Improving Women's Health
Health Challenges, Access and Prevention

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Health needs and services for various populations have come to the forefront as states work to make their systems more efficient and consider covering additional people under federal health reform implementation. This brief, the third in a series about women's health, highlights diseases and health challenges common to women; opportunities to improve access to care and effective treatment; and strategies to prevent conditions and health problems before they become problematic and expensive.

Women, who are key in maintaining healthy families, access the health system more than men, both for themselves and on behalf of their children. Many become pregnant and give birth, a significant health event, then typically become their child's primary caregiver, a role that greatly influences household health overall. Elder and long-term care issues affect women more often because they live longer; have higher rates of disability and chronic health problems; and lower incomes than men on average, which puts them at greater need for state and community resources, such as Medicaid.

Across her lifespan, a woman's health status matters to herself, her family and to state budgets. Legislators are wrestling with tight budgets and changing health laws—including the realities of implementing federal health reform under the Affordable Care Act (ACA). If women's needs are overlooked in these discussions, however, states lose important opportunities to improve the health of residents and gain partners in creating a healthier society.

Women's Health Brief Series

"Improving Women's Health: Opportunities and Challenges in Health Reform" (2012)

"Improving Women's Health: State Policy Options" (2011)

Women's Health Across the Lifespan webpage

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Diseases and Health Challenges Common to Women

Women experience unique health care challenges and are more likely to be diagnosed with certain diseases than men. Chronic diseases and conditions—such as heart disease, cancer and diabetes—are the leading causes of death for women. Nearly half of adults—133 million people—have a chronic illness, and half of those have two or more chronic conditions. Thirty-eight percent of women suffer from one or more chronic diseases, compared to 30 percent of men. According to the Centers for Disease Control and Prevention (CDC), 75 percent of all U.S. health care dollars treat people with chronic conditions. Managing chronic disease is often difficult for the uninsured, and women are more likely to lack insurance.

Chronic Diseases and Conditions

Heart Disease. Heart disease is the leading cause of death for women. Women may have more subtle symptoms of a heart attack than men, such as upper abdominal pain, lightheadedness or fatigue. "Heart Month" is nationally recognized in February, and the American Heart Association's Go Red for Women campaign encourages awareness. Many states have adopted similar awareness efforts. Two CDC grant programs—Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) and the National Heart Disease and Stroke Prevention Program (HDSP)—help states cover screening and related services for women.

Cancer. Cancer kills more than 250,000 women in the United States annually. Access to preventive services under the ACA should help more women detect some cancers earlier. In addition, raising awareness about symptoms and risk factors for particular cancers is an important component of prevention and early diagnosis, especially for cancers of the breast, lung, colon and skin, which are largely preventable. States can help ensure early breast cancer detection by increasing access to mammograms. Some states have taken legislative action to require the Human Papillomavirus (HPV) vaccine for pre-adolescent girls to prevent cervical cancer or have provided funding to make it more readily available. In an effort to reduce skin cancer rates, a number of states ban tanning bed use by minors.

Diabetes. The direct medical costs associated with diabetes totaled $116 billion in 2007; CDC reports that medical expenditures for patients with the disease are more than double the costs for those who do not have it. Diabetes, the seventh leading cause of death in the United States, can lead to serious and costly complications, including heart disease, stroke, amputations, blindness and kidney disease. Medicaid disease management services can save states money and help minimize complications. Some states require insurance coverage for various services and support state diabetes prevention and control programs within their health departments.

Depression. According to the Mayo Clinic, women are twice as likely as men to experience depression. The condition will affect one in five women at some point in their lives, most commonly between ages 40 and 59. Final rules from the U.S. Department of Health and Human Services related to essential health benefits under the ACA require individual and small group market plans to cover mental health and substance abuse treatment on a level comparable to medical and surgical services (known as "parity") beginning in 2014. For example, financial requirements—such as copayments and deductibles—and treatment limitations—such as number of visits covered—need to be equal to those for treatment of other medical conditions.

Osteoporosis. According to the National Osteoporosis Foundation, the disease affects 8 million women over age 50. Osteoporosis causes 2 million fractures at a cost of $19 billion annually, and costs will rise as the population ages. Medicare and Medicaid cover approximately 75 percent of associated health care costs, not including the nursing home costs that result from hip and other fractures. Thirty-four states and Puerto Rico have laws regarding osteoporosis, mostly to raise awareness; at least 14 states require insurance plans to cover osteoporosis-related treatments and services.

