Today's Topics in Health Disparities: What Might Health Reform Mean for Women of Color?
Kaiser Family Foundation
December 16, 2009

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CARA JAMES, Ph.D.: Hello and welcome to the Kaiser Family Foundation's Today's Topics in Health Disparities. I'm Cara James, the Foundation's Senior Policy Analyst on race, ethnicity, and healthcare. Today's Topics is a series of conversations that address issues relating to health and healthcare disparities in the U.S.

Today's topic, What Might Health Reform Mean for Women of Color, comes as Congress is considering two bills that would expand coverage to many uninsured individuals, more than half of whom are people of color. Women of color are more likely to be uninsured, tend to have worse access to care, and often worse health outcomes than their White counterparts.

Our conversation today will address how provisions in the bill might impact all women as well as those that may uniquely impact women of color. We will also discuss the recent recommendations of the U.S. Preventive Services Taskforce and the provisions in the bill regarding abortion. We welcome your questions so feel free to email us. The address is ask@kff.org.

Our panel today includes three distinguished guests whose bios are available on our website. In our studio, we have Alina Salganicoff, Vice President and Director of Women's Health Policy at the Kaiser Family Foundation and Judy Waxman,

Vice President in Health and Reproductive Rights at the National Women's Law Center. Joining us by telephone is Dr. Paula Johnson, Executive Director of the Mary Horrigan Connors Center for Women's Health and Gender Biology and Chief of the Division of Women's Health at the Brigham and Women's Hospital. I want to thank you all for joining us.

Dr. Johnson, I'd like to start with you just to give us a lay of the land to help everyone be on the same page as we're starting this conversation. What are some of the disparities that we see both between women and men as well as between women of color and their White counterparts?

PAULA JOHNSON, M.D., M.P.H.: So Cara, I think it's wonderful that today we're addressing sex differences but also we're putting this in the context of race and ethnicity. Just to begin with women versus men, it's just worth reminding everyone that women and men are different biologically. Every cell has a sex.

So in every aspect of health and disease, women are different. Women also have different social and environmental risks for disease. So for example, from the just differences in disease perspective, women have higher rates of depression, higher rates of autoimmune disease, and then there are disorders or diseases that present differently in women and have different outcomes like cardiovascular disease.

Then some of the social determinants of health are also different between men and women. For example, women have higher rates of poverty during their younger childbearing years and again at ages over the age of 65. So it's very important to look at data stratified by sex for a number of reasons.

So now if you move on to the race and ethnicity piece within sex, we know that amongst women that in all dimensions of health status, access to care, utilization, and looking at the social determinants of health, we know that women of color fair worst in many ways.

Examples are rates of diabetes or obesity, cancer mortality for example and breast cancer, I know we'll be talking about that later, cardiovascular disease for example where African American women fare the worst out of any group. They get the disease earlier and tend to die earlier, higher numbers of women of color living in poverty. So I think those are some of the issues that we face around disparities both between women and men but also within women amongst different women of different race and ethnicities.

CARA JAMES, Ph.D.: Thank you. So as we're moving into health reform, as I said, sort of one of the overarching goals of the health reform bills that we're talking about is to expand coverage to many of the millions of people who are uninsured. How are the bills going to go about doing that?

JUDY WAXMAN, J.D.: They deal with the structures of the bills are very similar however; details differ dramatically as you might imagine. So we don't exactly know what the end product will look like and that's a caveat I'll have to say again and again as we talk about this but I wanted to step back for one minute and say that in addition to the differences between men and women that Dr. Johnson talked about, men and women get health insurance in a very different way.

So we are looking to some changes that will help women in the access to health insurance arena. So for example, while most of us or I should say the majority of us in this country, get health insurance through an employer, women are more likely to get coverage through their husband's employer than their own. So that makes it less stable for them.

So a way for women to get coverage on their own in addition to getting it as a family is a big improvement. Women also are more likely to work part-time. So there needs to be a way to make sure even part-time workers get coverage.

Additionally as already stated, women make less money than men. So the affordability questions, how much the subsidies will be, how easy will it be for women who don't have as much money to actually afford the coverage is a very important issue to look at as well.

So in the general sense, what these bills try to do is make sure everybody can have health insurance. It's done in a variety of ways as I said. Two main features are Medicaid Now, which is the program for low-income Americans, is only available to some low-income people and there will be instead a floor. So everyone who is under a certain income level will have access to that program, will be creating a national floor, which will help many women and many men as well who don't have access to it now.

