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Original Article

Taming Healthcare Costs: Promise and Pitfalls for Women's Health

Amy Glynn, MBA, MPP,[1] Rose MacKenzie, JD, MPH,[2] and Therese Fitzgerald, PhD, MSW[1]

Abstract

When it comes to healthcare, women are often the primary decision makers for their families. Therefore, focusing on women and their health needs can have a profound effect on health reform efforts to control costs and improve quality for all segments of the population. The promise and pitfalls of cost containment reform in Massachusetts can serve as an informative case study for policymakers at the local, state, and federal levels as they attempt to reduce costs while maintaining quality of care. Massachusetts cost containment law, Chapter 224, seeks to control the healthcare cost growth through innovative approaches to increase efficiency and transparency including the adoption of new delivery system models, investments in wellness and prevention programs, and implementation of standard quality and evaluation measures. In this paper, we outline four approaches to delivering on the promise of cost containment reform to maximize women's access to comprehensive, quality healthcare while avoiding the pitfalls of cost containment's adverse impact on women's health.

Introduction

Massachusetts has long been at the forefront of healthcare and health reform, making a sustained commitment toward improving rates of insurance and access to care for its residents.[1] The Commonwealth's comprehensive 2006 health reform law, Chapter 58, achieved its goal of near universal health insurance coverage for Massachusetts residents and served as a model for the Affordable Care Act (ACA). Chapter 58 also provided subsidies to low-income residents to purchase health insurance, a central marketplace to purchase individual and family plans, and a core set of health benefits insurers are required to cover.[2] Reform provisions such as these are particularly important for women who are more vulnerable to gaps in insurance coverage and have higher rates of multiple chronic diseases compared with men, resulting in higher health costs and greater difficulty coordinating care.[3,4]

Having achieved its coverage goals, Massachusetts began to address the problem of rising healthcare costs in the state via legislation designed to reduce costs while improving quality of care culminating in the passage of a landmark reform law in 2012—the nation's first comprehensive legislation on cost and quality—Chapter 224, An Act Improving the Quality of HealthCare and Reducing the Costs Through Increased Transparency, Efficiency, and Innovation (''Chapter 224''). Chapter 224 seeks to control spiraling healthcare cost growth through innovative approaches to increase efficiency and transparency, including the adoption of new delivery system models, investments in wellness and prevention programs, and implementation of standard quality and evaluation measures.[5]

Massachusetts' experience with Chapter 224 provides an early lesson for state and federal policymakers as they develop and implement cost control measures under the ACA.[6] Given the current political climate, these approaches are even more vital for women in politically conservative states, as many states have seen erosions in funding and access associated with women's reproductive health, making many of these recommendations more challenging to enact. Fortunately, there is growing interest in state policies to improve access to women's healthcare. In 2014, over 30 states advanced some form of policy to improve reproductive and sexual health, even in traditionally conservative states like Louisiana, Idaho, Utah, and West Virginia.[7]

Massachusetts offers a good comparison model for other states implementing cost containment reforms, given that the state's high per capita spending on healthcare and insurance premiums have generally reflected national trends since the 1990s.[6] Despite similar healthcare spending and premium trends, Massachusetts is faring better in terms of lower uninsured rates and higher percentages of women

[1]Brigham and Women's Hospital, Mary Horrigan Connors Center for Women's Health and Gender Biology.
[2]National Institute for Reproductive Health/NARAL Pro-Choice, New York, New York.

Table 1. Healthcare and Health Outcomes Among Massachusetts and United States Women (2008–2013)

	United States (%)	*Massachusetts (%)*
Women 19–64 insured through employer	57	67
Women 19–64 insured through Medicaid	13	18
Uninsured women	17	3
Medicaid enrollees who are female	58	55
Adult women who have ever been told by a doctor they have diabetes	10.7	8.1
Women 21–64 who reported having pap smear within past 3 years	84	89.6
Women 40+ who reported having mammogram within past 2 years	74.9	84.6
Women 50+ who reported ever having colorectal cancer screening	68.6	75.0
Women who reported having cholesterol checked in past 5 years	79.7	85.9

Source: Kaiser Family Foundation. State health facts. Massachusetts and United States, 2008–2013.

accessing preventive care such as Pap smears, mammograms, and colorectal and cholesterol screenings compared with the national average, which may be attributed to proactive legislation that targeted coverage and access to care (see Table 1).[8,9] Now that Massachusetts has turned to cost containment reform, the successes and unintended consequences the law has had on women's health will illuminate areas for other states to incorporate when considering reforms.

