Insurance Barriers, Gendering, and Access: Interviews with Central North Carolinian Women About Their Health Care Experiences

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ABSTRACT

Background: Women face unique logistical and financial barriers to health care access. They also have higher health care expenditures and higher rates of morbidity. Women’s experiences while utilizing health care are historically less well researched and warrant exploration.

Methods: We conducted 14 semistructured interviews about women’s health care experiences with 11 women health consumers and 3 women health care practitioners in central North Carolina.

Results: When discussing their experiences, participants noted scheduling challenges, barriers related to insurance and cost, and dismissive or negative in-person encounters. Participants frequently discussed lack of resources for care postpartum. Practitioners noted lack of knowledge of disease burden, over-medicalization of women’s care, lack of care postpartum, and trends around changes in primary care. Women health consumers in this study faced challenges related to access and in-person experience of care delivery, which were echoed by the clinician interviewees. Barriers to optimal women’s health care exist even for those with insurance coverage and point to systemwide constraints as well as deficits in organizational culture.

Conclusion: Future clinical and research efforts should include 1) increasing awareness of and facilitating access to affordable postpartum care, 2) easing burdens around scheduling appointments and improved care coordination, and 3) more research exploring women’s experiences during in-person health care encounters. Concerns and barriers that women described may be due to systems-level requirements and constraints.

INTRODUCTION

Women face unique obstacles when seeking health care, including logistical barriers, often due to women’s roles as caregivers, and financial barriers, as women on average earn less than men.1,2 In 2010, women on average spent $7860 per capita on health care costs compared to $6313 per capita for men.3 Many of the differences in health expenditures are attributed to women’s longer life expectancy, increased morbidity, and health costs related to maternity care and menopause.4,6 Women utilize preventative care at substantially higher rates than men, with one 2005 US study finding that women on average had a preventative care visit rate of 74.4 visits per 100 persons compared to 44.8 per 100 persons for men.6

While women in the US have longer life expectancies than men (81.1 compared to 76.3 years9), women face higher rates of chronic illness and morbidity.10-14 In 2015, 38% of women suffered from 1 or more chronic illnesses compared to 30% of men.11 Women are more likely to experience depression and anxiety12 and report higher rates of chronic stress and minor daily stress.13 Women are also more likely to experience domestic, physical, and sexual violence, which can lead to adverse mental and physical health.15

There are well-documented gender discrepancies in health care costs and insurance coverage. Prior to the 2010 implementation of the Affordable Care Act, women were estimated to be paying between 50% and 80% more for monthly premiums than men on the individual market.16,17 Despite the Affordable Care Act’s 2017 mandate that preventative care services be included at no cost, many women with insurance reported paying out of pocket for critical preventative screening examinations, including pap smears (20%), mammograms (13%), and colonoscopies (7%).1

Although previous research has identified gendered differences in health care and health outcomes, less is known about women’s experiences and feelings about their interactions with the health system. Research specifically examining women’s experiences has focused on narrow subsets of women, such as lesbian women in rural settings,18 lesbian women becoming mothers,19 Somali immigrant women,20 deaf women,21 and women who have experienced intimate partner violence.22

While research on gender discrepancies exists, there is less qualitative research on women’s experiences, especially outside of narrow subgroups of women. This study provides exploratory research to help address the gap in qualitative analysis around how women experience health care encounters, approach their general health care, and advocate for their health care needs and to gain understanding into barriers that keep women from receiving optimal care.

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METHODS

Recruitment Method for Women Participants

Following Duke University Institutional Review Board approval, participants were recruited using convenience and snowball sampling methods in Durham, Wake, and Orange counties of central North Carolina. Snowball sampling is a recruitment method in which participants are asked to identify other potential participants within their network.23 The research team made contact via phone or email after confirming participants’ interest and willingness to participate. Participants completed a phone screening to confirm they met the following study inclusion criteria: ability to complete a one-time interview in English, willingness to be audio recorded, age 18 years or older, self-identified as a woman, and residing in Durham, Wake, or Orange counties. Upon completion of the interview, participants received an electronic $15 gift card to honor their time. A total of 11 women were screened; all 11 women were interviewed.

Recruitment Method for Practitioners

Practitioners were identified through colleagues and internet searches and were contacted directly via email with institutional review board approval. Six practitioners were contacted; 3 were interviewed. Practitioners did not receive compensation.

