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WHERE

**WOMEN FOR HEALTHCARE EDUCATION,
REFORM AND EQUITY**

**MANAGED CARE AND
WOMEN'S HEALTH SURVEY**

January 1 1998



WHERE

MANAGED CARE AND WOMEN'S HEALTH SURVEY

EXECUTIVE SUMMARY

Women's Health and Managed Care Study is the **first** study of its kind in the **United States** to **examine** in depth what managed care organizations are doing on **women's** health.

Over **75%** of all employees with health insurance are now in managed care organizations compared with **48%** in **1993**. Consequently, the transition to **managed care** has **happened** in an **extremely** short period of time, **often** causing **frustration** and confusion for **consumers, employers, providers, purchasers and payers**.

Managed care organizations offer many early intervention, prevention and health promotion, which make them significantly different from the traditional fee-for-service indemnity service system. This study **represents** an educational **effort** for consumers, plans, **providers** and on the range of women's health issues, **These issues** can be an integral **part of managed** care organizations.

Women's health **has traditionally** been **defined largely** in terms of those health needs that are **different from men:** reproductive **health, maternity care, breast and cervical cancer.** While these are **important health** issues, **women's health is** broader than these concerns.

We know that:

- ***240,000 women die each year from heart disease.***
- ***49,000 women die each year from lung cancer.***
- ***43,000 women die each year from breast cancer.***
- ***27,000 women die each year from colon cancer.***
- ***Women are three times more likely than men to have episodes of clinical depression.***

Women are also the **primary caregivers and caretakers** for themselves and their families. They **are the** major **caregivers for their parents and parents-in-law.**

We know that:

- ***Infant and pediatric asthma is on the rise.***
- ***Depression, suicide, alcohol and drug use among teens is rising.***
- ***81% of all pregnancies prior to age 19 are unintended.***
- ***57% of all pregnancies are unintended.***
- ***78% of all cases of depression in the elderly and 78% of all cases of alcoholism in the elderly are overlooked.***

Women for Healthcare Education, Reform and Equity (W.H.E.R.E.) wanted to identify what HMO's Managed Care Organizations are doing for **the** life span health needs of women and the **people** they care for **in their** families.

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THE PROCESS

Women for Healthcare Education, Reform and Equity (W.H.E.R.E.) sent surveys to the top 12 managed care organizations in Washington State. Six responded to the survey. Of the six, three are national, for-profit managed care organizations. Three are not-for-profit, statewide or regional organizations. Of the six, five are network/group model managed care organizations. One is a **staff model** managed care plan.

Network/group model plans contract with physicians and physician groups that contract simultaneously with many other managed care organizations. **Staff** model managed care organizations basically have their providers on salary, have their own health care facilities and do not see patients who are not members of their plan. For example, a network model managed care plan will use many local facilities and hospitals. A staff model has its own facilities and providers and does not see or treat patients who are not members of that plan nor are non-members allowed to use their hospital. Network models contract with hospital and providers who see members from many **different** plans.

After the survey results were compiled, the findings were returned to the plans. The findings was a listing of all their responses. The plans were listed only as plan one, plan two, etc. Each plan was told which one they were, so they could see their responses in comparison to their competitors. We gave the plans an additional three weeks to review the information and gave them the opportunity make any changes they wished. Three of the plans made changes. Three did not. We called them to confirm this before the final report was prepared.

W.H.E.R.E. is not naming the plans that responded or did not respond. We did not want to rank the plans that responded. Our goal was to demonstrate the many **differences** between plans so that consumers can see the difference and become **their** own best healthcare decision makers for themselves and their families.

The six plans that responded have a combined membership (covered lives) of **nearly 2 million members (1,716,390)**, or roughly the equivalent of 33% of the total population of Washington State (5.15 million people). Fifty-three (53%) percent of all Washingtonians have private, commercial health insurance (**2,729,500**). These findings, therefore, reflect the coverage of 63% of all people with private, commercial health insurance in the state.

WHY THIS STUDY?

The medical school curriculum has little in it specific to women's health. Adolescent medicine, which focuses on teen healthcare issues, is considered to be a subspecialty of pediatrics. Women are three times more likely than men to have episodes of clinical depression, so restrictions on mental health coverage can possibly have an adverse **affect** on women. Nearly 30% of all women will experience episodes of domestic violence and women live on an average of seven years longer than men. These issues warrant examination and planning as American healthcare moves into a predominantly managed care environment.

Managed care organizations are more likely to offer services that help prevent diseases than the traditional fee-for-service system. W.H.E.R.E. wanted to develop a baseline snapshot of what managed care organizations are doing. W.H.E.R.E. wanted to identify the range of preventive and health promotion coverage managed care plans are offering, and any areas of unmet needs or gaps. If managed care organizations have needs and gaps, then in all likelihood the same gaps exist in the traditional fee-for-service system or are even greater.

W.H.E.R.E. also wanted a baseline survey on managed care organizations so consumers can see how truly different health plans are in what they cover. No two health plans are the same. We intend to conduct the survey on an annual basis and expand the range of plans and states each year.

The survey was designed to be an educational effort for the health plans and to provide information to consumers, purchasers, public policy officials and providers about the full range of women's health and the health needs of children, adolescents and the elderly.

Our goal is to educate, not to rate health plans. It has been a relatively short time in the history of American healthcare that we have moved from a fee-for-service system to a managed care/primary care system. We recognize managed care has come a long way **from** the traditional fee-for-service system. We hope to work with plans to create a road map of ways to offer healthcare services that meet the needs of women and families.

Most importantly, W.H.E.R.E. wishes to increase the consumer's voice in healthcare decisions. We believe it is imperative consumer's take a more active role in their own healthcare. By providing a baseline of what managed care organizations cover, we can clearly show the range of responses and identify areas of common coverage or significant differences. We will also use the findings to create tools consumer's can use and begin a systematic educational campaign.

KEY FINDINGS

We were pleased to see the extensive work managed care plans are doing to educate their members and to provide some new health and **wellness** benefits. The traditional **fee-for-service** indemnity system traditionally has not covered the costs of these benefits nor provided for the costs of annual examinations, early screening and diagnosis. Managed care has introduced new and welcome steps. We applaud the directions these plans are taking.

Patient Education Materials:

All six plans sent their members health care handbooks, such as *Care Wise* or *Take Care of Yourself*:

Five sent their members health information quarterly.

One sent information monthly.

Four had health **fairs, wellness** classes, phone referrals and/or consulting nurses.

One had an outreach campaign on mammograms and pap smears.

One plan offered a \$250.00 community wellness benefit for its members.

Health and Wellness Benefits:

Two plans covered the cost of smoking cessation classes.

Three plans referred members to community programs for those programs.

Three plans covered the costs of nicotine replacement therapies, of which one had a co-payment.

Two plans covered enrollment fees in health clubs for all their members.

Two plans offered discounts on enrollment fees.

All six plans covered annual exams, mammograms and pap smears.

All six plans covered maternity and well-child care.

Two plans had contraceptive coverage except for male condoms and over the counter products.

These preventive measures, patient education materials, health and **wellness** programs are a needed new addition to consumer healthcare so patients can be more active participants in their own health care. But, we also found that there are many areas for improvement and found major **differences** between plans on the details of coverage for particular conditions.

What this study clearly indicates is that little consistency of coverage exists **from** plan to plan. Each covers benefits at very different levels, with different co-payments and have different relationships with providers. Consumers need to be aggressive in asking questions to assure their coverage needs are met.

SELECTED SUMMARY

Contraceptive and Maternity Coverage

While all the plans had maternity and well-child coverage, their coverage of contraceptive varied significantly.

Contraceptive Coverage:

Decisions about contraceptive coverage were said to depend largely on the employer contract. Only one plan covered all the contraceptives methods listed in the survey. One said it covered everything except condoms and over the counter (non-prescription) products; one said contraceptive coverage depended on the employer group; one said they did not cover contraceptives; and one covered contraceptives if the employee purchased the pharmaceutical benefit.