Alzheimer's. Alzheimer's disease disproportionately affects women—two-thirds of adults age 65 or older with the disease are women, and 60 percent of the nearly 15 million Americans who provide unpaid caregiving to a person with Alzheimer's are women. The disease also places a financial burden on families, who typically cover a majority of the estimated $56,800 average cost per year to care for a person with Alzheimer's, according to the Alzheimer's Association's Shriver Report. As the baby boomer generation ages, the number of people with the disease is expected to triple to 16 million by 2050. In response, many states have adopted state Alzheimer's plans that include ways to improve early detection, coordinate health care services, set training requirements for health professionals, and support people caring for their relatives. Further, states may ease the economic stress on family caregivers by reimbursing them under Medicaid and covering in-home and community-based services.

Challenges to Accessing Care

Obtaining proper treatment for chronic diseases and other health issues becomes difficult when people lack health insurance. Approximately 19 million women between the ages of 18 and 64 currently are uninsured. A 2008 Kaiser Family Foundation survey found that 56 percent of uninsured women did not receive needed care due to cost, while only 13 percent of women with health insurance cited cost as a barrier to receiving the care that they needed. Kaiser also concludes that women without insurance coverage often receive a lower standard of care and have poorer health than those who have insurance.

Opportunities to Improve Access to Care and Effective Treatment

To address the disparities in insurance coverage for women, states have taken a variety of actions to improve accessibility, including expanding Medicaid eligibility for pregnant women and prohibiting insurance policies that discriminate against women. The ACA has provided new opportunities to build on or expand existing strategies. Many of these opportunities are summarized below.

Expanding Access to Coverage and Care

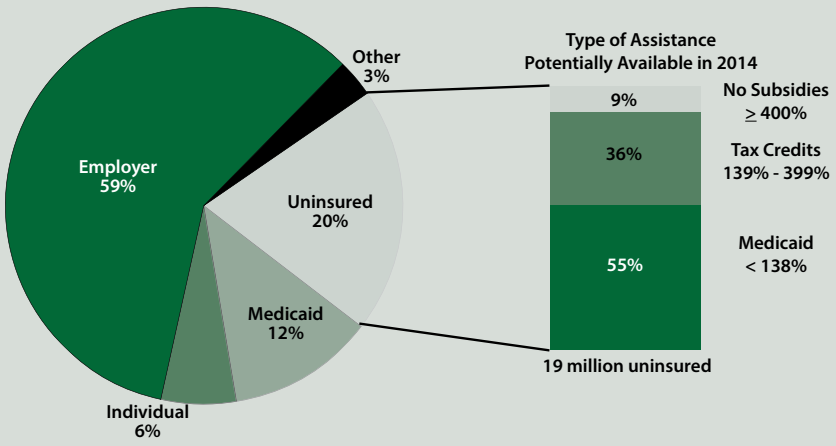
Beginning Jan. 1, 2014, the ACA will expand access to health coverage for millions of Americans, including up to an estimated 10.6 million women, by expanding eligibility for Medicaid under federal law, providing subsidies for private insurance purchase through the health benefit exchanges, and prohibiting denial of coverage based on health conditions. Along with increasing access to coverage, the ACA includes provisions designed to expand the health care workforce to increase the number of providers who are needed to meet the increased demand for services.

Medicaid Expansion. As enacted, the ACA required states to expand Medicaid eligibility to all Americans under age 65 whose family income is at or below 133 percent of the federal poverty guidelines ($31,322 for a family of four in 2013). Using the ACA's formula to calculate income brings the income eligibility level to 138 percent of the poverty level. The June 2012 Supreme Court ruling effectively made the Medicaid expansion optional for states, and the Department of Health and Human Services indicates that states will not face a deadline related to their decision about whether to expand their eligibility levels. Debates about whether to expand Medicaid are occurring in state capitols across the nation and may well continue into future years. Between 2014 and 2016, the federal government will pay 100 percent of the cost of medical care for the newly eligible Medicaid population. The federal share incrementally scales back to 90 percent by 2020 and continues at this level, with states picking up the 10 percent share.

The Kaiser Family Foundation estimates that expanding Medicaid would reach between one-third to more than one-half of currently uninsured women between the ages of 18 and 64, depending on the state. For example, 36 percent of uninsured women in New Hampshire and Vermont and 65 percent of uninsured women in Alabama would gain Medicaid benefits if these states expand their Medicaid eligibility to 133 percent of the federal poverty guidelines.

Assistance for Uninsured Women Under Health Reform

Taken together and fully implemented in all states, the American Health Benefit Exchanges and the Medicaid expansion could cover 13.5 million of the 19 million uninsured women between the ages of 18 and 64.



