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Dolores L. Mitchell
Group Insurance Commission, Commonwealth of Massachusetts

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Economic advancement for women may be inextricably linked to the state of their health and access to health care. This article warns that the debates and public policy dilemmas over health care delivery systems, their costs, who pays, and issues of coverage and utilization demands weigh greatly on women and their families. The author suggests that women especially must be careful consumers of health care plans and outlines some qualities they should seek in choosing such plans.

Health care issues affecting individuals and their families have long been of special concern to women. Given their traditional role as primary caretakers at both ends of the life cycle, that interest is obvious. If nothing else, it is self-interest. Who takes care of babies, well and ill, and who takes care of elderly parents — his or hers? The woman does. She also deals with the obstetrician, the pediatrician, the nursing home staff, and the insurance company or health plan.

Health care costs on the macro level are something else again. For many years insurance actuaries, health economists, and social planners have been concerned with the issue, and everyone from Oscar Ewing and Harry Truman to Senator Edward Kennedy has talked about health care for all, but no one has summoned up the political support to do anything about it.

Individual health care concerns and the larger issues of access to health care, as well as the cost of health care delivery systems, are key factors for women's long-term economic health. If women are to enter and remain in the work force in increasing numbers, they and their families must receive affordable health care when they need it.

A Brief Backward Look

In 1989, this region's largest telephone system waged a bitter sixteen-week strike, largely over health benefits and who would pay for them. The union was forced to give concessions on other important items in order to retain its system of noncontributory health benefits.

Health care cost containment has joined the list of the half dozen compelling political

Dolores L. Mitchell is executive director of the Group Insurance Commission, Commonwealth of Massachusetts.

issues of our time. Along with day care, education, jobs, drugs, and war and peace, health care and ways to provide and pay for it have become everyday subjects on editorial pages all over the country. Why this reemergence of the issue since Truman lost his bid to have the federal government provide national health insurance? The answer is perhaps better understood in the context of the history of medical care delivery systems since Truman.

The medical profession, having won its fight against the assumed evils of socialized medicine as reflected in Truman's insurance proposals, decided that its traditional approach of providing free care for indigent patients wasn't as efficient as agreeing to let third-party payers take care of the bills. Then the prepaid health plan movement got started with the success of the famous Kaiser Permanente group in California. The medical profession wasn't particularly enthusiastic about these plans, but they were fairly well restricted to the West Coast, and doctors eventually figured out that with some modifications, prepaid systems — if they were run by and for doctors — were a possible alternative to the old fee-for-service system. They actually organized a fair number of them themselves, and Independent Practice Associations, a variant of Health Maintenance Organizations (HMOs), were born.

Meanwhile, medical costs rose steeply as new technologies and increasing life spans fueled increased utilization. But even in the ups and downs of the American postwar economy, we basically could and did afford it. Today, with health care expenditures consuming 11 percent of the gross national product (GNP), the reality gap has emerged, sharp and disturbing.[1]

Used to believing as an article of absolute faith that they receive the best medical care in the world, Americans are disturbed at the onslaught of cost-containment strategies. Most of these suggest that staying in high-tech hospitals is not only expensive but might not even be safe whether or not the patient can pay for it. New mothers may resent going from the delivery room to their homes with barely a half-day stop in the maternity ward, all in the name of cost control, but we cannot simply ignore the fact that while our neighbor Canada spends less money per capita on health care than we do, infant mortality north of the border is 25 percent lower than it is in the United States.[2]

We also know that some of the procedures previously touted as making us the most medically advanced country in the world may not be necessary, or even desirable. For example, most health plans are reviewing Caesarean section rates to determine whether they are too high. Requiring second surgical opinions before hysterectomies are approved for coverage is becoming almost universal. The National Center for Health Statistics tells us that these two operations are the most common major surgical procedures performed in this country, and as the baby-boomers hit the age at which hysterectomies are most often performed, their medical necessity as well as their costs are coming under increasing scrutiny.[3]

Magazines, popular and professional alike, are looking into the way we deliver and pay for medical care, and no one is happy with what they see. Medical cost increases are reflected in insurance premium increases, not infrequently at the rate of 20 percent a year. Neither high-tech medicine nor preventive care measures seem able to stop or even slow the rates of increase.

A Brief Forward Look

Looming in the background are the costs of long-term care, whose dimensions are so huge that they are only beginning to be calculated. Long-term-care insurance products

suitable for a mass market do not exist, although the time is fast approaching when a significant share of the population will require such coverage.