Maternity and Well Child Care:

All the plans covered maternity, child care, and childhood immunizations. But, how they covered those costs **differed**. One had a \$250 deductible for maternity; one had no co-payments for pre-natal care visits; one had a \$15 co-payment per maternity visit.

All covered well child visits; one had a \$10 one time co-payment for well child visits; one had \$10 co-payment for each well-child visit and one had a variable co-payment depending on the coverage level the person chose.

Adolescent Health

This was the thinnest section of the report. Only one plan gave any consistent information on the health needs of teens. Most plans did not respond to any of the questions in this section. None of the plans were able to answer when a woman should have her first pap smear other than one plan that said age 18.

Women's Health

Heart Disease=

One of every two women will die from heart disease, or 240,000 women per year. The plans varied extensively about when women were first screened for cholesterol and risk of heart disease.

One plan said age 35; one said no age was recommended; one said 50; one said it was up to the physician to make the decision; one did not know if the screening was part of an annual exam or not.

Three said they had risk reduction programs, three said they did not. Of those with risk reduction programs, most used member newsletters and one offered classes.

Two covered the costs of enrollment fees in health plans to promote healthy lifestyles and two offered discounts on enrollments.

Two plans covered the costs of nicotine replacements; two did with a co-payment; one did not answer; one said no.

Lung Cancer:

49,000 women die from lung cancer every year.

Two plans covered the cost of smoking cessation classes; four did not.

Three referred members to community non-smoking groups; one did not; one did not respond; one covered the cost of the classes.

Breast Cancer:

43,000 women die from breast cancer each year.

All six plans covered the cost of mammograms at 100% for the test and the lab work.

One plan said mammograms were covered when authorized by the primary care doctor; one plan said every other year for women between 20-40, and every year over 40; one plan said they had internal guidelines; one plan did not respond to the question; one plan said annually, if medically necessary.

Colon Cancer:

*Colon cancer is the third leading cause of cancer **deaths** among women.* Of the six plans, only three said women had regular stool and rectal examinations.

Two plans said the exams began at age **50**; three plans did not respond; one plan said no age was specified.

Three plans said they asked women about a family history of colon cancer; three plans did not respond.

Cervical Cancer, Sexually Transmitted Diseases (STD's) and Ovarian Cancer:

All six plans said they covered the costs of pap smears.

Two plans said they used new digitized screening tests; one plan said they did not know **if they** used them or not; two plans did not respond; one plan said it was looking into the procedure.

Three plans said they gave information to women about **safe** sexual practice regardless of the gender of their partner; two plans did not respond; one plan did not give out information.

Menopause:

Two plans said they counseled women on estrogen replacement therapy (**ERT**) and hormone replacement therapy (**HRT**) at the onset of menopause; one plan did not respond; one plan said no, it was up to the primary care provider; one plan said only if medically necessary.

Four plans said hormone replacement therapy was covered in their benefits; two plans did not respond.

One plan said they used the guidelines of the American College of Obstetrics and Gynecology; one plan said they used the US Preventive Service Task Force guidelines; three plans did not respond; one plan said they used internal guidelines.

Three plans did not respond as to alternatives to HRT; one plan said they did not know; one plan said it had print materials; one plan said it was a decision between the doctor and the patient.

Four plans said they covered the cost of bone density tests; two did not respond.

Geriatrics/Senior Health:

Women on the average seven years longer than men.

Two plans had **wellness/mall** walking programs for seniors; three plans did not respond; one plan gave out health education information.

Three plans said they periodically reviewed medications with seniors; one plan said they did not periodically review medications with seniors; two plans did not respond. *

Three plans said they screened for alcoholism or medication abuse, one of which said they screened if medically necessary; one plan said they did not know; two plans did not respond. **

****Adverse drug interactions are the single most common reversible cause of dementia in the elderly.***

*****More elderly people are hospitalized for alcoholism than for heart problems.***

Mental Health:

Women are three times more likely than men to have episodes of clinical depression

Three plans indicated they screened women for depression; two plans did not respond; one plan said if medically necessary.

Three plans contracted with special mental health/behavioral **health** agencies for mental health services; one plan used their own providers; one plan used both.

Five plans limited mental health services to 20 out-patient visits per year; one plan had products that had either 5, 15 or 20 visits per year.

Hospital mental health care coverage ranged from 5 days to 60 days.

Drug Formularies:

Drug Formularies are lists of medications a health plan will pay for/cover as part of its benefits.

Five plans said they had “restricted” formularies; one plan did not.

Three plans said no prior authorization was needed for providers to prescribe medications; two plans said yes for a few of the medications; one plan said yes and the physician **must** have prior approval

Domestic Violence:

Nearly 30% of all women will probably experience episodes of domestic violence.

Three plans did not respond when asked if their providers were trained to recognize signs of domestic violence; one plan said yes; one plan said yes for certain groups.

Women of Color:

Women of Color are at higher risk of certain diseases, such as diabetes and hypertension than Caucasian women.

Three plans responded yes that they screened women of color for diabetes, hypertension and uterine fibroids; three plans did not respond.

Alcoholism, Substance Abuse and Chemical Dependency:

Four plans covered both in-patient and out-patient drug/alcohol dependency programs; one plan did not respond; one plan had internal treatment guidelines.

Alternative Therapies

All **six** plans covered alternative therapy providers. One includes naturopathic physicians as a primary care provider.

All six plans had limits on these providers. They range from 60 day to \$300 annual limit, or other limits based on the treatment and insurance benefits.

CONCLUSIONS

Managed care is making progress in prevention, education, early diagnosis and treatment. We hope they will continue in that direction. The gaps that exist in these organizations we can only assume are greater in the traditional fee-for-service system.

All the plans used primary care providers who were the main caregivers or who made referrals to other services.

Our recommendations reflect ways in which consumers can become more informed participants in their own health care and be more active in working with their employer, provider and insurance company in gaining access to services that affect themselves and their families. We have also made recommendations for managed care organizations so they can improve some services for women and families.

We hope this will serve as a baseline survey and promote discussions among consumers, providers, health plans, public policy and elected officials about developing an action agenda for the health of women and families.

Kathleen O'Connor
Founder/Executive Director
January 1998

MANAGED CARE AND WOMEN'S HEALTH SURVEY

SECTION I: RECOMMENDATIONS

Women for Healthcare Education, Reform and Equity (W.H.E.R.E.) has just completed a managed care survey asking what managed care organizations are doing for the life span health needs of women and the people they care for in their families. The results of that survey lead to the following suggestions:

I. CONSUMERS

Findings from this study clearly demonstrate how dramatically health plans **differ** in their relationships with their providers, the kinds of coverage they offer, the kinds of co-payments associated with office visits and access to medications. While managed care organizations have significantly improved patient education, such as offering members health books, newsletters and expanding coverage for mammograms and pap smears, there is much variation in coverage for other health needs for women and children.

Consumers must take a more active role in asking questions about their coverage and have checklists and guidelines to ask of plans, employers and providers to assure the health needs of families are being met.

- A. **Ask questions about coverage concerns of you and your family.**
These questions can focus on the health needs of your family. Ask age specific questions, such as pediatric care (child health), **contraceptive** coverage, maternity care, menopause, geriatric care (senior health), access to medications and access to providers of color.
- B. **Do not assume **all** health plans cover the same things.**
They don't.
- C. **Ask questions of your employer or make suggestions about coverage you would like to see included.**
- D. **Ask your plan for a checklist of healthcare concerns by age, so you can be a more informed and active participant in your own healthcare.**
- E. **Make a list of your family history of heart disease, cancer, osteoporosis, mental health, or family history of diabetes or stroke. Review these with your provider to develop a family and personal health/well-being action plan.**

II. MANAGED CARE ORGANIZATIONS

- A. **Create checklists for life cycle health needs that can be used by both consumers and providers.**

Consumers need to have information they can keep for their own family medical history. Members **often** change plans on an average of every three years. If consumers and providers have these checklists then both provider and members can have common expectations about We cycle care needs.

