires that new insurance plans cover breast and cervical cancer screening without cost-sharing beginning in 2010 and also requires coverage of additional women's preventive services, including well woman visits and contraception, free of charge, as of August 2012.[10]

Past Year Preventive Check-up Among Adults Aged 18 and Older,* By Age and Sex, 2010

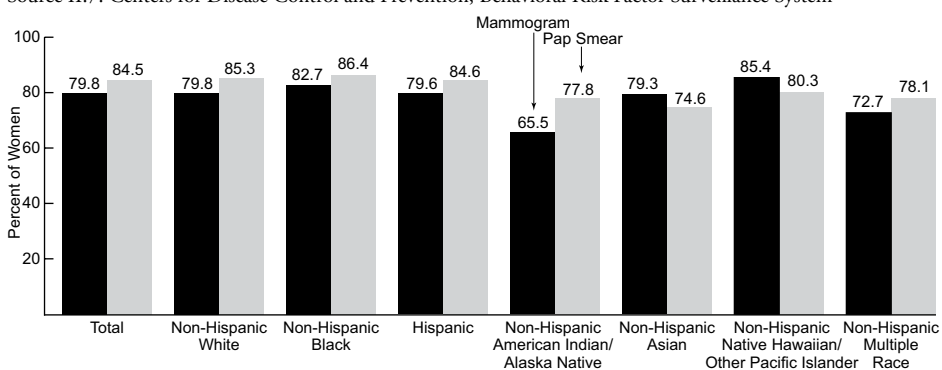
Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Report of a routine checkup in the past year, defined as a general physical exam that was not for a specific injury, illness, or condition; total estimates are age-adjusted.

Receipt of Recommended Breast and Cervical Cancer Screening Among Women,* by Race/Ethnicity, 2010

Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Based on U.S. Preventive Services Task Force recommendations of biennial mammography for women aged 50–74 years and a Pap smear every three years for women aged 21–65 years; all estimates are age-adjusted.

VACCINATION

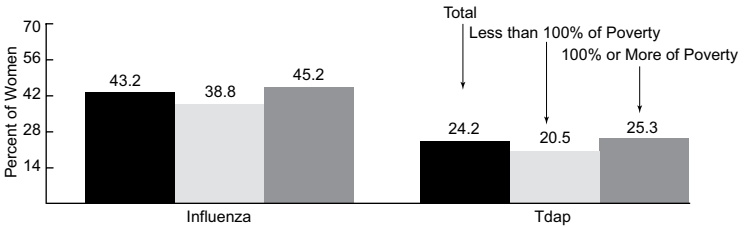
Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in mortality and morbidity for many infectious diseases.[11] An annual influenza (flu) vaccination is now recommended for all persons aged 6 months and older; however, it is especially important for certain groups, including pregnant women and older adults, who are at higher risk for flu complications.[12] In November of 2011, only 43.2 percent of pregnant women reported receiving flu vaccine for the 2011–2012 season. Those with household incomes less than 100 percent of poverty were less likely to have received vaccination than those living at or above poverty (38.8 versus 45.2 percent, respectively). To prevent potentially fatal infection in the newborn, a tetanus, diphtheria, and acellular pertussis (whooping cough) vaccine (Tdap) is also recommended for pregnant women (>20 weeks' gestation) if they have not received Tdap vaccination in the last 10 years.[13] In 2011, only 24.2 percent of pregnant women reported having received a current Tdap vaccination. Tdap vaccination was lower among pregnant women with household incomes below poverty compared to those with higher incomes (20.5 versus 25.3 percent, respectively).

Pneumococcal vaccination protects against a bacterial infection that may cause pneumonia or other illnesses that can lead to severe complications including death. Pneumococcal vaccination is recommended for young children, adults aged 65 years and older, those with certain health conditions including asthma, and for adults who smoke cigarettes.[12] In 2010, 61.3 percent of women aged 65 and older reported ever receiving a pneumococcal vaccination. Pneumococcal vaccination was lower among women with household incomes of less than 100 percent of poverty, compared to those with higher incomes (42.2 versus 64.1 percent, respectively).

