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Coverage and Costs of Family Planning Services in California

by

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Introduction

Family planning has fascinated me since high school. First a friend asked me to accompany her for a diaphragm fitting then as an exchange student I realized that my peers in Chile had only covert access to family planning information and services, and I watched some become pregnant. Similarly, in Brazil three years later the terror of botched abortion faced me when a hysterical woman servant asked a medical friend and me to treat her hemorrhaging. The problems of access and the need seemed enormous, and I wanted to learn more about all aspects of family planning.

In the summer of 1995 I received a Washington Health Policy Fellowship through which I interned at the Alan Guttmacher Institute, a non-profit, non-partisan corporation for reproductive health research. By the end of the summer I had perused several cost analyses of public family planning services and had read one study suggesting spotty and inadequate private insurance coverage of family planning services. Informed by these two issues, I wanted to explore the cost-effectiveness of private insurance provision of family planning services and if possible compare the cost-effectiveness of public and private family planning programs. One reason cited for the lack of any such evaluation was concern that a costs analysis may reveal that family planning services are not cost-effective for private insurers. However, in approaching this topic I found many holes in the current literature and the existing data which prohibited the performance of cost-effectiveness analyses of private family planning services.

Cost-effectiveness of family planning services evolved into coverage and costs of family planning services, a more manageable subject. I narrowed the topic to coverage and costs of individual health plans in California, a growing sector of the health insurance market. Coverage of services[§] does not mean free services; payment may take the form of premiums, copayment, a deductible, or coinsurance. Most covered family planning services include copayments. The research questions I address are: what coverage do individual health plans offer for family planning services in California?

How do individual health plans decide what coverage for family planning services they will offer? What factors are important in this process? Do insurers assess or calculate costs, benefits or cost-effectiveness of family planning services? If so, how do they undertake this?

Exploring the current coverage decision process leads to a more normative question: how should coverage decisions be made? Coverage decisions, as detailed in Section III., are driven by: 1) consumer demand, 2) medical necessity, 3) institutional philosophy and history, and 4) legal issues. The ideal coverage decision process would include those four factors plus: 5) wellness and prevention and 6) cost-effectiveness. Wellness and prevention services expand the traditional definition of medical necessity from treatment of active injury and illness to also include provision of services and information that maintain wellness and prevent illness and injury. Cost-effectiveness provides a systematic means to allocate resources in an environment of high health care spending and high demand for health care which exceeds the resources available to provide it.

Since my interest originated from the public sector perspective, I compared the public and private sector contexts for family planning services throughout. Medical delivery systems have often separated family planning services from other health services, as exemplified by Planned Parenthood Clinics and sexually transmitted disease clinics. Some women choose a clinic and confidentiality over a private doctor whom they otherwise use. In this sense, the public and private provision of family planning services probably overlap more in population served than any other constellation of medical services. The current trend to merge public medical services into private also stimulates comparisons of private and public provision of family planning systems.

Family planning encompasses those services which allow fertility control and pregnancy to become a choice. They are "those services that are needed by women in their childbearing years (usually defined as between the ages of 15 and 44)." (Rosoff

1993: 7) This paper uses the age range 15-44, although women under fifteen or over forty-four may need family planning services as well. Family planning also pertains to men, whose reproductive life span is about twice that of women, and who often are not targets of family planning technology or services. Women bear most of the burden to seek out, use and pay for family planning. The Alan Guttmacher Institute provides a woman centered definition of reproductive health services: "preconceptional risk assessment and care; contraceptive services and supplies; abortion services; voluntary contraceptive sterilization services; screening for STDs [sexually transmitted diseases] and cancers of the reproductive system, as well as routine gynecological examinations; basic infertility services; maternity care, including prenatal, delivery and postnatal care." (Rosoff 1993: 7) Sexually transmitted disease screening and treatment are excluded from the list of family planning services considered in this paper because they impact indirectly on fertility control and are socially sensitive. The social stigma attached to many STDs encourages people to receive anonymous care for such conditions and inhibits demand for such services through the individual's regular health delivery system.

A broad definition of family planning services embraces all of the above services and extends to birth rather than stopping at conception. Traditionally, family planning services have not included pregnancy services in part because of territorial concerns among public health professionals. Maternal and child health professionals consider pregnancy their domain and often want no link with family planning services, which historically were viewed as in opposition to pregnancy, childbirth and motherhood. However, this paper includes pregnancy care and delivery within the definition of family planning services.

This paper has three main goals, presented in three sections: to outline the role of family planning in health care, to explore individual health plan policies in California and how they cover family planning services, and to probe through qualitative interviews the coverage decision process for individual health plans and the role of cost-effectiveness in assessing family planning services.

Section I: Background Information on Coverage and Costs of Family Planning Services

I. Family Planning Services as a Component of Health Care Delivery

Some general characteristics of health care costs, payers, and markets are presented to characterize and provide a context for the individual market for health insurance in California and for family planning services. The health care market in California differs from the rest of the U.S.: it has a lower growth of per-capita health spending in the past decade and a much higher reliance on HMOs. California can be viewed as a model of what may happen as other states attempt to control health care inflation and HMOs grow.

The individual market reflects consumer demands more sensitively than employer-based or large group insurance. Examining the coverage chosen by individual consumers theoretically represents each consumer's preferences more accurately than group choices do; within the individual market, each person can decide what he is willing to trade off for each health service. In contrast, an employer can dictate to a certain extent what he perceives as necessary and appropriate for his employees health insurance package, regardless of a specific employee's preferences.

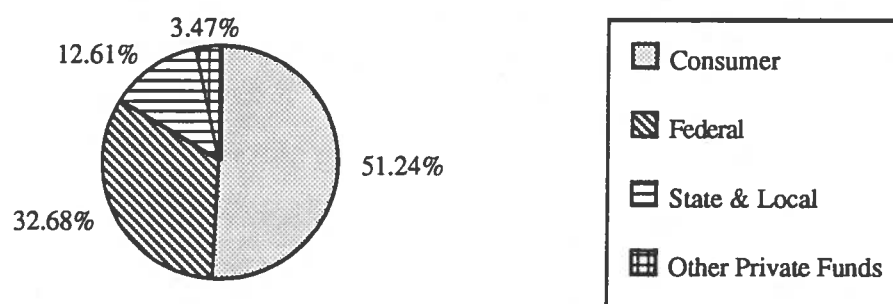
The instability of employer-based coverage and its dependence on a positive and healthy business cycle has stimulated the individual market, and projections anticipate continued growth of the individual market share (Somerville 1996: 4). According to Bill Gradison, president of the Health Insurance Association of America, about 10 million Americans relied on the individual insurance market for their health coverage in 1996 (Pear 1996), showing a growth of 17.6% and an increase of 1.5 million Americans since 1992 (Source Book of Health Insurance Data 1995: 37). Among insured Americans 14% purchase health insurance as individuals, and 61% receive health insurance through employers. Medicaid and Medicare cover the remaining 25% of insured people (Somerville 1996: 4). Within California, about 2 million people, or 7.5% of the non elderly population, in 1990-92 had private insurance unrelated to employment:

individual/family policies (Winterbottom et al 1995: 19). Among California's non elderly females in 1990-92, 8.9%, or about 1.2 million women, had individual/family policies (Winterbottom et al 1995: 27).

Total US personal health care expenditures in 1992 were \$727.1 billion. The Federal contribution can be decomposed into Medicare (\$135 billion), Medicaid (\$79.8 billion) and Other (\$31.8 billion) (*Hospitals & Health Networks* 1994: 52). The Consumer portion further breaks down into private health insurance, which paid \$216.6 billion, and out of pocket costs, which totalled \$155.9 billion (see Figure 1). In comparison, expenditures for women's reproductive services total \$40.7 billion (Costello 1994: 2).

Figure 1

1992: Who Pays for U.S. Personal Health Care



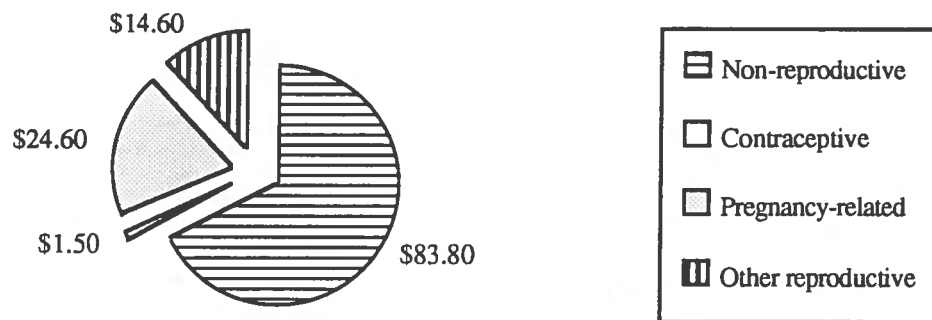
Women use more health care services than men during their reproductive years and spend more money on health services. Among women age 15-44, 88% utilize health care services annually as compared to 75% of men in the same age range in 1993 (Costello 1994: 5). Women also utilize preventive services much more than do men: in 1993 52.3% of women as compared to 26.8% of men received preventive care (Costello 1994: 13). Women age 15-44 spend \$573 on average for annual out-of-pocket expenditures for health care services as compared to \$342 per man (Costello 1994: 6). Women pay out of pocket for 56% of the cost of contraceptive services, including therapeutic abortions (Costello 1994: 13). Women also spend a higher proportion of their income on health expenditures

(Costello 1994: 17). This may reflect women's higher utilization of services, lower wages, health insurance status or other factors.

Reproductive services account for one-third of all health expenses for women age 15-44 (see Figure 2). They spend \$83.8 billion on non-reproductive health services and \$40.7 billion on reproductive health services, which consists of contraceptive services (\$1.5 billion), pregnancy related services (\$24.6 billion), and other (\$14.6 billion) (Costello 1994: 10). Other included such services as STD screening and treatment, PAP smears, pelvic exams and more. Per capita health expenditures for women are \$2,123; excluding reproductive services, this falls to \$1,429, much closer to the male per capita health care expenditure of \$1,272 (Costello 1994: 11).

Figure 2

**Health Service Expenditures, in billions, for women
age 15-44**



Pregnancy related services concentrate the health expenditures for reproductive services. A small portion of women age 15-44 (11%), about 33% of those using reproductive services, incur pregnancy related expenses (Costello 1994: 12).

Sonenstein et al surveyed women aged 21 to 40 in 1993 and asked about the source of payment for the last reproductive health care visit. Sixty-two percent of the women reported paying some or all of the cost; twenty-three percent paid the full cost out of pocket. For 24% of these women, private insurance covered the entire visit cost, and

for another 7% Medicaid paid the bill. An additional 7% of women reported no insurance coverage and no cost; the provider must have pocketed the cost or received a subsidy unknown to the woman. (Sonenstein et al 1995: 11)

II. Distinct Characteristics of Family Planning Services

Family planning services encompass several distinctive qualities which affect coverage and policy: they tend to be inexpensive, preventive, frequently provided, simple to perform, and emotionally laden. The emotional content of some family planning services, such as abortion and childbirth, separates them from most other health services. Family planning services can stimulate questions about personal and societal values of love, hate, righteousness, sin and moral turpitude among others. The lability and variety of meanings attached to family planning services necessitates confidentiality more than other forms of medical care: "Because reproductive health services are likely to be personal and socially sensitive, they may require special protection regarding the confidentiality of the services and the circumstances in which they are delivered." (Delbanco and Smith 1995: 2).

III. Legislative Impacts on Coverage and Costs of Family Planning Services

Legislation has gained an increasingly important role in health policy recently. Legislative action increased in the last year with 85 proposed bills with health impacts in 1995 as compared to 15 proposed in 1994 (*American Medical News* 1995c: 3). In California, this legislative trend has included coverage of family planning services.