Data Collection

Participants engaged in an initial phone screening, an informed consent, a demographic survey, and an hour-long, in-person audio-recorded interview. The semistructured interview guide was designed by the research team through an iterative process, based on previous research, and included questions pertaining to the following: daily stress, recent health care experiences, advocacy, social and support networks, motherhood, health care during and after pregnancy, preventative care experiences, and health care utilization.

The research activities were similar for the 3 practitioners, except that the practitioners only completed an informed consent and semistructured interview. An audio recording was taken for only 1 of the 3 interviews due to background noise in some of the available interview locations. The semistructured interview was designed to obtain practitioners’ perspectives on questions asked of the participants and covered opinions on women’s health care, gender discrimination, postpartum care, and insurance practices.

Data Analysis

Data were analyzed using a 2-coder, descriptive content analysis with an inductive approach24 relying on what the participants discussed and not using a priori themes. Analysis began early, with the first interview. The study team discontinued the data collection once thematic saturation was reached and no further new ideas were being seen in the data. Audio recordings were transcribed verbatim using the Temi audio transcription service (www.temi.com, 2019). NVivo 12 Pro software (QSR International Pty Ltd., 2018) was used to manage the transcription data and to develop codes to segment participants’ narratives into conceptual categories (eg, all text describing a similar concept). Content-driven emergent codes were identified and applied to the text for each of the conceptual categories (eg, potential themes related to responsibilities as caregivers). Three interview transcriptions were randomly selected and the 2 coders separately identified themes. After reconciling on emergent themes, researchers separately coded the next 3 interviews. Application of coding was then discussed for those 3 interviews.

Discrepancies in coding were resolved through iterative discussions between researchers. The initial 3 transcripts used to identify themes were recoded, and the codebook was revised accordingly. Coding was then completed on the remaining 8 transcripts. Code frequencies were examined across transcripts to identify salient factors for participants. For example, when coding for content around exploration of gender, coders looked for explicit mentions of participants’ gender affecting their care, mentions of health concerns that mainly affect women such as birth control or pregnancy, and mentions of caregiver duties affecting care or access. To conclude analysis, illustrative quotations were taken and used to demonstrate common themes. Women’s thoughts were reconciled with the perspectives given by the 3 practitioners interviewed.

Since there were only 3 practitioner interviews, content analysis was more simplistic. One open-ended question was asked exploring each of the following: observed gendering in care delivery (defined as treatment specific to stereotypical gender norms25), women as caregivers and that impact on their health, observed stressors for women, gender rating by insurance providers, and observed barriers to care for women.

RESULTS

Table 1 presents participants’ demographic characteristics. Of the 11 women interviewed, 7 had a master’s degree or higher. The 4 other women had a bachelor’s degree. The educational attainment for the study sample is higher than the average for the tricounty area from which the sample was drawn, in which 26% of the population has a bachelor’s degree or higher and 17% has some postcollege education.26 With an average age of 34 years (range, 25–52), the women interviewed were slightly younger than the average age of 37 years for the tricounty area. All of the women had
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<th>Theme 1: Barriers to an Optimal Clinical Encounter</th>
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| *Indicates the percentage who mentioned this theme among mothers. |

insurance. Insurance providers included Blue Cross Blue Shield, United HealthCare, Tricare, and Aetna. Two women had Medicaid or pregnancy Medicaid. Most women had a regular care practitioner (63%) and about half of the women interviewed had been pregnant and are mothers (45%). The 3 practitioners were all women physicians, including 2 current medical residents. While all 3 practitioners are internists, 2 practice primary care while 1 plans to focus medically on women’s issues. All 3 practitioners have large segments of their patient panels who use Medicaid.

Salient themes that emerged across the participant interviews (Table 2) can be separated into the following categories: barriers to an optimal clinical encounter, care postpartum, and exploration of gender.

Theme 1: Barriers to an Optimal Clinical Encounter

In response to questions around a recent health care experience, a time they had to advocate regarding their care, and a time they had delayed seeking care, every woman interviewed discussed barriers to either accessing care or receiving care that left them feeling upset or frustrated. Barriers can be further segmented into 3 categories: scheduling difficulties, insurance barriers and costs, and frustrating or dismissive in-person encounters.

Scheduling Logistics

The scheduling process, including general logistics, practitioner turnover, and timing due to insurance restrictions, was mentioned as a barrier by 73% of participants. Difficulties and confusion around scheduling resulted in switching practitioners, delays in seeking care, decreased engagement in preventative care, or forgoing care altogether.