- B. **Develop closer relationships with providers and contracting medical groups and clinics.**

The survey responses indicate managed care organizations may be deciding what they will re-reimburse providers without knowing in detail what their providers are doing or the kinds of patient education materials providers have in their offices.

- C. **Send member newsletters with patient health information to the participating clinics.**

- D. **Encourage your providers to take Continuing Medical Education courses on women's health, adolescent health, menopause and geriatric health.**

- E. **Develop life cycle standards for screening, testing, diagnosis and treatment that can be used by all plans.**

Professional associations exist that can recommend general life cycle standards for screening and diagnosis. Many of these standards **already** exist from the recommendations of groups such as the **U.S.** Preventive Services Task Force; the American College of Obstetricians and Gynecologists. Other suggested life cycle standards would include:

1. *Pediatric Care: Birth to puberty: Include testing for asthma.*
2. *Adolescent Care: **Puberty** to 18 or 20: Create standards for adolescent care that include ways to screen for depression, **STDs** and eating disorders. **STDs** are increasing among teens between the ages of 12 and 19. Herpes **alone** has risen from 1.6% of all teens between 1976 and 1980 to 5.6% between 1988 and 1994 (Center for Disease Control).
Develop recommendations and **standards** about first pelvic exam **and** pap smears for young women.*

3. **Women's Health: Adult:**
- a. **Heart Disease:** Heart Disease kills one of every two women. Offer all women baseline testing and screening for family history of heart disease, including cholesterol screening, which is not based on age, but on family history or other known risk factors.
Consider covering the costs of nicotine replacement and smoking cessation programs.
 - b. **Menopause:** Develop recommendations for your **providers** on issues facing women during menopause
Counsel women on the increasing risk of heart disease **after** menopause and risk of osteoporosis.
 - c. **Senior Women:** Washington state has one of the highest cervical cancer rates in the United States, with the deaths occurring in largely elderly women. Heart disease shows up later in women than in men and the symptoms women face may be different in women than in men.
Encourage your provider to take C.M.E. courses on geriatric health needs and heart disease in women.
 - d. **Contraceptives:** 81% of all pregnancies before age 18 are unintended 57% of all pregnancies are unintended
Most health plans cover maternity coverage as part of their benefits, but not contraceptives
We strongly recommend all health plans cover contraceptives.
 - e. **Domestic Violence:** Nearly 30% of all American women will be a victim of **domestic** violence.
We strongly recommend your primary care . . . providers have training in the symptoms of domestic violence and that your contracting providers have resource information in their offices for women.
 - f. **Mental Health:** Access to mental health services varies significantly from self **referral** to provider referral
We recommend working with existing groups such as Washington State Psychological Association or Psychiatric Association to develop guidelines on assessment and referral for depression, panic attacks **and** other mental health **disorders**.
 - g. **Women of Color:** Women of color are at higher risk for certain cancers, hypertension, diabetes and uterine fibroids than Caucasian women.
We recommend working with community groups who work with women of color to develop checklists for providers of some key health issues that may be unique to women of color.

- h. *Drug Formularies:* *We believe patients have a right to know if a managed care plan uses a restrictive **formulary** or not We also have concerns about how **formularies** may interfere with the **provider/patient** relationship. We would like to see documentation **that clearly demonstrates restricted drug formularies improves patient care or lowers overall health care costs.***

F. **Develop community partnerships.**

Many consumer organizations exist which complement the efforts of health plans. These organizations provide educational programs which could benefit members, plans and providers. Some of the organizations are: the March of Dimes, American Cancer Association and the American Lung Association.

G. **Appoint consumer members to your Boards of Directors.**

These consumer members could be from existing consumer organizations, such as the National Organization of Women (NOW), American Association of University Women (**AAUW**), Women for Healthcare Education, Reform and Equity (W.H.E.R.E.), the American Association of Retired Persons (AARP) or Labor.

H. **Continue the work in progress from a disease based model of care to a preventive, early intervention model.**

This could include:

1. *Offer more educational opportunities and cover costs to quit smoking.*
2. *Continue the work of **offering** discounts on memberships to health plans or providing a community benefit, such as **\$250/year for wellness** and education programs*
3. *Develop a woman's health action plan for your managed care organization so the above needs can be met in a systematic fashion for your organization.*

III. PROVIDERS

- A. Be more proactive in informing the plans of your recommendations for standards of care.**
- B. Work with health plans to develop educational goals on women's health, and especially adolescent health, heart disease, menopause, domestic violence, mental health and senior health.**
- C. Survey your women patients on recommendations they have for your clinic that would increase access for women and children.**
- D. Have information in the clinic or office on community resources that support your clinical efforts.**
- E. Develop a women's health education plan for your medical specialties.**

IV. PURCHASERS/EMPLOYERS

Most plans responded that coverage decisions depended on the employer or on the benefit coverage that was selected by the employer or employee (unless it was mandated).

- A. **Develop some standards of coverage you would like included in the health plans your company uses.**
- B. **Promote family friendly benefits that assure access to early diagnosis, treatment and preventive benefits.**
- C. **Create priorities for benefits that meet the health needs of women, employees and their families. Consider developing checklists for the health plans of the benefits that are of a high priority in assuring the health and well-being of your employees and their families.**
- D. **Continue the work of expanding employer purchasing cooperatives to expand coverage options for small employers.**
- E. **Work with consumer groups, the state, managed care plans and others to identify ways to cover the increasing number of individuals who do not have access to insurance so ways may be found to cover the dependents of your employees, especially children which are becoming the largest segment of the community without insurance.**

MANAGED CARE AND WOMEN'S HEALTH SURVEY

SECTION II: THE FINDINGS

L PRIMARY CARE PROVIDERS

Managed care is heavily dependent upon the “primary care” providers as the main healthcare provider patients use or see **first**. The primary care provider offers the care or refers the patient to others in the network (list) of providers who can offer specialty care. These primary care providers have also been called “gatekeepers” because they are responsible for overseeing and coordinating all patient care services.

Of the six plans that participated, all used primary care providers as the main healthcare provider who offers the care or makes referrals. The only exception to this was one plan that allowed women to see women’s health providers without authorization by the primary care provider.

Of the six plans that responded, all considered the following to be primary care providers:

- Family practice physician
- Internal medicine physician
- Pediatrician

Additionally:

- Three plans included **ARNPs** (Advanced Registered Nurse Practitioner).
- One plan also included physician assistants (PA)
- One plan included naturopathic physicians as a primary care provider, but did not use ARNPs or physician assistants

None of the plans listed obstetricians/gynecologists as a primary care provider.

when asked if individual primary care providers were capitated, i.e. paid a flat fee per patient:

- Two responded no.
- One responded no, but that it depended on the contract.
- One said yes, but only for 10% of the network.
- One said it depended on the product.
- One plan only capitates outside, non-plan providers.

When asked if the panel of doctors they contracted with were capitated:

- Three responded no.
- One yes, depending on the type of contract.
- One said it depended on the contract.
- One said 90% is capitated locally and 10% is capitated through it’s network.

When asked if the whole organization were capitated:

- One responded yes.
- Two said no. ,
- Three said it depended on the product line.

when asked which primary care providers were capitated:

- Four listed family practice physicians, internal medicine physicians, and pediatricians, as they outlined in response to question one (who is a primary care provider).
- One plan said the organization as a whole was capitated.
- One said no distinction was made between primary care and specialists when it came to capitation.