Many self-insured plans -- a large part of the managed care market -- are shielded from state regulations under the federal ERISA (Employee Retirement Income Security Act) exemption. The 1974 Employee Retirement Income Security Act prohibits states from taxing or regulating companies' self-insured health insurance plans and defines regulation of employee benefits, including health insurance if the company chooses to self-insure, as a

federal province (Serafini 1995: 349). About 2/3 of employers provide health insurance through risk retention programs which are protected by ERISA (Gostin and Widiss 1993: 2527). These self-insured company plans escape state insurance regulations, such as potential mandates to provide coverage for family planning. ERISA severely limits the impact of any state legislation related to health insurance. However, state legislation does impact the individual market, the focus of this discussion.

In 1994 California passed a direct access bill which mandates that women can see an obstetrician/gynecologist without first obtaining gatekeeper approval. Maryland, Louisiana and North Carolina also have similar direct access laws (*American Medical News* 1995c: 3). California individual insurance plans often highlight direct access to an obstetrician/gynecologist as a special benefit, without referring to the legal mandate (see Section II.). The purpose of such direct access bills remains unclear; the most obvious benefits accrue to the obstetrician/gynecologists who receive more patients.

Legislation related to family planning services which failed in the fall of 1995 includes mandating coverage of several contraceptives and a 48-hour hospital stay after delivery option. The California Assembly passed A.B.1101 in its 1995 session which required insurance companies to include several contraceptives in the coverage of prescription drugs. Californians for Affordable Health Reform (CAHR, pronounced care) opposed A.B.1101, citing an increase in health costs. CAHR includes "organizations representing small employers and health insurers" such as: California Chamber of Commerce, California Cattlemen's Association, California Hotel and Motel Association, California Farm Bureau Federation, National Federation of Independent Business, Western Growers Association, and the Alliance for Managed Care. The group argued that including contraceptive services as mandated in A.B.1101 would increase health costs, resulting in a compensatory decrease in quality of care or increase in premiums. The latter could result in loss of coverage for many employees.

CAHR specifically protested the inclusions of "certain types of reproductive and contraceptive drugs which the insurer believes are not cost-effective," which implies that cost-effectiveness plays an important role in coverage decisions and that they have information on the cost-effectiveness of privately provided contraceptive services, not available in the literature. CAHR summarized their position as: "Small business is very concerned that any mandates to cover will result in higher insurance premiums, thus reversing what is perhaps the most positive trend in reducing the problem of uninsured individuals among people who work." (Zaremborg 1995) However, adding contraceptives to the prescription drug plan increases the policy cost by about 1% for employer purchased policies, which does not seem like a large enough increase to discourage purchase (Burns 1993: 25). Governor Wilson vetoed the bill on October 24, 1995 (Caen 1995: A12). No state currently mandates coverage of contraceptive services (Sollom 1995: 86).

California Assemblywoman Liz Figueroa sponsored the 1995 measure to force HMOs to allow women to stay in the hospital at least 48 hours after delivery. A Kaiser pilot project to discharge some women from the hospital eight hours after delivery triggered Figueroa's 48 hour bill. The bill died in the fall of 1995 and will be reintroduced in 1996 (Russell 1995: A11). Similar bills have passed in other states this year. Figueroa envisions herself as a patient advocate, "a legislator letting providers know what the pulse of patients is." (*American Medical News* 1995c: 24)

Managed care groups perceive additional regulations as cumbersome and unnecessary, not as helpful communication from legislators of patient needs: they prefer to respond to consumer demands to change policies, not legal mandates. They cite low complaint rates and state that most patients are happy with the current market. The California Association of HMOs preferred to suggest alterations in bills rather than directly opposing them (*American Medical News* 1995c: 24).

IV. Public Provision of Family Planning Services

Public family planning services strive to provide the maximum choice in fertility at the minimum cost to people who can not afford these services in the private system. This comprehensive philosophy of family planning care has achieved such good coverage that the very poor on Medicaid and the middle-upper income women in HMOs and IPAs have the best coverage of family planning services (Ku 1993: 7). One study evaluating women's access to family planning services on the basis of insurance status found no difference between women with insurance and those uninsured (Kirkman-Liff and Kronenfeld 1994: 1012). However, when insured women were separated into those with Medicaid and those with private insurance, the Medicaid population surpassed the uninsured and the privately insured in terms of access to family planning services. The authors postulate that most employment based insurance does not include family planning services, and this decreases access to such services (Kirkman-Liff and Kronenfeld 1994: 1013).

The Office of Family Planning (OFP) provides public family planning services in California as do Medicaid, Title X clinics, and family planning clinics that do not receive Title X funds. In 1990, 1.9 million California women at risk of unintended pregnancy were teenagers or had family incomes below 250% of poverty: these women were in need of subsidized contraceptive services (Henshaw and Forrest 1993).

Total public expenditures for contraceptive services have decreased by 27% from 1980 to 1992 when inflation is taken into account (Sollom 1995: 85). However, Medicaid reimburses for family planning services and supplies at a rate of 90% as compared to 50-80% for other services, and all states must offer family planning services within their Medicaid programs (Ku 1993: 32). In 1992 a total of \$77 million in public funds were spent for contraceptive services; the state provided 44% of this, Medicaid paid 42% and Title X 14% (Daley and Gold 1993). Sterilizations cost \$14 million in public funds, and Medicaid paid for 77% of this (Daley and Gold 1993).

The Office of Family Planning in California exemplifies the public sector's tradition of separating family planning services from other health care. The Office of Family Planning served 748,807 clients with 1,455,709 visits in fiscal year 1993-94. Most visits (87%) were for contraceptive services; pregnancy tests accounted for 12% of visits. The remaining 1% of visits were for sterilizations and infertility services (Office of Family Planning 1995). The need to demonstrate the impact of the public resources which support family planning services has motivated several cost analyses of publicly provided family planning services (Forrest and Singh 1990a, 1990b; Brindis 1995).

The current trend in public services towards privatization applies to family planning: many public family planning services are merging into the private delivery system. Planned Parenthood has expanded its medical mission into general practice, which allows it greater flexibility to contract with private insurance organizations. California has pioneered this practice; Planned Parenthood of Vallejo and Planned Parenthood of Sacramento are two of the first Planned Parenthood affiliates to expand beyond public provision and only family planning services to private contracts and general medicine services. Distinctions between private and public health systems have blurred, and both systems face similar challenges such as how to best minimize costs and how to select which preventive services to include. When focusing on the individual market, this raises the issue of a publicly financed individual market: should it ever exist or should public funds always come with a mandated benefits package?

V. Private Sector Provision of Family Planning Services

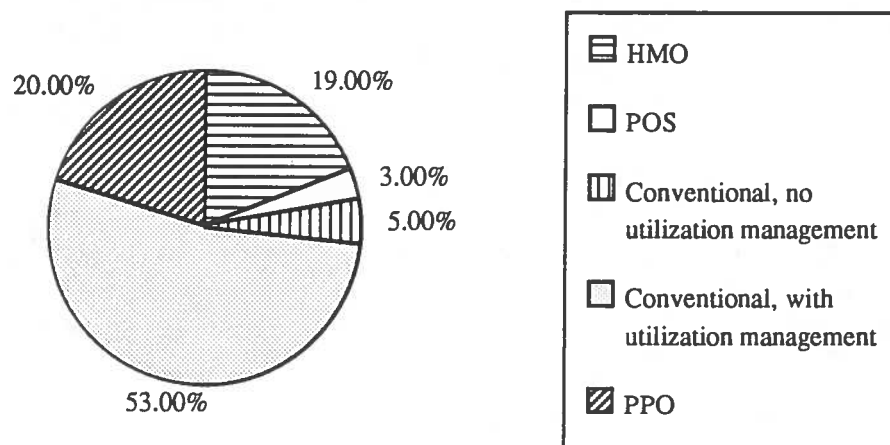
Private sector provision of family planning services varies and correlates most closely with the health plan type: indemnity insurance, preferred provider organization (PPO), point of service network (POS) or health maintenance organization (HMO). The traditional philosophy of indemnity insurance coverage provides for unpredictable risks and does not address preventive, elective services such as family planning which can be

anticipated. HMOs, as the name implies, have focused on health promotion as well as curative treatment, and usually include preventive services like family planning services. PPO and POS tend to have intermediate levels of coverage for preventive services like family planning.

California's health insurance market differs from the rest of the nation because of the much higher penetrance of HMOs. In northern California, one HMO (Kaiser) serves about 36% of the insured population (Russell and Hall 1996: A6). HMOs were estimated to control about 31% of the California private insurance market in 1991 (Deloitte and Touche 1993: 60), as compared to 19% nationally in 1992 (see Figure 3) (*Hospitals & Health Networks* 1994: 52). However, using the number of insured and the number of HMO enrollees in California provided by Winterbottom et al, the HMO enrollment penetration is about 50% (Winterbottom et al 1995). The Pacific region of the U.S. had an HMO enrollment penetration of 34.9% in 1994, the highest of any region, followed by the New England region at 27.5% (Delbanco and Smith 1995: 2). Another survey showed that HMOs covered 19.4% of the U.S. population as of January 1, 1995, up from 17.3% at the beginning of 1994 (*American Medical News* 1995b: 2).

Figure 3

1992 U.S. Market Share by Type of Private Insurance



From 1980-1991, per-capita health spending grew in California at 39%, as compared to a 63% growth in the rest of the U.S. (Krieger 1996: A-13), reflecting the

unique and highly competitive California market . California HMOs are expanding enrollment to include small groups; individual enrollment also is increasing, with 42% of California HMOs offering individual plans in the past five years growing to 58% in the future (Deloitte and Touche 1993: 66). California experienced an increase of 867,739 new HMO enrollees during 1994 (Krieger 1996: A-13). Eighty-six percent of California HMOs were profitable in 1991, with profit margins usually less than ten percent (Deloitte and Touche 1993: 71).

A 1995 survey of HMO enrollees across the US, including plans in southern California, revealed that customer satisfaction ranges from 36% - 69%; all individuals surveyed were members of employer based plans (Page 1995: 9). In contrast, a consumer satisfaction study performed in 1992 showed that 85% of Americans with health insurance expressed satisfaction with their plans, and HMOs scored the highest when participants ranked satisfaction by plan type on a scale of 1-4 (Jensen 1992: 42). Satisfaction apparently declined from 1992 to 1995 or the surveys used such distinctive methodologies as to bar comparisons. Among HMO enrollees in 1995, cost of the plan played a role in choice of plan at the time of enrollment and decreased in importance for later satisfaction: the greatest sources of dissatisfaction were customer service, plan administration and the plan's general concern for well-being. Pregnancy and delivery, the only family planning services assessed, received the best ratings of the eight categories of services evaluated; 89% felt that pregnancy and delivery care were "excellent or adequate." (Page 1995: 9)

Coverage of family planning services varies among private insurers and among each insurer's policies. Among products developed for individual purchasers, pregnancy, perinatal care, Pap smears, pelvic exams, abortions and sterilization are usually included in coverage, although temporary exclusion periods often apply, and abortion may be covered only if medically necessary. However, a survey of employer based health plans performed by the Health Insurance Association of America in 1990-91 revealed that 33% did not cover Pap tests (Costello 1994: 3). Many HMOs, about a quarter according to one survey of

Group Health Association of America members, contract out for abortion services to family planning agencies such as Planned Parenthood (Bernstein et al 1995: 18). The increased confidentiality may enhance and increase utilization of such services, or the extra hassle of a referral, travel and an additional appointment may inhibit and complicate the use of such services.

Plans less frequently include contraceptive services. Contraceptive services often elude coverage because they are not perceived as medically necessary (Burns 1993). Medically necessary usually means that a service treats an active injury or illness; I would add to this that medically necessary also encompasses services which health professionals provide to maintain or promote wellness. For example, membership in a gym would not be medically necessary although it may promote health because it is not provided by health professionals; contraception maintains the person's normal health and would be medically necessary under this definition. HMOs tend to cover all family planning services more than indemnity plans with point of service networks and preferred provider organizations in the middle (Uneven and Unequal 1994).