Why Women's Health?

Women use the healthcare system more than men and are often the gatekeepers to healthcare in their role as caregivers and healthcare decision makers for their families and often their communities.[10,11] Women are disproportionately impacted by the high cost of care, as they tend to have lower incomes than men, use more medical services, spend more annually on care, and are more likely to face challenges affording and accessing care primarily due to their reproductive healthcare needs, longer life expectancies, and increased risk for multiple chronic diseases.[12,13] Therefore, an analysis of cost containment reform through the lens of women's health is essential, as it provides policymakers with the ''canary in the coal mine'' for cost containment reform.[14,15] The impact of cost containment and quality improvement reforms on women will likely reverberate throughout the system, impacting all segments of society.

In this paper we outline four approaches designed to ensure the promise of comprehensive, quality healthcare under cost containment reform while evading many of the pitfalls and adverse impacts cost containment efforts could have on women's health (see Table 2). The four approaches include:

Table 2. Approaches for Ensuring Women's Health Under Cost Containment Reforms

Delivery system models in primary care settings
• Integrating the full spectrum of care is true innovation
• Integration of specialty services important to women's health
Prevention and wellness
• Nondiscriminatory wellness programs
• Evaluation of the impact prevention and wellness programs have on women's health is key
Quality measures and overall evaluation
• Sex- and gender-specific quality measures
• Sex and gender differences in evaluation of reform efforts
Confidentiality
• Access to confidential care

1. Delivery System Models in Primary Care Settings
2. Prevention and Wellness Programs
3. Quality Measures and Overall Evaluation
4. Confidentiality

Delivery System Models in Primary Care Settings

Delivery system models are innovative models of care intended to reduce costs by better coordinating care, using a team-based approach, and improving access to primary care services. National and state cost containment efforts have centered around Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMH) standards in primary care settings, with Massachusetts Chapter 224 including language to develop and implement standards to certify provider organizations as ACOs and PCMHs as well as oversee their compliance. Currently, certification processes for ACOs and PCMHs rely on a ''one-size fits all'' approach that does not incorporate the unique health needs of women across the lifespan. Emerging delivery system models should include protections in all regulations for women's health services, including recognizing the role of specialists and nurse practitioners on women's health and integrating reproductive, mental health, and comprehensive family planning services.

Integrating the Full Spectrum of Care is True Innovation

Recent research highlights that the majority of healthcare services women access are women's health services; the majority of women (56%) indicated that the top services they needed in the last 2 years were annual visits, followed by pap tests (49%), birth control (34%), and breast exams (29%).[16] This research reinforces the need for primary care to incorporate women's unique healthcare needs. In addition, the U.S. healthcare system is faced with challenges due to shifting demographic, political, and economic pressures including increases in elderly and chronically ill populations and higher demands for primary care services met with a shortage of primary care physicians.[17] Yet nurse practitioners are trained to provide services similar to primary care physicians,[18] and obstetrician/gynecologists (OB/GYNs) receive significant amounts of training in primary care during their residencies.[19] For many women, OB/GYNs are their primary

source for routine care,[20] and young, minority women are more likely to rely on OB/GYN providers as their primary source of care.[21] This research underscores the importance these types of providers have on women's health as they are commonly used by women as their primary source of care and, in some instances, their only source of care. Therefore OB/GYNs, nurse practitioners, and other specialty providers need comparable opportunities in new delivery models as they continue to assist in the delivery of primary care (Robin DaSilva, personal communication).

In addition, research shows that access to family planning services is critical for women to control their reproductive lives and is cost effective.[22] For example, about half of the 6.6 million pregnancies that occur each year in the United States are unintended,[23] and many women face health-related consequences for unintended pregnancies.[24] Providing family planning services helps avoid health issues related to unintended pregnancies and helps contain costs. This is particularly important for poor, minority, and low-income women who have the highest rates of unintended pregnancies.[23]

The ACA enables women who have never accessed care before to get the necessary care they need. Delivery system reforms and a shift toward prevention and primary care has the opportunity to help all women, particularly low-income women who are more likely to be in poorer health and have higher rates of chronic diseases, to be healthier over their lifespan which will drive down costs.[25] To recognize the full potential of these reforms and control costs, ACO and PCMH standards must build on women's existing relationships with providers delivering primary care and ensure access to family planning services. One way Chapter 224 was able to ensure women's health services was due to an amendment introduced by Senator Karen Spilka and women's health advocates that included explicit language of OB/GYNs and family planning services in additional ACO guidelines that the state commission may consider. Although this amendment does not make inclusion of OB/GYNs and family planning services a requirement for ACO accreditation, it does underscore the importance for states to include additional guidelines beyond minimum ACO requirements to meet the needs of their residents and to consider incorporating the unique health needs of women in delivery reform requirements. The omission of this inclusion in requirements for PCMHs could have enormous impacts on women's health and cost containment efforts since women's access to necessary services is not assured. As state commissions establish additional standards for ACO and PCMH accreditation, standards that take into account the unique health needs of women are necessary to ensure women have access to care across the lifespan.