Other includes programs such as Medicare and military-related coverage.
The federal poverty level for a family of three in 2010 was $18,310.
Source: KFF/Urban Institute analysis of 2011 ASEC Supplement to the Current Population Survey, U.S. Census Bureau; Kaiser Family Foundation, *Focus on Health Reform: Impact of Health Reform on Women's Access to Coverage and Care*, April 2010, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7987-02.pdf.

Health Benefit Exchanges. By January 2014, the ACA requires that states have a fully functional Health Benefit Exchange (whether run by the state, the federal government or as a partnership between them). The exchanges are an online, phone-supported marketplace for consumers to compare and purchase insurance policies or to be screened for eligibility and enroll in Medicaid. The federal government will offer premium assistance on a sliding scale to families with incomes up to 400 percent of the federal poverty guidelines ($94,200 for a family of four in 2013). The proportion of currently uninsured women ages 18 to 64 who will become eligible for federal premium assistance varies, depending on the state; Kaiser estimates rates are as high as 50 percent in New Hampshire and as low as 29 percent in New Mexico.

Private Sector Insurance. Employer-sponsored insurance coverage accounts for the majority (about 57 percent) of coverage for adult, non-elderly women; however, 24 percent of these women are covered as dependents on a spouse's plan, putting their health insurance at risk if their marital status or spouse's job changes. The ACA provides incentives to some employers to start or continue providing health insurance to their employees.

Large employers (those with 50 or more employees) must offer health insurance to full-time employees beginning in 2014. The insurance plans offered must meet minimum essential health benefit requirements. Small firms—those with fewer than 25 full-time employees—can take advantage of the Small Business Health Care Tax Credit to help offset the employer's cost of providing health benefits. To qualify, the employer must pay at least half of the insurance premiums, and the average annual employee wages must be less than $50,000.

More than 1 million young women also may gain access to employer-sponsored coverage through their parent's insurance option to cover dependents. In September 2010, the ACA required insurance plans that already covered policyholder dependents to make this coverage available until adult children reach age 26. Starting in 2015, large employers must offer coverage to child dependents up to age 26.

The ACA also added provisions that allow more people to gain coverage regardless of their health status. Starting in 2014, private insurance plans no longer will be able to deny coverage to people based on pre-existing conditions. Further, in 2014, the practice of charging women higher premiums in the individual insurance market, also known as gender-rating, will be prohibited. Without this prohibition, women have sometimes been charged 10 percent to 50 percent higher premiums than men.

Preventive Services. In 2010, the ACA prohibited copayments or coinsurance for specified preventive services, such as colonoscopies and influenza immunizations. Most relevant to women are the services that new health plans now must cover, including annual well-woman visits; a fuller range of contraceptive education, counseling, methods and services; services for pregnant women, including screening for gestational diabetes and breast-feeding counseling and equipment; improved screening for cervical cancer; counseling for sexually transmitted infections and counseling and screening for HIV; and domestic violence screening and counseling. In addition to new insurance plans, insurance policies that were in effect before the law was signed in March 2010 are subject to the new coverage requirements if they make substantial changes, such as increasing deductibles by more than 15 percent or reducing the share of the premium paid by the employer by more than 5 percentage points.

Essential Health Benefits. The ACA requires all new individual and small group health plans (sold both outside and inside exchanges) to cover a range of services. Essential health benefits include some services that are especially applicable to women, including maternity and newborn care, preventive and wellness services, and chronic disease management. In addition, essential health benefits include ambulatory patient services; emergency services; hospitalization; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices (e.g., to help regain lost functions or to help acquire new functions); laboratory services; and pediatric services, including oral and vision care. Coverage under the Medicaid expansion also must be equivalent to essential health benefits. States will continue to play an important role in determining what additional health insurance benefits must be covered in their states, including health plans that will be sold in the insurance exchanges.

Improving Treatment and Services

As the health care system expands, legislators are exploring a variety of options to restructure payment systems from the current fee-for-service model to models that help contain costs and focus services on preventing disease and maintaining health. The models discussed below are based on finding efficiencies in patient-centered care. More efficient health care also should lead to better health care, as patients receive assistance to manage complex medical conditions and avoid unnecessary costs, such as preventable emergency room visits. Given women's unique health needs, it is important that states keep these needs in mind as they consider larger health system models and changes.