Shingles vaccination, first recommended in 2006, protects against herpes zoster—a reactivation of the virus that causes chickenpox, which is called shingles. Shingles occurs mostly in older adults and produces a skin rash that can create debilitating pain lasting months or even years. The shingles vaccine is recommended for all persons aged 60 years and older, except for those with conditions that severely weaken the immune system.[12] In 2010, only 16.0 percent of women aged 60 and older reported receiving the shingles vaccination. Shingles vaccination was lower among women with household incomes below 100 percent of poverty than those with higher incomes (9.1 versus 17.4 percent, respectively).

Receipt of Selected Vaccinations* Among Pregnant Women, by Poverty Status, 2011†**

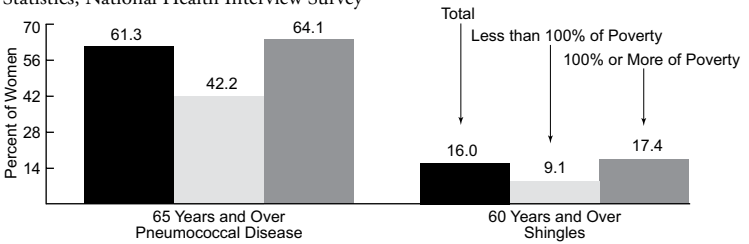
Source III.2: Centers for Disease Control and Prevention, Internet Panel Survey



*Having received the influenza vaccination since August 1, 2011; having received the tetanus shot including acellular pertussis (whooping cough) vaccine since 2005, when Tdap first became licensed and recommended. **Poverty level, defined by the U.S. Census Bureau, was $22,811 for a family of four in 2011. †Women pregnant at anytime from August to November were surveyed in November, 2011.

Receipt of Selected Vaccinations* Among Women, by Recommended Age Group and Poverty Status, 2010**

Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Having ever received the pneumonia shot; zoster or Shingles vaccine. **Poverty level, defined by the U.S. Census Bureau, was $22,113 for a family of four in 2010.

HIV TESTING

People aware of and receiving appropriate care for positive HIV serostatus may be able to live longer and healthier lives because of newly available, effective treatments. It is recommended that people who meet any of the following criteria be tested at least annually for HIV: those who have injected drugs or steroids, or shared drug use equipment (such as needles); have had unprotected sex with men who have sex with men, anonymous partners, or multiple partners; have exchanged sex for drugs or money; have been diagnosed with hepatitis, tuberculosis, or a sexually transmitted infection; received a blood transfusion between 1978 and 1985; or have had unprotected sex with anyone who meets any of these criteria.[14] In addition, the CDC recommends that all health care providers include HIV testing as part of their patients' routine health care and that all pregnant women be tested during their pregnancy.

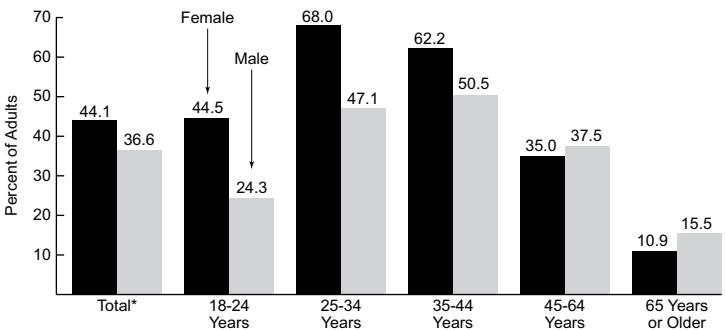
In 2008–2010, 40.3 percent of adults in the United States had ever been tested for HIV (data not shown). Overall, women were more likely than men to have been tested (44.1 versus 36.6 percent, respectively). Within younger age groups (18–44 years), women were more likely to have been tested than men, however, men were more likely to have been tested at older ages (45 years and older).