*When asked if the **primary** care provider was at financial risk for referrals to specialists:*

- One said only 10% of their primary care providers were at risk for referrals.
- One responded yes.
- Two said no.
- One said it depends on the contract.
- One did not respond

When asked if there were a ‘withhold’ or a percent of capitation held back for pharmaceutical costs:

- One said they did not know.
- Two did not respond.
- One said they had no ‘withhold’ and pharmaceuticals were not part of the primary care doctor’s capitation.
- Two said it varied by contract. (Of these two, one said it also varied by age mix of the patients.)

when asked if they offered a point of service (POS) option which enables members to use providers outside their panel/network:

- Five plans offered their subscribers point of service options. The patients had to pay a higher percentage of the costs. One of the five plans had a higher co-payment
- One said their POS was a **different** product with different benefits and structure than their HMO product.

II. Reproductive and Maternity Health

*The plans were asked if they covered all forms of contraception (male and female) including: birth control pills, IUDs, diaphragms, hormone implants, hormone injections, morning **after** pill, sterilization (men and women), condoms (male and female), *spermicides*, cervical caps and natural family planning:*

- One said yes.
- One said yes, except for male condoms and over the counter contraceptives.
- Two said it depended on the employer group buying the coverage.
- One said no.
- One said contraceptives were covered if the patient purchased the benefit (presumably the pharmaceutical benefit, but that was not specified).

*When **asked if this coverage was for all products, preferred provider organization (PPO), points of service (POS) or only for their health maintenance organization (HMO) product:***

- Two said it was for all products.
- Three did not respond.
- One said it was only for the HMO product.

When asked which were covered:

- One listed all products as being covered.
- One said it covered birth control pills and hormone implants if the coverage was decided, and charged a \$5 co-payment. (The same plan said **IUDs**, diaphragms, hormone injection, morning **after** pill, sterilization for men and women and natural family planning were covered under the co-pays associated with out-patient physician visits).
- Two said there were no co-payments for prescription contraceptives, and the patient co-payment depended on the provider chosen.
- One said all the contraception methods listed were covered, but had either \$5, \$7, or \$10 co-payment depending on the co-payment method the patient selected. (The same plan said they did not cover the female condom).
- One indicated that the co-payment depended on the plan the patient selected.

*When it came to maternity coverage, including maternity/prenatal care, midwifery, and home **delivery/midwifery** services:*

- One plan did not respond.
- Four said they had maternity coverage for their group/commercial products for all these services.
- One said yes for all, except for home deliveries.

When asked if their individual product covered the same services:

- Three said yes to all products listed.
- One did not offer an individual product.
- One did not respond.
- One responded yes to all but one product listed.

When asked about prenatal visit co-payments:

- Two did not respond.
- One had a one time \$10 co-payment.
- One had a \$15 co-payment per visit.
- One had \$5/7/10 co-payment depending on the contract.
- One said it depended on the group.

When asked if there was open enrollment or enrollment restrictions for their individual policies regarding maternity:

- None of the plans listed restrictions

When asked if pregnant women were routinely screened for HIV/AIDS:

- Two said yes.
- One said yes, with the consent of the patient.
- Three said it was left to the discretion of the provider.

III. Well Child Care

When asked if the plan covered routine well-child care:

- All six plans said yes.

When asked how much the co-pay/deductible is for the routine well-child care coverage:

- Two had no deductible and no co-payment.
- One had a \$10 co-payment for each visit.
- One had a \$15 co-payment for each visit.
- One had either a \$0, \$5, \$7 or \$10 co-payment depending on the patient's choice.
- One said the co-payment depended on the contract.

When asked if immunizations were covered in well-child care:

- One plan did not respond.
- One plan said it covered immunizations through age 16.
- Three said it covered immunizations through age 18.
- One listed no age limit.

When asked if out-patient care, vision, dental, and hearing were covered in well-child care:

- AU covered out-patient care and vision and hearing screening, **if it** were done by the primary care provider.
- Dental was not covered unless the member purchased the dental option.
- Hearing and vision were covered for screening only.

When asked if infants and children were routinely screened for asthma, one of the fastest growing diseases of childhood:

- Three plans did not respond.
- One said it did not know.
- One said **if it** was medically necessary.
- One said no, but hopes to develop a plan for future screening.

When asked how they determined to screen for asthma:

- Five plans did not respond.
- One said the primary care provider did the screening.

When asked how the plan screened for child sexual abuse:

- Three did not respond.
- One said it did not know.
- One said the primary care provider does the evaluation.
- One said their providers were trained to look for evidence of abuse.

IV. Adolescent Health

When asked if their plan offered a specialty in adolescent health:

- F O U R said no.
- One did not respond.
- One said yes.

If yes, the plans were asked to outline the components of that program.

All plans, but one left this blank:

- The plan that said yes had an adolescent center that offered teen parenting and drug/alcohol awareness classes and sober and social support groups. Other educational information was available in print form for teenagers.

When asked if they had clinical protocols that would help identify adolescents who may be at risk for depression, suicide, alcoholism and drug abuse:

- Three said no.
- Two did not respond.
- One said yes.

when asked what tools were used:

- Five did not respond.
- One said they used a modified Beck scale*

when asked if eating disorders were routinely discussed with adolescents:

- Two did not respond.
- Two said they did not know.
- One said yes if medically necessary.
- One said yes.

when asked if teens were routinely given Hepatitis B injections:

- Two did not respond.
- Two said yes.
- One said no.
- One did not know.

When asked if these immunizations/injections were covered:

- Two said yes that they were completely covered.
- Four did not answer.

**The Beck scale is one of several different clinical tools to assess depression.*

When asked if teens could obtain contraceptives without parental consent:

- One said they did not know.
- Three said yes.
- Two did not respond.

When asked if teen women were screened for STDs:

- Two did not respond.
- Two said yes.
- One said yes, if medically necessary.
- One indicated that it did not know.

When asked if they provided information to teens on STDs, and/or HIV/AIDS or both:

- Two did not respond.
- Two said both.
- One said both, if requested.
- One said neither.

When asked if they were talking to young women about the importance of developing bone mass for later years to reduce the risk of osteoporosis:

- Three did not respond.
- Three said yes.

*When asked at what age a woman should have her first pap smear**:*

- Three of the plans did not respond.
- Two said no age was recommended.
- One plan said age 18.

When asked were the plans counseling teens on delaying or limiting their sexual partners to reduce STD risk:

- Three did not respond.
- Three said yes.

**** The correct answer is when they become sexually active or about age 18, whichever comes *first*.**

V. Women's Health

Too often, women's health has been defined in terms of reproductive functions and organs. **W.H.E.R.E.**, therefore, developed a list of some of the leading causes of death in women and asked the health plans to respond to these concerns.

A. Heart Disease

Heart disease kills 240,000 women every year compared to 49,000 from lung cancer and 43,000 from breast cancer.

when asked if their physicians regularly screened women for risk of heart disease, and specifically, if cholesterol/lipid screening is a regular part of an annual exam:

- One said no.
- One said they did not know.
- Three said yes.
- One said that it was up to the physician but it was recommended once every five years for low risk patients.

When asked if women were asked about a family history of heart disease:

- Four said yes.
- One said they did not know.
- One did not respond.

When asked if women who were at risk of heart disease, such as smoking, family history, high bloodpressure, abnormal lipids, cholesterol, little exercise, were counseled on heart disease: ..

- Five said yes.
- One said they did not know.

When asked at what age annual cholesterol/lipid checks started for women:

- One said age 35.
- Two did not respond.
- One said they did not know.
- One said age 50.
- One said no age was recommended

When asked to list the clinical guidelines/protocols they used to screen for heart disease:

- One did not respond.
- One said they did not know.
- One said family history, weight, blood pressure, cholesterol/lipid testing and exercise.
- One used the US Preventive Services Task Force recommendations.
- One used internal guidelines and said testing for cholesterol may start earlier than **50** if the patient is assessed as being at risk.
- One used guidelines on smoking cessation to providers and members.