National employer insurance surveys have ignored the question of contraceptive coverage: "We don't have any information on birth control benefits," according to Ken McDonnell, analyst at the Employee Benefits Research Institute (Burns 1993: 23). Although over 90% of U.S. employees are covered by prescription plans, these plans may exclude contraceptives (see Figure 5). Richard Koresh of the Health Insurance Association of America explains, "In general, contraceptives that have medical indications, such as the Pill, are covered only when they are medically necessary or if there is a medical reason to avoid pregnancy, a range of different kinds of elective contraceptives may be covered." (Burns 1993: 23) Thus, contraceptives may escape coverage because they are not perceived as medically necessary.

HMOs provide comprehensive coverage of family planning services (Bernstein et al 1995: 18). HMOs value preventive care, and they tend to cover oral contraceptives. The

Managed Care Digest. HMO edition reported that 79% of HMOs included oral contraceptives in their prescription drug plans and 21% did not in 1992; 42% of HMOs excluded drugs used for fertility treatments (Costello 1994: 12). Both PacifiCare and Kaiser Permanente view contraception as a standard benefit, reflecting the emphasis given to preventive care in the HMO system of health care delivery. Daniel Danzig of Kaiser described his HMO's position, "Contraception is just a standard part of benefits. It's a very basic part of health care. To exclude coverage just wouldn't make sense." (Burns 1993: 26) Philip E. Dew, M.D., senior vice-president for medical affairs at the Arizona HMO Intergroup praises birth control as a cost limiting benefit: "If ever there was an example of a way to control costs, it is covering birth control." (Burns 1993: 26)

Indemnity plans do not consider contraception to be medically necessary. They will cover any family planning or other service requested by the employer; if subscribing as an individual, there is no similar tailoring of benefits. Contraceptives are not considered a "core benefit," and as Kathy Worthington, manager of coverage policy at Aetna Health Plans, explained: "Indemnity care is based on the philosophy that you get reimbursed for a loss rather than for preventive care," and she cites the example of car insurance, which does not cover oil changes, "even though doing so might save money in the long run....Our assumption is that because people are employed, they can afford to pay for contraception if they don't want children." (Burns 1993: 24) However, some observers believe that excluding contraceptive or other family planning services from coverage restricts access to these services (Sonenstein et al 1995: 13).

A 1993 survey of large employer insurance coverage of reproductive health services also found that HMOs covered all family planning services more frequently than indemnity plans; point of service networks and preferred provider organizations fell in between the HMOs and indemnity plans for coverage. Prescription drug plans included oral contraceptive coverage among 94% of HMO drug plans and among 34% of indemnity drug plans (see Figure 4) (Uneven and Unequal 1994: 16).

Figure 4

**Private Insurance Coverage of Prescription Drugs and Oral Contraceptives
by Plan Type**

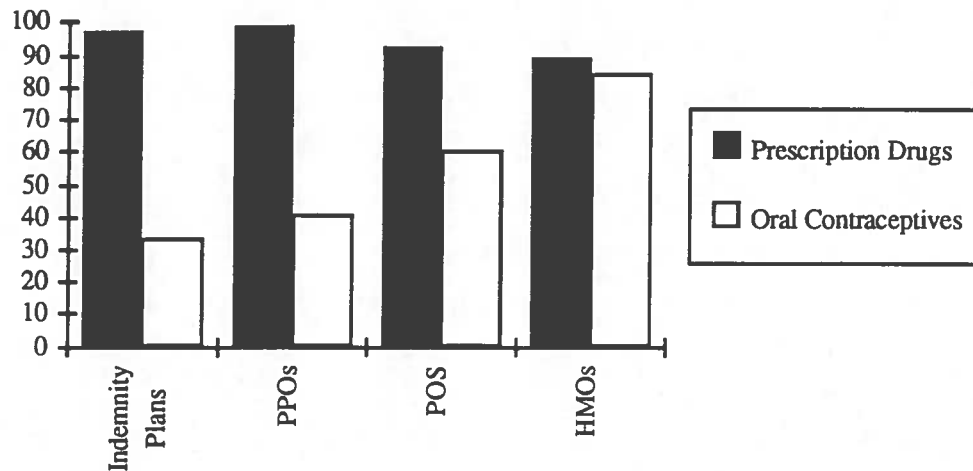
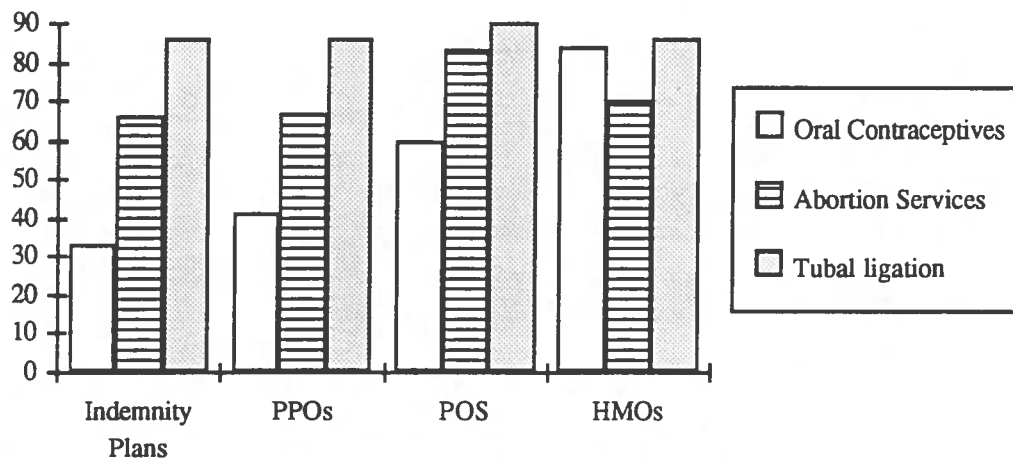


Figure 5

**Private Insurance Coverage of Oral Contraceptives, Abortion Services, and
Tubal Ligation, by Plan Type**



Abortion services, when perceived medically necessary or appropriate by the health care provider, receive coverage in 70% of all types of health care policies, much more than contraception (see Figure 5). Tubal ligation, an irreversible and highly effective method of contraception, is covered at much higher rates, averaging around 85% of plans (Uneven

and Unequal 1994: 18). The more expensive and more effective services which do not rely on the patient's ongoing compliance experience higher rates of coverage.

In summary, the literature indicates that provision of family planning services through employer based insurance depends mainly on insurance plan type and the nature of the service. Services which inflict a greater financial burden, and thus perhaps fit better with the indemnity philosophy of covering the unexpected and catastrophic, receive higher rates of coverage, as do services perceived as more permanently effective. The high coverage of abortion services and sterilization procedures confirm this. Conversely, a temporary inexpensive measure like contraception shows much diversity in coverage rates. The indemnity plans include contraceptives the least often, followed by PPOs, and POS; HMOs are most likely to cover contraceptives.

The scanty literature on private provision of family planning services reflects the low value of family planning services to private payers. Family planning is unimportant for marketing and plan selection (see Section II.). Some policy makers believe that the costs of adverse health consequences that occur without preventive services, such as family planning services, must be identified before coverage can be advocated (Stewart 1995: 75). However, the low profile of family planning services in the literature extends to costs analysis and cost-effectiveness approaches to family planning services.

VI. Costs Analysis and Family Planning Services

The overwhelming growth of health care expenditures indicates a need to limit and maximize resource utilization. Costs analysis provides a tool to evaluate allocation of resources and can inform the efficient use of health care dollars. Cost-effectiveness facilitates the goal of performing more services per dollar; a cost-effective program achieves this the best among a limited set of alternatives (Jensen 1991: 298). Costs-benefits analysis assigns a monetary value to benefits of a service and to the costs of its provision;

benefits include medical and social benefits (Montgomery 1995: 339). The summation of benefits and costs are compared as a savings/cost ratio.

Cost-effectiveness can be used to rank alternative methods of using resources to accomplish a specific objective, such as preventing pregnancy or providing family planning services (Montgomery 1995: 347). The social costs of each method determines its rank; social costs refer to the value of these resources when put to their best alternative use (Montgomery 1995: 347). Cost-effectiveness analysis does not select or evaluate the specific objective; the choice to pursue a program goal, such as the provision of family planning services, must be made independently of the cost-effectiveness of various methods to achieve that goal (Jensen 1991: 299).

The private sector has not chosen to pursue provision of comprehensive family planning services, as demonstrated through the literature and interviews cited in this paper. Thus, no cost-effectiveness analysis have been conducted on this goal. However, the public sector has used cost-effectiveness analyses to demonstrate the positive economic impact of comprehensive family planning services. Some studies do this to such an extent that it appears they are using cost-effectiveness to justify the goal choice (comprehensive family planning services), although this does not fall within the ability of cost-effectiveness to prove.

Several studies have performed cost analyses, usually cost-benefit approaches, of public sector expenditures for contraceptive services and family planning services in California. These studies usually compare the current existing programs and no program, and results always show that current programs achieve the output of family planning services (or some subset of them) at a lower cost than no program. Pregnancy rates and the associated public costs of pregnancy and child-raising are often selected as output measures. The estimate of savings per \$1 spent ranges from \$7.70 for contraceptive services alone in California vs. \$4.40 nationally (Forrest and Singh 1990a and 1990b). For family planning services in California the savings to cost ratio per \$1 spent ranges from

\$3.32 to \$7.28, with an average savings/cost ratio of \$5.05 (Brindis 1995: 3). Savings derive from the decrease in public costs that attend unintended pregnancies: abortions, prenatal and maternity care, medical care, welfare, supplementary nutritional programs during the first two years after birth (Forrest and Singh 1990, Aug.: 161). The variability in average savings/cost ratio demonstrates how such savings/cost analyses "depend on details in the assumptions employed and the range of health and social services under consideration" (Brown and Eisenberg 1995: 241). Studies comparing a single intervention over time with a static baseline incorporate many sources of bias: distribution of fixed costs over users can create an appearance of falling costs, time can change outside factors, and the characteristics of the client population may be unknown (Jensen 1991: 311). Although some believe that the public sector benefits of family planning funding have been exaggerated and others express concern about the caliber of data used, critics still agree that family planning expenditures probably decrease net claims on public budgets (Brown and Eisenberg 1995: 243; Ku 1993: 48).

No analogous cost-benefit or other cost analysis calculations for family planning services have been performed for the private sector in the literature, probably because of the increased variability in coverage options, costs and benefits selected to include in a model. Separating the expenditures and costs of family planning services from integrated health care delivery presents problems (Janowitz 1993: 63). The cost and payment structure complicates this: for example, with HMO and managed care patients in capitated plans the capitation fees are paid regardless of cost of services (Ku 1993: 39). Also the taxpayer's benefit-cost approach restricts the evaluation to the impact of one form of public expenditure on another (Brown and Eisenberg 1995: 241); this assumed relationship between the funding of the two services is tenuous for public services and usually non-existent for privately provided services (welfare funds do not impact on the private insurer's funds).

Cost-effectiveness is a relative concept, based on the comparison of two programs or a program and the current status quo, which achieve the same output or level of effectiveness (Montgomery 1995: 338). The programs compared must provide similar services (have the same output) and serve similar client populations for comparison to be valid (Jensen 1991: 309). Output measures combined with cost estimates allow comparisons of the costs and impacts of various approaches to service delivery (Kenney and Lewis 1991: 412). The program which provides the same level of effectiveness at a lower total social cost merits the label cost-effective (Brown and Eisenberg 1995: 240).

Several issues complicate the application of cost-effectiveness to family planning services: economies of scope and whether the proper constellation of services are evaluated; the significance of the scale of operation; nontraceable costs (costs spread across all components of the program); quality control; measuring demand; and the preventive nature of family planning services (Kenney and Lewis 1991: 416). Many impacts and benefits of family planning services occur in the future so a discounting of future benefits needs to occur. Also prevention programs, affect the probability of certain events, and there is uncertainty as to the actual benefits and outcomes (Montgomery 1995: 351). Outcome reflects the demand generated by the program, the resources spent on the outcome and characteristics of the method and individual. Information and counseling about the methods also impact on the outcome of the family planning services and are difficult to quantify and measure objectively, although clearly of value (Kenney and Lewis 1991: 417; Montgomery 1995: 353).

