A report prepared by the
Women's Research and Education Institute

Women's Health Insurance Costs and Experiences

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WOMEN'S HEALTH CARE
COSTS AND EXPERIENCES

A report prepared by the
Women’s Research and Education Institute
Betty Dooley, Executive Director

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WREI

1994
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EXECUTIVE SUMMARY

WOMEN ARE MORE LIKELY to use health care services during their reproductive years than are men. Unfortunately, many health plans fail to adequately cover the preventive and reproductive services women need, leaving them out of the benefit package altogether or requiring copayments and deductibles. Uninsured women have no coverage at all for reproductive and preventive services. The consequence of this inadequate coverage for reproductive and preventive services is that women of childbearing age spend more out-of-pocket for health care services than men spend. Women also spend a larger proportion of their income on health care than men do.

Two areas of frequent health care use for women are reproductive services and preventive services. Annual gynecological examinations, pregnancies, infertility treatments, abortions, and contraceptives all constitute reproductive health needs predominantly or exclusively borne by women. Women are also more likely than men to access the health care system for preventive services, often related to their reproductive needs. The extent to which health insurance covers these services affects women’s out-of-pocket expenditures and often determines whether or not women seek care.

This report focuses on health insurance coverage and expenditures for reproductive and preventive services among women of childbearing age (age 15 to 44). It provides the latest and most comprehensive measures of the adequacy of women’s health insurance coverage for all health care services and for reproductive and preventive health services in particular. Measurements of the adequacy of health insurance coverage used in this report include: 1) the percent of total expenditures covered by health insurance; 2) the level of out-of-pocket expenditures; and 3) out-of-pocket expenditures in relation to income. The key findings of this report are:

**Women of childbearing age are much more likely to use health care services than their male counterparts.**

- Eighty-eight percent of women age 15 to 44 use health care services during the year while 75 percent of men in this age group use health care services.
Women age 15 to 44 are twice as likely as men in their age group to use preventive services, and average expenditures are higher for the women users.

*Out-of-pocket expenditures are higher for women of childbearing age than for their male contemporaries.*

- Women age 15 to 44 pay 68 percent more in out-of-pocket expenditures for health care services than their male counterparts ($573 per woman versus $342 per man).

- Women account for 63 percent of out-of-pocket expenditures for the population age 15 to 44, although only just over half of Americans in that age group are women.

*Women spend a larger proportion of their income on out-of-pocket health expenditures than men.*

- Women account for 7.4 million (69 percent) of the 10.8 million Americans age 15 to 44 who have out-of-pocket health expenditures that exceed 10 percent of their income.

- Almost 5 million *privately insured* women age 15 to 44 have out-of-pocket expenditures in excess of 10 percent of their income.

- Almost 20 percent of uninsured women have out-of-pocket expenditures in excess of 10 percent of their income.

- More than one-fourth of poor women of childbearing age have out-of-pocket health expenditures that exceed 10 percent of their income.

*The coverage of reproductive services is important because these services account for a large portion of women’s health spending.*

- Expenditures for reproductive services for women of reproductive age total $40.7 billion, which is one-third of all health expenditures for women in this age group.

- Reproductive services account for much of the difference in total per capita expenditures between men and women. If reproductive ser-
services are excluded for women, per capita expenditures for women are $1,429 and per capita expenditures for men are $1,272.

- Women with a pregnancy-related hospital stay pay nearly $1,100 out-of-pocket for these hospital stays.

- Women of childbearing age pay 56 percent of the cost of contraceptives out-of-pocket.

**Gaps in insurance coverage of reproductive services discourage women from seeking needed services.**

- Although the 1978 Pregnancy Discrimination Act required coverage of pregnancy by employee group health plans, individual health policies can still exclude pregnancy from coverage.

- Under Medicaid, all states must cover contraceptive services, sterilization, and Norplant devices, but only 12 states assume the cost of all abortions for Medicaid recipients. [The Clinton administration recently decided to require all states to help pay for abortions for low-income women in cases of rape or incest or if needed to save the life of the woman.]

- The Health Insurance Association of America’s survey of private health insurance plans offered by employers in 1990 and 1991 found that 79 percent of plans covered mammograms and 67 percent covered Pap tests—leaving large numbers of women without coverage for these important services.