The few [small] attempts I’ve made have been just a little frustrating trying to find someone that accepts new patients with my health insurance. I live in Durham, work in Raleigh, so trying to figure out where I should go… And so, I just haven’t found a general practitioner. Like when I’ve tried before, I don’t know if I was making the right choice and then I was getting conflicting information from what I saw online. (Patient in late 20s)

Insurance/Cost Barriers

Insurance barriers and costs were mentioned by 91% of the participants. Insurance costs affected medication choices and resulted in delays in seeking necessarily or recommended care.

I had birth control. I used [contraception ring] … I had been using it and then at a certain point it no longer allows you to pick it up at your local pharmacist, … you had to do it through mail. However, because I travel so much for work, the [contraception ring] has to be refrigerated, so it would be dropped off at my door. And if I am on a trip for 3 days or something, it spoils after 24 hours. So, it kept being sent to my door when I was away despite me telling them that I was not able to have this service. If it was at a pharmacist, it would have cost $175. If it had been sent to my house it would be free, but that just wasn’t an option. So, I ended up just going off [contraception ring] because of the stress… [It] probably took me like 5 to 10 phone calls between my provider, [pharmacy], and my insurance provider … a huge pain. (Patient in mid-20s)

What’s a barrier now, particularly with arthritis. This is hard because physical therapy they don’t cover very much. And so that really would be what they would recommend as kind of my long term … go into physical therapy. And you know, the copays, they’re horrible. They’re over $50 and they want you to go 2 or 3 times a week. (Patient in early 50s)

Dismissive or Negative In-Person Encounters

Most women (73%) mentioned in-person encounters where they felt dismissed or unheard. These negative encounters

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<th>Table 1. Characteristics of women participants (n = 11)</th>
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resulted in diminished patient trust, caused patients to switch practitioners, and affected some women’s overall interaction with the health care system.

… And while we were there, I had an additional lump [breast] that I wanted to be checked out and one of the doctors just said like, “Oh, it’s probably because you bumped yourself.” And I was like, I never had that happen before…. The supervising doctor came in and I decided to ask again and asked if I could also get another lump [breast] x-rayed … but it was like mental gymnastics to ask a third time to get that checked out. (Patient in late 20s)

… When I was in grad school I didn’t have a primary care physician and I was like I have insurance why don’t I go see a doctor and have a wellness check, get my cholesterol checked … and I felt like the guy was so patronizing and he’s like, “You do triathlons? That’s really unhealthy for your body.” And I was like what are you talking about? Like I’m doing the just above the minimum recommendations. You don’t know who I am. (Patient in early 30s)

Theme 2: Care Postpartum

For the 5 participants who are mothers, when asked about their health throughout pregnancy and their approach to health since becoming a mother, 80% mentioned frustrations and developed the care they received postpartum. This included not feeling taken seriously by medical practitioners, difficulty in accessing care with an infant, and being unsure of symptoms of common health concerns postpartum.

I think the pediatricians were always more like, let’s make sure that the girl’s healthy and as long as she’s [baby] healthy, let’s help mom focus on that. But not really ask what else is going on with mom. (Patient in early 30s)

I was seeing a physical therapist for pelvic floor issues and she actually just left the [health care system] … so now I had to get re-established with someone else…. That’s going to fall to the bottom of my list because I just don’t have that luxury of dropping him off at daycare or depending on a sister or someone that could come over and watch him. And it’s just, it’s just going to fall to the bottom. I mean, you feel like you’re going to the spa just to get your basic medical care needs. (Patient in early 30s)

Theme 3: Exploration of Gender

This category captures general impressions and aspects of care that feel inherently gendered. Responses in this category came from questions around a recent health care experience (within the past year), a time they had been concerned about their health, a time they had to advocate regarding their care, and if they ever felt they were treated differently because of their gender. These instances captured women’s feelings regarding poor practitioner rapport when dealing with typically female health issues and instances where women felt patronized or unheard in appointments. Every woman interviewed had experiences that fit into this category.