Most of the family planning literature does not resolve three additional problematic issues: individual costs of time and money to gain access to services; the multiple dimensions of services; and how to translate service statistics gathered by programs into final output measures (Montgomery 1995: 354). The last issue also raises questions about contraceptive failure rates and how they vary among individuals and the fickle nature of wantedness; most models have used the couple years of protection (CYP) approach which

assumes fixed wantedness status and uses theoretical failure rates for the contraceptives (Montgomery 1995: 359). One study approximates the dynamic nature of wantedness by decreasing the cost of unintended pregnancy to reflect the fact that only 31% are permanently unwanted and that the other 69% of pregnancies would occur within the next two years according to the model used (Trussell, Koenig, Ellertson, and Stewart 1995: 4). Valid cost-effectiveness evaluations can occur only when the programs compared have sufficient similarities, such as similar population served and similar services provided (Jensen 1991: 299).

Cost-effectiveness requires data which rarely has been gathered for family planning services. The shortage of and poor quality of data has hindered rigorous cost-effectiveness evaluations of U.S. family planning programs (Brown and Eisenberg 1995: 240; Ku 1993: 50). The data gap for private insurance coverage has been described as "serious" (Ku 1993: 51). Difficult to obtain data needed to create cost functions includes: information on the wantedness of each pregnancy; characteristics of each individual served (age, income, race, education, expectations, attitudes) and how much it costs to reach that person; user's motivation level; provider characteristics (private, clinic, or other); knowledge of methods; insurance status; current use of difficult to reverse methods (sterilization, Norplant); and the availability of other programs with similar services in the area (Montgomery 1995: 341). Without such information the analysis functions informally and postulates the unavailable data about cost functions so as to continue. Most of the family planning cost-effectiveness literature depends on two unproved assumptions: 1) a single output indicator can represent the multiple dimensions of output and 2) average costs are constant over the range of output (Brown and Eisenberg 1995: 240). Even beyond the cost-effectiveness approach, little formal program evaluation of U.S. family planning programs has occurred (Montgomery 1995: 338).

Most family planning cost-effectiveness studies in the U.S. evaluate only specific family planning methods such as the emergency contraceptive pill (ECP) or a set of

contraception methods. These studies often include both a public payer setting and a private managed care payer setting, both of which are measured against a no treatment output (Trussell et al 1995; Trussell, Koenig, Ellertson, and Stewart 1995). Within the emergency contraceptive pill study, two means of delivery are evaluated in both payer settings, against a cost comparison of no treatment (Trussell, Koenig, Ellertson, and Stewart 1995: 2). However, the study does not address the issue that the two delivery modes might attract and serve different populations: one delivery system provides the ECP in advance, before the user even knows she will need it, and the other provides the ECP immediately after unprotected intercourse. Few other cost-effectiveness studies of family planning in the U.S. assess more than the current delivery mode and its complete absence.

Most of the cost-effectiveness analyses of family planning services in the U.S. utilize comparisons of hypothetical scenarios with the current delivery system to advocate a program goal. For example, the emergency contraceptive pill study moves from a comparison of hypothetical programs with the current haphazard delivery of the ECP to a conclusion that advocates a new program goal: emergency contraception coverage, which will result in decreased unintended pregnancies and cost savings (Trussell, Koenig, Ellertson, and Stewart 1995: 8). As established earlier, cost-effectiveness does not serve as a valid means of policy goal selection, only for delivery system comparison. However, when no delivery sets the standard for comparison and is proven to be more expensive, this leads to policy recommendations based on cost-effectiveness studies.

Few studies have applied pure cost-effectiveness approaches to family planning services in the U.S. The most complete cost-effectiveness approach to any family planning services found in the literature was "The Economic Value of Contraception: A Comparison of 15 Methods" (Trussell et al 1995). A comparison between a public and a private model to analyze costs of fifteen methods of contraception with an outcome measure of pregnancies prevented found that the initial cost of obtaining contraception did not predict the actual value (Trussell 1995). Private costs were consistently greater than public. This

analysis did not address questions of coverage or diversity in plans and costs; it used an averaged national claims database to model the private payer, which did not include HMOs. The model used also assumed that public and private payers cover the full cost of contraception, abortion, sterilization, and childbirth (Trussell et al 1995: 495). The cost of pregnancy was tracked until hospital discharge for the mother and infant or termination of the pregnancy. The above public sector studies have used the costs incurred during the first two years of life for assessing the cost of the pregnancy to the system.

Through this model, contraceptive methods result in savings for third-party payers, although the individual incurs the costs of the contraceptives. This leads to the question: would an increase in contraceptive coverage affect the payer's bottom line? Such an increase in coverage could inflate payer costs, since individuals would absorb the costs of contraception otherwise, or it could save the payer money if it resulted in improved access and use of contraception and thus decreased unintended pregnancies (Trussell et al 1995: 500). Many California employers assume that the burden of such contraceptive costs outweigh the benefits and endanger the quality of existing care and premiums. The organization CAHR based their opposition to a legal mandate for contraceptive coverage on the perceived negative economic impact of paying for contraception as detailed earlier. As discussed in Section III, most third party payers have not attempted to answer this question and have opted instead to simply minimize costs by not covering contraception.

Few costs analyses of privately provided family planning services have been completed which limits the role of costs analyses in the current coverage decision process for family planning services. More work has been done to show the savings/cost advantages of public family planning services. Formal costs analyses of private family planning services do not appear in the literature or in the interviews conducted in Section III. The resources required to calculate cost effectiveness may not pay off for private providers at this point in time when cost effectiveness tools are developing (see Section III. for more discussion).

Section II: Review of Coverage and Costs of Family Planning Services Among Selected Individual Health Plans in California

To establish a baseline of coverage for family planning services, individual policies of five major insurers in California were analyzed: Blue Cross, Blue Shield, Foundation Health, Kaiser and PacifiCare. This review focused on which family planning services are covered and at what cost to the subscriber, and the information obtained served as a base for the interviews in Section III. This analysis also has limited itself to individual products, a small portion of the health insurance market, because individual purchases reflect consumer preferences more sensitively and because individual plans have fewer options. Within large group employer-related insurance, each group can demand whatever package it wants. This results in such a diversity of coverage and costs that comparison loses its utility. Individuals, however, are offered a finite number of packages from among which to choose.

I. Parallels Among Individual Plans

All plans engage in age-rating and region-rating; plans do not assess gender rates because the law forbids this (Section III. discusses this further). Some regional issues arise. Certain more rural and sparsely populated counties do not appear in many plans: Monterey, Santa Barbara and San Louis Obispo for example. Southern California's premiums usually surpass northern California's. All premium information is provided in Appendices 1-5. All organizations encourage the younger spouse to be the applicant as lower rates may apply, and all require the applicant to agree to binding arbitration to resolve any disagreements or dissatisfactions. All organizations offer individuals HMO and PPP options, except for Kaiser which only operates as an HMO. Ranking of California HMOs by size in 1991 revealed that among those surveyed here, Kaiser of Northern California ranked first in the state, followed by PacifiCare (fourth in the state), and Foundation Health (eighth in California) (California Almanac 1993: 28). Health Net was the third largest

HMO in 1991; it does not offer an individual product and was therefore excluded from this survey (Ibid: 28).

Coverage and costs of services are based on the information presented in each organization's information packets. Most competition occurs on the basis of price because the consumer can easily see and compare price, and price is what is compared here. There is little to differentiate among the products themselves, and no easy index for quality of care exists so most consumers rely on price to differentiate among and select a health plan. Individuals may use the same comprehensive approach, looking for the most complete package only. None of the literature referred to decision factors within the individual market specifically.

The non-technical literature reflects the services each organization believes will market successfully and sell their products: "managed care organizations must differentiate themselves in a manner that is meaningful to the market if they are to prosper...." (Clarke 1995: 64) Reproductive services in general do little to differentiate managed care organizations for consumers and thus, "it is unlikely that family planning, reversible contraceptives, or abortion will have a serious effect on the selection of a managed care plan." (Clarke 1995: 69) Prevention and wellness programs rate low in the decision to choose a health plan; contraception and family planning fall into this category (Clarke 1995: 65). From the policy perspective, interviews presented in Section III. show that family planning services receive a low priority within decision making. This concords with the consumer's decision process, which also usually ignores family planning services.

The range of family planning marketing indicates its fluctuating importance. Certain aspects of family planning services are viewed as more attractive and valuable to potential enrollees: Pap smears, pelvic exams, sterilization, pregnancy, prenatal and well-baby care. The non-technical literature presents information about the rates and coverage for these services in bold or in tables; pictures of smiling babies and mothers grace many brochures. Services such as abortion, oral contraceptive pills, IUDs, Norplant, Depo

Provera, sexually transmitted disease screening and treatment usually are not highlighted, often found in small print, and sometimes are not mentioned at all. This manifests the low-involvement nature of family planning services, which are perceived to be provided equally well by all providers, and are not a means of differentiation for most consumers (Clarke 1995: 64). A low-involvement purchase carries little risk, and the consumer perceives the decision as simple and thus gathers little information; there is little pressure or demand for the insurer to provide such services.

Marketing of women's health has focused on obstetrics. Pregnancy and delivery include an intense level of personal involvement and high anticipation which motivate a great desire for information about maternity services. Also, maternity services are socially valued. Many consumers collect and analyze data on various products to evaluate maternity coverage, and maternity coverage is more likely to be used as a meaningful criteria in selecting a plan (Clarke 1995: 68). This correlates with the better and more prominent presentation it receives in brochures. In contrast, few consumers investigate provision of other family planning services such as contraception or abortion. This results in part from routinely good provision of care in family planning services like contraception, and abortion services and a perception of safety with these services (Clarke 1995: 70). Consumers perceive that any health insurance organization can deliver good contraceptive, abortion, and sterilization services, and these services thus exert little influence on marketing by managed care organizations or on the consumer's choice of health plan.

Most plans do not cover infertility services or pregnancy initiated within the six (sometimes twelve) months previous to entry to the plan. Infertility is a high involvement service, so a managed care organization could cultivate a meaningful difference through its offering of these services; Kaiser has chosen to cover 50% of limited infertility services, for legal reasons detailed in Section III. However, most companies choose not to cover infertility services because of the high costs and because the Health Care Financing

Administration (HCFA) determined that "these procedures are unusual, infrequently provided, and not necessary for the protection of individual health." (Clarke 1995: 69)

II. Blue Cross

Blue Cross has provided health care coverage in California since 1937 and now functions in conjunction with CaliforniaCare Health Plans and WellPoint Life Insurance as a for-profit organization. Blue Cross began as a non-profit, and as repayment for its many years of non-profit tax status it must contribute more than \$2 billion to charitable purposes (Kreier 1996: 5). Only in 1995 did Blue Cross receive permission to use its Blue Cross brand name to market for-profit products (Kreier 1996: 5). Blue Cross guarantees coverage to any applicant by dividing subscribers into three risk levels. All the information on individual product coverage and costs presented here applies to Level I, the lowest risk level.

HMO Product

Upon joining CaliforniaCare, Blue Cross's HMO product, the subscriber must select a Participating Medical Group (PMG) or Independent Practice Association (IPA) within 30 miles of home; a Primary Care Physician must be chosen from this PMG or IPA. The Primary Care Physician then coordinates all of medical needs and services. The annual copayment limit is \$2,000 for an individual and \$4,000 for a family or couple. No maximum lifetime benefits limit coverage.

The available Benefit Summary for the Blue Cross HMO provides less details than most plans' benefits sections. Within family planning, certain services stand out because they receive no mention, implying the possibility of no coverage: pelvic exam, Pap smear and diagnostic services. The silence on these services contrasts with much of the other plans' literature which touts the coverage of PAP smears and pelvic exams as basic women's health care.

Blue Cross limits its coverage on several family planning services. Contraceptive drugs and devices, all services related to infertility or sexual dysfunction (except when it results from a physical abnormality, defect or disease) do not qualify for coverage. In the fall of 1995 Blue Cross had a pregnancy exclusion such that any pregnancy with conception on or after the effective date of coverage was covered; more recently the policy changed so that even delivery is included as of the effective date of coverage.

