Women’s Health Care
Why It Matters in the Health Care Reform Debate
by Gregg Davis

The Patient Protection and Affordable Care Act was signed into law by President Barack Obama on March 23, 2010. Different provisions of the law will be phased in over the next decade. Still central to America’s debate is whether the new law will change status quo spending on health care from an unsustainable path to one that will “bend the cost curve.” The factors underlying the present trajectory of health care spending are complex and intertwined, making any debate on health care reform challenging for the American public to comprehend. One way to bend the cost curve is to identify differential patterns of health care utilization and spending. Identifying where “excess rates of disease” occur, and addressing ways to reduce those diseases, is one direct way to bend the cost curve. For example, four diseases that are highly amenable to reduced prevalence rates through preventive measures alone are diabetes, hypertension, stroke, and renal disease. One study quantified the increased costs to the U.S. health care system at $337 billion for these four diseases over a 10-year period, nearly two and a half times the projected savings in all the health care bills before Congress. So why focus on health care disparities?

Disparities in health care reflect variations in access, utilization, and health status among certain demographic groups. One group that is large in number and a frequent user of health care is women. Compared to men, women are more likely to be raising children alone, have lower incomes and hence more likely to be on Medicaid, and have higher rates of chronic illnesses. Women are also more likely to use community health centers and other government programs that provide health services to low-income individuals. Women also serve as the primary decision-makers regarding health matters for family members, so they indirectly control health care spending for the entire family.

Improving the health of all population groups is vital if we are to succeed in changing the current unsustainable path of health care spending. Postponing health care due to cost or lack of insurance is expensive. In Montana, more than $54 million is spent each year on avoidable emergency room visits alone. Improved health increases productivity and reduces the strain on the health care system.

Women are more frequent users of health care than men. Women are almost one and a half times more likely than men to have visited health care professional 10 or more times in the last year. (Figure 1). Nearly 75 percent of all women have seen a health care professional within the last six months, compared to only 61 percent of men.

Although the proportion of women and men in Montana without health insurance is comparable (17.6 percent for women versus 20.2 percent for men), among all adults

**Figure 1**
Number of Medical Office Visits in the Past 12 Months, Percent by Gender, 2008

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>12.3</td>
<td>10.1</td>
</tr>
<tr>
<td>4-9</td>
<td>25.7</td>
<td>20.4</td>
</tr>
<tr>
<td>10+</td>
<td>28.2</td>
<td>16.9</td>
</tr>
</tbody>
</table>


**Figure 2**
Percent Forgoing Medical Care, By Gender and Income, 2007

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>80%</td>
<td>75%</td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td>$20,000-$39,999</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>$40,000-$59,999</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>$60,000+</td>
<td>40%</td>
<td>20%</td>
</tr>
</tbody>
</table>

19-64 years of age and across all income classes, women are more likely to forego needed medical care due to cost (Figure 2). Women are also more likely to forego cost effective preventive services, such as colon cancer screening and dental exams.

For adults 65 years of age and older, women report more health problems than men (Figure 3). And for every age and race group, women are more likely than men of the same age to have one or more physical limitations, and these differences between men and women in the prevalence of one or more physical limitations widens with increasing age. As a result, women on average spend 17 percent of their income on health care while on Medicare, compared to 15 percent of income for men 65 years of age or older. Out-of-pocket spending for women is also higher than that for men (Figure 4). Women on average spend more than $400 more per year than men on health care.

Disparities in health for women occur due to access and utilization problems, social determinants, and health status. Figure 5 shows how women in Montana fare relative to women in the United States on select disparity measures. The proportion of women without health insurance, a usual source of care such as a family physician, mammograms, and Pap smears reflects a woman’s ability to obtain timely medical care and use of preventive services. On all dimensions, women in Montana, including minority women, fare worse than their national counterparts. Interestingly, fewer minority women (non-white) in Montana failed to get a Pap smear within the last two years when compared to all women in Montana and the United States. But on all other measures, the proportion of minority women who did not receive recommended medical care is well above that for white women nationally and in Montana. Delayed or avoided medical care places additional burdens on the health care system when care is eventually sought, resulting in higher medical expenditures, and sometimes, less favorable outcomes.