Additionally, the way I like to think of it is on top of Medicaid will be what the bills are calling an exchange. I like to think of it and excuse the commercial reference but I explain it as something like Travelocity where there will be a variety of companies offering their wares and the individual can go to this exchange, Travelocity like entity, and pick among the plans that are available. They will all have to have approximately the same kind of benefits in varying degrees.

There will be subsidies available up to a certain income level for those folks who will need help buying in the exchange. That's the basic structure. Obviously, it has many more details.

CARA JAMES, Ph.D.: So we're going to take a little bit because I want to pick apart and talk about what are the implications for each of our sort of broadly speaking women and

also women of color as we're going forward with those but to just sort of start with, as you mentioned, there are differences in coverage, as Dr. Johnson mentioned, differences in coverage rates for women of color compared to White women. So right now, what are those differences in terms of coverage variations across groups?

ALINA SALGANICOFF, Ph.D.: Well we know that Latinas, in particular, are much less likely to have insurance coverage much higher rates of uninsurance among the Latino population, African Americans as well, and also Native Americans.

So these are groups that are a special need for assistance both in terms of coverage either through Medicaid or through subsidies. These are also communities that are disproportionately low-income. When we are talking about women, they even fall to the lower parts of the income range so that this assistance will really be critical in promoting access to coverage.

CARA JAMES, Ph.D.: So Judy, you said that the bills will expand coverage to everyone. Is that the case or are there some people who are left out in our coverage expansions?

JUDY WAXMAN, J.D.: Yes. I appreciate that clarification. We talk about it as everyone but certainly it won't be everyone for a variety of reasons but some of the main

groups that are left out are people who are here that are undocumented.

In other words, they do not have correct papers to be here and also even immigrants who have documents who are here under color of law, as it's called; they will have some difficulty as well if they haven't been here five years taking up all of the options. So those are groups we can point to.

We also know that there will be some people who will fall through the cracks. There will be a penalty. So there is in both bills a requirement that, I'll say everyone and you'll know what I mean, sign up for a health plan and there will be a financial penalty if they don't, but the estimates are that not everyone who will be eligible will actually be enrolled.

CARA JAMES, Ph.D.: Alright. So let's take back and you mentioned, we'll start with the exchange. So what are some of the benefits to the exchange for women? Are there any specific caveats in terms of what must be covered or what we can't do anymore?

ALINA SALGANICOFF, Ph.D.: Well they've left the benefit package actually the fine detail has yet to be determined. They speak in very general terms about what the benefits are in terms of coverage of services. Some specific services that are of particularly importance to women are specified.

One is maternity care and that is really to address a major shortcoming that has been identified in the individual insurance market work that actually Judy's group has highlighted the big gap that we have where individual plans actually don't cover maternity care and in fact charge women extra if they want to get a rider so that maternity care is guaranteed.

In addition, there are a series of preventive services that are identified as the services that are recommended from the U.S. Preventive Services Taskforces. We could talk a little more detail later on about those particular recommendations but they're identified as services that must be provided and free of cost sharing so that that's been a particular barrier.

We know actually from research when we're speaking of women of color, around mammography rates. In fact, even minimal cost sharing can serve as a barrier to getting basic screening services. So that would be an important issue.

In addition, we have coverage of hospitalization and drugs and so a lot of the kind of what people think of as basic coverage is generally outlined but it's going to be left to an external advisory committee to basically identify the final benefits.

PAULA JOHNSON, M.D., M.P.H.: Can I jump in here for one second because I do think that this is going to be a particularly important, once the bill is passed, this is going to be a particular important piece of work that will be undertaken that we will need to really keep an eye on in terms of the scope of benefits that are covered according to an insurance exchange and the actual benefits with regard to procedures for prevention like mammography or like other preventative tests that are recommended by the U.S. Preventative Taskforce is going to be important but the other piece that's going to be very important are the cost sharing that is sometimes involved with a preventative visit.

So there's the cost of the test and then there's the cost of the actual visit. These are areas as well that can be a disincentive for low-income women to seek preventative care. If we remember some of the disparities that exist in health and disease, this is an area that is going to be very important to follow up on.

CARA JAMES, Ph.D.: What are, Dr. Johnson, some of the challenges that you see with the women that are coming through your center there?

PAULA JOHNSON, M.D., M.P.H.: In Massachusetts, if you know we, actually let me back up and say that our current two

bills in Congress have a lot in common with what we've done in Massachusetts under Chapter 58.

It's our Massachusetts health care reform, which really focused on expanding coverage with both an employer mandate, an individual mandate, and then similarly as we're talking about it, an insurance exchange and a board that really determines what is covered, who can get in and what is covered in that insurance exchange.

