Delays in Diagnosis and Treatment of Hashimoto's Thyroiditis in Women Over 60: Barriers and Policy Solutions

Word Count: 2380

October 15th, 2025

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Abstract

Introduction: Hashimoto's thyroiditis is the leading cause of hypothyroidism in the United States, affecting approximately five percent of the population (Cleveland Clinic, N.D.), with women ages 65 plus experiencing the highest burden (NIDDK, 2021). As an autoimmune disorder that develops gradually, Hashimoto's often remains undiagnosed for years. Symptoms of Hashimoto's, such as fatigue, weight gain, and mood changes, are frequently mistaken for normal aging experiences or symptoms of menopause, contributing to widespread diagnostic delays and poorer outcomes among women over sixty.

Background: Despite the availability of effective treatments such as lifelong levothyroxine therapy, systemic gaps in screening and insurance coverage hinder timely diagnosis and care. The U.S. Preventive Services Task Force (USPSTF) does not recommend universal thyroid screening, citing insufficient evidence for population-level benefits. This contributes to many women at high risk being undiagnosed until advanced stages (Becheru, 2025). Additionally, Medicare and Medicaid typically cover thyroid testing only when deemed "medically necessary," excluding patients in the subclinical phase. These limitations, exacerbated further by socioeconomic disparities, geographic barriers, and low health literacy, deepen inequities in early detection and treatment.

Proposed Framework: Addressing these disparities calls for a comprehensive public health and policy strategy. Four complementary strategies—updating age- and gender-specific screening guidelines, enhancing provider education, improving patient awareness, and reforming insurance coverage—form the foundation of a more equitable thyroid care model. Provider training, including electronic health record (EHR) prompts and ongoing education programs, can minimize diagnostic delays. Meanwhile, patient-centered campaigns and standardized insurance policies can encourage earlier testing and consistent treatment.

Conclusion: Lowering delayed diagnoses among older women with Hashimoto's thyroiditis requires systemic reform. By strengthening screening policies, enhancing clinician education, and ensuring equitable insurance coverage, healthcare systems can improve early detection, decrease long-term complications, and improve quality of life for this vulnerable population.

Introduction

Hashimoto's thyroiditis, the leading cause of hypothyroidism in the United States, impacts about every 5 in 100 Americans (National Institute of Diabetes and Digestive and Kidney Diseases, 2021), with elderly women experiencing the most significant burden. A thyroid is a “small, butterfly-shaped gland in the front of your neck. It produces hormones that regulate how the body uses energy. Hypothyroidism, or underactive thyroid, “happens when your thyroid gland doesn't make enough thyroid hormones to meet your body's needs” (MedlinePlus, N.D.). Women are seven to ten times more likely to develop Hashimoto’s than men, making it a distinctly gendered health concern (Dalili Medical, N.D.). Among women aged sixty and older, postmenopausal hormonal changes further increase susceptibility to autoimmune disorders (Allara Health, 2025). As an autoimmune condition, Hashimoto's develops gradually, often progressing silently over many years. Its vague symptoms, such as fatigue, weight changes, and mood disturbances (Wilson, 2021), are frequently dismissed as aging, resulting in widespread misdiagnosis (Penn Medicine, N.D.). By the time the disease is recognized, many women have already suffered significant health effects. Because delayed diagnosis and unequal access to consistent treatment worsen outcomes for older women, stronger screening policies, improved provider education, and more equitable Medicare coverage are essential to addressing these disparities.

This manuscript focuses specifically on the delays in diagnosis and treatment of Hashimoto's among “financially insecure” women aged sixty and older, a population that faces a disproportionate burden of autoimmune thyroid disease and relies heavily on federally regulated health insurance programs. This paper first provides clinical and epidemiological background on Hashimoto's thyroiditis, followed by an examination of the structural, social and insurance related barriers that contribute to delayed diagnosis and unequal health care access proper care (despite treatments being available). It then analyzes the health and economic consequences of delayed detection in older women and then concludes by proposing targeted public health and policy solutions.