So when the endocrinologist was like, this is something that we see really frequently in women and not so much in men and we’re not really sure why, that makes me think like, well a lack of investment in researching medical conditions that affect women more than men, which is just like a frustrating part of the patriarchy, but even more insidious is … is it because it’s like on the throat and there’s generations of [a] pattern of women’s voices not being heard in the world. And so, there’s literally a big obstruction growing around my throat for no reason as like inherited trauma. (Patient in early 30s)

I already felt dumb as a 23-year-old asking for birth control for the first time. I’m kind of covering up my reasons why I hadn’t gotten it before. And then just to be told like, “No, why are you even asking us about that?” Like that was the tone I was getting…. I didn’t know if it’s because I am a woman or because I was asking dumb questions or maybe I wasn’t asking dumb questions…. But I felt like this didn’t make me feel good and I want to be free to ask these questions and it’s not my fault that I don’t know these things. And so, I don’t want to be made to feel dumb. Even if a lot of it is me projecting, I can find someone who can explain things nicer. (Patient in late 20s)

I think people are very quick to dismiss women of a certain age as, oh, hey, you’re just premenopausal. You’re getting fat. You’re not, you know 22, and, or they assume that you’re eating poorly, you know, as opposed to your body is just not metabolizing properly. (Patient in early 40s)

Practitioner Perspectives

Reported practitioner perspectives are based on notes from in-depth interviews. Practitioner discussions centered around knowledge of disease burden, medicalization and coordination of women’s care, lack of care postpartum, and trends in primary care. All 3 practitioners interviewed for this study had large panels of Medicaid patients, which may not be representative and may affect their perspectives.

Knowledge of Disease Burden

Two practitioners noted that cardiovascular disease is the number 1 killer of women in America, yet cardiovascular disease is not discussed as much in the general women’s population. Focus often centers around issues that on the surface seem more specific to women, like breast cancer. This is an example of a knowledge gap between the general population of women and what practitioners consider major issues.

Knowledge also pertains to where we prioritize training and research. One practitioner noted the lack of training when talking to women about domestic violence or sexual
assault. She specifically mentioned feeling there is a lack of clear protocol for next steps should a woman present with that type of trauma.

**Medicalization and Coordination of Women’s Care**

Two practitioners discussed how women inherently have more contact with the health system compared to men, mainly due to contraceptive and reproductive health from a young age. Women are also subject to more frequent preventative screenings. Practitioners discussed how increased contact can be positive as it frequently brings women in for care, but they emphasized that increased contact can also burden patients. For example, contraceptive needs, such as an intrauterine device, require separate appointments or a visit with a subspecialist, which logistically can be challenging and often a more expensive copay. Practitioners emphasized that if we are going to ask more of patients (another appointment and copay), we need to make the logistics of coordinating this separate visit easier on patients.

**Care Postpartum**

While 2 practitioners noted concerns over care postpartum, 1 practitioner discussed how she feels that as a system we care about women only up until they have children. Another echoed these sentiments, discussing how she feels opportunities and resources for prenatal care are abundant but that care for mothers diminishes once the baby is born.

**Primary Care**

Practitioners discussed some noticeable trends in primary care and wellness visits. First, practitioners noted that more women are utilizing obstetrics and gynecology as their primary care. One practitioner noted that for young, healthy women with few risk factors, seeing an OB/GYN as their primary care practitioner is fine, but it is possible that other concerns, like hypertension or diabetes management, can go without sufficient treatment if women replace primary care altogether. Practitioners also discussed the increased system burden in wellness visits, citing increased documentation as the main culprit. One practitioner indicated that thorough documentation is currently both the best and worst thing about care.

**Overlap Between Women Practitioners and Women Participants**

Many concepts addressed during practitioner interviews overlapped with themes from participant interviews. Ideas discussed by practitioners around how women substitute reproductive check-ins for primary care and how women’s care is inherently medicalized due to reproductive health serve as an example. Most participants were taking birth control and checked in with some type of medical practitioner regularly to ensure continued access and reproductive health. For the most part, the check-ins described by participants were not traditional primary care visits and were solely for continued reproductive health questions, highlighting concerns addressed by practitioners around how women interact with the medical system frequently but not optimally.

Participants also echoed what was discussed by practitioners regarding insufficient postpartum care and the need for better care coordination. When discussing postpartum care, participants noted feeling dismissed when bringing up concerns in encounters or they had issues accessing care altogether mainly due to their new roles as mothers. The feelings of dismissal and difficulties with access noted by participants may point to larger systems issues and highlight the importance of care coordination. When access is difficult, and time is a barrier, it may be difficult for patients to seek out the best type of practitioner for their specific needs. This idea is captured well in the example of when a new mother was in a pediatric appointment and felt dismissed when she brought up her struggles adapting to motherhood. The pediatrician probably did not have the expertise to deal with the mother’s issues, which is possibly why she said they should focus on the child in that encounter. Recognizing in that type of encounter that the mother needs a referral to a different type of practitioner takes increased care coordination and improvement in transitions of care, which can be difficult to implement.