The plans were asked for whom they had a risk reduction program or intervention:

- Three said all patients.
- One did not respond.
- Two did not know.

When asked what risk reduction intervention they used:

- One did not respond.
- Four said their member newsletter; two of which added patient education materials to their member newsletter.
- One offered classes in addition to patient education materials, even though it did not have a newsletter.

When asked if they offered smoking cessation classes for their members:

- Four said yes, one said yes only **if they** were referred to community resources.
- Two said no.

When asked if those resources were free of charge:

- Two said they were covered in benefits.
- One said they were covered in their benefits **if the** patient chose the prescription co-pay.
- One did not respond.
- Two said the question was not applicable, because it was covered.

When asked if they covered membership in health clubs to promote exercise:

- Two said yes they covered the enrollment fee for both men and women.
- Two said no neither for men or women.
- **Two** said they had agreements with clubs for enrollment discounts.

When asked if they had lower premiums for non-smokers:

- One did not respond.
- Two said no.
- One said they did not know.
- One said they gave a \$250 community wellness benefit for the cost of health education and wellness classes offered by participating providers in the community.
- One said they offered a **wellness** benefit program for the price of the classes offered by the participating providers in the community.

When asked if the plan covered pharmaceutical interventions for smoking cessation, such as nicotine gum or the nicotine patch:

- Two said yes.
- One said yes, with a co-pay.
- Two said no.
- One did not respond.

When asked if women are counseled on Estrogen Replacement Therapy (ERT) or Hormone Replacement Therapy (HRT) in regard to heart disease:

- Two said yes.
- One said no.
- One said if medically necessary.
- Two said it depended on the doctor and patient.

B. Lung Cancer

Lung Cancer is the leading cause of cancer deaths in women and kills 49,000 women each year.

When asked if women were regularly asked if they smoke:

- Three said yes.
- One said they did not know.
- Two did not respond.

When asked (again) if they offered smoking cessation classes:

- Two said yes.
- Four said no.

When asked if they did not, if they referred patients to programs in the community:

- Three said yes.
- One did not respond.
- One said no.
- One said it was not applicable because they offered smoking cessation classes.

When asked to whom patients were referred:

- Three said hospital programs, the American Lung Association or the American Cancer Association.
- One did not respond.
- Two said it was not applicable, because they covered the costs.

C. Breast Cancer

Breast cancer is the second cause of cancer deaths among women.

When asked if the plan covered the cost of mammograms:

- All six said yes.

When asked how often:

- One did not respond.
- Two said when authorized by the primary care provider.
- One said every other year for women between 20 and 40, and every year for women over 40.
- One said as directed by internal guidelines.
- One said annually if medically necessary

When asked if mammograms covered the costs of both the technician and the lab:

- All six plans said they covered both.

When asked if there were cost sharing or were mammograms covered at 100%:

- Five said they were covered at 100%.
- One did not respond.

When asked if they had videos for women on breast self-examination, treatment protocols and procedures:

- Three said yes.
- One said no.
- One said no, but that they had printed materials.
- One said that they have proactive guidelines and printed **materials**.

When asked if the plan had a breast cancer support group:

- Four said no.
- One did not respond.
- One said yes, including a lesbian support group.

When asked if they referred patients to other community support programs:

- Four said it was not applicable.
- One said yes.
- One did not respond.

D. Colon Cancer

Colon cancer is the third leading cause of cancer deaths in women

When asked if women were given regular rectal and stool examinations:

- Three said yes.
- Two did not respond.
- One said rectal exams only.

When asked at what age these examination began:

- Two said age 50.
- Three did not respond.
- One said there was no specified age.

When asked if colonoscopies were included in the exams:

- Two said no.
- One said no, that they used the US Preventive Services Task Force guidelines.
- One said no, only if medically necessary.
- Two did not respond.

When asked if colonoscopies were a fully covered benefit:

- Four said it was not applicable.
- Two did not respond.

When asked if women were screened for a family history of colon cancer:

- Three said yes.
- Three did not respond.

When asked whether all women were screened or only those at risk, such as family history or lifestyle:

- Three said only those at risk.
- Two did not respond.
- One said they used the US Preventive Services Task Force guidelines.

When asked what other tests were used:

- Four did not respond.
- One said the primary care provider could choose the tests.
- One said they used Hemoccult and other tests.

E. Cervical Cancer, Sexually Transmitted Diseases (STDs) and Ovarian Cancer

When asked if their plan covered the costs of pap smears:

- All six plans said yes.

When asked if this covered the exam and the lab work:

- All six plans said yes.

When asked when a coloscopy was recommended:

- Two did not respond.
- One said they did not know.
- Two said it was up to the discretion of the primary care physician obstetrician/gynecologist or Advanced Registered Nurse Practitioner (ARNP).
- One said it depended on an abnormal pap smear.

when asked if there were pap smear guidelines that were specific to Lesbians:

- One did not respond.
- Five said no.

When asked if they used the new digitized screening tests for pap smears:

- Two said yes.
- One said they did not know.
- Two did not respond.
- One was looking into the procedure.

When asked if women were, regardless of their partner's gender, routinely screened for STDs and HIV/AIDS:

- One said they did not know.
- Two did not respond.
- One said only on request.
- One said routine screening was done on chlamydia and others by request.
- One said routine screening and interview questions were asked, only if there were risk factors.

When asked if information about safe sexual practices were given to all women patients, regardless of the gender of the woman's partner:

- Three said yes.
- Two did not respond.
- One said no.

When asked if they gave information on safe sexual practice, were patients referred to other community groups, such as s Planned Parenthood:

- Three did not respond.
- One said this was not applicable because they did not offer the information.
- One had internal educational preventive health guidelines.
- One said they had pamphlets and printed materials available.

When asked if they had clinical guidelines for ovarian cancer:

- Two said yes.
- One did not respond.
- Three said no.

F. Menopause

When asked if women were counseled on Estrogen Replacement Therapy (ERT) or Hormone Replacement Therapy (HRT) at menopause:

- Two said yes.
- One did not respond.
- One said no.
- One said it was up to the primary care provider (PCP).
- One said only if medically necessary.

When asked if ERT/HRT were covered in their benefits:

- Four said they were covered.
- Two did not respond.

Of the four that said they were a covered benefit, if they were subject to co-payments:

- Four said they were covered.
- Two did not respond.

When asked what guidelines or criteria were used to determine if HRT were recommended:

- Three did not respond.
- One said American College of Obstetrics and Gynecology (ACOG).
- One said US Preventive Services -Task Force (USPS-TF).
- One said internal guidelines.

When asked what alternatives to HRT were given to women:

- Three did not respond.
- One said they did not know.
- One said printed materials.
- One said it was between the doctor and the patient.

When asked if they covered the rings and creams for HRT:

- Three did not respond.
- One said no.
- Two said yes if authorized or on a case by case basis.

When asked if Naturopathic physicians were available to women under their benefit package for menopause counseling or diagnosis and treatment:

- All six plans responded yes.

when asked what coverage is available:

- One said Naturopathic doctors are a PCP in their plan.
- Three said they were covered as a referral from the PCP.
- One said it was treated as a referral to a specialist and had a \$10 co-pay.
- One said they were **fully** covered and had applicable co-payments.

When asked if they used the National Osteoporosis Foundation 's risk factor guidelines to determine if a woman is at risk of Osteoporosis:

- Two said no.
- Two did not respond.
- One said yes.
- One said it was up to the physician.

When asked on what basis women were screenedfor osteoporosis:

- Four did not respond.
- Two had internal guidelines.

When asked if women with known riskfactors have access to bone density tests:

- Four said yes.
- Two did not respond.

When asked which tests are used:

- Four responded Dexascan.
- Two did not respond.

When asked if those tests were covered:

- One did not respond.
- Three said yes, all were covered.
- Two said some of the costs were covered.