Background on Hashimoto's Thyroiditis

Hashimoto's thyroiditis, also called chronic lymphocytic thyroiditis, is an autoimmune disorder in which the immune system attacks the thyroid gland, reducing its ability to produce hormones over time (NIDDK, 2021). This damage, caused by the immune system, eventually results in hypothyroidism: a condition where the thyroid is underactive and does not produce enough thyroid hormones. Diagnosis generally involves a combination of methods: physical examination, blood tests to measure thyroid-stimulating hormone (TSH) and thyroxine (T4), and testing for thyroid peroxidase (TPO) antibodies, which confirm the autoimmune nature of the disease (Mayo Clinic, 2025). In some cases, ultrasound imaging may be recommended if antibodies are not clearly detected or if gland structure must be assessed (NIDDK, N.D.). Although Hashimoto's can develop at any age, it is most often found in the age range of 30-50 year old women. Because its onset is gradual and its symptoms are nonspecific, many women do not receive a diagnosis until the disease has significantly progressed (Penn Medicine, N.D.). Pregnancy can influence the development of Hashimoto's, as typical changes in immune function during and after pregnancy may trigger or worsen the disease, and untreated hypothyroidism during pregnancy can increase risks for miscarriage, preterm birth, and developmental issues in the baby (Mayo Clinic, 2025). For women over sixty, the consequences of undiagnosed or untreated Hashimoto's are dire. Hormonal changes after menopause increase vulnerability to autoimmune conditions, while common comorbidities - such as cardiovascular disease, high cholesterol, and osteoporosis - can worsen outcomes when the thyroid is dysfunctional (Allara Health, 2025). Untreated hypothyroidism in this age group can also reduce quality of life, contributing to fatigue, depression, and long-term complications. In women over sixty, the effects of untreated Hashimoto's are typically more chronic and impactful, making this population particularly important to study (American Thyroid Association, N.D.).

Barriers to Early Diagnosis and Treatment

One significant barrier to early detection is the subtlety of Hashimoto's symptoms. While symptoms vary for each diagnosed patient, the most common experiences for older women are fatigue, mood changes, and weight gain, which are also often attributed to natural aging, menopause, or stress (Dalili Medical, N.D.). Because of this, patients and providers may delay ordering thyroid tests, leaving the condition undetected (Dalili Medical, N.D.). Existing research confirms delayed diagnosis of Hashimoto's thyroiditis reflects systemic failures rather than individual oversight. Healthcare experts from The National Library of Medicine (NIH) identify delayed diagnosis, symptom dismissal, inequitable access to care as persistent gaps across autoimmune disease affecting women. Nonspecific symptoms, such as fatigue and weight gain are frequently minimized and dismissed due to common age related factors which leads to prolonged diagnostic timelines. These delays are further compounded by socioeconomic status, insurance variability, and health literacy barriers, disproportionately affecting financially insecure women. This literature supports the conclusion that that delayed diagnosis is driven by intersecting biological, social, and structural factors rather than patient behavior alone (Goulmamine, 2024)

Healthcare system limitations

Screening policies represent one of the most significant obstacles to the timely diagnosis of Hashimoto's thyroiditis. The U.S. The Preventive Services Task Force (USPSTF) does not endorse universal thyroid screening, citing insufficient evidence to assess the potential benefits and risks (USPSTF, N.D.). While this cautious stance may seem appropriate for the general population, it leaves numerous high-risk individuals, such as women with Hashimoto's symptoms, undiagnosed until their condition has advanced. Without broad screening guidelines, thyroid dysfunction is typically identified only when patients manifest overt hypothyroidism. Earlier testing, however, could pinpoint at-risk individuals sooner and enable interventions during the subclinical phase, when careful monitoring or simple lifestyle modifications might slow disease progression (Shomon, N.D.). By restricting proactive screening, existing policies delay care and allow avoidable complications to arise.