With respect to race and ethnicity, non-Hispanic Black women and men were most likely to have ever been tested (59.6 and 55.9 percent, respectively), while non-Hispanic Asian women and men were least likely to have ever been tested (34.7 and 30.7 percent, respectively). Women were generally more likely than men to have ever been tested for HIV within every race and ethnic group.

Among women who had not been tested, 78.6 percent reported that they had not been tested because they thought it was unlikely they had been exposed and 19.1 percent reported that there was no particular reason they had not done so (data not shown).

Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2008–2010

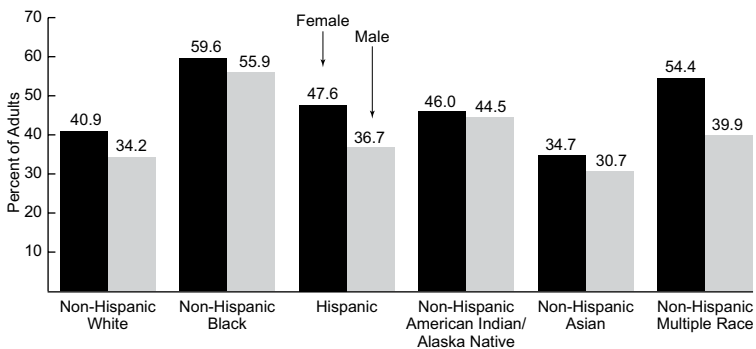
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Total estimates are age-adjusted.

Adults Aged 18 and Older Who Have Ever Been Tested for HIV,* by Race/Ethnicity, 2008–2010**

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Estimates are age-adjusted. **The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results.

MENTAL HEALTH CARE UTILIZATION

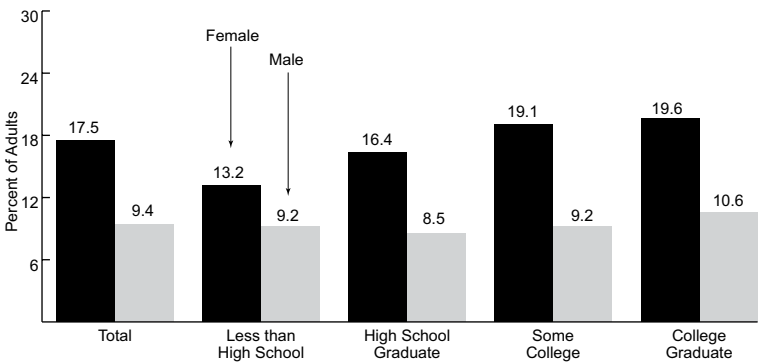
In 2009–2010, nearly 31 million, or 13.6 percent of adults in the United States reported receiving mental health treatment in the past year for a mental, behavioral, or emotional disorder other than a substance use disorder. Women were more likely than men to receive treatment or counseling (17.5 versus 9.4 percent), which is roughly commensurate with the higher prevalence of mental illness (excluding substance use disorder) among women (see page on Mental Illness).[15] Utilization of mental health services was more common among women with higher educational attainment. Approximately 20 percent of college-educated women reported past year mental health treatment compared to 13.2 percent of women without a high school diploma.

Over 17 million women aged 18 years and older reported using prescription medication for treatment of a mental or emotional condition, representing 15.1 percent of women, which is almost twice the proportion of men (7.7 percent). Women were also nearly twice as likely as men to report receiving outpatient mental health treatment (8.4 versus 4.6 percent, respectively). Less than 1 percent of men and women received inpatient treatment in 2009–2010 (data not shown).

In 2009–2010, mental health services were needed, but not received in the previous year, by about 11.5 million adults, corresponding to 5.1 percent of adults in the United States. Women were almost twice as likely as men to have an unmet need for mental health treatment or counseling in the past year (6.6 versus 3.4 percent, respectively; data not shown). Among women, cost was the most commonly reported reason for not receiving needed services (46.9 percent) followed by the belief that the problem could be handled without treatment (26.5 percent), not having enough time (17.6 percent), and not knowing where to go for treatment (15.1 percent).