**Disadvantaged women are less likely to receive preventive care.**

- Sixty percent of women who lack health insurance don’t get preventive services; the majority of women with health insurance do.

- The majority of black women (57%) and Hispanic women (57%) fail to get preventive services; the majority of non-Hispanic white women (55%) do.

- The lower a woman’s income, the less likely she is to get preventive services: 55 percent of women below the poverty line do not receive preventive services.
These findings show that women have a lot to gain from health care reform. President Clinton's Health Security Act would make some major changes in improving women's access to preventive and reproductive services. Universal insurance coverage would mean that no woman would be left wholly responsible for her health care costs. Health insurance coverage, by itself however, is not enough. Women need a comprehensive benefits package that includes reproductive and preventive services with minimal copayments and adequate subsidies for those who have low incomes.
RESULTS

Women of reproductive age are more likely to have health insurance coverage of some type than are men, largely because more women have Medicaid coverage (Table 1). However, women still have higher out-of-pocket health costs than men have. Women are more likely to use health care services, especially reproductive and preventive services, during their reproductive years. Eighty-eight percent of women age 15 to 44, compared to 75 percent of men, used health care services in 1993.

Unfortunately, many health plans fail to adequately cover preventive and reproductive services, leaving them out of the benefit package altogether or requiring copayments and deductibles. As a result, women of reproductive age spend a larger proportion of their income on health care than men spend.

Table 1 - Health insurance status of women and men age 15 to 44, 1993 (estimated).

<table>
<thead>
<tr>
<th>Insurance Status</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent insured</td>
<td>81.8</td>
<td>77.7</td>
</tr>
<tr>
<td>Private insurance</td>
<td>72.7</td>
<td>73.9</td>
</tr>
<tr>
<td>Employer-provided</td>
<td>67.1</td>
<td>67.3</td>
</tr>
<tr>
<td>Other group</td>
<td>0.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Individual</td>
<td>4.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Public insurance</td>
<td>8.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Medicaid</td>
<td>7.7</td>
<td>3.1</td>
</tr>
<tr>
<td>Medicare</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>Percent uninsured</td>
<td>19.0</td>
<td>22.3</td>
</tr>
<tr>
<td>Total percent</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Alternative measures of uninsurance
Uninsured part of year        | 14.9  | 16.9 |
Uninsured all year            | 7.8   | 10.6 |

Note: Insurance status is based on a point-in-time measure. Data from the fourth round of the survey were used. The alternative measures of uninsurance are based on all four rounds of the survey. These estimates reflect changes in the population between 1987 and 1993, but do not account for trends in insurance coverage over the period.

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels; see technical appendix.
While women were 51 percent of the noninstitutionalized population age 15 to 44 in 1993, they paid 63 percent of the out-of-pocket health care expenditures within this group (Figure 1).

**Figure 1** - Out-of-pocket health care expenditures for persons age 15 to 44 by sex.

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels; see technical appendix.

On a per capita basis, women of childbearing age had out-of-pocket expenditures for health care services that were 68 percent higher than men had ($573 compared to $342) (Figure 2).

**Financial impact of higher health care use among women**

The higher use of health care services and higher expenditures among women age 15 to 44 has implications for their financial well-being. Higher proportions of women age 15 to 44 with health care use had high out-of-pocket expenditures for all health care services in 1993: 28 percent of women paid more than $500 out-of-pocket, compared to 16 percent of men. Most important, over twice as many women (7.4 million compared to 3.4 million men) had out-of-pocket expenditures for health care services that exceeded 10 percent of their income (Figure 3).
Figure 2: Per capita health expenditures for persons age 15 to 44 by sex.

![Chart showing health expenditures by sex and insurance coverage]

Figure 3: Persons age 15 to 44 with out-of-pocket health expenditures that exceed 10 percent of income, by type of insurance coverage and sex.

![Bar chart showing out-of-pocket expenses exceeding 10% of income]

Note: Out-of-pocket expenditures as a percent of income were calculated by dividing an individual's out-of-pocket expenditures for health care services during the year by an individual's share of family income. An individual's share of family income was defined as total family income divided by the number of persons in the family.