Table 1. Coverage and Costs

<u>Services</u>	<u>Copayments</u>
Well baby care	\$10
Health education	None: some services subject to copayment
Office visit	\$10
Normal pregnancy care/delivery & Cesarean section	After \$1,000 deductible, no charge
Inpatient physician services	After \$1,000 deductible, no charge
Inpatient hospital and ancillary services	After \$1000 deductible, no charge
Pregnancy complications	None
Abortion	\$250
Tubal ligation	\$250
Vasectomy	\$150
Outpatient prescription drugs	
Participating pharmacy (30 day supply only)	\$10 formulary; \$15 non-formulary
Non-participating pharmacy (30 day supply only)	\$15 formulary; \$20 non-formulary
Drugs ordered through mail service drug program (60 day supply only)	\$20 formulary

Blue Cross premiums reflect geographic region and age. California is divided into six areas: Areas 1, 2 and 3 are mainly northern California and Areas 4, 5 and 6 southern California. A trend to higher rates in southern California is observed. See Appendix 1.

Preferred Provider Product

This option offers three Prudent Buyer plans: the Classic Co-pay with deductibles of \$250 or \$500, the Classic Deductible with deductibles of \$1,000 and \$2,000 and the Basic Hospital with a \$2,000 deductible. The Basic Hospital covers only hospital services and specifically excludes maternity care. It provides no family planning care. Benefits of the two Classic plans (Preferred Providers and Non-Preferred Providers) are shown below (Table 3).

For the \$250 and \$500 deductible plans, the deductibles apply only when the subscriber uses a Non-Preferred Provider.

When Preferred Providers are used, all copayment percentages refer to the Negotiated Fee rate. When Non-Preferred Providers are utilized, the copayment percentages refer to the Limited Fee Schedule; any amount billed above the Limited Fee Schedule is paid by the subscriber.

Table 2. Classic Plans

<u>Deductibles</u>	<u>Option 1</u>	<u>Option 2</u>	<u>Option 3</u>	<u>Option 4</u>
	\$250	\$500	\$1,000	\$2,000
Annual maximum	\$2,500	\$3,000	\$3,000	\$4,000
copayment: In-network				
Out of network	\$3,000	\$3,500	\$3,000 plus any amount over the limited fee schedule*	\$3,000 plus any amount over the limited fee schedule*
Maximum protection	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000

* Amount over the limited fee schedule does not apply toward copayment limit.

Table 3. Coverage and Costs

<u>Provider</u>	<u>Preferred Providers</u>	<u>Non-preferred Providers*</u>	<u>Preferred/Non-Preferred Providers</u>
<u>Services</u>	<u>Copayments</u>		
<u>Plan Option</u>	<u>Option 1/Opt. 2</u>	<u>Option 1/Option 2</u>	<u>Option 3/Option 4</u>
(Deductible)	\$250/\$500	\$250/\$500	\$1,000/\$2,000
Well baby care	\$20/25	35%	50%/0
Office visit	\$20/25	35%	80%/70%
Stay Well: Pap smear and visit	Not listed	Not listed	80%/70%
Normal pregnancy care/delivery & Cesarean section	\$1,000 plus 25%	\$1,000 plus 35%	After additional \$1,000 deductible, 80%/70%
Inpatient hospital and ancillary services	\$250/\$300 day	After deductible, 35%	After additional \$1,000 deductible, 80%/70%
Pregnancy complications or elective abortion	\$1,000 plus 25%	\$1,000 plus 35%	After additional \$1,000 deductible, 80%/70%
Tubal ligation	Not listed		
Vasectomy	Not listed		
Outpatient prescription drugs: separate deductible	None	\$100/member	\$100/member for both
Participating pharmacy (30-day supply only)	Formulary: 20% generic, 30% brand name; Non-formulary: 40% for generic or brand name		
Non-participating pharmacy (30 day supply only)	Formulary: 40% limited fee schedule for generic, 50% for brand name; Non-formulary: 60% for generic and brand name		
Drugs ordered through mail service drug program (60 day supply only)	\$20 each prescription/refill		

*Deductible only applies to Non-Preferred Providers.

A twelve month waiting period after enrollment applies to pregnancy, elective abortion, and sterilization procedures. Although the law requires that prior coverage credit be applied to waiting periods for pre-existing conditions, this does not pertain to pregnancy, elective abortion, or sterilization. All plans also exclude: infertility services, contraceptive drugs and devices prescribed for birth control and medically unnecessary services as determined through Utilization Review.

The state is divided into the same six areas as detailed under the Blue Cross HMO section. Again, southern California shows a trend to higher rates than northern California. Areas 1 and 2 have very similar premiums. See Appendix 1.

III. Blue Shield

Blue Shield, a non-profit organization, offers an HMO plan and a preferred provider plan to individual purchasers. Brochures for both plans highlight certain options on their covers, many of which pertain to family planning services. Family planning services, well baby care, prenatal care, health education programs and Pap tests are listed on the HMO brochure, and family planning, maternity benefits, well baby care, and Pap tests appear on the Preferred Provider cover. Pregnancy related services such as perinatal care and delivery are subject to a twelve month waiting period after enrollment. Blue Shield limits all covered services to those which it determines are "medically necessary;" a blanket medical necessity exclusion applies to all care.

HMO Product

Blue Shield solicits the input of subscribers to its policies through its "Public Policy Participation Procedure." Through this, at least one third of the Board of Directors are subscribers who have no financial interest in Blue Shield. Each family member selects a Personal Physician, and women may self-refer to an obstetrician/gynecologist in this Personal Physician's medical group for an annual well-woman exam (as required by law). Any services not obtained from or approved by the Personal Physician will not be

reimbursed; all covered services are covered only if performed, prescribed or authorized by the Personal Physician except for emergency services or urgent services outside your area. In such cases, Blue Shield determines whether services are emergency services or medically necessary in a manner consistent with "generally accepted medical standards." (*The Blue Shield Personal HMO* 1995: 7) The annual copayment maximum is \$2,000 per member and \$4,000 for all covered members of a family.

Blue Shield HMO specifically excludes many family planning services from benefits: all infertility services, treatment of sexual dysfunction, contraceptives and contraceptive devices, vasectomy or tubal ligation reversal, repeat vasectomy or tubal ligation, pregnancy and vaginal delivery for the first twelve months of enrollment, premarital blood tests, penile devices and surgery (except as medically necessary), and term delivery outside the Service Area (unless Blue Shield finds that the member was there because of circumstances beyond her control or because of extreme personal emergency).

Table 4. Coverage and Costs

<u>Services</u>	<u>Copayments</u>
Well baby care	No charge
Annual pelvic exam	No charge
Annual Pap test	No charge
Health education and promotion	No Charge
Office visit	\$15
Diagnostic services	No charge
Prenatal visits (including in high-risk pregnancy, diagnostic procedures for genetic disorders of fetus)	No charge
Postnatal visits	No charge
Delivery	
Inpatient physician services	No charge
Inpatient hospital and ancillary services	\$1000 copayment, then 20% of allowed charges
Family planning counseling	\$15
Abortion	\$100
Tubal ligation	\$100; no charge if performed with delivery or abdominal surgery
Vasectomy	\$75
Outpatient prescription drugs	
Drugs purchased at a participating pharmacy (34-day supply maximum)	\$15 brand name; \$10 generic
Drugs ordered through mail service drug program (90 day maximum supply)	\$17 brand name; \$9 generic

Although pregnancy, maternity care, abortion, and sterilization services are excluded for the first twelve months of enrollment, involuntary complications of pregnancy such as miscarriage, cesarean section, toxemia and ectopic pregnancy are covered. After the first twelve months of enrollment, maternity care, abortion and sterilization services are covered benefits.

Blue Shield outlines a three step Appeal Procedure for resolving any disagreement with Blue Shield. After contacting the HMO Member Services Department, Administrative Review, and Consumers Affairs Department and receiving written responses from all three, the subscriber may then initiate legal procedures.

Although the premiums do not provide for the permutation of a single parent and child, the brochure advises single parents to insure the child through a separate child policy rather than use the "party of two" option. Rates vary by region and Blue Shield offers its HMO plan in six regions in California: three northern regions and three southern regions. The southern California rates tend to be lower than northern California rates; the inverse is true for Blue Cross and Foundation Health. See Appendix 2.

Preferred Provider Product

Four deductibles are offered: \$250, \$500, \$1,000 and \$2,000. A family's total deductible is twice the individual amount, regardless of family size. The deductibles are waived for certain covered services, and the copayments for these services do not apply towards the deductible. Routine office visits to Preferred Physicians for the \$250 and \$500 deductible policies have no deductible; the copayment is \$15 and \$20 respectively. The annual copayment maximums are \$2,000 per person and \$4,000 per family, unless you have utilized Non-Preferred Providers: the copayment maximum then rises to \$5,000 per person and \$10,000 per family. The Preferred Provider option carries a lifetime benefit maximum of \$6,000,000 per covered individual.

The exclusions applied to Preferred Provider plans parallels that of the HMO plan. The following procedures and services are not covered: sexual dysfunction

treatment, infertility, reversal of surgical sterilization, and penile implant devices and surgery. In all Blue Shield plans, IUD insertion is covered although the actual device is not covered. For the first twelve months of enrollment, vasectomy, tubal ligation, prenatal care, vaginal delivery, cesarean section, and post-delivery care are excluded. Family planning benefits exclude infertility services and contraceptives.

Table 5. Coverage and Costs

<u>Services</u>	<u>Preferred Providers</u>	<u>Non-Preferred Providers</u>
Office Visits*	20%	50%
Pap test**	20%	Not covered
Well baby care	20%	Not covered
Consultations*	20%	Not covered
Tubal ligation	20%	Not covered
Vasectomy	20%	Not covered
Abortion	20%	Not covered
Pregnancy: prenatal care, non-emergency complications, vaginal delivery, cesarean section, and post-delivery care	After separate \$1,000 copayment, 20%	After separate \$1,000 copayment, 50% of allowed charge of \$600/day plus all charges above the \$600/day
Pregnancy complications: emergency	20%	20%
Outpatient Drugs (No deductible)		
At pharmacy	20% allowed charges	20% allowed charges
Mail service drug program (up to 90 day supply)	\$17 brand name drug; \$9 generic	

* For \$250 and \$500 deductible plans, the deductible is waived for these services and they cost \$15 and \$20 per visit, respectively.

** Preventive coverage: not subject to deductible

Within each deductible amount, the rates vary by region. Blue Shield again divides California into six regions: regions 1,2 and 3 are in northern California and regions 4, 5 and 6 in southern California. More counties are included in the Preferred Provider plan than through the HMO: most of the new counties are in the northernmost portion of California. The addition of many rural and sparsely populated counties to the preferred provider regions exposes one of the structural weaknesses of HMOs: they only function well with a minimum population density. See Appendix 2. for premiums.

The northern California rates for Preferred Provider are lower than the southern California rates, the inverse of the relationship among Blue Shield's HMO rates.

IV. Foundation Health

Established in 1978 as a non-profit organization, Foundation Health Corporation converted to for-profit in 1984 and became a publicly traded corporation in 1990. The public relations brochure acknowledges the trend to for-profit management within health care stating, "As the state of health care changed, so did we." (*When you need us, we'll be there brochure* 1995: 1) Foundation Health's conversion to for-profit preceded the 1986 Tax Reform Act which limited the ability of non-profits to retain capital for acquisition or growth purposes and thus encouraged for-profit conversions (Kreier 1996: 5). The chief executive officer received a salary of \$12.99 million in 1994 (Mitka 1996: 3).

Foundation Health offers HMO, PPO, dual choice (HMO and PPO), and point-of-service coverage (HMO and indemnity). Foundation Health recently entered the HMO market for individuals and families. In 1993 Foundation Health first began offering health insurance plans to individuals.

HMO Product

The HMO product for individuals and families includes three levels of coverage with rates which vary according to three variables: the level of coverage, the region of residence, and age. The rates apply to two regions. Butte, Colusa, Nevada, Sacramento, Solano, Sutter, Yolo, Yuba, Amador, Calaveras, Fresno, Kern, Kings, Madera, San Joaquin, Tulare and parts of El Dorado, Glenn, Placer and Tehama counties compose the region assessed lower rates. Alameda, Contra Costa, Marin, Merced, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus and Tuolumne counties make up are the higher rate region. See Appendix 3. for premiums.