Past Year Mental Health Treatment/Counseling* Among Adults Aged 18 and Older, by Educational Attainment and Sex, 2009–2010

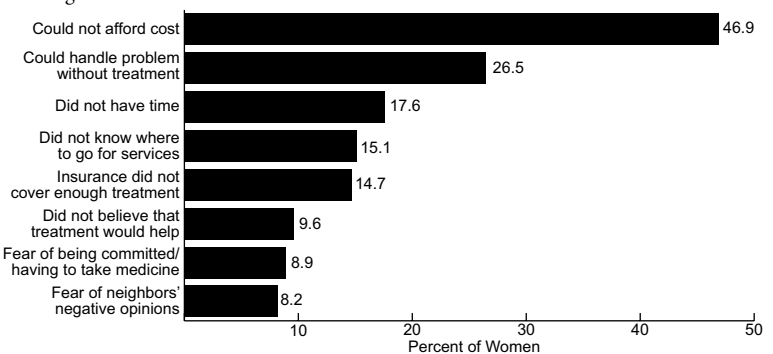
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excludes treatment for alcohol or drug use.

Reasons for Not Receiving Mental Health Treatment/Counseling* Among Women Aged 18 and Older with an Unmet Need for Mental Health Services, 2009–2010

Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Defined as a perceived need for mental health treatment/counseling that was not received.

ORAL HEALTH CARE UTILIZATION

Regular dental care is essential to promote oral health and to prevent and treat tooth decay and infection. Untreated dental disease can produce significant pain and disability, and can result in tooth loss. In addition to daily brushing and flossing, the American Dental Association recommends regular dental exams and cleanings.[16] Overall, 60.7 percent of adults reported having a dental visit in 2008–2010 (data not shown). Women were somewhat more likely to have had a past-year dental visit than men (64.1 and 57.0 percent, respectively).

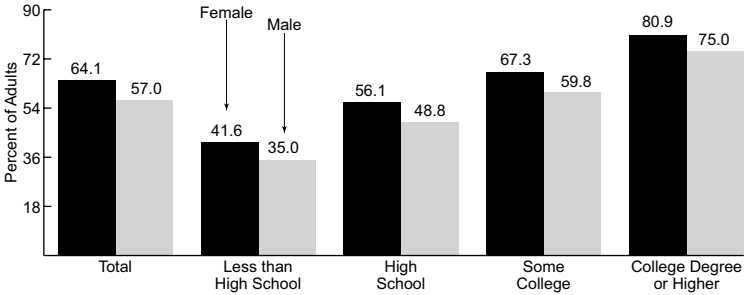
Among both men and women, those with higher levels of education were more likely to have had a dental visit. For example, 80.9 percent of women with a college degree or higher had a past year dental visit, compared to only 41.6 percent of women with less than a high school education. Similarly, three-quarters of men with at least a college degree reported a past-year visit compared to 35.0 percent of those who did not graduate high school.

The proportion of women experiencing an unmet need for oral health care varies by race and ethnicity. In 2008–2010, 16.5 percent of women reported that they did not obtain needed dental care in the past year because they could not afford it; however, unmet need for care ranged from 9.1 percent among non-Hispanic Asian women to 30.3 percent among non-Hispanic women of multiple races.

Cost remains a significant barrier to receiving dental health services, even among adults with health insurance. Approximately 10 percent of women with private health insurance reported that they did not obtain needed dental care in the past year due to costs, while the same was true for 18.8 percent of women with public coverage. Those without insurance fared worse, however, with 43.4 percent of uninsured women reporting that they did not obtain needed care due to costs (data not shown). Even those with public or private insurance may face cost barriers due to limited or no coverage for dental services.[17]