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels; see technical appendix.
Table 2: Percent of women age 15 to 44 spending more than 10 percent of income for health care services by demographic characteristics, 1993.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Percent with Out-of-Pocket Expenditures Exceeding 10% of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>All women</td>
<td>12.7</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>12.8</td>
</tr>
<tr>
<td>Not married</td>
<td>12.7</td>
</tr>
<tr>
<td>Insurance status(^a)</td>
<td></td>
</tr>
<tr>
<td>Private insurance</td>
<td>11.1</td>
</tr>
<tr>
<td>Medicaid</td>
<td>7.8</td>
</tr>
<tr>
<td>Uninsured</td>
<td>18.4</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>13.1</td>
</tr>
<tr>
<td>Non-Hispanic black and others</td>
<td>10.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>13.5</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>10.8</td>
</tr>
<tr>
<td>Full-time</td>
<td>10.0</td>
</tr>
<tr>
<td>Part-time</td>
<td>16.4</td>
</tr>
<tr>
<td>Not employed</td>
<td>16.0</td>
</tr>
<tr>
<td>Income level(^b)</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>26.3</td>
</tr>
<tr>
<td>Near poor</td>
<td>21.1</td>
</tr>
<tr>
<td>Low income</td>
<td>18.7</td>
</tr>
<tr>
<td>Middle income</td>
<td>12.1</td>
</tr>
<tr>
<td>High income</td>
<td>4.7</td>
</tr>
</tbody>
</table>

\(^a\) Insurance status is based on an individual’s insurance coverage during the fourth round of interviews.

\(^b\) Income levels are based on family income as a percent of the federal poverty level by family size. Poor is income less than 100 percent of the poverty level. Near poor is income between 100 and 124 percent of the poverty level. Low income is income between 125 and 199 percent of the poverty level. Middle income is income between 200 and 399 percent of the poverty level. High income is income of 400 percent of the poverty level or more.

Note: Out-of-pocket expenditures as a percent of income were calculated by taking an individual’s out-of-pocket expenditures for health care services during 1987 divided by an individual’s share of family income. An individual’s share of family income was defined as total family income divided by the number of persons in the family.

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women’s Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels; see technical appendix.
Women of childbearing age have higher out-of-pocket expenditures than their male counterparts, even among those with health insurance coverage. Nearly one out of three women with private health insurance spent more than $500 out-of-pocket for health care services in 1993, while less than two out of five men with private health insurance had this level of expenditures. Over twice as many women age 15 to 44 with private health insurance spent more than 10 percent of their income for out-of-pocket health expenses than men in this age group (4.7 million women compared to 2.3 million men) (Figure 3).

Some groups of women age 15 to 44 are especially vulnerable to high health care costs. Women who are most likely to spend large proportions of their income on health expenditures are poor, uninsured, or work part-time (Table 2 and Figure 4).

Figure 4 - Percent of women age 15 to 44 with out-of-pocket health expenditures that exceed 10 percent of income, by income level.

![Bar chart showing percentage of women with out-of-pocket health expenditures exceeding 10 percent of income by income level, with categories labeled Poor, Near-poor, Low-income, Moderate income, and High income.]

Note: Out-of-pocket expenditures as a percent of income were calculated by dividing an individual’s out-of-pocket expenditures for health care services during the year by an individual’s share of family income. An individual’s share of family income was defined as total family income divided by the number of persons in the family.

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women’s Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels; see technical appendix.
- More than a quarter of women with income below the poverty line had out-of-pocket expenditures in excess of 10 percent of their income.

- Almost 20 percent of uninsured women had out-of-pocket expenditures in excess of 10 percent of their income.

- Sixteen percent of part-time women workers, compared to 10 percent of full-time women workers, had out-of-pocket expenditures in excess of 10 percent of their income.

Reproductive services

One of the primary reasons women age 15 to 44 have higher health care use and expenditures than men in this age group is the extent of reproductive health services they require during their childbearing years. In fact, in 1993, expenditures for reproductive services for women age 15 to 44 totaled $40.7 billion, which is one-third of all health expenditures for women in this age group (Figure 5).

Figure 5 - Expenditures for reproductive services as a proportion of total health expenditures for women age 15 to 44.

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels; see technical appendix.
Reproductive services account for much of the difference in total per capita expenditures between men and women. [Per capita expenditures equal aggregate expenditures divided by the total number of women or men—including both users of health care services and persons who do not use services.]