On health status measures – obesity, smoking behavior, and psychological distress – women in Montana fare comparably to women in the United States. Again the exceptions are the state’s minority populations, where particularly for obesity and smoking behavior, Montana’s minority women are well above that of U.S. women.
According to the U.S. Department of Health and Human Services, twice as many women as men between the ages of 45 and 54 have strokes. One in four women dies from heart disease. Cancer mortality rates (not shown) for American Indian women are almost 50 percent higher than for all women in the United States (230.6 per 100,000 compared to 162.2 per 100,000).

Social determinants also influence a woman’s ability to access health care and maintain healthy lifestyles. Fewer women in Montana are without high school degrees than their national counterparts. Montana women are comparable to their national counterparts in terms of female-headed households with children and those living below the federal poverty level. But again, minority women in Montana have rates of poverty and female-headed households with children well above national averages.

More women in Montana (47 percent) than nationally (43 percent) live in areas designated as primary care shortage areas, where access to medical care is limited or nonexistent. Almost six in 10 live in areas designated as mental health shortage areas. Crucial for these underserved areas are primary care providers. These providers often serve as the first point of entry into the health care system for undiagnosed medical problems. But primary care providers are in decline nationally and in the state of Montana, leaving some without health care access.

Lack of access is also compounded by the insurance situation many women face. Although on average more women are insured, fewer have insurance through job-based employment (38 percent versus 48 percent for men), and significantly more are a dependent on their spouse’s insurance (25 percent versus 13 percent for men). The Joint Economic Committee of Congress estimates that 1.7 million women have lost health insurance since December 2007, with 75 percent losing their insurance because of a spouse’s job loss. Divorce and widowhood may also leave many women uninsured.

**Health Care Reform and Women**

The arduous process underlying health care reform is now over. Now the difficulty of unraveling the effects of reform begin. While it will be several years before the full ramifications of health reform become apparent, certain provisions are certain to benefit women in particular. Almost immediately efforts are to commence to enhance the collection and reporting of data on race, ethnicity, sex, language, and disability status, with analysis to monitor the trends in disparities to follow. Also for fiscal 2010, support for the delivery of evidence-based and community-based prevention and wellness services that address health care disparities, especially in rural areas, are funded for five years.

A recent study found that among those falling into the Medicare Part D prescription “donut hole,” women are particularly at risk. For individuals spending between $2,850 and $6,440 per year in prescription medicines, Medicare’s payment share was in effect zero. Now, effective this year, Medicare beneficiaries who reach the Medicare Part D coverage gap are eligible for a $250 rebate. Then over the next decade, the co-insurance rate is phased down from its present 100 percent to 25 percent. And in 2011, pharmaceutical companies are to provide a 50 percent discount on prescriptions filled in the Medicare Part D coverage gap.

Within the next six months, qualified health plans are to provide at a minimum coverage without cost sharing for preventive care and screenings for women. Cost sharing for important prevention services provided by Medicare and Medicaid are eliminated beginning in 2011. And effective in October of this year, Medicaid coverage for tobacco cessation services for pregnant women begin.

Community Health Centers and the National Health Service Corps, so important for increasing access to health care for low-income and rural residents, will receive increased funding of $11 billion nationally over the next five years beginning in 2011. The Indian Health Care Improvement Act, originally signed into law in 1976, has over the past 10 years had no authorization for appropriations. With President Obama’s signature, the act is now permanent. Changes in the act improve the overall delivery of health care for American Indians and Alaska natives.

Effective next year is the Community Living Assistance Services and Supports (CLASS) program. Following a five-year vesting period, women will be able to receive cash benefits to purchase non-medical services necessary to keep them in their communities. And since women represent a disproportionate share of dual eligibles, those on both Medicare and Medicaid, a new office for the coordination of care should be of benefit. And finally, adults without children will now benefit from the expansion of Medicaid through the guarantee of a benchmark benefit package providing at a minimum essential health benefits.

Any expansion in Medicaid should disproportionately benefit women since nationally they represent nearly two-thirds of Medicaid beneficiaries.

Of course, there are many provisions of the law that should increase access to the health care system for women and other minorities. Exactly how the reform plays out on bending the cost curve while at the same time improving the health status of Montanans is difficult to predict. Isolating each component of the health reform law and separating its affects from all other components will prove challenging. But one thing is certain, we will still be debating the merits of the reform for years to come.

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