By the year 2030, 21 percent of us will be over sixty-five.[4] As we look down the road toward 2000, we see health care costs continuing to rise. The 13 percent of the population that will be over sixty-five will be very difficult to constrain in their health care expenditures. We already know that per capita spending on health care for people sixty-five and over is three and a half times that for the population at large. The surge in over-sixty-fives will drop off again in another twenty-five or thirty years, but in the intervening years costs will escalate under the twin pressures of numbers and intensity of care common to the older age group. Businesses have begun to evaluate their financial exposure for retirees, and they don't like what they find. The Financial Accounting Standards Board has sent tremors through the business and government worlds by telling benefit administrators to begin to calculate future costs for retirees and to expect to accrue costs during employees' working careers. An actuarial study conducted at the behest of the 1989 Massachusetts budget act to see what the health insurance costs would be for retirees already covered by the state was calculated as a $2.7 billion liability.[5]

Prices, Costs, and Consumption Patterns

The increases of 18.7 percent from 1983 to 1985 in Medicare costs have been attributed to physicians "gaming" the system, but a study of five states quoted in *American Medical News* in 1988 suggested that the growth comes largely from outpatient surgery and increased numbers of participants.[6] That view is supported by Health Care Financing Administration (HCFA) studies predicting 15 percent of GNP for health expenditures by 2000 in contrast to today's 11 percent. HCFA confirms the increase in outpatient rather than inpatient services as a major source of the increase: "In 1986, hospital employment (including government hospitals) accounted for almost two-thirds of all health service employment; a decade later, that share had fallen to 55 percent. There can be no doubt that cost containment has played a role in this trend." This data suggests that cost containment, when it means careful monitoring of inpatient services, has had an effect, but the bulge in the balloon of total costs has simply gone somewhere else.

Another way of tracking costs is to look at prices. *Prices* are hard to measure, but inflation appears not to be due to physician charges alone.[7]

Prescription drugs	+8.6%	1985–1986
Physician fees	+7.2%	
Hospital prices	+6.0%	

The reason for the expenditure increases is only partly price inflation, up 54 percent from 1985–1986. Population growth in that same period was 11 percent; the remaining 35 percent is attributable to increased consumption — more intense consumption and changes in the demography of consumers. Dr. Jeff Goldsmith, a prominent Chicago health policy analyst, agrees that technology-driven increases account for between 30 percent and 40 percent of rising costs.[8]

Who Pays?

A larger share of the cost is being paid for by consumers through higher premiums, more copays and deductibles, a cutback in Medicare (the federal program that covers eligible

seniors sixty-five and over) contributions, and regrettably, an increase in the numbers of uninsured. The 1988 Medicare Catastrophic Coverage Act, the largest expansion of Medicare since its creation in 1965, did enact a first — indexing in the form of an income tax surcharge to pay the costs of the added benefits. Signed into law with the support of a number of groups, including the influential American Association of Retired Persons, it aroused the ire of senior voters when word slowly got around that the cost of the increased coverage was going to be financed exclusively by them. In a rapid reversal Congress repealed the legislation. There does not yet seem to be a consensus on how to pay and who should pay for expanded services for the elderly.

How Costs Are Paid and Reviewed

A quick review of how we pay for health care in this country should set the context for discussing alternatives. After Medicare, Medicaid is the largest third-party payer in America for long-term-care services. Medicaid, enacted during Lyndon Johnson's war on poverty, pays for medical expenses of the poor and for long-term care of the elderly — once they become poor enough.

Most health insurance, however, is still related to one's employment. Traditional indemnity insurance has been the primary mode of delivery, with post hoc reviews of utilization added to many programs as cost concerns escalated in the early 1980s. In 1982–1984, with that concern getting more intense, utilization review became almost universal, and efforts to reduce hospitalization became very serious. This was also the time when HMO membership began to move out of the narrow geographic bands of the West Coast and upper Midwest. By 1984 and thereafter, what has come to be known as managed care has become almost universal. Managed care is essentially the intervention of independent reviewers, usually medically trained professionals, who attempt to ensure that health care usage fits into a pattern of acceptable practice. Managed-care procedures range from organizing a total program of responsibility for health care services in a staff model HMO to requiring pre-admission certification for a prospective hospitalization by traditional insurance carriers.

HMO membership became significant in 1985 and thereafter, moving into the East from its base and making slower inroads in the South. However, some of the concepts first used by HMOs have been adopted by almost all commercial carriers, namely, pre-certification of hospitalization and second surgical opinions.