Sterilization procedures are touted as covered services, but the copayment is not given. Pregnancy is a pre-existing condition if it requires care within six months of joining plan or if you received care for pregnancy in the six months previous to joining. Infertility treatment is not covered.

Table 6. Coverage and Costs

<u>Services</u>	<u>Copayment</u>		
	<u>Premier</u>	<u>High</u>	<u>Standard</u>
Well baby care to 2 yrs.	\$7	\$15	\$20
Annual Pap smear and pelvic exam*	7	15	20%
Newborn delivery, per admission	100	100/day, days 1-5	500
Pre-natal and post-natal visits	7	15	20
Family planning	15	15	20%
Office visits and surgery	7	15	20
Outpatient prescription medications, max. \$2,500/yr., Generic	5	10	10
Brand name	10	15	15

* Women can self-refer to a participating obstetric/gynecologist once a year for these services, as required by law.

Preferred Provider Product

Foundation Health defines its preferred provider organization (PPO) as "a network of doctors, hospitals, and other providers who have agreed to provide medical services at reduced negotiated fees." (*Summary of Benefits* 1995: 2). Non-Preferred Provider services are paid at a lower benefit percentage levels. Nothing is reimbursed for preventive care and outpatient prescription medications received at non-Preferred Provider sites. The PPO divides California into five different rate regions. The two regions available for HMO rates are listed here for comparison: the Bay and Stanislaus region and the Sacramento, North Central, Delta and South central region. These are all northern California regions; the other three regions are in southern California and have higher rates than the northern California regions. Southern California is divided into Los Angeles County (with the highest rates for the state); Orange, Ventura and Santa Barbara counties; and Riverside, San Bernadino and San Diego Counties. Only Los Angeles rates are provided to show the full range of rates; the other two southern California regions have lower rates than Los Angeles and higher rates than the northern California regions.

Deductibles range from \$250-\$5,000 annually. PPO benefits apply only after the deductible has been met. Deliveries include a separate \$1,000 facility charge deductible, per delivery. For deductibles less than \$1,000, the deductible is waived for in-network office visits and for prescriptions purchased at a participating pharmacy. For families, the deductible applies separately to each family member. However, a family deductible limit

exists as well: it is \$750 for the \$250 deductible plan and \$1500 for the \$500 plan (three times the individual deductible). For the higher deductibles the limit is twice the individual deductible:

Individual Limit	\$1,000	\$2,000	\$5,000
Family Limit	2,000	4,000	10,000

Each family member can contribute only the individual deductible limit to the cumulative family deductible limit. The maximum lifetime benefit per person is \$5,000,000. See Appendix 3. for premiums.

The maximum out-of-pocket limit annually, after the deductible has been met, is \$1,500 per individual and \$3,000 per family when only Preferred Providers are seen. Foundation Health pays 100% of covered services for the rest of the year. If any non-Preferred Providers are utilized, the maximum becomes \$4,000 per person and \$8,000 per family, and Foundation Health pays 75% of covered services for the remainder of the year.

Some services have the deductible waived, and the beneficiary pays a fixed copayment, as detailed below with reference to family planning services; these are prices if a Preferred Provider is used. For these services with waived deductible, the maximum out-of-pocket limit does not apply, and the beneficiary must always pay the appropriate copayment. After satisfying the deductible, all payments are based on the negotiated rates the participating provider has agreed to accept for providing a covered service: if the accepted amount was \$100, Foundation Health would pay \$85, and the beneficiary would pay \$15.

All scheduled hospital admissions and surgeries require prior authorization. When not obtained, benefits decrease by 25%. Medically necessary is defined through a "professional review process" that identifies the "necessary and appropriate treatment of the patient's illness according to standards of medical practice generally accepted and provided by the medical community."

The brochure advertises several services as covered and lists no copayment amount: testing for venereal diseases, surgical sterilization, diaphragms, and intrauterine devices.

Foundation Health covers these services after deductible has been met.

Table 7. Coverage and Costs

Not subject to deductible

Deductible:	\$250/\$500	\$1,000	\$2,000/\$5,000
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Services

Well baby care	\$15	\$20	15% *
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Annual Pap & pelvic exam	\$15	\$20	15%*
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Outpatient prescription drugs**	\$5 for generic 30-day supply; \$10 for brand \$5 for generic 90-day mail order supply; \$15 for brand name		
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* After deductible has been satisfied

** Only through participating pharmacies and limited by a \$1,500 maximum benefit per calendar year.

Covered after deductible met:

Deductible:	\$250/\$500	\$1,000	\$2,000/\$5,000
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Services

Prenatal care	15%	15%	15%
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Delivery	\$1,000 + 15%	\$1,000 + 15%	\$1,000 + 15%
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Medically necessary abortion	15%	15%	15%
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Well-baby care includes newborn hospital visits, office visits, and routine immunizations until age two. The *Summary of Benefits* includes the annual Pap smear, pelvic exam and mammography as recommended under the title of "Well Woman Care," a section which targets women's interest in their reproductive health.

Various family planning exclusions apply to Foundation Health's coverage: abortion, unless medically necessary, is not covered. Infertility services and supplies are not included. Many contraceptive methods are excluded in the "Outpatient Prescription Drug Benefit Exclusions and Limitations:" progesterone, implantable medications and devices such as Norplant, and other contraceptive medications and devices, contraceptive foams, condoms, abortifacients, and menstrual induction medications. These probably all arise from the broader disclaimer that "Medication that is not Medically Necessary for the treatment of the condition for which it is administered is excluded;" fertility does not require contraceptive treatment. While not inappropriate, contraception does not fit within the narrow confines of "medically necessary." However, a sales representative stated that oral contraceptives, IUDs, and diaphragms can all be purchased through the prescription

benefit. A six month preexisting condition provision applies to pregnancy: the beneficiary may not have received medical treatment or advice for pregnancy within the six months prior to the policy enrollment date.

V. Kaiser Permanente

Kaiser Permanente is a federally qualified health maintenance organization and non-profit institution. However, the individual plans it offers are non-federally qualified. Kaiser defines HMO as "a health plan that provides health care services to its Members using doctors and facilities located within a specific geographic area." (*Disclosure Form and Evidence of Coverage* 1995, Part One: 1.) Kaiser sells its plans directly. It does not pay a commission to third parties who broker sales, so brokers generally do not provide information on Kaiser.

Kaiser Permanente of Northern California announced in November 1995 new policies which decrease frequency of routine PAP smears, pelvic exams and prenatal checkups for healthy women; Kaiser physicians state that this will reallocate resources to improve quality and effectiveness of care. The schedule of PAP smears and pelvic exams shifts from annual to bi- or triennial. Yvonne Crites, chief of obstetrics/gynecology at Kaiser's Santa Teresa Medical Center in Santa Clara, emphasizes that, "there is no blanket policy regarding Pap smears at Kaiser Permanent;" rather, "current guidelines" allow a physician to recommend less frequent Pap smears (once every two or three years) for women who meet "specific guidelines" (Crites 1995: A20). The American College of Physicians recommends Pap smears every three years. Kaiser also identifies women who have not received a Pap smear in three years and asks these women to come receive tests (Ibid: A20). The process of this policy change is discussed in Section III.

The new policy for pregnancy recommends that a physician or nurse-practitioner first examine pregnant women at the twelfth week of pregnancy. The total number of visits for a pregnancy has decreased from thirteen to nine, as compared to fifteen

recommended by the American College of Obstetrics and Gynecology. Any woman who requests more frequent exams or appointments may have them. Fewer visits allow patients to receive more time with Kaiser staff at each visit and entitle each patient to an ultrasound (not available to all before this protocol). "Under this program, our members get more information than ever before, more education and more time at their appointments," Dr. Yvonne Crites explained (Ibid: A20). The Kaiser Santa Clara site has used this protocol for the past two years, and in 1995 most Northern California Kaiser facilities adopted it (Russell 1995: A11).

Criticism of the new policies centers on the identification of healthy women: the new policies assume that a woman at high risk for complications in a pregnancy or for cervical cancer through her lifetime sexual behaviors will be screened out and receive more frequent care. However, without physical exam and history early in the pregnancy or annual PAP smears, some high risk patients will go undetected. In the case of cervical cancer, women may not wish to identify as high risk or to reveal details of their sexual lives to health care providers, increasing the danger of assuming low risk (Russell 1995: A11).

Kaiser has instituted several changes to its individual product in the past year, many of which impact on family planning benefits. In the fall of 1995 Kaiser added a drug plan to the individual plan and expanded its coverage of contraceptives. As of 1996, the Kaiser individual product covers: birth control pills, diaphragms, cervical caps, injectable contraceptives and internally implanted time-release contraceptives. Several contraceptives were specifically excluded in the disclosure form prior to 1996: diaphragms, condoms, IUDs, oral contraceptive pills, injectable contraceptives (outpatient), and internally implanted time-release medications (outpatient, such as Norplant). "Benefits are provided only for medically necessary covered services that are prescribed, provided, authorized, or directed by a Medical Group physician to prevent, diagnose, or treat a medical condition," and medically necessary includes services or items that: "1) its omission would adversely

affect a Member's health and 2) its provision constitutes a medically appropriate course of treatment for the Member." (*Part One: Copayments & Benefits* 1996: 7).

Pregnant applicants may apply only after delivery. Newborn or adopted children are accepted without medical evaluation if enrolled within 31 days of birth or adoption.

Table 8. Coverage and Costs

<u>Services</u>	<u>\$5Copay</u>	<u>\$15Copay</u>
Preventive and routine care per visit	\$5	\$15
Gynecological visits	\$5	\$15
Prenatal visits	\$5	\$5
Maternity care: hospital services	\$0	\$0
Routine well-baby (age 0-2)	\$5	\$5
Well-baby after age 2	\$5	\$15
X-rays and laboratory tests (Pap)	\$3	\$5
Family planning counseling*	\$5	\$15
Health education classes:		
family planning	\$5	\$15
birth techniques	\$5	\$15
Fertility services (diagnosis and treatment of infertility provided at 50% of charges)	50%	50%
Prescription charge	\$7	\$7
*including pre and post-abortion counseling and information on birth control		

The prescription charge for injectable contraceptives and internally implanted time release drugs such as Norplant approximate the cost of conventional therapy for the same time period. For example, the cost of injectable contraceptives can be calculated by multiplying the prescription charge (\$7) by the number of cycles provided by the drug (usually three for Depo-Provera, which then would cost the member \$21). A similar calculation is performed for Norplant or any other contraceptive which lasts longer than one month; a limit of \$200 is placed on the prescription charge regardless of duration of therapy.

Copayment limit for 1996

One person	\$1,536	\$1,536
Two people	\$3,072	\$3,072
Three or more	\$4,085	\$4,085

The 1996 Copayment limits are slightly lower than in 1995. Application forms for individuals include six questions to be answered only by women over age 12. These questions ask about: date of most recent menstrual period, pregnancy status, abnormalities

of most recent menstrual period, abnormalities of menstrual periods, female organs or unusual vaginal bleeding; complications of pregnancies; and menopause, hysterectomy and tubal ligation status. The application asks both genders about past history of sexually transmitted diseases, infertility problems, and AIDS. The application also includes an agreement to use only binding arbitration to settle any disputes with Kaiser.

Kaiser initiated a new premium structure in 1996 based on region, family structure, age, and richness of benefits. Previously, the premiums reflected only richness of benefits and family structure. This has decreased many of the premiums. See Appendix 4.

VI. PacifiCare

PacifiCare, a for-profit corporation, recently entered the individual sales market. In April 1995 they began selling individual HMO and Point-of-Service coverage in Santa Barbara and San Louis Obispo counties. In February 1996 they began sending out informational packets and marketing plans in several northern California counties: Alameda, Butte, Contra Costa, Humboldt, San Francisco, San Mateo, Santa Clara , Kern (except zip codes 93555 and 93556) and San Joaquin (except zip codes 95304, 95376, 95378, and 95385). Until February 1996 they would only send you information if you resided in Santa Barbara or San Louis Obispo counties. They hope to expand to more counties and are awaiting state approval to proceed.