When asked it they had recommended guidelines for Endometiral biopsy, Osteoporosis Risk Reduction, Risk of Heart Attacks and Strokes, Diet Counseling; such as calcium sources and soy products, Low Fat Intake and Exercise:

- Four said yes.
- One did not respond.
- One said **wellness** classes only.

G. GERIATRICS

Women live on the average, seven years longer than men.

When asked if women were counseled about diseases associated with aging, such as arthritis and Alzheimer's disease:

- Four said yes.
- Two did not respond.

when asked what clinical protocols they used to counsel women on diet and nutritional needs for the elderly:

- Three said they used the US Preventive Service Task Force Report (1996).
- One said they did not know.
- One did not respond.
- One said they were currently planning the wellness programs for their seniors.

When asked if they had a Medicare Risk Contract (Medicare HMO):

- Four said yes.
- One said no.
- One did not respond.

When asked what wellness/prevention plans they used for seniors:

- Two listed mall walking and exercise and nutrition programs.
- Three did not respond.
- One gave out health education information.

When asked if they provided information on senior housing:

- One said yes.
- One did not respond.
- Four said no.

When asked if they provided information on long-term care insurance:

- One said yes.
- Three said no.
- One did not respond.
- One said they did not know.

When asked if medications were periodically reviewed with seniors:

- Three said yes.
- One said no.
- Two did not respond.

when asked who did the review:

- One indicated it was not applicable, because they did not do the screening.
- One said the physician did the review.
- Two listed physicians, nurses and pharmacists.
- Two did not respond.

When asked if seniors were screened for depression:

- One said yes.
- One indicated yes, if medically necessary.
- Three did not respond.
- One did not know.

When asked what instruments were used:

- Two indicated that guidelines were being developed.
- Four did not respond.

When asked if the tests were based on patient self-referral or other indicators:

- Five did not respond.
- One indicated that it was a combination of self-referral and other routine assessments.

When asked if seniors were screened for alcoholism or medications abuse:

- Three said yes, one of which said only when medically necessary.
- One said they did not know.
- Two did not respond.

When asked how they were screened:

- Four did not respond.
- One said it was patient/doctor choice.
- One said by questionnaire.

When asked if adult children were involved in the annual health examinations of their parents:

- Four did not respond.
- One said it was up the patient.
- One said they did not know.

When asked if they had a respite benefit for caregivers:

- One said yes, through their hospice program.
- Three did not respond.
- Two said no.

When asked if their plan covered a hospice benefit:

- Four said yes, both in-patient and out-patient.
- Two did not respond.

When asked if there were a difference in co-payment between the in-patient and out-patient benefit:

- One said yes.
- Three said no.
- Two did not respond.

when asked if the plan covered home health care:

- Four said yes, one had a co-pay of \$5, 10, or \$15; one had a co-payment of \$15.
- Two did not respond.

VI. Mental Health

Women are three times more likely than men to have episodes of clinical depression.

When asked if clinicians regularly checked for depression in women patients:

- Three said yes.
- Two did not respond.
- One said if medically necessary.

When asked if this was done by the primary care provider or if patients were referred to a mental health specialist:

- Two said primary care provider.
- Two said both.
- Two did not respond.

When asked if their mental health benefits were in the plan or offered through a mental health “carve out” benefit*

- Three said they used carve out benefits, one of which said that the carve out benefit was for chemical dependency (alcohol and drug abuse) only.
- One said they used their own providers.
- Two showed a mixed of health plan providers and carve out benefit.

When asked what process the patient had to use to obtain services through the carve out:

- One said there was a 24 hour, self-referral number.
- One said the patient could call the number on the back of their member card.
- One said self-referral.
- One said a referral **from** the primary care provider was required.
- One used their own providers, not a carve out and they had internal guidelines.
- One said the patient had access through a 800 telephone triage number.

When asked how the carve out gave value to the patient:

- One did not respond.
- One said that it was not applicable (they did not use one).
- One said the carve out provided in-patient visits and brief focused therapy.
- One said the carve-out provided reviews and recommended options.
- One said that it provided a wide range of services.
- One said by referral, **preauthorizations** and case management process.

A “carve out” benefit is one that **is not provided directly by the plans. In these cases, they contract with other organizations that provide mental health services with **providers** that are members of that **specialty organization**.*

when asked whether the primary care doctor or the mental health carve out screens the patient for mental health disorders:

- One did not respond.
- Two said the carve out company.
- Two said the primary care provider.
- One said both.

when asked if mental health screening was part of the annual exam:

- Two said yes.
- One said they did not know.
- One **said no**.
- Two did not respond.

When asked what tests were used:

- Two said this was not applicable.
- Three did not respond.
- One said they used internal guidelines.

when asked if mental health counseling were provided, if it had limits:

- All six plans indicated they had limits.

When asked if they had limits, what were they:

- Five said 20 mental health visits per year.
- One said the limits were 10, 15, or 20 visits.

When asked how many hospital days per year were allowed for mental health visits:

- One said 10 days.
- One said 60 days.
- One did not respond.
- One said it varied by the plan selected, either 10 or 30 days.
- One said 5-10 calendar days.
- One said it varied by contract, but largely 12 days at 80% of the cost.

When asked what tests were used for panic attacks:

- Two did not respond.
- Three said self-referral.
- One said self-referral and/or evaluation by the primary care provider.

When asked if the tests for depression and anxiety attacks were from a patient's self concern or part of standardized testing:

- Two responded standardized exam.
- Two did not respond.
- Two said self-concern only.

When asked what examinations were used:

- One said they did not know.
- Two did not respond.
- Two said the question was not applicable.
- One said they used the **HH** I-5, subset of Q 45 Hamilton scale*.

When asked if pharmaceutical or mental health referrals were covered in their benefit package:

- All answered yes, one noting that only **if it** were in-house.

If yes, the plans were asked who had prescriptive authority:

- Three said primary care provider, mental health specialist and psychiatrist.
- Three said primary care provider and psychiatrist.

When asked if the plans covered SSRI medications (new anti-depressants):

- Five said yes and one of the five had a co-payment requirement.
- One did not respond.

When asked if the plan covered other psycho-pharmaceutical products:

- All six plans said yes.

When asked who could prescribe those medications:

- All said psychiatrist, family practice provider, and other primary care provider.

*when asked if they had a "prior authorization"*** requirement for SSRI products:*

- One said yes.
- Five said no.

*When asked what the "prior authorization"*** requirements were:*

- The one plan with the prior authorization requirement said patients were directed to Formulary drugs, but patients could use non-Formulary drugs, if ordered.

**These are standard mental health tests.*

****Prior authorization means the physician must have approval from the health plan before they can prescribe certain medications.**

VII. Drug Formularies

Drug formularies are essentially the list of medications a health plan will cover/pay for its members.

When asked if their plan used drug formularies which defined the medications clinicians could order for their patients:

- Five said yes.
- One said no.

When asked if their plan used a mail-order pharmacy:

- All six said yes.

When asked how patient education material were provided for the mail-or&r pharmacy:

- One did not respond.
- One said by **direct** mail to their members.
- One said it was mailed with the medication.
- Three said information was provided through the welcome packets • one said they did updates in member newsletters, one said they sent patient information and one said the pharmacist provided patient information.

When asked if a particular drug was not included in their Formulary, and the provider and patient wished to use another drug, what percentage of the cost did the patient have to pay:

- One said they had an open Formulary.
- One said they must use a generic, if available.
- One said most of their products did not have a Formulary, but for those that did, the medical director must approve the authorization and co-payments were required.
- One said that no cost differences were applicable if the member had the prescription benefit rider, that the co-payments were the same.
- One said there was 0% co-payment or the normal co-payment was required.
- One said co-payment was applied.

when asked what appeal procedures were in place for patients who wanted to appeal a medication that was not on the Formulary:

- Three said yes.
- One did not respond.
- **Two** said they were not needed, because the formularies were open.