If spending for reproductive services for women of childbearing age is excluded from the health care spending for this population, the difference in per capita health expenditures for women and men narrows from $2,123 to $1,429 per capita for women, compared to $1,272 per capita for men. The high overall expenditures associated with reproductive services among women of childbearing age resulted in out-of-pocket expenditures for each woman who used reproductive services of approximately $350.

There are many gaps in coverage which discourage women from gaining access to reproductive services. For example:

- The 1978 Pregnancy Discrimination Act required coverage of pregnancy by employee group health policies. However, individual health policies can still exclude pregnancy from coverage or can charge a woman more by claiming that pregnancy is a voluntary condition.

- Some states mandate that private health insurance policies cover some reproductive services. These state mandates, however, do not apply to firms that self-insure nor do they necessarily apply to the Medicaid programs in these states.
  
  -- In 1991, 42 states mandated coverage for mammograms.
  
  -- In 1992, 10 states mandated coverage for infertility treatment.
  
  -- In 1991, 8 states mandated coverage for Pap tests.

- Under Medicaid, family planning services (except abortion) and supplies are mandated for recipients; however, the definition varies from state to state. All states must cover contraceptive services, sterilization, and Norplant devices, but only 12 states assume the cost of all abortions for Medicaid recipients. [The Clinton administration recently decided to require all states to help pay for abortions for
low-income women in cases of rape or incest or if needed to save the life of the woman.)

- Among privately insured women age 15 to 44, 12 percent had private insurance that did not cover maternity care in 1985 because they 1) could not afford the premiums or 2) were non-spouse dependents of a policy holder.  

- The Department of Labor reported that 20 percent of health insurance plans offered by medium and large firms did not provide maternity coverage for dependents except when pregnancy complications arose.

- The Health Insurance Association of America's survey of private health insurance plans offered by employers in 1990 and 1991 found that 79 percent of plans covered mammograms, 28 percent covered in vitro fertilization, and 67 percent covered Pap tests.

- HMOs are more likely than conventional insurance plans to cover reproductive services, but many HMOs did not cover drugs related to fertility treatments (42 percent) or oral contraceptives (21 percent) in 1992.

Reproductive services have been classified into three broad groups for purposes of this report: 1) pregnancy-related; 2) contraception, including induced abortion; and 3) other reproductive services, such as routine gynecological exams, Pap tests, infertility testing and treatments, and treatment for diseases related to a woman's reproductive system (see methodology and technical appendix).

**Pregnancy-related health care services** constituted the largest expenditure portion (60.4 percent) of reproductive services for women of childbearing age, but are required by a small proportion of women each year (approximately 11 percent of all women in this age group and one-third of women using reproductive services). Total health care expenditures for pregnancy-related services averaged $3,906 for users in 1993. Pregnant women paid $623 on average out-of-pocket for pregnancy-related services. Hospital care related to giving birth comprises one of the largest portions of out-of-pocket expendi-
tures for expectant mothers. Women with a pregnancy-related hospital stay paid nearly $1,100 out-of-pocket for these hospital stays.\textsuperscript{12}

Contraceptive services, including induced abortions, are less well covered by insurance than pregnancy-related and other reproductive services. Although the average out-of-pocket payment is small compared to pregnancy-related and other reproductive services, women of childbearing age paid 56 percent of the cost of contraceptives out-of-pocket in 1993.

Other reproductive services constituted approximately one-third of reproductive services expenditures for women of childbearing age. These services had the highest level of coverage from private insurance (62 percent) and women using these services paid an average of $210 out-of-pocket annually for these services in 1993.

Health insurance coverage for reproductive services among women of childbearing age varied by age in 1993. Medicaid covered a larger proportion of expenditures for teenagers and women in their early twenties, while women age 30 and older had much higher percentages of coverage from private health insurance. These differences reflected the economic and social situations of women in these different age categories, the eligibility rules of the Medicaid program, and the types of reproductive services these women received.

Preventive services

Women also use preventive services more than men do and have higher expenditures for these services. Almost twice the percentage of women age 15 to 44 used preventive health care services in 1993 than their male counterparts (52.3 percent of women compared to 26.8 percent of men). The average annual expenditure for preventive care for women who used services in this age group was $333 (Figure 6).