Value-Based Insurance Design. The ACA permits health insurance plans to use value-based insurance design, within HHS guidelines. This strategy designs health benefit plans to rely on a system of incentives and disincentives to promote prevention, maintain health and control costs. Plans align the value of the service with a patient's out-of-pocket cost; for instance, plans may cover a highly effective medication for a chronic condition (e.g., blood pressure or diabetes medications) at low or no cost but have a high copayment for services that are recognized as overused, such as back surgery for pain that could be remedied with a cheaper alternative, such as physical therapy. Public and private plans have incorporated this strategy, with some success, but reliable data on effectiveness are limited.

Medical Homes, Health Homes and Accountable Care Organizations. Research indicates that the medical home model—which focuses on efficiency—helps to improve health care and control costs. The medical home consists of a team of physicians, nurses, nutritionists, pharmacists and social workers to coordinate all aspects of a patient's care. Nearly every state has restructured provider payments to promote medical homes for at least some Medicaid beneficiaries. States also are using the model in pilot programs and state employee health plans.

A similar model, called a Health Home, is a Medicaid option specifically for patients who have several chronic conditions, such as diabetes, heart disease or arthritis; who have one condition and are at risk for a second; or have a serious, persistent mental health condition. This model builds on the medical home's coordinated care approach and also makes providers responsible for wrap-around services, such as comprehensive care management; care coordination and health promotion; transitional care from inpatient settings and follow-up; individual and family support; referral to community and social support services; and health information technology to link services as appropriate.

The ACA contains various provisions that support implementation of the medical home model, including new payment policies, Medicaid demonstrations and creation of Accountable Care Organizations (ACOs). Similar to medical homes, ACOs operate on a larger scale as a medical neighborhood. All providers—from the primary care doctor to the specialist to the hospital—have a financial stake in improving patient health. This model requires significant payment restructuring and can involve more than one payer system.

Medicaid Managed Care. States also are exploring innovative ways Medicaid managed care may help to contain Medicaid costs or at least make them more predictable for states to plan budgets. While 71 percent of Medicaid beneficiaries currently are enrolled in managed care, these contracts account for only 20 percent of Medicaid spending because the most expensive beneficiaries, the elderly and people with disabilities, typically are not included. Some states are expanding Medicaid managed care to include these populations. States also are including performance measures in managed care contracts to both protect quality and contain costs. These measures may include incentives, such as shared savings, for companies that find ways to reduce costs.

Prevention and Wellness

Prevention and wellness initiatives protect and improve health for both the entire community and certain groups. To prevent disease and promote healthy behaviors, policymakers may consider initiatives related to immunizations, nutrition and oral health.

Promoting Healthy Lifestyles

Eating nutritious foods, exercising, maintaining a healthy weight and reducing risky behaviors can help prevent many chronic diseases. States may consider engaging caregivers and parents in efforts to combat childhood obesity. Parents usually determine the types of food available in the home, provide recreational opportunities and promote daily

Immunizations

Immunizations for children and adults are a cost-effective cornerstone of public health. Providers play an important role in educating parents about the availability, safety and importance of vaccines. Recent outbreaks of pertussis—commonly known as whooping cough—across the nation serve as a reminder that vaccines still play an important role in preventing disease. In 2012, CDC received 41,000 reports of pertussis, including 18 deaths (mostly infants younger than 3 months who were too young to be vaccinated). States support immunizations by administering federal vaccine programs; collecting public health data; enacting laws to require vaccinations; ensuring that maternity care practices include vaccines for mothers during pregnancy or immediately postpartum to protect newborns; and amending scope of practice laws to allow pharmacists to administer some immunizations so that they are more readily available to the public. The ACA made recommended vaccines available as a preventive service without cost sharing under insurance plans; it now allows states more flexibility to purchase vaccines under the immunization grant program, known as Section 317.

physical activity. Parents also serve as role models for their children, and their health is closely tied to that of their children.

State policies can influence environmental and economic conditions that encourage families to make healthy choices. Legislators can enact policies that encourage healthy food options in schools, physical activity, and the complex task of making healthy food available in communities. States also are designing communities to make it easier to be physically active by promoting walking and biking trails and ensuring safe routes to school. The federal government has recently made community transformation grants available to select communities in every state. The grants are designed to engage partners from various sectors—such as the education, transportation and business sectors and faith-based organizations—to improve the health of their residents. Some states provide grant programs to localities. A 2012 Robert Wood Johnson Foundation study shows states that take comprehensive action to reduce childhood obesity rates have proven successful.

Some employers also are encouraging healthy lifestyles for their employees. Employer-sponsored health promotion programs—also known as worksite or workplace wellness programs—encourage regular physical activity, stress management, healthy eating and not smoking. Providing ways to change behaviors associated with a higher incidence of chronic disease and disability can lead to healthier employees, lower health care and health insurance costs, reduce absenteeism and increase productivity.