Even after diagnosis, inequities persist in access to proper treatment. Factors such as socioeconomic status, rural residence, limited access to healthcare providers, and low health literacy all shape whether patients receive timely care (Chen, 2023). Nutrition gaps also matter, since iodine intake and overall diet can affect thyroid health. These social determinants disproportionately impact older women, especially those with limited financial resources or inadequate insurance coverage. Together, they reinforce disparities in who gets diagnosed and treated in time.

Impacts of Delayed Diagnosis in Older Women

Women over sixty who are diagnosed late with Hashimoto's thyroiditis face more severe complications because their thyroid function has been impaired for a longer time. Prolonged hypothyroidism can worsen high cholesterol and bone density loss, raising the risk of fractures and other osteoporosis-related complications (Allara Health, 2025). Cognitive decline, including slower processing and reduced memory, can also occur due to chronic thyroid hormone deficiency, affecting independence and daily functioning (American Thyroid Association, N.D.). Beyond physical health, delayed diagnosis affects social and functional well-being. Cognitive and physical limitations may force older women to rely on caregivers, reduce participation in social activities, or increase dependence on community support services (American Thyroid Association, N.D.). Late-stage hypothyroidism increases lifetime healthcare expenditures. Advanced disease requires more frequent lab tests, imaging, specialist consultations, and potential hospitalizations, creating a greater financial burden for both patients and Medicare (Shomon, N.D; Nall; CMS, N.D.). Early detection could prevent many of these costs by enabling monitoring and timely intervention before the disease progresses.

Treatment Access and Coverage Issues

Lifelong levothyroxine therapy - a daily medication regimen that can be taken in the form of a tablet or liquid and requires regular blood tests - is the standard prescription drug treatment for hypothyroidism and effectively replaces deficient thyroid hormones (Adminendocrinemdsms, 2024). Regular monitoring ensures proper dosing, and supportive lifestyle or dietary changes may help optimize outcomes (Dalili Medical, N.D.; American Academy of Family Physicians, 2021).

Coverage gaps

Even when women acknowledge symptoms or seek testing, access often hinges on insurance regulations. Medicare usually covers thyroid-stimulating hormone (TSH) tests only when deemed “medically necessary,” meaning patients in the subclinical stage may face denied coverage for screening until their condition deteriorates (CMS, 2025; Nall, 2025). This limitation reduces opportunities for prevention and early diagnosis. Medicaid regulations differ by state, and out-of-pocket expenses for lab tests, specialist consultations, and follow-up appointments can further discourage patients from pursuing care (Chen, 2023). Coverage restrictions also apply to treatment: while levothyroxine is affordable, insurance disparities can hinder or complicate consistent access, especially for women with limited financial resources. These structural barriers create inequities in who receives both early screening and ongoing treatment, highlighting the need for more uniform coverage policies.

Policy and Public Health Solutions

Tackling the disparities in outcomes for older women with Hashimoto’s thyroiditis necessitates both systemic policy changes and grassroots public health initiatives. While effective treatments are available, gaps in diagnosis and access hinder women—especially those over sixty—from obtaining timely care. Four key areas for intervention emerge: *screening guidelines, provider education, patient awareness campaigns, and insurance coverage reforms.* Addressing disparities in Hashimoto's thyroiditis requires coordinated policy and public health interventions aligned with existing research on autoimmune health inequities. The NIH emphasizes that fragmented approaches are insufficient and that effective reform must integrate clinical guidelines, provider education and health policy through an intersectional lens that accounts for age, gender and socioeconomic status (Goulmamine, 2024). The four strategies proposed in this manuscript (screening guidelines, provider education, patient awareness and insurance reform) reflect these established recommendations and aim to reduce diagnostic delays and inequitable access to care among older women.