With regard to coverage of benefits, we're pretty fortunate in Massachusetts in that even before reform, we had a number of benefits that I think are particularly important to women, already mandated. So for example, abortion, cervical and breast cancer screening, contraceptive services, and maternity health were already mandated.

So those naturally were brought over to the new insurance products but in addition to that, we have actually worked out a plan where a certain number of preventative visits are not subject to co-pays or deductible, which I think has really been a very positive move as well.

CARA JAMES, Ph.D.: Okay. So I want to keep on the prevention because we did get a question about the prevention for a minute. What, in the bills, is specific to prevention if anything?

JUDY WAXMAN, J.D.: There is a provision in both bills that says that preventive services will be covered with no cost sharing. So that's great. Now the question is what will those services actually be? Both bills now do reference the U.S. Preventive Services Taskforce we've been talking about. Many of the services that they recommend will be included in every package with no cost sharing.

Additionally, there will also be the possibility of another federal agency defining particularly for women, some additional preventive services that may not be included in the taskforce recommendations. For example, well woman visit, which is exactly what Dr. Johnson was referring to. So there is this opportunity really both for children and for women to have additional preventive benefits defined as in the mandatory with no co-pay category.

CARA JAMES, Ph.D.: That was in the Mikulski amendment.

PAULA JOHNSON, M.D., M.P.H.: The other area around prevention that isn't strict health care delivery that is also in different ways in both bills is really the strengthening of the public health system, which is our goal is to not only improve coverage and to improve access to care but to improve the health of populations that cross over between health care delivery and public health will be critically important.

Things like developing investing in our public health infrastructure, community transformation grants, there is a provision for a public health council to really coordinate the nation's approach to public health. These are not specifically women's health but they are going to be very important to the health of women.

ALINA SALGANICOFF, Ph.D.: I agree Paula. I think that that was one of the, I mean it's exciting. It's one of the first times we've actually seen in federal legislation an acknowledgment of recognition that we need to be investing in healthy communities and developing a strategic plan for doing that and doing a lot of experimentation, I mean in a positive way in terms of trying to both look at what works, what doesn't work, and evaluate it so that we have some real evidence to guide our work in that area, our investments.

CARA JAMES, Ph.D.: Along those lines Dr. Johnson, you mentioned in your discussion of the overview of disparities some of these social determinants and when we talk about housing and education and income and things like that, are these also part of the pieces that might be considered in preventive services or are there efforts to work on improving communities and working with schools to improve the situation?

PAULA JOHNSON, M.D., M.P.H.: In the bill actually there is a significant investment in for example, community

health centers. There's some investment, some provision for investment in school-based health centers, which I think really address some of these issues.

So I do think that these bills really do take a different step towards that end as well as really mandating the collection of race and ethnicity data. I think this cannot be underestimated in terms of importance as we are talking about here.

If we know that there are these racial and ethnic disparities within sex, the only way that we can continue to really strategically address them is by getting the right measures with regard to the impact of policy that's implemented and doing kind of looking at the data by sex and then by race, sex groups is going to be critical in us really figuring out the progress that we're making.

CARA JAMES, Ph.D.: Alright. So let's talk a little bit, we've got some coverage. We're still not sure what that coverage is actually going to cover because the benefits still need to be addressed.

ALINA SALGANICOFF, Ph.D.: Fine-tuned.

CARA JAMES, Ph.D.: Fine-tuned, yes, but we have talked now a bit, everybody's mentioned the U.S. taskforce on preventive services, so let's talk a little bit about that. This has been a hot button issue in women's health in the

recent weeks in terms of their recommendations around mammography and PAP smears. First of all, what did they say for those who may have missed it?

JUDY WAXMAN, J.D.: Well the U.S. Preventive Services Taskforce said that as opposed to their old recommendations, they now have new ones for mammography and that is for women under 50 years old. There should not be required routine mammograms. Still if your doctor recommends, you should get one but not an every year thing plus for over 50 years old, women should get mammograms every other year instead of every year.

Both of those recommendations, as I said, are a change from what they said in the past. They put out many statements that said that they just thought that women were being overtested and that the extra testing was causing more harm than good.

CARA JAMES, Ph.D.: Right. So there are a couple of directions I want to go with this because one is we've seen a lot of information coming out lately on disparities and Dr. Johnson mentioned those disparities in cancer deaths, screening rates for women of color. So first following on this piece, given that women of color are more likely to die of breast cancer and cervical cancer than White women and given that we

have these lower screening rates for these groups, what do we tell women of color that they should be doing.