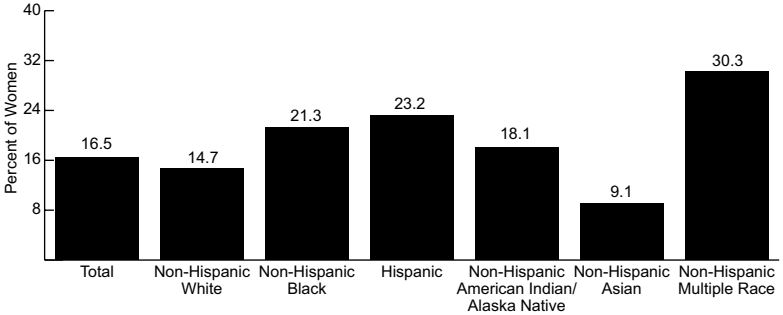
Past Year Dental Visit Among Adults Aged 18 and Older, by Level of Education, 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Unmet Need for Dental Care Due to Cost Among Women Aged 18 and Older,* by Race/Ethnicity, 2008–2010**

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Past year report of needing dental care but not getting it because of cost. **The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results.*

HEALTH CARE EXPENDITURES

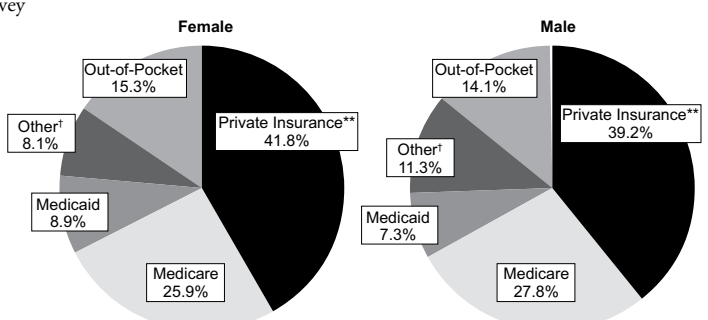
In 2009, the majority of total health care expenses for both women and men were covered by public or private health insurance. For both men and women, about 40 percent of expenses were paid by private insurance and about 35 percent were paid by Medicare or Medicaid. However, compared to men, health care costs for women were more likely to be paid out of pocket (15.3 versus 14.1 percent) and less likely to be paid by other sources (8.1 versus 11.3 percent).

In 2009, 90.0 percent of women had at least one health care expense, compared to 77.6 percent of men (data not shown). Among adults who had at least one health care expense, the average expenditure per person, including expenses covered by insurance and those paid out-of-pocket, was slightly higher for women ($6,011) than for men ($5,389). However, men's average expenditures significantly exceeded women's for hospital inpatient services ($20,268 versus $14,558, respectively). Women's expenditures significantly exceeded men's only in the category of office-based medical services ($1,772 versus $1,447, respectively). The overall mean health care expense was greater for women because of the greater percentage of women incurring more expensive services. For instance, 10.3 percent of women had hospital inpatient services, which includes childbirth delivery, compared to 6.4 percent of men.

Overall per capita health care expenditures have increased substantially in the past decade. In 2009, average health care expenses for women and men were 83.0 and 87.9 percent higher than in 1999 (data not shown). The increasing development and utilization of new technologies may account for a large part of rising health care expenses.[18] The Affordable Care Act of 2010 contains a number of provisions to reduce costs to consumers and more generally, for example by limiting co-payments for covered benefits and testing new payment systems for Medicare to improve quality and efficiency.[18]

Health Care Expenses of Adults Aged 18 and Older, by Sex and Source of Payment*, 2009

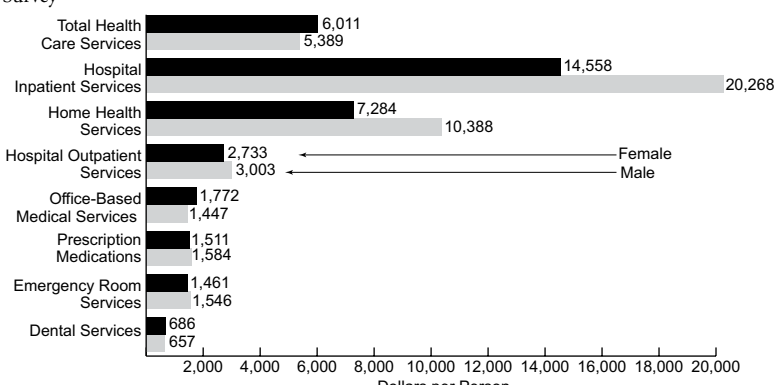
Source III.4: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