Screening Guidelines

The U.S. Preventive Services Task Force (USPSTF) currently does not recommend universal thyroid screening, citing insufficient evidence of population-level benefits (USPSTF, N.D.). In its latest recommendation statement, the USPSTF explained that while there is fair evidence that thyroid-stimulating hormone (TSH) tests can detect subclinical thyroid dysfunction, data are insufficient to show that treating such dysfunction improves long-term outcomes like cardiovascular health, mortality, or quality of life. The Task Force also noted uncertainty about what TSH levels should trigger treatment and concerns about potential harms such as overdiagnosis or overtreatment (U.S. Preventive Services Task Force, 2015; American Academy of Family Physicians, 2015). However, the lack of widespread screening recommendations causes many older women to go undiagnosed until they develop advanced hypothyroidism. Given that women are seven to ten times more prone to developing Hashimoto's than men (Dalili Medical, N.D.) and that risk increases post-menopause (Allara Health, 2025), focused screening for women over forty could significantly reduce overlooked diagnoses. Routine thyroid-stimulating hormone (TSH) and thyroid peroxidase antibody (TPOAb) tests for at-risk groups could help providers identify subclinical disease earlier, thus slowing progression and preventing long-term complications of untreated hypothyroidism (Shomon, N.D.; NIDDK, 2021). Revising USPSTF guidelines to endorse age- and gender-specific screening would be a crucial initial step toward enhancing outcomes. The absence of age and sex specific screening recommendations has been widely criticized in autoimmune literature. NIH highlights that current clinical practice guidelines often fail to incorporate life stage factors such as menopause, despite evidence that hormonal transitions significantly influence autoimmune disease onset and progression. The authors note that guidelines developed without diverse representation or intersectional considerations limit their applicability to older women, contributing to underdiagnosis and delayed treatment (Goulmamine, 2024). This paper supports calls for revised screening frameworks that move beyond universal population based models and instead prioritize high risk subgroups. To acknowledge the complexity of reforming screening guidelines, it's important to recognize that there is no state-level legislation currently mandating preventative thyroid screening, and federal screening standards are largely guided by the U.S. Preventive Services Task Force (USPSTF). Under the Affordable Care Act (ACA) preventive services recommended by the USPSTF with an A or B grade must be covered by Medicaid expansion programs, even private insurance plans, without cost sharing (111TH CONGRESS 2d Session, 2010). However, because USPSTF does not currently recommend routine thyroid screening, these protections do not apply. Therefore, revising screening guidelines would require collaboration between federal institutions, such as USPSTF, research institutions that generate clinical evidence (as USPSTF only updates policies when new/relevant data arises) and federal agencies that implement the recommendations into coverage policy.

Provider education

Even when screening is available, diagnosis can be delayed because Hashimoto’s symptoms often resemble those of normal aging, menopause, or depression. Fatigue, mood fluctuations, and weight gain are frequently misattributed to “expected” life-stage issues in older women (Dalili Medical, N.D.; Penn Medicine, N.D.). Thus, educating providers is crucial. Medical schools, continuing education programs, and specialty associations should include training on recognizing thyroid problems in women, especially in older patients who show subtle or overlapping symptoms Enhancing clinical awareness will help minimize diagnostic delays, ensuring patients are tested sooner and treated more consistently by incorporating thyroid-focused case-based training in medical and nursing curricula, implementing electronic health record (EHR) prompts to flag high-risk older women with nonspecific symptoms, and offering continuing medical education (CME) sessions emphasizing the overlap between thyroid dysfunction and aging (Mayo Clinic, 2025; American Thyroid Association, N.D.). Provider education reforms would be implemented at both federal and institutional levels. Under the proposed policy framework, the Centers for Medicare and Medicaid (CMS) would be responsible for developing standardized training to educate providers on early autoimmune thyroid symptoms and updated coverage rules and recommendations. Research further underscores provider education as a critical component. According to Goulmamine, public health expert, autoimmune diseases are frequently overlooked in primary care settings due to insufficient training on sex and gender specific symptoms. The authors document how women's autoimmune symptoms are often dismissed and psychosomatic or age related (Goulmamine, 2024). This literature supports expanded provider education initiatives that emphasize recognizing autoimmune disease across the female life course, addressing bias and integrating autoimmune screening into routine evaluations for high risk women. These findings reinforce the need for standardized federal training efforts, such as CMS led educational modules.