Both men and women pay much higher percentages of preventive care out-of-pocket than they do for non-preventive care. This occurs because preventive care is often not well covered by insurance. Insurance plans may not cover the costs of preventive care because individuals have not yet met their plan's deductible. Unfortunately, the likelihood of out-of-pocket expenditures often serves as a deterrent to seeking preventive care.
Figure 6 - Percent of persons age 15 to 44 who use preventive services, and average expenditures per user of preventive services, by sex.

<table>
<thead>
<tr>
<th>Percent using preventive services</th>
<th>Average expenditures per user for preventive services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women 52.3%</td>
<td>$333</td>
</tr>
<tr>
<td>Men 26.8%</td>
<td>$230</td>
</tr>
</tbody>
</table>

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels; see technical appendix.

The use of preventive health care services varies among women age 15 to 44. Minority women, those without health insurance coverage, and those with lower incomes are less likely to receive preventive care services (Figure 7).

- The majority of black and Hispanic women (57 percent) don't get preventive services; the majority of non-Hispanic white women (55 percent) do.

- Sixty percent of women without health insurance fail to get preventive services, whereas the majority of women with health insurance do get these services.

- The lower a woman's income, the less likely she is to get services: 55 percent of women below the poverty line do not receive preventive services.
Many of these factors overlap, but they suggest that access to care, coverage for preventive services, and the ability to pay for care affect whether a woman receives preventive care.

**Figure 7** - Percent of women age 15 to 44 who do not use preventive services, by insurance coverage, race/ethnicity, and income level.

**PERCENT NOT USING PREVENTIVE SERVICES**

- Covered by insurance: 44.7%
- Not covered by insurance: 60.1%
- All: 47.7%
- Non-Hispanic white: 44.7%
- Non-Hispanic black and others: 56.8%
- Hispanic: 56.5%
- Poor: less than 100% of poverty: 54.6%
- Near poor: 100-124% of poverty: 52.5%
- Low income: 125-199% of poverty: 52.0%
- Middle income: 200-399% of poverty: 47.1%
- High income: 400%/+ of poverty: 43.3%

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels; see technical appendix.
METHODOLOGY

This study relied on data from the 1987 National Medical Expenditure Survey (NMES). These data represent the most recent nationally representative data detailing the health care use and expenditures of Americans. The analysis is based on the Household Survey of NMES, which included questions concerning the use, expenditures, and sources of payment for health care services for the civilian, non-institutionalized population. For each medical event, surveyors recorded the reason for seeking health care services and the expenditures for the service. Sources of payment for services included out-of-pocket payments, private insurance, Medicaid, Medicare, and other third party payers. The survey also asked information about health insurance status.

The NMES data was updated to 1993 levels based on changes in the population, changes in health expenditures, and changes in income levels from 1987 to 1993.

Reproductive services have been classified into three broad groups for purposes of this report: 1) pregnancy-related services; 2) contraceptive services, including induced abortion; and 3) other reproductive services, such as routine gynecological exams, Pap tests, infertility testing and treatments, and diseases related to a woman’s reproductive system. Reproductive services were identified on the basis of 1) diagnoses (ICD-9 codes); 2) self-reported reasons for seeking health care services; 3) brand-name and generic contraceptive and menopausal prescription medications; and 4) procedures (CPT-4 codes at the two-digit level).

Preventive services were identified primarily through the reason for a medical visit, i.e., general check-ups, vision exams, immunizations, maternity care for normal pregnancies, and if no specific diagnoses were indicated for the visit. Preventive services were restricted to medical provider visits and outpatient visits.

A more detailed explanation of the data and definitions used in this report is provided in the Technical Appendix.

CONCLUSION

Women of childbearing age depend upon our health care system. They are more likely to use health care services than men, largely because of their greater need for preventive and reproductive services. Unfortu-
nately, many women lack adequate coverage for these services—either because they are uninsured altogether or because their insurance plans exclude these services or require deductibles and copayments.

The result is that women of childbearing age have higher out-of-pocket costs for health care than men have. In fact, they pay 68 percent more out-of-pocket than men do. When you consider that women's incomes are lower than men's, their health spending looks particularly troublesome: Over twice as many women of childbearing age have out-of-pocket expenditures that exceed 10 percent of their income compared to men in this age group (7.4 million women compared to 3.4 million men). Uninsured and low-income women are especially vulnerable to high out-of-pocket costs.