When asked if the medication prescribed by plan physicians had to have prior approval in order for them to prescribe medications:

- Two said no.
- One said no, **if** it was on the Formulary.
- One said yes, but for a very few drugs.
- One said yes, such as growth hormone medication and MG drugs.
- One said yes.

VIII. Domestic Violence

When asked if their providers received training on domestic violence:

- Three did not respond.
- One said they did not know.
- One said yes.
- One said yes for certain groups.

When asked from whom the providers received the training:

- Four did not respond.
- One said internal family health teams with **RNs**, and **MSWs**.
- One said they used grants, studies and other doctors to train providers and that two doctors were dedicated to this work,

When asked what information was provided in the clinics about community resources for child abuse and domestic violence:

- Three did not respond.
- One said they did not know.
- One said internal guidelines, such as Family Health Teams, Crisis lines, Shelters,-, Resources for Lesbians and Police Resources.
- One said they had printed materials with protocols and also clinical social workers.

When asked if their providers knew how to screen for domestic violence in Lesbian couples:

- Four did not respond.
- One said they did not know.
- One said yes.

When asked if they knew of community resources for lesbian victims of domestic violence:

- Three did not respond.
- Two said yes.
- One said they did not know.

When asked to list what the resources are:

- One listed the statewide domestic violence hot line.
- Four did not respond.
- One said they did not know.

Ix. Women of Color

Women of color are at higher risk for certain diseases, such as diabetes and hypertension, than' Caucasian women

When asked if women of color were screened for: diabetes, hypertension and uterine fibroids:

- Three plans said yes.
- Three did not respond.

When asked if they had outreach programs for people of color or women of color:

- Four plans said no.
- Two did not respond.

When asked if their providers referred women to community programs that offered screening and testing for women of color:

- Two said yes, if necessary.
- Three did not respond.
- One said no.

When asked if they worked with community groups that did outreach programs to women of color:

- Two said yes.
- Two said no.
- Two did not respond.

When asked what groups:

- One named the cross-cultural health project, and volunteers on clinics and boards.
- Three did not respond.
- Two said it was not applicable.

When asked what translation services they provided:

- Two did not respond.
- Two said all languages listed.
- One said they used US West Translation Services.
- One said they had materials in Spanish, Vietnamese and Laotian.

When asked how these services were provided:

- **Two** said through phone and AT&T, and local translation services.
- Two did not respond.
- One said they had some in-house services and some contracted services.
- One said they only translated materials for Healthy Options (Medicaid) members.

X. Alcoholism, Substance Abuse and Chemical Dependency

When asked if their clinicians regularly checked for alcohol and drug abuse in women:

- Two said yes.
- One said yes, if medically necessary.
- Three did not respond.

When asked what clinical protocols were used to check for alcohol and drug abuse in women:

- One said they did a test every four years.
- Four did not respond.
- One said they did not know.

When asked if alcohol and drug abuse diagnosis was part of the annual exam:

- Three did not respond.
- Three said yes; one indicated only if medically necessary and one indicated that testing for substance abuse is done every four years.

When asked how patients were screened for alcohol and drug abuse:

- One did not respond.
- Two said self-referral.
- Three said self-referral with family intervention and blood and urine tests.

When asked what treatment protocols for alcohol and drug abuse were used:

- Three did not respond.
- One said they did not know.
- One had internal guidelines.
- One used the tools of a behavioral health service.

When asked what drug dependency programs were covered by their benefits:

- One did not respond.
- Four said they covered both in-patient and out-patient benefits.
- One said they had internal guidelines.

When asked if their providers screened for eating disorders:

- One said yes.
- One said yes, if medically necessary.
- Three did not respond.
- One said they did not know.

When asked about the treatment protocols they used for eating disorders:

- One said they did not know.
- Four did not respond.
- One said they had a questionnaire for the patient and a handbook that helps the doctor to evaluate.

When asked if the treatments were covered under their benefits:

- One said they did not know.
- Four did not respond.
- One covered treatment as an out-patient benefit.

XI. Patient Education Materials

When asked to identify what patient education materials were sent to patients:

- Five plans said they sent information to their members quarterly.
- One sent information every other month.
- All six said they sent family care handbooks, such as Care Wise.
- Four said they had health fairs and patient education wellness classes, nurse triage, phone referrals and a consulting nurse.
- One said they had a newsletter and handbook
- One did an outreach campaign for women on mammograms and pap smears in addition to the member newsletter and handbook.

When asked what materials were in their providers' offices that were specific to women and what form were they in:

- One said they did not know.
- One did not respond.
- One said the information was not available.
- One said the information varied widely by group practice and clinic system.
- One said many items were available, and all were available in print form.
- One said the items were available, but they were not sure of the format.

When asked if their health plan offered community education seminars on health issues:

- Three said yes.
- Three said no.

when asked the costs of the program:

- Three said it was not applicable.
- One offered members a \$250 annual allowance for community programs.
- One said theirs were generally free.
- One said they had had a pilot project that was no longer on-going.

When asked if their plan covered the cost of obesity/weight reduction programs:

- One did not respond.
- One said no.
- One said it varied with the plan the patient chose.
- Three said yes.

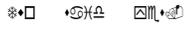
When asked if the plan covered nutrition counseling as a covered benefit:

- Five said yes.
- One did not respond.

When asked if their educational materials depicted racial and sexual minorities:

- All six plans said yes.

When asked if their providers had lists of community resources in their provider offices:

-  Three did not respond.
- One said they did not know.

When asked which directories were used:

- Two did not respond.
- One did not know.
- One said it was not applicable.
- One said it varied by physician group.
- One said it had internal listings and directories.

When asked if there were health professionals associated with the provider's office that could answer patient questions:

- One said they did not know.
- Two did not respond.
- Two said yes.
- One said yes, but that it varied by group.

When asked who conducted most of the patient education/prevention programs:

- Four said either nurses, social workers, hospital **staff** and dietitians, physicians, pharmacists, health education specialists and other consumers.
- One said that they had a Quality and Education Unit at the health plan.
- One did not respond.

XII. Alternative Therapies

When asked if their plan covered the cost of acupuncturists, naturopathic medicine, chiropractic medicine, and other alternative therapies:

- Five said yes.
- One did not respond.

When asked to identify the co-payments associated with that coverage:

- Three said they were covered at 100% like regular providers.
- One had a \$300 per year limit.
- One did not respond.
- One said they had co-payments associated with the visits.

When asked if these providers were strictly for special services, such as pain management and smoking cessation:

- Two did not respond.
- Four said yes, one of which said they had some restrictions.

When asked if these visits must be made under referral by the primary care doctor to be covered in the benefitpackage:

- One did not respond.
- One said no.
- Four said yes.

When asked if visits to these providers were time limited, or limited to a specific number of visits:

- One did not respond.
- Five had liits ranging from 60 days, to \$300 annual limit, to other limits depending on the treatment and benefits.

When asked if their providers recommended calcium supplements to women or just women entering menopause:

- Four plans did not respond.
- Two said all women.

When asked if their providers recommended vitamin therapies to women who were not pregnant or menopausal:

- Four did not respond.
- One said they did not know.
- One said yes.

When asked on what basis they made those recommendations:

- Five did not respond.
- One said it was based on the medical condition and diet of the patient at the time of the **initial** assessment.

SECTION III: THE SURVEY

MANAGED CARE AND WOMEN'S HEALTH SURVEY

I. BACKGROUND

In mid-1997, Women for Healthcare Education Reform and Equity (W.H.E.R.E.) designed a survey to examine the broad range of women's health needs and how these needs were being met in managed care organizations.

Managed care organizations are designed to provide health promotion, disease prevention, early diagnosis and screening in a primary care system of care in which one primary care provider oversees all the patient's healthcare needs. These providers either offer the service themselves or refer the patient to specialist for care.