Patient Awareness Campaigns

While provider education is crucial, patient awareness also plays an important role in early diagnosis. Many women may not attribute their symptoms to thyroid dysfunction or may not realize they are at increased risk despite having a family history of autoimmune disease (American Thyroid Association, N.D.). Public health campaigns—through local clinics, senior centers, and community organizations—can bridge this gap. Community-based initiatives that highlight the importance of thyroid testing, particularly for women over forty with a family history of autoimmune disorders, could empower patients to pursue testing sooner. Accessible educational materials, such as online resources, culturally appropriate pamphlets, and workshops, can improve health literacy and reduce stigma linked to thyroid conditions (Chen, 2023).

Insurance reforms

Finally, equitable access to treatment relies on insurance policies. Medicare presently covers TSH testing and levothyroxine prescriptions only when they are considered “medically necessary” (CMS, 2025; Nall, 2025). This definition leaves out patients in the early, subclinical phase who might gain the most from close monitoring or early intervention. Medicaid coverage varies by state, exacerbating disparities in access for low-income women (Chen, 2023). Reforms should ensure that diagnostic tests and treatment are covered at earlier stages of the disease, rather than only after advanced hypothyroidism has developed. Broader coverage would help prevent costly long-term complications such as cardiovascular disease, osteoporosis, and cognitive decline—ultimately saving money for both patients and the healthcare system as a whole (Shomon, N.D.; Allara Health, 2025). Insurance reform in this context refers to reclassifying thyroid screening from a diagnostic laboratory test to a preventative service, which are covered. Under the ACA, private health plans and Medicaid expansion programs are required to cover preventative services by the USPSTF and it also authorizes Medicare to expand coverage for preventative services consistent with USPSTF recommendations which demonstrates that preventative screening falls within established federal guidelines. The proposed insurance reform would require CMS to move thyroid screening into the preventative services list, making one annual screening covered without cost sharing for eligible beneficiaries. This reform would address and primarily impact the older women, who represent a large share of Medicare users. Among approximately 66 million Americans covered by Medicare (CMS, 2024), an estimated 36.3 million are women aged 65 and older. If even 25% of this population (about 5 million individuals) receive annual screening at an estimated cost of 30 to 50 U.S. dollars, the total annual cost would range from approximately 272 to 453 million dollars nationwide. Rather than creating a new funding system, these costs would be reallocated through existing Medicare Part B preventative services spending. Because thyroid screening is a relatively low cost compared to the potential treatments of advanced hypothyroidism complications, this reallocation would amount to less than 0.1% of the total federal health spending (Fiscal Data Explains Federal Spending, N.D.).

Together, these four strategies - targeted screening, provider education, patient awareness, and insurance reform - provide a comprehensive framework for reducing disparities outcomes for older women with Hashimoto’s thyroiditis.

Conclusion & Call to Action

Delayed diagnosis and inconsistent access to care significantly worsen outcomes for women over sixty years with Hashimoto's thyroiditis. The issue isn't that effective treatments don't exist, but that women frequently remain undiagnosed until their condition has progressed. By that time, hypothyroidism may have already led to irreversible complications, reduced quality of life, and increased healthcare costs. Proactive screening, particularly for women over forty, could identify thyroid dysfunction early and prevent years of silent disease advancement (USPSTF, N.D.). Fair insurance coverage would guarantee that women in the subclinical stage receive the necessary tests and medications before their conditions deteriorate (CMS, 2025). Educating providers could help reduce biases and enhance diagnostic accuracy, while public health campaigns centered on patients would encourage women to seek testing and advocate for their own health. Among these strategies, prioritizing an update to screening guidelines is crucial, as early detection enhances the effectiveness of every other intervention. However, all four reforms—screening, provider education, patient awareness, and insurance coverage—are vital and interconnected. Only by implementing them together can the United States tackle the gendered disparities in thyroid care and ensure that older women receive the prompt, equitable treatment they deserve.

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