I think Dr. Johnson really looking to you as our sort of residential clinical expert on this, what are you seeing there in your center and what are you telling women as they come through the door there?

PAULA JOHNSON, M.D., M.P.H.: I just do want to clarify just one thing, which is that the actual screening rates are slightly better for certain populations of women of color. There is a little bit of variation but in spite of that, for example if we look as you said, if we look at the mortality rate from breast cancer that for Black women is significantly higher than for White women in spite of a slightly higher screening rate.

So if we step back and look at the guidelines, there's this fuzzy area between 40 and 49 and I think it's worth clarifying a few things. What Judy said is absolutely right in terms of what the taskforce recommended but there's this notion that we can kind of talk with our physician and figure out what's right for each individual person and that potentially mammography is not necessarily the best test for those 40 to 49.

I think we would all agree that mammography is not the ideal test and for sure for younger women, it does actually

lead to more false positives than for older women but it's the best test that we have number one. Number two, there is no doubt that mammography between the ages of 40 and 49 saves lives. It just takes more of them to save a life. You get more false positives when saving a life.

So in my mind, I think that we haven't heard the end of this yet and at this point in time, we are not recommending that women change their practice between the ages of 40 and 49. I don't think the data, at least what I have seen, has not been analyzed rigorously by race. I just don't think we're there yet.

The other piece I just want to also make a statement about is the new guidelines also, new recommendations also stated that teaching breast self-exam was no longer indicated. I want to clarify that as well because what they meant to say was that teaching traditional breast self-exam may not be the best way to know your own breasts and that knowing your own breasts and understanding when there's a new abnormality, which requires a type of exam but maybe not the kind you learn in your doctor's office is absolutely critical to identifying changes that can lead to a diagnosis.

CARA JAMES, Ph.D.: Okay. So bringing this back to the health reform conversation, if we're talking about a scope of

benefits that may be covered, how might these recommendations impact those benefits?

ALINA SALGANICOFF, Ph.D.: Well as a matter of fact, the mammography, there was an amendment to the Mikulski amendment that Senator Vitter introduced that actually says that they should follow the U.S. Preventive Services Taskforce with the exception of this particular most recent recommendation around mammography. It's unfortunate that what happened is that the issue of mammography got tangled up with health reform.

So there was a tremendous amount of confusion, one generally after the recommendations were issued even though the particular committee that reviewed them did not consider cost as a factor right away as we're discussing health reform, a lot of people assumed cost was a factor. We've done, a lot of organizations have done polling. Three quarters of women actually believe that cost was an issue and for women it is an issue in terms of it can be expensive. So that is a consideration. I think that people are worried about that.

I think that around the two issues, the mammography issue then got tangled in with the abortion issue where there are a lot of groups of women that feel that is health reform actually going to be providing benefits that are important to them, concerned that they're not going to get their mammograms

covered and not going to have abortion coverage, which are two reproductive health services that many women believe are critically important so that the whole issue around the mammography came out of miscommunication, misunderstanding, and then the timing was also difficult. Then compounding that, there is a lot of debate among very informed people about whether these are the right recommendations.

CARA JAMES, Ph.D.: So you brought up the other hot button issue of abortion. What do the bills say about abortion?

JUDY WAXMAN, J.D.: Yes. I think I can address that. Both bills have an underlying provision, which some people may have heard is called the CAPS amendment. Basically what it says is if you are part of this exchange and that's what it's addressing, benefits within the exchange then plans will decide whether or not they want to, the insurance companies will decide whether or not they want to have abortion covered in their plan and by the way, most do now.

What happened then is if you are a person who gets a subsidy, so the federal government money subsidy, would be in one pot and then part of the money that you put in yourself, as all of us do, we pay partly our own money towards the premiums a little slice of your own money would go into a separate pot and abortion coverage would be taken out of that.

The reason this set up was put in those bills is so that we can assure that federal money doesn't go for abortions. I mean there's obviously difference of opinion on whether federal money should be used on abortions but it appeared as if that was a sticking point for many members of Congress.

So this way of accounting and making sure no federal money would go for abortion is what was decided as a fair way. Nobody has to buy the plan that has abortion in it but if you want to then buy a plan with abortion covered. No federal funds will pay for it. That's the basic set up in both bills.

What happened, however, was there was an additional amendment that was offered in both houses, passed the House, was defeated in the Senate. That is what people are calling the Stupak amendment named for the Congressman from Michigan. What that particular amendment does is pretty much bar any plans from covering abortions.