**Percentages may not sum to 100 due to rounding. **Includes Tricare (Armed-Forces-related coverage). †Includes other public programs, such as Department of Veterans Affairs, Indian Health Service, and community clinics, worker's compensation, as well as other unclassified sources.*

Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Category of Service and Sex, 2009

Source III.4: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



QUALITY OF WOMEN'S HEALTH CARE

Health care quality indicators can provide important information about the effectiveness, safety, timeliness, patient-centeredness, and efficiency of health services.[19] Some common indicators used to monitor women's health care in managed care plans include screening for chlamydia and cervical cancer, and the receipt of timely prenatal and postpartum care.[20]

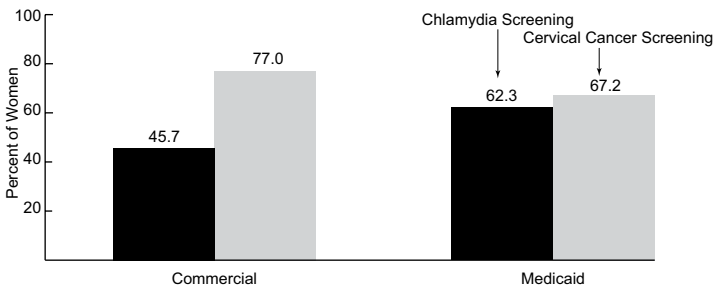
Often referred to as a "silent" disease because most infected individuals do not experience symptoms, chlamydia is the most commonly reported bacterial STD in the United States.[21] In 2010, women aged 21–24 years enrolled in Medicaid were more likely than those enrolled in commercial plans to have been screened for chlamydia (62.3 versus 45.7 percent, respectively).

In comparison, cervical cancer screenings appear to be more accessible to women with commercial coverage than to those covered by Medicaid. Among women aged 21–64 years, cervical cancer screenings were received at least once during the previous 3 years by 77.0 percent of commercially-insured women and 67.2 percent of those covered by Medicaid. Cervical cancer is almost entirely preventable with appropriate screening, evaluation, and treatment.[22] [See pages on *Cancer* and *Preventive Care*.]

In 2010, women with commercial insurance coverage were also more likely than those with Medicaid to have received timely prenatal and postpartum care. More than 90 percent of commercially-insured women received prenatal care in either their first trimester or within 42 days of enrollment, compared to 83.7 percent of those covered by Medicaid. Similarly, 80.7 percent of women with commercial coverage had a postpartum visit between 21 and 56 days after delivery, compared to 64.4 percent of women participating in Medicaid. Although Medicaid-insured women are less likely to have received timely prenatal and postpartum care than commercially-insured women, they have made greater improvements since 2001. For example, the proportion of women receiving timely postpartum care increased 21.5 percent among Medicaid participants compared to 4.8 percent among commercially-insured postpartum women.

HEDIS®* Screening for Chlamydia and Cervical Cancer,† by Payer, 2010**

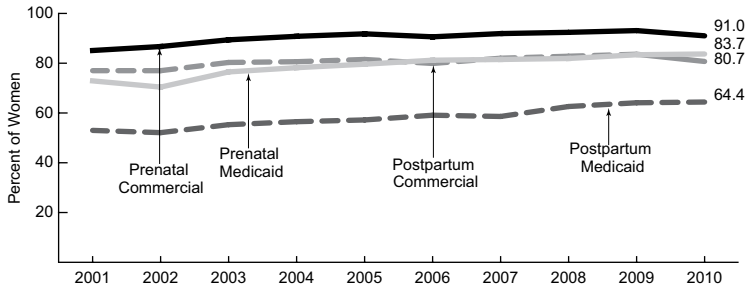
Source III.5: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active women aged 21–24 years who had at least one test for Chlamydia in the past year. †The percentage of women aged 21–64 years who had at least one Pap test in the past 3 years.*