Integration of specialty services important to women's health

Integration of specialty services, including mental health, in primary care services is critical for PCMHs and ACOs to provide comprehensive care for women.[26] Many women's healthcare providers, particularly reproductive and sexual health providers, operate independently without ties to larger healthcare organizations, such as large hospital systems already exploring opportunities to become ACOs or PCMHs, and overwhelmingly use a fee-for-service structure.[27] In order to fully protect women's access to vital services, providers must be fully integrated into new structures or be allowed to continue operating independently using a payment system that adequately compensates them for their work. Although results from the 2013 National Survey of ACOs demonstrate low levels of behavioral health integration in primary care models, one ACO surveyed demonstrated successful integration of behavioral health by paying their psychiatrists hourly to support primary care physicians caring for patients with behavioral health issues.[27] While the psychiatrists are paid hourly for this primary care support, the actual primary care are reimbursed under a shared savings model that produce savings due to the primary care provider's ability to better manage patients.

As new delivery models are developed in primary care settings, it is crucial that commissions and advisory boards that develop standards and provide oversight of implementation contain members from women's health fields and have backgrounds in health disparities to ensure new delivery model standards that accommodate the shifting needs of women as they age, resulting in better coordination, improved quality and lower costs. Unfortunately, although women's health advocates were able to successfully amend the final law to include consideration of OB/GYNs for additional ACO guidelines, requirements for the inclusion of women's health experts or female stakeholders representing the needs of priority populations of women on newly created commissions and advisory boards are lacking in Massachusetts' final law.

Prevention and Wellness Programs

Research shows that prevention and wellness programs decrease or prevent the development of chronic diseases, promote healthier lifestyles, and reduce overall costs.[28,29] However, without a commitment to including subgroups of women in prevention and wellness programs and reporting out on the impact such programs have on segments of the population, states will miss a crucial opportunity to address a main source of rising costs, poor quality of care, and inequities in the healthcare system.

Nondiscriminatory wellness programs

Chapter 224 provides a tax credit to businesses that implement wellness programs. Most of these programs offer incentives to their employees, such as a reduced premium, when they engage in certain health activities including going to the gym or achieving a specific health status as a nonsmoker. This can result in discriminatory practices if alternative ways to meet benchmarks are not available and protected from subjective decisions. Low income, working parents may face significant barriers to using a program designed without the inclusion of child care arrangements, rural employees of large companies may not have access to the same health facilities as their urban counterparts, and those with chronic diseases must rely on a provider's subjective opinion on meeting certain health standards.[30] Women are more likely to be low income, responsible for child care, and are disproportionally affected by chronic diseases.[12,13] Currently, no research examines the effectiveness of wellness programs that specifically raise or lower an individual's healthcare costs, an issue particularly problematic for low-income women.[31] In addition, there are

no accountability mechanisms in place to monitor and measure the effectiveness of wellness programs to improve health outcomes, an area of concern for priority populations who already have barriers such as child care, transportation, time, and financial concerns to overcome in order to access these programs.[31]

In order for women to gain from these new wellness incentives, there must be protections in place for employees who are unable to take part in the programs and alternative ways for them to earn incentives. Protections should include rigorous evaluation of wellness program certification standards to ensure they are effective and nondiscriminatory, expanded resources to help lower-income employees access wellness programs, and standard measurements to assess the impact wellness programs have on access to care, costs, and health outcomes.[32]

Evaluation of the impact prevention and wellness programs have on women's health is key

Massachusetts Chapter 224 includes a focus on prevention and wellness programs as a mechanism to improve quality and decrease costs throughout the healthcare system by establishing a Prevention and Wellness Fund (the Fund) to award communities committed to eliminating health disparities with grants to implement research-based interventions.[33]