We call it a de facto ban because the way it's written, in effect, no plans in the exchange would really be able to offer abortion for any of the women who have subsidies and even for the women who buy plans without subsidies. That amendment, as I say, passed in the House, was defeated in the Senate, and so what remains in the Senate is the CAPS amendment I previously described.

ALINA SALGANICOFF, Ph.D.: Yes and just to be clear, the one thing that they both also say is that abortion will not be part of the essential benefit package. So it's not included. The issue with the Stupak amendment is that the kind of default is no coverage.

If a plan wants to offer abortion coverage, they have to have a wholly separately operated plan that offers the abortion coverage, which would be difficult for insurance companies to operationalize or they could buy a rider. In five states, there are actually bans on coverage, insurance coverage of abortions. These riders really don't exist.

So even though the legislation will be there, there's concern that women are not going to have access to abortion coverage. There is even some have raised issues that this issue perhaps even would have tentacles in the employer-sponsored market right now so that it would affect coverage for women who are currently receiving employer-sponsored coverage. So there's a lot of concern that women are not going to have access to abortion coverage even if they want to buy it.

PAULA JOHNSON, M.D., M.P.H.: The magnitude of the potential impact here with regard to this restriction would be really quite significant. If we think about the almost six million women who are now purchasing their insurance through the individual market, potential impact in the employer market,

and then couple that with the Guttmacher Institute gives us data that about 50-percent of pregnancies amongst American women are unintended.

If we look at disparities in that area, it's about 60 to 70-percent in African American women estimated number and about 55-percent in Latino women and a very significant percentage of those, maybe up to 40-percent or so, are actually terminated in terms of those unintended pregnancies. This is a very significant issue.

I think that we would all agree that better prevention and planned pregnancies, etc. are critical but this is an area where a full scope of reproductive health care services for all women is really just essential and it's essential for women's health.

CARA JAMES, Ph.D.: So one of the things that I know we look at in disparities and also in health coverage in general, access to care. So we've talked a bit about the expansions that are put in place with these bills and what we might hope but let's talk about actual access issues and challenges.

One of the questions that we have that came in is what elements of the bills expand access to primary care providers in underserved areas because we know that having insurance alone doesn't get you in the door.

JUDY WAXMAN, J.D.: Absolutely. One thing and then you can do number two, the thing that pops in my mind right off is that at least in the House bill, the Medicaid program, which is again the program for the lowest income people here in the country has a provision to raise the reimbursement rate for primary care doctors and lots of people say Medicaid is a great program in terms of what it covers and the fact that it doesn't really charge the individual cost sharing.

One of the problems is sometimes it's hard to find the doctor that will actually see you if you are a Medicaid recipient. So raising the reimbursement rate for primary care doctors would be a wonderful improvement to make more primary care doctors available for this population.

ALINA SALGANICOFF, Ph.D.: Yes, I mean I think that the primary care focus is really critical, the Medicaid reimbursement, but in general, I think that we have a recognized shortage of primary care providers. That's not just physicians but also we really need to do a lot of work in terms of building the workforce for nurse practitioners, physicians' assistants as well. This is particularly a problem in underserved communities and communities that are disproportionately high numbers of communities of color where we don't have adequate providers.

So I think that the bills recognize that. There is one commission that's going to be started to look at workforce and look at the distribution. I think that's really important, recognizing that we have a maldistribution right now not only in terms of specialty but where also physicians and other personnel actually reside or practice. I think that the other issue that's really important is in terms of community health centers and investments that we have in terms of additional funds for community health centers.

The network of safety net providers is going to be critical and getting back to the issue that Judy was talking about, about where immigrants and undocumented, I mean these proposals, both of these bills are incremental expansions. There are a lot of people that are going to be left out but those people are still going to have health needs.

I always think back to the whole swine flu issue where we had an epidemic that started in a population that was mostly immigrants, at least in the early stages who didn't have health coverage, who didn't have a primary care provider.

So a lot of those infections were unattended and became very acute. So we have to realize that we live and they talk about the global health, so it's going to be really important that we have a very strong safety net to continue to provide care for these communities.

PAULA JOHNSON, M.D., M.P.H.: Can I jump in with two points? One I do want to get back to the safety net hospital because I think that's another important issue that we can learn a bit from the Massachusetts experience but before that, just talking about primary care, we do have some interesting data from Massachusetts and that we were able to add oh about almost 450,000 people to the insurance roles.