This look at women's spending for health care services tells only part of the story. The other part is that high health care costs discourage women from receiving needed care in the first place. The data show that the lower a woman's income, the less likely she is to get needed preventive services. In fact, 55 percent of women below the poverty line do not get preventive care.

Women have a lot to gain from health care reform. President Clinton's Health Security Act would make some major changes in improving women's access to preventive and reproductive services. Universal insurance coverage would mean that no woman would be left wholly responsible for her health care costs. Health insurance coverage, by itself however, is not enough. Women need a comprehensive benefits package that includes reproductive and preventive services with minimal copayments and adequate subsidies for those who have low incomes.

The President's Health Security Act takes important steps in this regard as well. Family planning, prenatal care, abortion, and contraceptives are all included in the basic benefits package. The financing of the President's plan has more ambiguous implications for women. Low-income persons would receive subsidies for the purchase of health insurance, but the level of those subsidies may be insufficient for low-income women. If women sign on to managed care plans, no copayments would be required for preventive services, but a copayment would be required for reproductive services.

Health care reform must ensure that costs no longer serve as a deterrent to seeking preventive and reproductive services. Providing subsidies for low-income women to enable them to purchase insurance would solve part of the problem. In addition, copayments should be eliminated for the preventive and reproductive services that women require. Only then will health care reform eliminate the financial barriers that discourage women from receiving the care they need.
ENDNOTES

1. The per capita health spending for men includes reproductive-related services, which are minimal.


7. Ibid.


10. Ibid.


12. Not all women with pregnancy-related health care services during calendar year 1987 had a hospital stay because of the time period covered by the survey. Women who became pregnant after March 1987 would most likely have given birth during 1988.
TECHNICAL APPENDIX

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TECHNICAL APPENDIX

This technical appendix provides a brief description of the data used for the analysis, methods for identification of reproductive and preventive services, definitions used in the analysis, and the methodology for updating 1987 data to 1993 levels.

Data used

This analysis relied on data from the 1987 National Medical Expenditure Survey (NMES). The NMES collected data on health expenditures, as well as demographic and economic characteristics of individuals. This analysis is based on the NMES Household Survey, which represents the civilian non-institutionalized population. The NMES Household Survey included questions concerning the use, expenditures, and sources of payment for health care services. For each medical event, surveyors recorded the reason for seeking health care services and the expenditures for the service. Sources of payment for services included out-of-pocket, private insurance (both employer and individually purchased), Medicaid, Medicare, and other third party payers. The survey also asked information about health insurance status.

This study focused on women age 15 to 44 and their use of and expenditures for health care services. Reproductive services and preventive services were highlighted. Due to the lack of a standard classification for reproductive and preventive services, services were classified on the basis of classification systems used in other studies. Three caveats are offered regarding the classification system used in this study:

- First, some services have been deliberately classified as both reproductive and preventive services. For example, outpatient pregnancy visits have been classified in both categories because these visits are certainly related to reproduction, but also could arguably be considered preventive services to ensure a healthy pregnancy. Because the study does not present any totals for the combination of reproductive and preventive services, this classification...

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1 Other payers include services provided by public clinics, CHAMPUS, the Veteran's Administration, Maternal and Child Block Grants, charity care, and other public and private sources of funding.
tion scheme does not double count either use of or expenditures for these services.

- Second, limitations in the data may affect the classification of services. Diagnoses and procedures are coded based on the responses of survey participants. To the extent a respondent incorrectly reported or failed to report a diagnosis or procedure, the classification used in this report would be biased. We therefore decided to utilize fairly broad categories for classification.

- Finally, the data cannot support the examination of some specific services because of the limited number of observations (e.g., abortions). Also, some specific services could not be identified because of the nature of the service and the classification systems used in the survey. For example, mammograms cannot be identified separately in the data because there is not an ICD-9 diagnosis code for this service and radiological procedures were not coded in detail.

Reproductive services

Reproductive services were classified into three broad groups for purposes of this report: 1) pregnancy-related; 2) contraception, including induced abortion; and 3) other reproductive services, such as routine gynecological exams, Pap tests, infertility testing and treatments, and diseases related to a woman’s reproductive system. We identified reproductive services in the data based on: 1) diagnoses (ICD-9 codes); 2) self-reported reasons for seeking health care services; 3) brand-name and generic contraceptive, menopausal, and fertility prescription medications; and 4) procedures (CPT-4 codes at the two-digit level).