HEDIS®* Timeliness of Prenatal and Postpartum Care,† by Payer, 2001–2010**

Source III.5: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of pregnant women who received a prenatal care visit in either the first trimester or within 42 days of enrollment. †The percentage of women who had a postpartum visit on or between 21 and 56 days after delivery.*

INTERNET USE FOR HEALTH INFORMATION

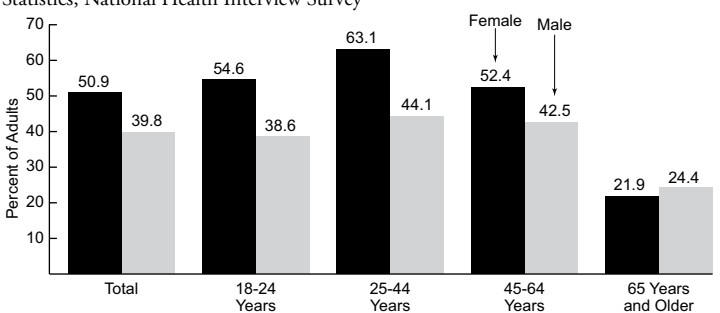
Due in part to the growth in high-speed broadband, wireless networks, and mobile devices, the percentage of adults in the United States who use the Internet has increased substantially, from 47 percent in 2000 to 78 percent in 2011.[23] With regard to health, the Internet can provide valuable information on specific conditions, rankings and reviews of medical professionals, health assessment questionnaires, and other tools to better inform consumers of treatment options and preventative measures.[24] However, disparities in Internet access persist by age, race and ethnicity, education, and income.[23]

In 2009, 45.5 percent of all adults reported having used the Internet to obtain health information in the past year (data not shown). Overall, women were more likely than men to have utilized this resource (50.9 versus 39.8 percent, respectively). Internet use for health information also varied by age. Among women, those aged 25–44 years were most likely to use the Internet for health information (63.1 percent) while similar percentages of men, about 40 percent, had used the Internet for health information between 18 and 64 years of age. For both women and men, those aged 65 and older were least likely to use the Internet for health information and there was no significant sex difference among this age group (21.9 and 24.4 percent, respectively).

Internet use for health information increased greatly with income and education. Among women, two-thirds of those with household incomes of 400 percent or more of poverty had used the Internet for health information in the past year, compared to less than one-third of those with incomes below the poverty level (66.3 versus 29.2 percent, respectively). Similarly, women with a college degree were more than 5 times as likely as women who had not finished high school to have used the Internet for health information (74.6 versus 14.5 percent, respectively; data not shown). With respect to race and ethnicity, Internet use for health information was highest among non-Hispanic White women (57.0 percent) and lowest among Hispanic women (31.9 percent; data not shown).

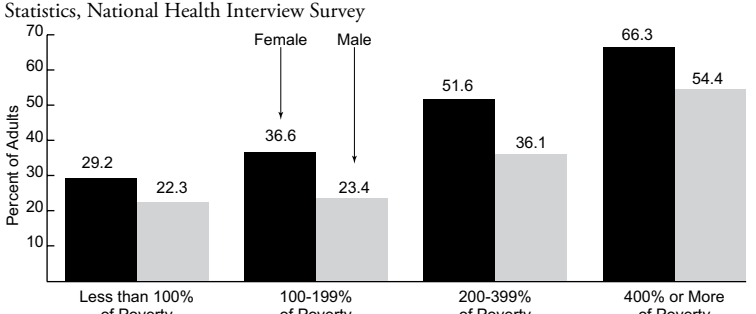
Adults Aged 18 and Older Who Used the Internet for Health Information in Past Year, by Age and Sex, 2009

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Adults Aged 18 and Older Who Used the Internet for Health Information in Past Year, by Poverty Status* and Sex, 2009

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Poverty level, defined by the U.S. Census Bureau, was $23,021 for a family of four in 2009.