When we look now, data from last year, from 2008 in terms of who was having trouble, really having difficulty getting access to a primary care provider, it's really those who were under 300-percent of the poverty limit, federal poverty limit, and that includes those women and men who had Medicaid just as Judy suggested, and this issue of workforce and incenting workforce is something that these bills will be important in.

We'll probably need to take additional steps in figuring out how to boost primary care providers determine new models of care that include physicians, nurses, and other allied health care professionals but we can see the handwriting on the wall that this will be a very significant problem as are the dearth in some other areas that are very important to women's health.

For example in mental health and also thinking about the cultural competence of the workforce and diversity, these are all issues that are going to be very important.

CARA JAMES, Ph.D.: So Paula, we had actually a question specifically for you on the Massachusetts health reform that was passed there and have you seen disparities reduced as a result of what Massachusetts has done or is it too early to tell?

PAULA JOHNSON, M.D., M.P.H.: It is. We're beginning to see some early data not in terms of health outcomes but obviously in terms of utilization. We've now covered more people. There's been improvement but interesting, in our bill, we do have a Massachusetts Health Disparity Council. With that council, we don't have good data yet but they are in the process of creating a report card.

So over the next year or so, we will be able to really better understand not just issues of access but really begin to get a handle on whether or not we're making an impact on the health of people who have traditionally been without access.

There are also programs, for example, demonstration programs that not only have to do with the Medicare population but also focus on the Medicaid population, for example, improving diabetes care, so really targeted programs that

really focus on quality. We would hope, over the next year or two, we'll begin to really see impact in those areas.

CARA JAMES, Ph.D.: Okay. So before we leave the workforce piece, we've talked about this and this was actually a topic that we did for a previous Today's Topics, was looking at is the health care system ready for health reform but for people who may have missed it, what do we see as the specific ways in which the bills are talking about increasing the workforce?

ALINA SALGANICOFF, Ph.D.: Well I mean you talk about increasing incentives but in addition to that, as I said, changing in terms of both training slots. I think there's loan forgiveness programs as well so that they have incentives that are built into legislation. I think it's in both the House and the Senate, both have those as well. As well, also the other thing is dealing with a cultural competency, which I believe is in the House bill—

PAUL JOHNSON, M.D., M.P.H.: Yes.

ALINA SALGANICOFF, Ph.D.: —Which is a really, really important issue. I think we don't reimburse. We don't do a very good job in terms of training health professionals to really deal with the issues. When you talk about communities of Color, this is really a critical issue.

CARA JAMES, Ph.D.: So, one of the other questions that we had relates specifically to the disparity-specific provisions of the bills and what are they in the bills? Do we have, and you mentioned the cultural competency piece but are there differences between the House and the Senate?

ALINA SALGANICOFF, Ph.D.: Well the other side is the issue that Paula raised, which I think is a really important issue is in terms of requiring data collection, which is in the Senate side. I think you don't have data, you don't know. As a researcher, I can't tell you how many times that really is a barrier. A lot of times, we have data but we don't have enough data to really analyze this. I think that this is a huge issue with gender.

I think it's a huge issue in terms of studying race/ethnicity and when we want to try to understand what are the special issues of women of color, we often fall short because we don't have adequate data to really start to understand this issue.

The issues, we talk broadly about women of color but the issues can be very different both for each of the different communities and within the communities as well. So I think this has potentially great power to allow us to really learn so much more to be much more responsive to the needs.

JUDY WAXMAN, J.D.: Another response to that really is that this bill, while it is a big step forward, is really an incremental step forward. It is a big incremental step forward and not everything is going to be taken care of. We know that.

I mean it is really like Dr. Johnson is saying, it is a major step to covering everyone and to try to deal with a variety of the issues that will rise under this, many demonstration projects, many let's try this or try that, but it's really the first big step. There will be many more steps. So I agree with Alina, data will be crucial for us to know what next steps we have to take.

CARA JAMES, Ph.D.: So one of the, in the data collection pieces that they have on the Senate side is that in addition to race and ethnicity and primary language, we'll collect disability. One of the questions that we have that came in was what, in the health reform proposals, will improve the situation for women with disabilities or is that addressed?

JUDY WAXMAN, J.D.: Well it's really addressed in the broadest sense that again everybody, everybody will be able to have access to a health insurance plan that has a wide range of coverage and we will get to talk about this a little more that is affordable. So that is really something not to be lost in this discussion that that is not the case now for so many people who can't afford it at all or who have disabilities.

Again it will not necessarily take care of every problem but if everyone has basic comprehensive affordable health care, that will be amazing.