Pregnancy-related services included diagnoses for:

- Ectopic and molar pregnancy (ICD-9 6300-6339);
- Other pregnancy with abortive outcome with the exception of induced abortion (ICD-9 6340-6349 and 6390-6399);
- Complications mainly related to pregnancy (ICD-9 6400-6489);
- Normal delivery and other indicators for care in pregnancy, labor, and delivery (ICD-9 6500-6599);
• Complication mainly in the course of labor and delivery (ICD-9 6600-6699); and

• Complications of the puerperium (ICD-9 6700-6769).

In addition, the following codes\(^2\) included in the ICD-9 classification were used to identify pregnancy-related services:

• Normal pregnancy (V22);

• Supervision of high risk pregnancy (V23);

• Postpartum care and examination (V24);

• Outcome of delivery (V27); and

• Pregnancy exam or test (V72.4).

Finally, we included obstetrical procedures identified by the National Health Interview Survey (NHIS) classification of operations and non-operative procedures (codes 72-75) in this category:

• Forceps, vacuum, and breech delivery (72);

• Other procedures inducing or assisting delivery (73);

• Cesarean section and removal of fetus (74); and

• Other obstetric operations (includes normal delivery) (75).

**Contraceptive services** included diagnoses for induced abortion (ICD-9 6350-6389) and V codes for:

• Encounter for contraceptive management (V25); and

• Presence of intrauterine contraceptive device (V72.4).

In addition, expenditures for the prescribed contraceptives in Table 1 were included in this category. It should be noted that the vast majori-

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\(^2\) V codes are "supplementary classification of factors influencing health status and contact with health services."
ty of expenditures in this category of contraceptive services were for prescribed contraceptives.

Other reproductive services included diagnoses for:

- Syphilis and other venereal diseases (ICD-9 900-999);
- Malignant neoplasm of female reproductive organs (ICD-9 1790-1849);
- Disorders of breast (ICD-9 6100-6119);
- Inflammatory disease of female pelvic organs (ICD-9 6140-6169);
- Other disorders of female genital tract (ICD-9 6170-6299).

In addition, the following V codes were used to identify other reproductive services:

- Venereal diseases (V1.6);
- Gonorrhea (V2.7);
- Other venereal diseases (V2.9);
- Procreative management (V26);
- Antenatal screening (V28);
- Gynecological exam (V72.3);
- Examination for venereal disease (V74.5);
- Screening for breast malignant neoplasms (V76.1); and
- Routine cervical Papanicolaou smear (V76.2)

Also included in this category were operations on the female genital organs identified by the National Health Interview Survey (NHIS) classification of operations and non-operative procedures (codes 65-71):
- Operations on ovary (65);
- Operations on fallopian tubes (66);
- Operations on cervix (67);
- Other incision and excision of uterus (68);
- Other operations on uterus and supporting structures (69);
- Operations on vagina and cul-de-sac (70); and
- Operations on vulva and perineum (71).

Finally, expenditures for prescribed menopausal and fertility therapies shown in Table 2 were included in the other reproductive services category.

Preventive services

We identified preventive services primarily through the reason for a medical visit, i.e., general check-ups, vision exams, immunizations, maternity care for normal pregnancies, and if no specific diagnoses were indicated for the visit. We restricted preventive services to medical provider visits and outpatient visits. Outpatient maternity care for normal pregnancies was included as both a reproductive and preventive service. Due to the self-reported nature of the data, it appears that most routine gynecological examinations have been classified as preventive services because very few were specifically identified through the V72.3 code under other reproductive services.

Definitions

Income levels are based on family income as a percent of the federal poverty level by family size. The poor include persons with income less than 100 percent of the poverty level. The near poor are defined as those with income between 100 and 124 percent of the poverty level. Low income persons are defined as those with income between 125 and 199 percent of the poverty level. Middle income persons are those with income between 200 and 399 percent of the
poverty level. High income persons have income of 400 percent of the poverty level or more.

Out-of-pocket expenditures as a percent of income are calculated by taking an individual’s out-of-pocket expenditures for health care services during the year divided by that individual’s share of family income. An individual’s share of family income was defined as total family income divided by the total number of persons in the family (including children).