Preferred Provider Organizations (PPOs) are somewhat similar to HMOs. A network of preferred providers is organized and subscribers agree to use those providers. Members can go out of the network and consult non-PPO providers, but those who do pay a larger portion of the bill. This contrasts with HMOs, which may refuse to pay for services performed by nonmembers of their provider network. PPOs are making inroads in the East, but not in any great numbers, particularly since the traditional Blue Cross/Blue Shield has such a strong market position in this part of the country. In Massachusetts in mid-1988 there were thirteen PPOs in operation; nationally about 1.3 million people belong to a PPO.[9]

A clear majority of employers have given up insured coverage, preferring to undertake the risks of paying their employees' medical bills themselves. Some private groups prefer such self-insurance because it exempts them from Employee Retirement Insurance Security Act of 1974 provisions, which require maintaining mandatory reserves, paying premium taxes and mandated benefits, and adherence to other restrictions.

Much has been written about the 37 million uninsured, both the poor and those whose employment is in service or part-time jobs that do not offer insurance. The concern has become serious enough to inspire a national debate. The Commonwealth of Massachusetts has committed itself to covering all those who cannot get insurance. The prestigious *New England Journal of Medicine*'s January 12, 1989, issue formally called for national health insurance. Major employer groups have begun to voice concern over the health insurance "tax" that adds $600 or more to the price of their products, a price not included in goods produced by foreign competitors in countries providing national health insurance or direct medical services. There is certainly no national consensus about what to do, but one is surely in the making.

Women and Health Insurance

Less often discussed is the data about women and health insurance. Seventeen percent of women from fifteen to forty-four years of age are estimated to have no health insurance, private or public. Those are women's most critical years, when they need more health care because of their high reproductive health requirements, to say nothing of the long-range effects on the health of a new generation. In 1985 women comprised 71 percent of all hospital admissions among people aged fifteen to forty-four; of those 9.8 million admissions, half were either for delivery or reproductive problems. Women in this age group are slightly more likely to have insurance than men, largely because of Medicaid, but almost 10 percent of insurance plans still exclude maternity benefits entirely.[10] A Colorado case ruled that such an exclusion was discriminatory and ordered the company to pay.[11]

Among all age groups, 14.5 percent of women are uninsured. Given that women are more likely to be poor and to live longer than men, the figure should cause concern. Poverty is the single most relevant contributor to being uninsured, regardless of marital status, but an unmarried woman is more likely to be uninsured than a married one. Ethnicity is also relevant. A survey that applied controls for income and marital status found that Hispanic women are more likely to be uninsured than black women, suggesting that government programs have worked in the black community but have not done as well among the Hispanic population.[12]

In brief, the uninsured woman is younger, more apt to be unmarried, less educated, and poorer than the population at large. Of concern for the future is the employment pattern for these women, who are found in precisely those growing areas of employment least likely to provide insurance coverage — service and retail sales.

Health and insurance issues of particular concern to females include reproductive issues associated with obstetrical and gynecological practices. The shortage of obstetricians and gynecologists has been fairly widely documented, and the reasons also fairly well acknowledged. Anger at Medicaid reimbursement levels and fear of malpractice litigation have driven many practitioners from the field. These traditional concerns have been the subject of new perceptions added by the awakening and occasionally militant consumer movement in health care. Groups like the Women's Health Collective, and its influential publication *Our Bodies, Our Selves*, have had a real impact on the nature of the relationships between doctors and women patients. Women have forced male physicians to think again about how they treat women.[13]

Issues of a specific medical nature are just as important as those of relationships between doctor and patient. Teenage girls, perhaps as a result of peer pressure, are particu-

larly susceptible to medical problems associated with early sexual activity. They suffer from a group of sexually transmitted diseases, frequently neglecting to get early diagnosis and treatment. Alcoholism and drug abuse are on the rise. Eating disorders afflict young females far more than their male counterparts. And of course, teenage pregnancy has reached what some are calling epidemic proportions.[14]

Interestingly enough, the Women's Health Collective leadership is as concerned with too much as with too little in the way of medical intervention. The overprescribing of tranquilizers, unnecessary surgery, the use of interventionist therapies in normal births, are all areas in which less may be better than more and the interests of the patient may coincide with those of the cost-conscious insurer or employer.

Among older women, breast cancer, the increase in lung cancer rates, hypertension, and heart disease are all consequences of the new stresses in women's lives. Obesity and osteoporosis are concerns of older women; until recently, relatively little has been done in these fields to keep women healthy as they age. The small number of good studies on prevention, whether breast-screening programs or premenstrual syndrome, all verify the incredible cost of ignoring these problems, but only recently have medical insurance policies covered these procedures. Mammography coverage, for example, did not become mandatory in Massachusetts until 1988.