Legislators working with women's health advocacy groups were successful in amending Chapter 224 to include a commitment ''to include women, racial and ethnic minorities, and low income individuals'' in programs funded by the Fund.[33] This change brought funding guidelines in line with federal grant requirements that require grantees to include women and minorities in studies under the 1993 National Institutes of Health Revitalization Act.[34]

Additional amendment language proposed by women's advocacy groups, mandating that the evaluation of outcomes for these funded programs be stratified by sex, sex–race groups, and by socioeconomic status, failed to make it into the final law. Although progress has been made toward including priority populations of women in prevention and wellness programs, without routine analysis and reporting on the impact of interventions on these subgroups—including the intersection and interaction of race and sex—we cannot fully understand whether the proposed interventions improve prevention and wellness for specific segments of the population. Research demonstrates that interaction effects of sex and race are key in interventions uncovering health disparities in all aspects of care.[35]

Quality Measures and Evaluation

With major changes to the U.S. healthcare system underway, states should assess the impact these changes have not only on healthcare costs, but also on the quality of care provided. Without sex-specific quality measures and evaluation tools, we are unable to effectively analyze the impact such reforms may have on all segments of the population.

Sex- and gender-specific quality measures

To ensure appropriate evaluation of reforms, states should choose quality measures that include metrics for women's unique healthcare needs and sex-specific measures to evaluate quality and access to healthcare. In Massachusetts, Chapter 224 mandates the development of a standard of healthcare quality measures known as the ''standard quality measure set,''[36] yet fails to explicitly include sex- and gender-specific measures. Women not only use more specialty care than men, they are also significantly more likely to report problems with their healthcare.[37] To better understand women's health issues, it is important to implement quality measures specific to women. For those measures relevant to both men and women, it is key to analyze and report on how quality outcomes differ due to biological sex differences or gender-linked psychological, social, or cultural factors.[38]

Women-centered measures are important for several reasons. First, women are the major consumers and key health decision makers for their families and are therefore the key stakeholders and patients in improvements to the health system writ large.[39] Second, the healthcare system as a whole needs to identify improvement efforts in women's health and identify gaps in access and quality to ensure all segments of the population benefit from cost reduction and quality improvement efforts.[38] Lastly, reducing sex and gender disparities are crucial to improving access to outcomes of care, essential components of any successful health reform efforts to improve quality and reduce costs.[38,40] As new health reforms are underway, states must effectively monitor implementation and track progress through quality measures. For example, ACO leaders expressed the need for better and more appropriate quality measures to meet the behavioral health needs of their patients.[41] In one study, many ACO surveys focused on depression screening because of the inclusion of this measure in their Medicare ACO contracts.[41] But we know that women's behavioral health issues extend far beyond this one measure.

A lack of healthcare quality measures for many conditions specific to women is problematic, as is the failure to analyze sex- and gender-based differences in care.[42] One study conducted by the Institute of Medicine Committee examining U.S. preventive services for women found that there was insufficient evidence to develop new recommendations for women due to a lack of analysis on quality outcomes stratified by sex and gender, and that further high-quality research is needed to understand and better address preventive services for women.[43] To ensure that high-quality care is being provided, it is essential that quality measures include measures to address women's unique health needs across the lifespan. These measures can include access to well-woman visits and preventive services, reproductive and mental health access, access to confidential services, and others. Quality measures that include women's health needs will help better inform policy makers where fragmentation and other issues lie, so that targeted solutions can be implemented. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) are measures used by the majority of U.S. health plans to measure quality of care and service.[44] Although there are HEDIS measures specific to women's health such as mammograms and pap smears, for measures that include both sexes, results are not reported out by sex or gender, hindering the evaluation of quality of care for both women and men.[45]

Sex and gender differences in evaluation of reform efforts

Evaluation of cost containment reform should include collection, analysis, and reporting of data by sex. Evaluation

should also include an analysis of the intersection of sex and race/ethnicity, socioeconomic status, disability, age, and other relevant demographics to monitor and evaluate health disparities under cost containment.

Given that women are disproportionately impacted by certain challenges related to affordability of healthcare, transitions between coverage, and being uninsured,[12,13] understanding how diseases develop differently in women and men is essential for addressing health disparities. Despite numerous studies, very few states have taken proactive steps to conducting sex-specific data collection. With amended language suggested by women's advocacy groups, Section 274 of Chapter 224 now requires the creation of a special Massachusetts Diagnostic Accuracy Task Force to report on ''the extent to which diagnoses in the Commonwealth are accurate and reliable, including the extent to which different diagnoses and inaccurate diagnoses arise from the biological differences between the sexes.''[46] This is a vital first step toward including evaluation of sex differences but lacks analysis on subgroups of women and men, such as African American, Latina, young, older, and disabled women and men. Results from a survey analysis found that although 97% of Massachusetts women have health insurance coverage, there were higher rates of uninsurance among young, Latina, and single women.[47] This nuanced level of data will help the Commonwealth reach the remaining uninsured and help to address health disparities by closing gaps in coverage and affordability for subpopulations that remain at risk. Only then can the state truly address the rising cost of care for all populations.