PacifiCare Health Systems is a publicly owned national corporation with over 1.4 million members in California, Florida, Oklahoma, Oregon, Texas and Washington. It was established around 1973 (*Disclosure Brochure for Northern California* 1995: 16). PacifiCare announces flexibility as a trait it cultivates in its brochures; it lists premiums for children only and, like Blue Cross, for single parents. PacifiCare also boasts that it carries one-year accreditation by the National Committee for Quality Assurance (NCQA) and that it is the first HMO in California to do this.

All PacifiCare information packets emphasize certain services, including Well Woman benefits. The southern California packet includes a sheet highlighting "Well Woman Benefits" which targets future women enrollees and offers: pelvic examination, Pap smear test, manual breast examination and instruction to perform self-examination at home, and educational literature on women's health issues through the Member Services Department. The Northern California information presents a "Well Woman Program" which "makes it easy for any woman to receive her annual exam to maintain her good health" and assures the woman that she can choose an obstetrician/gynecologist without a referral. Well Woman is separated out for special attention in highlighting boxes and text as are preventive services which are described as Well Baby Care, breast and pelvic examinations among other benefits.

Both Individual Enrollment Health Questionnaires probe for information on reproductive health, especially female. The Southern California version uses two questions investigating reproductive health that apply to both sexes: in the last five years, has the applicant taken any prescription drugs or experienced any indications of, symptoms of, diagnoses of, treatment for or health services for sexually transmitted disease. Five additional questions delve into women's reproductive health over the preceding five years: any disease or disorder of the reproductive organs including, without limitation, irregular menstruation, hysterectomy or D&C; complications of pregnancy; cesarean section or abortion; currently pregnant; and date of last menstrual period.

The Northern California questionnaire asks about history of and treatment for AIDS and sexually transmitted diseases for both sexes. Women also must supply information on any history of infertility or "Other female disorder" in the last five years, date of last menstrual cycle if of childbearing age, and pregnancy status. Men must indicate if they are currently an expectant father, even if the mother is not listed on the application. In all plans, each member can select a different Primary Care Physician, enhancing confidentiality if desired.

All benefits are covered only when the service is medically necessary. Medically necessary pertains to: "treatment of an active illness or injury which have been established in accordance with generally accepted professional standards, and are determined to be: a) rendered for the treatment or diagnosis of any injury or disease; b) appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards; c) not furnished primarily for the convenience of the Member, the attending physician, or other provider of services; d) furnished at the most appropriate level which may be provided safely and effectively to the Member." (*Disclosure Brochure for Northern California 1995: 25*)

All PacifiCare individual plans carry the same exclusions: pregnancy within twelve months previous to coverage and medical care, advice or treatment for pregnancy in that preceding twelve months. Infertility services and reversals are not covered benefits, nor is sexual dysfunction. Some forms of family planning are excluded, specifically "injectable or implantable devices" which encompasses intra-uterine devices, Norplant, and Depo-Provera. For all of these, PacifiCare covers the procedure but not the device. However, drug coverage includes oral contraceptive pills. All plans include abortion after the twentieth week of pregnancy only if the mother's life is threatened. Until 20 weeks, the point of service plans only cover In-Network (Option 1) abortions.

HMO Product

PacifiCare offers two HMO plans: both have unlimited maximum benefits and maximum annual copayments of \$1500/3 maximum per family; "when 3 covered family members each reach \$1,500, the Annual Copayment Maximum is satisfied for the family." Maternity care includes a \$1,000 deductible, and no other medical services carry a deductible. The annual copayment maximum does not apply to prescription drugs or Maternity Deductibles. No coverage differences exist between the Northern and Southern California plans, as presented in the disclosure brochures. However, premiums are higher

in the Northern California regions which PacifiCare covers. See Appendix 5. for premiums.

Table 9. Coverage and Costs

<u>Service</u>	<u>Copayments</u>	
	<u>HMO 10</u>	<u>HMO 15</u>
Office Visits*	\$10	\$15
Well Baby Care	\$10	\$15
Health education	0	0
Diagnostic lab tests	\$10	\$15
Vasectomy	\$150	\$150
Tubal ligation	\$250	\$250
Perinatal visits	\$10	\$15
Delivery (normal or cesarean)	\$1000 deductible	\$1,000 + 20%
Pregnancy complications	\$250	\$250 per admission
Physicians services in hospital	\$0	20%
Hospital and other related services	\$0	20%
Abortion (until 20th week)	\$250	\$250
Abortion after 20 weeks	Not covered	Not covered
Infertility services	Not covered	Not covered
Prescription Drugs		
Retail (one month supply)	\$10 generic; \$25 brand name	\$10 generic; \$25 brand name
Mail order (three month supply)	\$20 generic; \$65 brand name	\$20 generic; \$65 brand name

*Office Visits include preventive services such as breast and pelvic exams and Pap smears.

Individual Point-of-Service Products

Three benefit levels exist which vary in premiums, copayments and freedom of provider selection. Option One is "in-network," allowing visits only to a specific Primary Care Physician that you select from providers contracted with PacifiCare. Option Two allows medical care from any participating provider listed in the "Individual Provider Directory" or in the "Preferred Provider Network Directory." Option Three provides the broadest range of providers: any licensed provider in the United States who does or does not contract with PacifiCare. PacifiCare's portion of copayment is then based on a Limited Fee Schedule. Sterilization is not covered for the first twelve months of enrollment under Options Two and Three. Referrals authorized by the Primary Care Physician are covered as "In-Network" benefits. All "Out-of-Network" non-emergency hospital admissions require pre-authorization, based on medical necessity.

Table 10.

<u>Coverage Details</u>	<u>Option One</u> <u>(In-Network)</u>	<u>Option Two</u> <u>(Preferred Providers)</u>	<u>Option Three</u> <u>(Non-preferred Providers)</u>
Deductible	0	\$250 or \$500 or \$1000	\$250 or \$500 or \$1000
Separate Maternity Deductible	\$1,000	\$1,000	\$1,000
Maximum Benefits	Unlimited	\$2,000,000	\$2,000,000
Annual Copayments Maximum	\$1,500	\$3,000	\$4,500

Table 11. Coverage and Costs

<u>Service</u>	<u>Option One</u> <u>(HMO 10)</u>	<u>Option Two</u>	<u>Option Three</u>
Office Visits	\$10	20%	30%
Well Baby Care	\$10	20%	30%
Health education	0	Not covered	Not covered
Diagnostic lab tests	\$10	20%	30%
Pelvic exam	\$10	20%	30%
Pap smear	\$10	20%	30%
Vasectomy	\$150	Not covered	Not covered
Tubal ligation	\$250	Not covered	Not covered
Perinatal visits	\$10	20%	30%
Delivery (normal or cesarean)	\$1,000	\$1000 + 20%	\$1000 + 30%
Pregnancy complications	\$250; \$0 *	20%	30%
Physicians services	\$0	20%	30%
Hospital and other related services	\$0	20%	30%
Abortion (until 20th week)	\$250	Not covered	Not covered
Abortion after 20 weeks	Not covered	Not covered	Not covered
Infertility services	Not covered	Not covered	Not covered
Prescription Drugs			
Retail (one month supply)	\$10 generic; \$25 brand name		
Mail order (three month supply)	\$20 generic; \$65 brand name		

* Pregnancy complications are covered with a \$250 copay in the Southern California policy. The Northern California policy pays in full for this.

Drug coverage applies to any prescription written by a licensed physician and filled at an In-Network pharmacy. No coverage is offered for pharmaceuticals purchased out of network. The annual copayment limit does not include the "Out-of-Network" deductible, charges above the Limited Fee Schedule in Option Three, prescription drugs or any separate deductible such as maternity. Again, the Northern California policies cost more than those offered in Southern California. The two southern counties included, Santa Barbara and San Luis Obispo, are less urban and covered by less health plans than the Northern California counties discussed here. See Appendix 5. for premiums.

VII. Comparisons of Coverage and Costs Among Individual Health Plans

A basic set of family planning services were culled from those mentioned in the non-technical literature: PAP smear, pelvic exam, normal pregnancy, well baby care, oral contraceptives, IUD, diaphragm, abortion, tubal ligation, and vasectomy. STDs were excluded from the review of individual plans as explained in the Introduction. The costs of receiving these family planning services through the richest plan offered by each organization were compiled (See Table 13). Listed costs reflect the cost for one service (one well baby care visit for example) or for one month of a prescription or for one device (IUD or diaphragm). When generic and brand prices are listed for drugs, the brand price was cited. All preferred provider prices are the cost of obtaining a service within network. Table 13 summarizes the data presented on each plan's coverage and costs and displays the variety of coverage and cost combinations.

Some plans did not cover some of the family planning services surveyed. Subscribers to such plans would pay out of pocket to receive such services, and the costs of obtaining various family planning services in the community are estimated below. Most community prices are higher than copayments in the plans which offer these services as benefits.

Table 12. Community Costs for Alameda County

<u>Item</u>	<u>Average Cost in 1996</u>
Oral contraceptives (1 month)	\$23
Diaphragm	\$29
IUD	\$270
Normal delivery	\$6,300
Abortion	\$325
Tubal ligation	\$1,500
Vasectomy	\$400

Device prices are based on the average cost quoted over the phone by Thrifty's pharmacy and Long's pharmacy; IUD price was cited by the office of a Berkeley obstetrician/gynecologist. Procedure prices are based on those charged by Planned Parenthood of Oakland except for normal delivery. Alta Bates Hospital provided hospital charges for a normal delivery which includes a one day hospital stay.

The most sporadic coverage appears in the various forms of contraception surveyed: oral contraceptives, IUDs, and diaphragms. This agrees with the data on employer based coverage of family planning services, as discussed in Section I. Only Foundation Health (HMO and PPP) and Kaiser cover diaphragms and IUDs. Foundation Health (HMO and PPP), Kaiser and PacifiCare (HMO and PPP) all offer oral contraceptives as a drug plan benefit.

To provide some perspective on the total cost of each individual policy, the annual premium also is listed in Table 13. The annual premium equals the total monthly premiums paid in a year. The premium rate used was that for a single 25 year old living in Alameda county, and the richest plan offered was selected. Annual premium cost does not correlate with the richness of family planning service benefits.

The greatest cost variations arise in pregnancy and abortion benefits. Hospital charges for pregnancy range from \$0 at Kaiser to \$1,000 deductible plus 25% in Blue Cross's PPP option (approximately \$2325 using the community cost for a normal delivery of \$6,300). Foundation Health's HMO and Kaiser (also an HMO) have substantially lower pregnancy copayments, at \$100 and \$0 respectively, than all other plans. All other plans surveyed assess at least a \$1,000 deductible for a normal delivery. Abortion services cost the individual subscriber anywhere from \$0 (Foundation Health's HMO) to \$1,000 deductible plus 25% (Blue Cross's PPP option), and PacifiCare's PPP does not cover abortion, which has a community cost of \$325.