Medical Costs and Ethics

The 1988 Harvard Community Health Plan annual report, "Making Difficult Health Care Decisions," deals with the issue of technology and the appropriate extent of its utilization. The report discussed the work of the Loran Commission (named for the navigation instrument) comprising representatives of medicine, law, economics, ethics, and public policy who met to discuss the ethical and economic consequences of new medical technologies. As they put it, "The infinite inventiveness of the human imagination is on a collision course with finite resources." The commission notes the paucity of sound and generally accepted evaluation techniques and of procedures for a health plan or insurer to determine what should be covered, at what cost, for which patients.[15]

The report also notes that the most dramatic examples of having to choose measures whose ultimate success are most in question tend to occur at the beginning and end of life, but similar choices must be made at all levels of the life cycle.

Along with increasing longevity, the expansion of expensive heroic techniques constitutes the major force behind rising costs, as *Business Week* magazine pointed out in a science and technology analysis. Often the heroic measures themselves have not been evaluated for their overall effectiveness, according to this analysis. The article estimates that half the annual cost increases in medical care are attributable to technology. The promised cost savings from these sophisticated interventions that may help, but don't cure, have simply not been realized.[16]

From the premature infant whose first few months of life in intensive care can cost up to $1 million to the people sixty-five and older who spend 35 percent of our health care dollars even though they account for only 11 percent of our population, the decisions on how and whom to treat become more and more questions of public policy as well as of medical care. Medical ethicists have joined the discussion to ensure that the moral dimension is kept in mind as decisions are made on treatment plans.

The "who pays for whose care" questions are not restricted to the very young or the

very old. Health care dollars for people actively in the work force are distributed as unevenly as they are in extreme life cycle cases. A Dun and Bradstreet study cited in *Insurance Times* points out that half the health care dollars spent by the respondents were on behalf of only 3.8 percent of the employees and their families.[17]

Strategies to control costs cited in *Insurance Times* and elsewhere range from shifting costs to employees to managing utilization. Most of them work, but none of them cure. Review of hospital utilization, both planned and unplanned, has become commonplace. Use of special plans to lower drug costs (generic drugs and discounted programs of one kind or another) is increasing. Second surgical opinions, particularly for overperformed operations such as hysterectomies, are required in the early stages of most plans. Second opinions tend not to reduce incidence of surgery but supposedly serve to change behavior patterns, particularly those of physicians. All these programs have an effect on costs, particularly during the first few years of implementation, but the pressures of age, technology, and overall medical inflation overwhelm the savings over time.

I have not touched on the special issues of long-term care except inferentially in discussing the aging of the population. Quality insurance for long-term care is not universally available. Major insurers have expressed relatively little enthusiasm for creating products for this predominately female market. Innovative strategies for combining Medicaid dollars with private insurance dollars are being studied, but broad new programs are not likely in the immediate future. In the meantime, annual costs for long-term care have begun to climb from $22,000 per person in 1985 to $30,000 in 1987 to an estimated $60,000 for the year 2000. Just as the business community has begun to believe that national intervention may be called for in meeting escalating health care costs, so may financing long-term care be the next frontier in insuring Americans against costs that simply cannot be funded privately.

Social policy thinkers have come up with a whole series of institutional and financial techniques to supplement HMOs and PPOs. Funding arrangements, including financial incentives crafted for the purpose of affecting plan selection, are proposed as "solutions" to adverse selection. (Adverse selection is the tendency of people with no current health risks to join plans that offer the most comprehensive coverage. In practice, this usually means that those who do have medical problems select traditional over managed-care plans.)

Traditional indemnity plans have adopted elements of managed care in response to their clients' concern about escalating costs. Meanwhile, individuals and groups distressed by these costs have begun to ask questions before they sign up for a benefit at work, and sometimes before they even agree to take a job. The benefit plan offered by a prospective employer looms larger and more important as a factor in job selection. The growing consciousness of self-supporting women, who may also be heads of household, has concentrated more attention on the details of benefits programs. They have always been important but have frequently been left to chance or the beneficence of employers as to content.

A Woman's Insurance Program

Today, when having no coverage or inadequate coverage can cause financial ruin, women are carefully reading the small print of health plan documents. The checklist that follows includes some elements of fine-print items to look for in reviewing benefit plans. It con-

centrates on health benefits, excluding other issues that may be of equal importance, for example, pensions. But I do have two brief comments about disability insurance and life insurance.