More broadly, participants also reported feeling rushed and dismissed in appointments, which relates to concerns noted by practitioners around increased demands in wellness visits. One participant specifically noted feeling like their practitioner was going through a checklist in their visit and that if her concern did not fit nicely into one of the checkboxes, then it was not addressed or considered important. This example demonstrates how the burden on practitioners for increased screening and documentation is being passed down to patients, affecting the care they receive and their comfort with practitioners.

**DISCUSSION**

This study sought to broaden our understanding around women’s experiences with health care. Specifically, this study examined how women experience in-person health care encounters, their overall approach to health care, how they advocate around health care needs, and barriers that exist for women to receive optimal care. Additionally, this study captures impressions of care that feel inherently gendered.27-29

Although the women in this study had insurance and higher education levels, they still had trouble navigating scheduling logistics, had stories of feeling dismissed, and were not always receiving optimal care. While prior research highlights the need for increased cultural competency for vulnerable subgroups of women, 18-22 this study demonstrates the need for an improved approach for treating all women.
Adaptation of practitioners’ approach to in-person encounters is needed. Themes addressed by participants around feeling dismissed or unheard could be rectified in part by increasing visit lengths. Encouraging longer in-person appointments fits into current shifts in health care reform away from fee-for-service models and toward value-based payment reform.

It will also be important to continue work to decrease burdens around scheduling and logistics. In recent years, the health system has worked to be more adaptive and user-friendly, with initiatives around patient-centered primary care involving more flexibility and transparency for patients. Results from this study suggest the need for continued work to expand the use of remote communication options and remote health check-ins or nontraditional clinic hours to reduce barriers for patients to access care. Indeed, the utility of remote care has been placed in the spotlight with the recent COVID-19 coronavirus pandemic.

From discussions with mothers and practitioners, it is clear there is a need for improved care postpartum. Most of the mothers interviewed discussed instances of feeling ignored or dismissed or having trouble accessing proper care after birth. In addition to concerns around inadequate care postpartum, some mothers mentioned childcare with an infant being a substantial barrier for them making it to an appointment. One option to reduce the burden on new mothers and ensure their care needs are met is to combine care for new mothers with their babies’ wellness visits. This may involve housing OB/GYN practices in spaces with pediatricians to link care involving mother and child.

A strength of this study is the in-depth line of inquiry we were able to explore. However, study participants were not representative of the broader population in central North Carolina due to the small sample size. They were, in general, more educated and not as racially and ethnically diverse as the larger population. Even in this group of women who had a high level of education, access, and insurance, dismissive care still served as a major barrier to optimal treatment. Additionally, this study was advertised as aiming to examine women’s unique experiences and barriers to care, which may partially explain the largely negative sentiment expressed by participants. Concerns discussed by this group are likely amplified for women of color and women from lower-income backgrounds and lower-resource settings. Future research should include a more diverse range of women to gain a more complete scope of the problem.

Experiences with dismissive care likely reflect systems issues around increased burden on practitioners in encounters and historical norms around women’s treatment, rather than practitioner intent. Future research should examine how to ensure patients feel like more than a checklist, and how to ease burdens around access and cost. Special attention should be given to mothers and postpartum care. Future efforts should focus on increasing awareness and facilitating access to affordable postpartum care, easing burdens around scheduling appointments and care transitions, and conducting more research regarding women’s experiences during in-person encounters.

We should also consider training standards to make sure women-specific health care is covered more robustly in practitioners’ training. Examples may include training in responding to domestic violence, sexual assault, and women’s mental health and also how implicit biases can affect care toward women.

Disclosure Statement
The author(s) have no conflicts of interest to disclose.

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Authors’ Contributions
Lena JP Cardoso, MPP, designed the study, primarily conducted the data collection, collaborated on the data analysis, and prepared the manuscript. Anna Gassman-Pines, PhD, designed the study and prepared the manuscript. Nathan A Boucher, DrPH, PA, MS, MPA, CPHQ, designed the study, collaborated on the data analysis, and prepared the manuscript. All authors have given final approval to the manuscript.

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References
33. Geronomos AT, Hicken M, Keene D, Bound J. “Weathering” and age patterns of allostatic load scores among blacks and whites in the United States. Am J Public Health 2006 May; 96(5):828-33. DOI: https://doi.org/10.2105/AJPH.2004.060749, PMID:16380565