ALINA SALGANICOFF, Ph.D.: I think the other issue is around the long-term care assistance, around the class act, which would be a voluntary program to start investing. I mean it's a longer term issue but where people would pay into a fund and get some level of subsidy, support after they turn 65 or after they need, should they need long-term care assistance but I think that it's one of the issues that we talk about often around Medicaid where often the range of services that women or individuals with disabilities need are not covered in a basic insurance plan.

They're often not necessarily health services that they need to live and continue to live in a community independently. This focuses primarily in terms of health care delivery. I think we're moving, as we said, to community health but I think that we still have a lot of work to do in order to provide coverage for the range of services that people with disabilities need.

CARA JAMES, Ph.D.: I mean that's a good point. It also moves us to another issue. I mean a lot of the health reform conversation that's been specific to women has focused primarily on women in their sort of reproductive years. What

are the challenges that we see for women who are post-reproductive years that they have? Well I'll leave it at that to start off with and then ask my question after that.

JUDY WAXMAN, J.D.: Okay. Well a couple of things come to mind. One is that right now, women at 55 to 64 approximately are the age group of women that most do not have coverage because, as you think about it, if the woman's more likely to have coverage through her spouse. Her spouse is a little older typically and he retires and goes on Medicare, she's left with nothing. So again the fact that everyone will have access to some coverage is a great boon to that particular population.

Another issue, which we skipped over and I think is appropriate here is when insurance companies now, for individuals buying insurance and certainly for smaller groups of employees, company that has fewer than say 50 or 100 employees, they're called small groups in this legislation, insurance companies often make their premiums based on a whole variety of issues, certainly past health experience of the group but also the age of the group and the gender of the group.

What this legislation will do is modify the number of various factors insurance companies can use. So for example in the Senate bill at least for organizations that have under 100

employees and for individuals, companies can no longer say we're going to charge more just because you're a woman. We have a campaign called *Being a Woman is Not a Pre-Existing Condition*. That's what that's about. We're trying to say that should be barred in all insurance plans. House goes all the way. The Senate goes part way.

Another big thing though, speaking of older women, is that both the House and the Senate restrict age. They don't do away with age as a factor but they restrict the variation that companies can use. Again Senate up to 100.

CARA JAMES, Ph.D.: To estimating the premium cost?

JUDY WAXMAN, J.D.: To estimating the premium cost. So that means that women that are older and men that are older but certainly if you're older and sicker, you will not have to be paying outrageous premiums or your company will not have to be paying outrageous premiums on your behalf. It'll be spread among all employees. So that is a major improvement really.

ALINA SALGANICOFF, Ph.D.: I think there are two issues. One is the communities of colors are more likely to be working for small employers so that this is also going to have a disproportionate positive impact in terms of the affordability issue but I think also the other issue around the ban on pre-existing conditions and guaranteed issue, older women are more likely to have chronic conditions.

So when you start cutting out coverage for conditions that they need coverage and assistance for, it's not a useful product. So this is going to address some of that major gap. So that's really important.

Then the other issues, there are a lot of Medicare issues and others have discussed that but one of the important things would be eliminating the donut hole for older women who are—yes, that's going to be a really important benefit for older women.

PAULA JOHNSON, M.D., M.P.H.: That's absolutely correct. If we look at the dollars spent or by older women or the proportion of income spent by older women on health care compared with men. This is where there's a significant sex difference and obviously within sex. There's also racial and ethnic differences. So these issues, with regard to not only access but also paying for drugs, etc., are going to be very important to all women.

CARA JAMES, Ph.D.: So as we move forward, this is an incremental step and if by some chance we get it passed, there are going to be some implementation issues that happen. What are some of the big challenges? I think first of all, what type of a timeline are we talking for health reform if the Senate passes this and we get something in February? Does everyone get a card in March?

ALINA SALGANICOFF, Ph.D.: No.

JUDY WAXMAN, J.D.: No, not really. No. There will be a couple of things that will happen right away like there'll be some interim steps to help people that have no coverage with very serious health conditions. So there'll be some things you'll see happen right away but as you can imagine, it's complex. I mean people keep saying why is it 2,000 pages? Well our system is very complex. So building on it will take planning.

The exchanges we have been talking about, first of all, we're not sure yet whether it's going to be one national exchange or it will be state by state exchanges. That's a big open question. Although it's 2,000 pages, it's broad and vague on many issues. So there will be a lot of work to make it operational. It will be a few years until we will start to see the pieces actually fall into place, 2013, 2014, 2015.