Women should get disability insurance if they possibly can. Individuals are five times as likely to be laid up as they are to die during the course of their normal working careers. Income protection, particularly for a family's largest or only income, can be critical. A policy that covers at least 60 percent of salary should be considered a minimum threshold. Premiums are paid either on a pretax or a posttax basis. That 60 percent figure should be higher if premiums are calculated on a pretax basis because payments will be taxable. One should look for a full benefits package, one that continues to pay if the insured person remains disabled until at least age sixty-five. The prospective buyer should also be sure to understand provisions about waiting periods and exclusions.

With the possible exception of those whose children are economically independent, women should consider and select life insurance programs exactly as men do.

Keep a few benchmarks in mind in selecting a health plan or before participating in designing or negotiating for one at work. It is unfortunately true that most people don't read the materials about benefits until after they have made their selections, frequently relying on word of mouth as the most common determinant of choice. There are differences among plans to be considered.

When deciding between an indemnity plan — one that provides free choice of doctors and hospitals — and an HMO or PPO, take into account that much depends on lifestyle, income, and family status. HMOs, with their younger populations, are almost always less expensive, but they are also almost always more restrictive. Patients may have to select a specific facility if the plan is a staff or group model HMO and will probably have to put up with intermediaries between themselves and physicians or between a primary care physician and specialists. Many people are willing or even relieved not to have to find their own specialist; others find the restrictions onerous. Those who already have established relationships with a doctor or doctors may prefer the flexibility and freedom of the indemnity approach.

Checklist

These are some of the elements prospective purchasers may want to review before choosing a health plan.[18]

Dependent Coverage: Are children eligible? Spouses? At what cost?

Waiting Periods: Does the plan make patients wait before coverage begins? How long?

Disenrollment: Can one switch to another plan? How and when?

Preexisting Conditions — Exclusions: What are they? Do they remain in effect indefinitely?

Availability of Physicians/Hospitals: Are doctors who participate in the plan listed? Are those listed guaranteed to be available for new members? What hospitals are used? Are doctors' credentials described?

Literature: Is a member handbook or brochure available? Does it describe the patients' responsibilities? Does it tell how to get emergency care?

Managed Care: Is one assigned to or able to select a primary care physician? How does one go about notifying the plan if a patient goes to the hospital or wants to consult a specialist?

Where is care delivered? Is the site accessible to the handicapped? What hospitals are used? Where does a patient go for emergency treatment? Is there coverage for a person who becomes ill out of town? Is a health center the preferred kind of facility or does the subscriber insist on seeing an independent practitioner in an office?

Procedures, Paperwork, and Related Issues: How are patients or their providers reimbursed? If paperwork is involved, is it burdensome or reasonable?

Benefits: Be sure to check on preventive services as well as diagnostic procedures. Family planning and abortion services are not covered in many plans. Are they covered in the plans one is considering? Gynecological services of all kinds should be reviewed before enrolling in any plan.

- Durable medical equipment coverage often causes conflicts. It may not be necessary to anticipate ski accidents or even more unpleasant mishaps, but knowledge of its policy on wheelchairs and prostheses, for example, provides an indication of a plan's level of coverage.
- There is a floor for psychiatric care benefits under state law, but check on the ceiling for both inpatient *and* outpatient services.
- Home Health Care: Private duty nurses are rarely covered, but some caregivers' services may be. The same is true for hospice care — not all plans cover it, nor do they cover non-hospital-based programs. Find out whether coverage is available.

These items cover some, but not all the issues that buyers might investigate in reviewing insurance options. A woman cannot possibly know her future circumstances or medical needs, but the level of information provided and described clearly or made readily accessible does tell something about a plan. The response to telephoned follow-up questions tells still more. The personnel or benefits department where one works, if it is doing its job well, is a third source of solid information. General circulation newspapers occasionally publish articles on health and health insurance issues, but they are rarely detailed enough to turn a reader into an expert on this somewhat arcane but important subject. The best choice might be to consult the index of the *Reader's Guide to Periodic Literature* in the reference room of a public library for articles on health and other kinds of insurance. The information can be of critical importance to women and the families for whom they are buying insurance. It's too important to be left to chance.❧

Notes

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13. Judy Norsigian, speech at a symposium sponsored by the Health Data Consortium, May 19, 1989.
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15. "Making Difficult Health Care Decisions," Harvard Community Health Plan, 1988 annual report.
16. "High-Tech Health Care: Who Will Pay?" *Business Week*, February 6, 1986, 74–78.
17. *Insurance Times*, March 28, 1989, 5.
18. In drafting this checklist, I borrowed liberally from the *Buyer's Guide to Health Plan Selection, 1989–1990*, a publication of Worcester Area Systems for Affordable Health Care.