Confidentiality

Increased transparency is a crucial aspect to curb the healthcare cost growth to make consumers more aware of the cost of services and determinants of their own health status, to make informed healthcare decisions, and assess the benefits and limitations of healthcare services.[48,49] Studies show that greater transparency supports healthcare reform efforts and healthcare quality.[49,50] Both Chapter 224 and the ACA aim to increase transparency and reduce healthcare costs. However, increasing transparency may have unintended consequences when it comes to ensuring access to confidential services. As efforts to reduce healthcare costs by increasing transparency are implemented, it is essential to ensure safeguards are in place to protect patients' access to confidential services.

Access to confidential care

Explanation of Benefit (EOB) forms are one type of insurance communication that provides detailed information to the policy holder on the type and cost of medical services received by each beneficiary, with the intent to make costs of services more transparent. EOBs are routinely sent to the primary health plan policy holder each time individuals on that plan access care, even for services where no cost-sharing is required. Sensitive health information is frequently disclosed in an EOB violating a patient's right to privacy and breaching confidentiality, a fundamental tenet in the delivery of healthcare.[51] For example, minors/young adults, now covered until the age of 26 on a parent's health insurance plan under new provisions in the ACA, may be deterred from seeking sexual or reproductive health services or other sensitive health services for fear of EOB disclosure to parents. This age provision has led to increased insurance rates for young people across the country, including 1.1 million young women, many of whom will need access to sensitive preventive care including contraception, mental health treatment, and substance abuse services.[52.53] For women experiencing domestic, physical, or sexual violence, disclosure to an abusive partner or family member via the EOB may trigger additional, even more intensive abuse. As people enter the healthcare system in increasing numbers post-ACA and as an increased focus on cost and transparency intensifies across the U.S., it will be increasingly important to develop methods and strategies that ensure access to confidential care.

Without access to confidential care, many women may forgo or delay care. Research demonstrates that delayed or forgone treatment is likely to lead to major health problems and serious health consequences over the long term.[54] For example, a survey of adolescent women found that 11% would delay accessing HIV or other sexually transmitted infections services if parental involvement were mandated,[55] and another national survey of adolescents found that the most commonly cited barrier to sexually transmitted infection testing was that their parents would find out ''they were having sex.''[56] Delaying or forgoing care can put individuals at higher risk for untreated health conditions and complications which can further escalate healthcare costs.[57] Without access to confidential care, efforts to reduce costs by increasing transparency may actually lead to higher expenditures down the road, which is particularly problematic to women who are more likely to face healthcare affordability challenges.

In addition, without access to confidential care, individuals often utilize free care at community health clinics rather than through private insurance.[57] This places a burden on community clinics which are already facing shortages of funding.[57] For example, more than 60% of clinics reported clients choosing their facility because they provide care in a safe and confidential setting.[58] Confidentiality is key to maintain patient–provider relationships and ensure patients get the necessary care they need. It is essential as Massachusetts and the nation at large moves towards greater insurance coverage and healthcare transparency to consider the cost-effectiveness of providing confidential care.

Conclusion

The passage of Massachusetts Cost Containment Law Chapter 224 informed women's health advocates of unintended adverse affects of certain provisions the law could have on women. This spurred on the filing of several amendments to ensure women's health needs are addressed under the law. However, despite five amendments to Chapter 224, more work must be done to meet the needs of women. As Massachusetts and other states pass legislation to control costs, it is essential to consider the impact these laws will have on women's health including the opportunity to improve care for populations of women who have delayed or foregone care contributing to rising cost over the long term. The good news is that many opportunities to improve women's health are included in the law and provide Massachusetts with the promise

and unique opportunity to be a leader and model for other states by focusing on women's health equity as a means to improve quality and access to care for all while reducing costs.

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Address correspondence to:
Therese Fitzgerald, PhD, MSW
Mary Horrigan Connors Center
for Women's Health and Gender Biology
Brigham & Women's Hospital
1620 Tremont Street
Boston, MA 02120

E-mail: tfitzgerald1@partners.org