So we're talking about three, four, five years until we start to see the Medicaid expansions actually go into effect and then the exchanges go into effect. We really won't all have a card for about four or five years.

CARA JAMES, Ph.D.: What are the big implementation challenges looking forward? I mean you've mentioned now that we could have state exchanges. So state flexibility, how much is that going to play in what's passed?

ALINA SALGANICOFF, Ph.D.: The state issues are sizeable and particularly now, I live in California where we're facing unprecedented shortfall yet again. I mean it's really a huge issue because a lot of the states are really strapped right now.

So they are very concerned that they are not going to have the resources to do what they need in order to implement it. Everything from trying to implement the Medicaid expansions, although most of it is federally financed, part of it will not be and particularly in terms of what their particular responsibilities will be in terms of insurance regulation, setting up the exchanges. So that's an enormous issue.

I think we're going to have a really interesting discussion in terms of implementation around the benefit package. When you talk about issues for women, I think this is going to be critical. There are a lot of, as I said, not a lot is specified issues about family planning, is that going to be covered, this has not been issued. I haven't seen that in the bill yet.

JUDY WAXMAN, J.D.: It's not there.

ALINA SALGANICOFF, Ph.D.: But in terms of specifically what the benefits are and that's what's going to be covered I think is going to be a major issue. Then the issue about the

affordability, are these subsidies going to be adequate. I think that that's, when you look at implementation, we may pass what we have because this is the price tag that we were given but is this going to be an adequate amount to actually help people?

PAULA JOHNSON, M.D., M.P.H.: The cost issue is going to be a very significant one. As we look at our Massachusetts experience, we had a very large, what we called, free care pool, which was contributed to by a combination of the state, private business, and health care institutions. We were able to use that money to help subsidize insurance products in the exchange. I think Alina is absolutely right.

In a time of tremendous economic difficulty, balancing out where the dollars come from and go to in this plan around implementation is going to be critical and also not taking dollars necessarily from infrastructure and programs that help to provide, for example, safety net services as we implement health care reform. It is a very delicate balance and one that is not going to be easy carrying out.

CARA JAMES, Ph.D.: So I thought I would close with our last question that came in from a viewer and a future doctor as a matter of fact. So they wanted to know in addition to the changes, which are up for debate in Congress now, what changes would you most like to see made to our health care system to

improve health for women of color and how would we go about making those changes?

ALINA SALGANICOFF, Ph.D.: Oh, an easy question.

CARA JAMES, Ph.D.: An easy question [laughter].

ALINA SALGANICOFF, Ph.D.: Paula, do you want to take that one?

PAULA JOHNSON, M.D., M.P.H.: That is a good one.

JUDY WAXMAN, J.D.: Well that is a good one. I'll just say what comes to mind is while it's great for everybody to have insurance and for us to have a sufficient number of providers and a wide range of providers available, sometimes groups, particularly vulnerable groups need outreach. They need folks in the community to sort of help them figure out how do they get into these programs, what is the path they would like to follow, where are the providers that they need to go to. They need advice.

I mean we all need advice but particularly sometimes vulnerable populations who are not yet in the system really could use folks on the ground to be outreach people, advisors, a whole network would be really helpful to making the system really work for the folks who need it.

PAULA JOHNSON, M.D., M.P.H.: Can I add in, what I would say is that this iteration of health care reform is about coverage and we all know that coverage is critically important

but it's not adequate. What I would hope is that this begins the conversation, truly begins the conversation about how to achieve new levels of health in our population across the board but particularly for the most vulnerable.

If I were a young person thinking about going into medicine, I would view that as the ability to dream large and really think about what are the interesting new models that not only help to transform delivery but really as I stated earlier, and as we've been talking about, bridge health care delivery and public health with regard to communities because it's really not until we do that that we are going to do things like decrease obesity rates.

Really think about the full range of change that needs to occur. To me, that's what's exciting about this period of time. It's going to be what happens now but what is it open the door for us to do in the future?

CARA JAMES, Ph.D.: I think that's great. That's a good way to end indeed.

JUDY WAXMAN, J.D.: We'll all second that.

ALINA SALGANICOFF, Ph.D.: We'll all be busy for quite a while I'm afraid, in a good way we hope.

CARA JAMES, Ph.D.: Yes, definitely more to come. We will have many more conversations as we go forward. Before we close, I would like to thank Judy Waxman, Dr. Paula Johnson,

and Alina Salganicoff for joining me today. I would like to thank all of you for your questions. On our web page, you will find resources on today's topic that may be useful to you. Again, I'm Cara James of the Kaiser Family Foundation. Thank you.

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.