Insurance status is based on whether an individual received coverage from a particular source or was uninsured during the fourth round of interviews. Insurance coverage for 1993 is based on population changes from 1987 to 1993. The estimates do not incorporate trends in insurance coverage over the period.

Inflating expenditures from 1987 to 1993

The 1987 data from the NMES were updated to 1993 levels based on changes in per capita health expenditures from 1987 to 1993 as reported by the Health Care Financing Administration Office of National Health Statistics. The population data were also adjusted from 1987 levels to 1993 using changes by age and sex based on data from the Bureau of the Census. Finally, income levels were adjusted from 1987 to 1993 based on the change in real wages over the period. These adjustments allow for a more realistic picture of current expenditures for health care services in a broad sense, but do not account for more subtle changes over the period. For example, to the extent that coverage for reproductive or preventive services changed from 1987 to 1993, the adjustments described above would not account for these changes.

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### TABLE 1
PRESCRIBED CONTRACEPTIVES USED IN THE ANALYSIS

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnodiol Diacetate</td>
<td>Brevicon</td>
</tr>
<tr>
<td>Estradiol</td>
<td>Contraceptive Agent</td>
</tr>
<tr>
<td>Medroxyprogesterone</td>
<td>Demulen</td>
</tr>
<tr>
<td>Nonoxynol</td>
<td>Demulen-28</td>
</tr>
<tr>
<td>Norgestrel</td>
<td>Depo-Provera</td>
</tr>
<tr>
<td></td>
<td>Estradiol</td>
</tr>
<tr>
<td></td>
<td>Levlen</td>
</tr>
<tr>
<td></td>
<td>Loestrin</td>
</tr>
<tr>
<td></td>
<td>Lo/Orval</td>
</tr>
<tr>
<td></td>
<td>Micronor</td>
</tr>
<tr>
<td></td>
<td>Modicon</td>
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<tr>
<td></td>
<td>Nordette</td>
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<tr>
<td></td>
<td>Norinyl</td>
</tr>
<tr>
<td></td>
<td>Norlestrin</td>
</tr>
<tr>
<td></td>
<td>Ortho-creme</td>
</tr>
<tr>
<td></td>
<td>Ortho-novum</td>
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<tr>
<td></td>
<td>Ovcon</td>
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<td>Ovral</td>
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<tr>
<td></td>
<td>Ovrette</td>
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<tr>
<td></td>
<td>Ovulen</td>
</tr>
<tr>
<td></td>
<td>Tri-Levlen</td>
</tr>
<tr>
<td></td>
<td>Tri-Norinyl</td>
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# TABLE 2
PREScribed fertiLITY AND Menopausal TherAPIes 
used in the analysis

<table>
<thead>
<tr>
<th>Fertility</th>
<th>Generic</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Bromocriptine</td>
<td>Chorex</td>
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<tr>
<td></td>
<td>Chorionic Gonadotropin</td>
<td>Metrodin</td>
</tr>
<tr>
<td></td>
<td>Clomiphene</td>
<td>Parlodol</td>
</tr>
<tr>
<td></td>
<td>Menotropins</td>
<td>Pregnyl</td>
</tr>
<tr>
<td></td>
<td>Mestranol</td>
<td>Pergonal</td>
</tr>
<tr>
<td></td>
<td>Urofollitropin</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Menopausal</th>
<th>Generic</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chlorotrianesene</td>
<td>Amen</td>
</tr>
<tr>
<td></td>
<td>Estrogens</td>
<td>Conjugated Estrogens</td>
</tr>
<tr>
<td></td>
<td>Estrone</td>
<td>Curretab</td>
</tr>
<tr>
<td></td>
<td>Estropipate</td>
<td>Delestrogen</td>
</tr>
<tr>
<td></td>
<td>Progesterone</td>
<td>Depo-Estradiol</td>
</tr>
<tr>
<td></td>
<td>Quinestrol</td>
<td>Depogen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Estinyl</td>
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<tr>
<td></td>
<td></td>
<td>Estrance</td>
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<tr>
<td></td>
<td></td>
<td>Estraderm</td>
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<td></td>
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<td>Estrovis</td>
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<td>Ogen</td>
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<tr>
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<td>Premarin</td>
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<td></td>
<td></td>
<td>Premarin Vaginal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Premarin w/ Methyltestosteron</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Próvera</td>
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<tr>
<td></td>
<td></td>
<td>Tace</td>
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