Oral Health

Dental health is an important component of women's overall health. Oral infections, such as tooth decay and gum disease, can affect the entire body. Low-income adults often do not have access to dental care, which may lead to emergency room visits for oral disease. According to the Pew Charitable Trusts, preventable dental conditions were the primary reason for more than 800,000 emergency room visits in 2009. Regular dental care can lead to cost savings for states by reducing the number of oral health problems addressed in hospitals for patients who have no other access to care. Various ACA initiatives exist to increase access to oral health services, including requiring Medicaid and private insurance plans to cover oral health care for children.

Prevention, Pregnancy and Reproductive Health

In addition to public health efforts, pregnancy provides an opportunity to promote women's overall health and establish a strong foundation for children's health. A child's health during the prenatal, infancy and early childhood periods influences his or her health later in life. Promoting healthy behavior before a pregnancy—including strategies such as well-woman visits and taking folic acid—can promote a healthy pregnancy. Efforts also can be made to avoid significant health care costs by reducing pregnancy and delivery complications. According to the March of Dimes, prematurity/low birthweight is the second most expensive condition for inpatient hospital care, requiring an average hospital stay of 26 days. States already are investing significantly, since Medicaid covers approximately 40 percent of births. Abundant data exist to highlight the most effective policies legislators can consider to ensure that mothers give birth to healthy babies and provide them with a strong start.

Prenatal and Maternity Care. Ensuring that women receive prenatal care—regular check-ups with a provider that include screening for conditions such as gestational diabetes or birth defects, monitoring for potential complications, and education to encourage healthy behaviors such as smoking cessation and healthy eating—can reduce the risk of premature delivery, low birthweight and infant mortality. Infants of women who receive late or no prenatal care are twice as likely to have a low birthweight, compared to infants of women who receive prenatal care during the first trimester. A 2004 study by the Wisconsin Department of Health Services showed that the average cost of Medicaid services for the first four years of a very low birthweight baby's life was $61,902, compared to $7,260 for a baby born at normal weight. The ACA requires private insurance policies to include coverage of essential health benefits for maternity and pregnancy care. In addition, the ACA eliminated cost-sharing requirements for tobacco cessation counseling and pharmacotherapy treatments for pregnant Medicaid beneficiaries as of 2010. Substance abuse and mental health treatment services must be available in private insurance plans and Medicaid in 2014. The ACA also included $1.5 billion in grants to states over five years to offer voluntary home visiting services to families with young children to improve outcomes in health, education, child abuse and family well-being. Home visiting programs provide new parents with a range of services by trained professionals, including in-home education and support from pregnancy through the first years of an infant's life.

Teen Pregnancy Prevention. Young women who become pregnant may especially benefit from care and services that ensure they remain healthy. The ACA addresses teen pregnancy prevention through a variety of state grant programs designed to educate adolescents about preventing pregnancy and sexually transmitted infections. The current U.S. teen pregnancy rate is the lowest in 30 years, and research attributes the decline to more responsible behavior by teens—fewer are having sex and those who do use contraception more effectively. Policymakers also can help prevent teen pregnancy through various efforts tailored to specific state needs. Health system partnerships with school districts and community colleges offer promising prevention programs. States and community-based organizations can take advantage of grants to implement teen pregnancy prevention programs through various federal funding streams that can help provide abstinence and/or comprehensive sex education to young people.

Family Planning. According to the Centers for Disease Control and Prevention, roughly half of all pregnancies in the United States are unintended. Family planning services help prevent unplanned pregnancies and help to ensure that children are brought into families that are ready to care for them. Medicaid programs must cover family planning services—such as contraceptives and sexually transmitted infection screening and treatment—and the federal government pays 90 percent of the cost. Through family planning expansion waivers, states have been able to extend services to certain people—including men, women who lose postpartum coverage and those under age 19—who otherwise would not be eligible for Medicaid. The ACA gives states additional flexibility to offer family planning services through an amendment to the state's Medicaid plan, without the need to apply for or renew a waiver.

Looking Forward

As policymakers consider the broad range of health policies in their state, they may want to explore opportunities to improve women's health. Improving access to insurance coverage, preventing and reducing chronic health conditions, and promoting wellness significantly affect the lives of women of all ages. Because women represent the cornerstone of a family's overall health, ensuring they have access to quality care also can lead to improved health for children and families. Many innovative opportunities are available to policymakers to address the unique health challenges women face and to improve the overall health of women in their state.

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