Women's health traditionally has been largely defined in terms of those health needs that are different **from** men: reproductive health, maternity care, breast and cervical cancer. While these are important health issues, women's health is broader than these concerns.

Each year:

- *240,000 women die **from** heart disease.*
- *43,000 women die from lung cancer.*
- *-women die from colon cancer.*
- *49,000 women die from breast cancer.*
- *Women are three times more **likely** than men to have episodes of clinical depression.*

Women are also the primary caregivers for themselves and their families. They are the major caregivers for their parents and parents-in-law. Therefore, W.H.E.R.E. wanted to examine health issues for children, teens, adults and seniors to address the **full** range of women's health and health care-giving needs.

We know that:

- *infant and pediatric asthma is on the rise.*
- *adolescent depression, suicide, alcohol and drug use among teens is rising.*
- *81% of all pregnancies prior to age 19 **are** unintended and 57% of all pregnancies are unintended*
- *78% of all cases of depression **and/or** alcoholism in the **elderly** are overlooked*

W.H.E.R.E. wanted to identify, therefore, what managed care organizations are doing for the life-span health needs of women and the people they care for in their families.

II. WHY THIS STUDY?

- Medical school curriculum has little in it specific to women's health.
- Adolescent medicine, which focuses on teen healthcare issues, is considered to be a subspecialty of pediatrics.
- Women are three times more likely than men to have episodes of clinical depression, so restrictions on mental health coverage could possibly have an adverse affect on women.
- Nearly 30% of all women will experience episodes of domestic violence.
- Women live an average of seven years longer than men.

These issues warrant examination and planning as American healthcare moves into a predominantly managed care environment.

W.H.E.R.E. assembled a panel of women's health specialists to examine what the major managed care plans in Washington state are doing in women's health related issues. We selected managed care organizations because these they use a primary care approach which focuses on preventive care, health promotion, and early screening and diagnosis.

In short, managed care organizations are more likely to offer services that help prevent diseases than the traditional fee-for-service system which pays for services based on the disease for which patients are being treated.

W.H.E.R.E. wanted to develop a baseline snap shot of what managed care organizations are doing. We wanted to **identify** the range of preventive and health promotion coverage managed care plans are offering, and any areas of unmet needs or gaps.

III. OUR GOAL

This survey was designed to provide information to consumers, purchasers, public policy officials and providers as well as to be an educational effort for the health plans about the **full** range of women's health and the health needs of children, adolescents and the elderly. Our goal is to educate, not to rate, endorse or blame health plans.

It has been a relatively short time in the history of American healthcare since we have moved from a fee-for-service system to a managed care/primary care system. We hope to work with plans to create a road map of ways to offer healthcare services that meet the needs of women and families.

W.H.E.R.E. aims to increase the consumer voice in healthcare decisions. We believe it is imperative that the consumer take a more active role in her/his own healthcare. By providing a baseline of what managed care organizations cover we can clearly show the range of responses and identify areas of common coverage or significant differences.

IV. METHODOLOGY

W.H.E.R.E. assembled some of the leading public, private and academic consultants in the development of the survey. It is one of the most complete and comprehensive surveys on women's health, to date. It is the first of its kind in the nation, and probably the first assessment of what managed care plans are doing on many issues related to the health of women and families.

Those who reviewed and added to the survey included public health professionals; academic researchers with specialties in women's health; clinicians; teen health specialists, providers of color; nurses and physicians; and lesbian healthcare specialists.

The survey was mailed to the twelve major health maintenance organizations (**HMOs**) and Preferred Provider Organizations (**PPOs**) in Washington State. Each health plan received three copies. The main copy was sent to the Director of Communications, Public Relations, or Marketing, depending on the kind of position the health plans had. The other two copies were sent as carbon copies to the Medical Director and to the Director of Nursing. Each department knew the other departments had been mailed copies.

Of those twelve that were sent surveys, six responded. Of the six that responded, one was answered by the Director of Authorization, one by the Director of Nursing. The responses of the other four were coordinated internally within their organization. Two were coordinated through Marketing and Public Relations and two were coordinated internally by Quality Assurance Directors. The survey had two major stages:

Stage One: The surveys were sent in early July. All the health plans were called when they did not respond to the end of July deadline. Those plans that did not respond were called at least twice: once in July and once in August. Extensions were granted to the end of September.

Stage Two: After the findings was compiled, W.H.E.R.E. sent the **summary** back to the person in each plan that responded. We indicated they were plan 1 or plan 2 or plan 3. None of the plans were identified by name. This way they clearly had the opportunity to see how their responses compared to the responses of the other plans.

We told them that they had another two to three weeks to change or add to any of their responses and that we would make any changes they made. Three plans sent in changes. We telephoned the three we did not hear **from** and talked with them personally or left voice mails stating that if we did not hear back from them within a week, we would proceed with the information they had provided us to date.

The **final** report, therefore, reflects the plans' first response, as well as any revisions they chose to make.

The survey was 26 pages **long**. We know it was thorough and onerous for the plans to complete. We appreciate the time and effort it took them to complete the survey and thank them for their efforts and indulgence in responding to our request.

V. CHARACTERISTICS OF THE MANAGED CARE ORGANIZATIONS

Of the six plans that responded, three are national organizations and three are local to Washington State. The three national managed care organizations are for-profit. The three Washington State based managed care organizations are not-for-profit.

Of the six plans that responded, three are licensed as **HMOs**. The rest are licensed as "Health Care Services Contractors" (**HCSC**). AU are managed care plans. One of the more interesting findings is that the responses did not vary between those organizations that are licensed as HMO's and **HCSC's**.

All except for two are network model **HMOs**. These network or group model plans contract with providers who have independent private practices in the community. These same physicians **often** also participate in several managed care organizations at the same time. The physicians who provide healthcare services for one plan may also be the same physicians who are providing services for other plans at the same time. Only one plan is a **staff** model HMO. This means their facilities and providers treat only their members and do not treat patients from other plans.

In the staff model, the physicians are salaried rather than paid on a contract basis by the health plan. This particular staff model, unlike most **HMOs** in the nation, is a cooperative model HMO. It's policy and procedures and direction are set by a consumer/member Board of Directors. While the other plans have Boards of Directors, their boards may not be composed of people who are enrolled in their health plan. Less than ten **HMOs** in the nation have the same cooperative/member model Board of Directors.

In short, the organizations that responded reflect the organizational structures of **HMOs** and other managed care organizations throughout the United States. We have every reason to believe these **findings** reflect the activities of most managed care organizations in other parts of the United States. Given the length of time managed care has been in Washington State, nearly **50** years, we also have reason to believe that these managed care organizations may be more fully developed than managed care organizations in other states.

The combined "covered **lives**"/**members** for these plans is **1,929,242** or roughly 36% of all people in Washington State (5.516 million).

VI. NATIONAL IMPLICATIONS

This study is important for women and families in Washington State and nationally. Managed care was born on the West Coast. Washington State is a heavily managed care state and one of the first in the nation to introduce managed care into the healthcare system. We can state with confidence that the patterns and the ranges of responses identified in Washington State will be the same, if not worse, in other states.

Nationally, the major shift **from** the traditional fee-for-service healthcare system to a managed care system has happened within the last three years. In 1993, 48% of all employees nationally who had insurance through their workplace used the traditional **fee-**for-service system. By 1996, only 23% of insured employees were in the **traditional-fee-**for service system. Consequently, many consumers, employers, employees, providers and managed care plans are struggling to understand how managed care/primary care really differs **from** the fee-for-service system.

In short, if the range of responses we found between the plans in Washington State is relatively wide, then we believe it is fair to assume that the responses from managed plans in other states are the same or could be even greater.

VII. OUR THANKS

Our thank-s to health plans:

- We would like to thank the health plans for their sincere effort to be responsive to this survey.

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