Table 13. Costs of Selected Family Planning Services Across Individual Health Plans

Family Planning Service	Plan Type	PAP smear	Pelvic exam	Normal pregnancy	Well Baby Care	Oral Contraceptives	IUD
Blue Cross	HMO	\$10	\$10	\$1,000	\$10	NC	NC
	PPP	\$20	\$20	\$1000 + 25%	\$20	NC	NC
Blue Shield	HMO	\$0	\$0	\$1000 + 20%	\$0	NC	NC
	PPP	20%	\$15	\$1000 + 20%	20%	NC	NC
Foundation Health	HMO	\$7 for PAP	and pelvic	\$100	\$7	\$5 generic; \$10 brand	same
	PPP	\$15 for PAP	and pelvic	\$1000 + 15%	\$15	\$5 generic; \$10 brand	same
Kaiser	HMO	\$3	\$5	\$0 hospital charges	\$5	\$7	\$200
PacificCare	HMO	\$10	\$10	\$1,000	\$10	\$10 generic; \$25 brand	NC
	PPP	20%	20%	\$1000 + 20%	20%	\$10 generic; \$25 brand	NC
Family Planning Service		Diaphragm	Abortion	Tubal ligation	Vasectomy	Annual Premium (monthly premium x 12)	
Plan Name	Plan Type						
Blue Cross	HMO	NC	\$250	\$250	\$150	\$1,128	
	PPP	NC	\$1000 + 25%	25%	25%	\$1,116	
Blue Shield	HMO	NC	\$100	\$100*	\$75	\$1,440	
	PPP	NC	20%	20%	20%	\$1,128	
Foundation Health	HMO	same	\$0	\$0	\$0	\$1,476	
	PPP	same	15%**	15%**	15%**	\$1,068	
Kaiser	HMO	\$7	\$5	\$5	\$5	\$948	
PacificCare	HMO	NC	\$250	\$250	\$150	\$1,116	
	PPP	NC	NC	NC	NC	\$1,272	
	NC = Not covered			*Free with delivery of abdominal surgery			
				** After deductible			

Section III: The Process of Coverage Decisions, With a Focus on Family Planning Services

After compiling benefits and costs information, I wanted to probe the policy process behind the current coverage in each plan reviewed. To achieve this, I wished to interview at least one person who worked in each of the reviewed health plans and some health professionals who worked in health administration and policy outside of these plans. Interviews and information gathering conversations addressed two topics: 1) exploring how the health insurance and HMO industries make decisions about the coverage of family planning services, and 2) if and how they assess or calculate the costs and benefits of such services.

I. Methods

1. Procedure

I approached the Committee to Protect Human Subjects and obtained an exemption, allowing me to engage in conversations and interviews focusing on the provision of family planning services within individual health plans. I requested permission to explore several aspects of the provision of family planning services within the individual sales portion of health insurance: what services are covered, what is the cost of services to the enrollee, how does the insurer/health maintenance organization (HMO) decide what services will be covered, how does the insurer/HMO decide who to contract with, how does the insurer/HMO think about the cost-effectiveness of coverage and what factors determine this. However, during the interviews I prioritized the topics of coverage decision process for family planning services and the role of cost-effectiveness analysis in this process.

2. Subjects

All people involved in providing health insurance willing to spend time talking with me qualified as subjects for this study. This comprised a variety of professionals and the list of participants' titles includes: insurance broker, chief operations officer, physician-

administrator, medical director, clinical services director, administrator in the regulatory services department, professional in a company's health policy department, sales representative, and health plan administrator. None of the interviews represent the patient's perspective or attempt to probe this: I am exploring only the third party's decision to cover family planning services and the role of cost-effectiveness approaches in third party perception of benefits of these services.

3. Recruitment

Participants were initially approached by phone or in person. Subjects were selected on the basis of prior personal connections and or the need to talk with representatives from the five reviewed health plans. In some cases this necessitated cold calling the health insurance company or HMO and completing several phone calls before locating the appropriate person or discovering that the specific health plan did not wish to participate. I introduced myself as a graduate student in Health and Medical Sciences at the University of California, Berkeley who is studying how family planning services are provided to individual purchasers of health insurance. If the person showed interest in continuing the conversation at this point, I discussed the confidential and voluntary nature of the interview and presented the potential harms and benefits -- no direct benefits and the possible harms included frustration with the discussion or with misspent time. Consent was then sought. After receiving consent, a mutually agreeable time was arranged, and the interview was conducted. Several interviewees requested more information before the interview day and were sent letters specifying the issues I wished to discuss with them (see Appendix 6).

All interviews occurred between January 20, 1996 and March 15, 1996.

4. Confidentiality

No names were recorded or codified during the interview or transcription process. To protect the confidentiality of the interviewees none of the interview information is presented in a manner that links it with the individual source. Only sales representatives and secretaries whose positions do not reveal their identity and whose names I never

learned are associated with specific institutions; all other participants' professional titles are not connected with their institutions. However, individual's statements are associated with the participant's institution. All interviewees were assured that their responses would not be disclosed in a manner which could in anyway be linked to him or her. All subjects were informed of their right to refuse participation at any point during the interview. Although some interviews were recorded by tape, the interviewee sometimes decided to turn the tape off and make statements off the recording. All names have been changed, and those used in this paper are used only for convenience of discussion and consistency of viewpoint.

II. Limitations of Interviews

Qualitative research provides an excellent means to describe a process or experience. It does not show causality nor does it serve to prove or disprove a hypothesis (Morse and Field 1995: 16). Qualitative interviews provide background knowledge which facilitates theory development; they do not test theories (Morse and Field 1995: 17). Qualitative interviews elicit unique views and descriptions, which allow observation of a trend and formulation of theory, but the data are not valid for generalizations.

The interview methodology used in this study engenders several limitations. Participants and settings may have imposed constraints on much of the information gathered. Selection effects occur because many professionals who participate in the coverage decision process are not accessible to a graduate student; these professionals or their secretaries believe that academic endeavors waste their time. Only certain professionals with more respect for academic enterprises, an interest in self-reflection, a belief in open information, or some other distinguishing quality choose to allocate time for an interview with a graduate student in health and medical sciences. This may reflect individual or institutional ethics. Sometimes an institutional policy of not helping students exists as experienced with Foundation Health; sometimes an institution supports openness and self-study which eases access for a graduate student as occurred with Kaiser.

The selection effects may also reflect the level of credibility I conveyed to the various research participants. Some participants may have refused to participate or altered or censored information because of my perceived lack of credibility (Morse and Field 1995: 145).

Professionals who thought that I would be critical of the coverage decision process their company employed may have opted out of the interview process or simply not returned my calls. Some people may have interpreted my focus on family planning services as a critique of their current coverage of these services and reacted defensively by not talking with me. Some institutions may view the coverage decision process as confidential, privileged and sensitive information and may reveal only parts or none of it to an outsider.

Each person was interviewed once, and at two institutions two people were interviewed. Within qualitative research, single interviews evoke concern about the reliability and validity of the information (Morse and Field 1995: 145). Since institutional processes rather than individual experiences were the subject of discussion, I felt that single interviews served to adequately portray this more defined, objective and less emotional topic and that repeated interviews would annoy participants more than build trust and rapport.

The setting may have impacted on the quality of conversation conducted. Phone interviews were generally impromptu. The participant received little time to prepare, and this may have resulted in more honest or less serious, poorly thought through responses. In person taped interviews allowed the participant to think about the issues and to control the physical space and privacy. The act of recording the conversation may have inhibited some participants. Most participants, taped or phone interviews, expressed concern about quotation around certain statements or out of context, and this probably restricted statements.

My assumptions and perceptions have also served as a sieve through which all the information is presented. I entered into this topic after reading public sector analyses of the cost-effectiveness of family planning services, and the public sector approach influenced my thinking and led to constant comparison between the public and private sector in my mind. Although I attempted to conduct all interviews in an open, flexible and non-judgmental manner, I have defined the topics, guided responses and selected the text which struck me as most revealing for this paper. The manner in which each institution and participant treated me also may have affected my perceptions.

III. Findings and Analysis

A total of eight interviews were conducted, four by phone and four in person. Phone interviews were not taped, and information was recorded by note-taking. Those performed in person were audio-taped and transcribed. All five of the health plans reviewed in Section II. were included as were two additional insurance organizations. However, after six attempts nobody at Foundation Health would speak with me so Foundation Health is not represented in the interview data; I also could not contact anyone at Blue Cross after four attempts. At all the other organizations I approached I was able to find somebody who would speak with me and provide their opinion on the policy process of coverage decisions and cost-effectiveness. In addition to Blue Cross, Blue Shield, Kaiser, and PacifiCare I interviewed administrators at the California Advantage Plan which the California Medical Association is developing and at the University of California, Berkeley Student Health Center which also contracts with Blue Cross for emergency and catastrophe coverage. Throughout this section Kaiser refers to Kaiser Permanent of Northern California.

1. Access to and Availability of Participants

Access correlated with the organization's profit status and may mark the civic mindedness of the corporation. Among the original five plans reviewed, participants at the

two non-profits -- Blue Shield and Kaiser -- demonstrated increased availability and responsiveness to graduate student research. Within the for-profit organizations, Foundation Health, Blue Cross, and PacifiCare, it proved difficult to contact or recruit participants.

In approaching Foundation Health I first called the general information number and was referred to the Individual Sales Department. Individual Sales in turn referred me to the corporate office; the corporate office secretary transferred me back to Individual Sales, where I left a message for a supervisor who never returned my calls. I then called the corporate office again, and the secretary informed me that when she has permitted people writing papers to talk with the administrative professionals they have complained. Her superiors had instructed her to screen callers writing papers or engaged in other academic endeavors because they (the administrative professionals) do not have time to talk with students or academics.

Accessing participants at Blue Cross also proved challenging. Through phone calls, I was able to leave messages, but no calls were ever returned. I then pursued contact through a private broker who handles the Blue Cross contract with the University of California, Berkeley. The broker and I discussed my interview project and its goals; at the broker's request, I faxed a letter specifying the topics I wished to discuss (similar to Appendix 6.). The broker read the letter and decided a Blue Cross representative should answer these questions on policy. The broker forwarded the letter to an employee of Blue Cross who works with individual health plans; this person did not respond to the broker or me.

At PacifiCare a sales representative, Sara, refused to refer me to a more highly placed administrative or policy professional. However, she was willing to provide her perspective on the process of coverage decisions for family planning services. Although Sara promised to ask her administrative superiors my question about how coverage decisions are made, she indicated that it was unlikely she would receive an answer or that I

would be contacted with a response. I have not received any further information from PacifiCare.

Blue Shield has a medical policy office to which I was directed by the corporate office secretary. By phone I interviewed Shannon who informed me that family planning services are treated as contractual limitations. They are elective benefits that are acquired as riders on plans. All preventive care can be provided only through riders because not every account wants these services, and the rider system allows only those who want a specific service to purchase it.

Blue Shield's HMO product is capitated so family planning service coverage depends on the IPAs (Independent Practice Associations) with which Blue Shield contracts. The obstetrician/gynecologist or other primary care physician may choose to provide any portion of family planning services, as the physician sees fit within the given capitation. Thus, coverage of family planning services is not guaranteed nor specifically excluded.

I conducted two audio-taped interviews with Kaiser employees: John and Sally. Sally had requested more detailed information about the interview beforehand and had prepared to answer the questions faxed to her; this resulted in a more focused interview than that performed with John.

An additional three interviews were completed with representatives from two group health plans. Two audio-taped interviews were conducted at the Tang Center, which provides the University of California at Berkeley's student health services. The Student Health Insurance Plan (SHIP) offered through Blue Cross differs from individual plans because it is a group purchase. However, each student may elect to purchase the SHIP or some other health plan; each student is required to have some type of health insurance. However, SHIP resembles an individual plan in that the student chooses to buy that plan and then pays for it. The Tang Center administers the funds. Dependents of students and UCB faculty also may choose to purchase insurance which provides service through the

Tang Center. The Tang Center receives funding through student Registration fees and is financially separate from the Blue Cross SHIP. As one participant (Connie) explained, "...when we talk about the insurance plan, and what the insurance plan covers, that plan is not what funds the Health Service and is not what covers family planning services in-house." The SHIP provides for care received off-site or for services not provided on-site.

The drug plan is offered through SHIP and receives no subsidy from student registration fees: this means that students pay out of pocket for pharmaceuticals such as oral contraceptives and can then claim reimbursement for 80% of the costs up to \$300 annually. The pharmacy benefit provides many family planning services: it covers prescription family planning devices and drugs. The pharmacy offers excellent prices to students because of its ability to buy in bulk:

Now luckily, because we are a clinic... our pharmacy is subject to incredible discounts, clinic discounts, especially with oral contraceptives, but the same thing is true with diaphragms, diaphragm jellies, and creams, condoms ... our pharmacy's birth control costs are about 50% of if you go to Walgreen's or any local....so though the student is paying for it out of pocket [no Registration fee subsidy] she's getting a very, very good price. And everything's not-for-profit, so that whole element is not a part of this. -- Connie

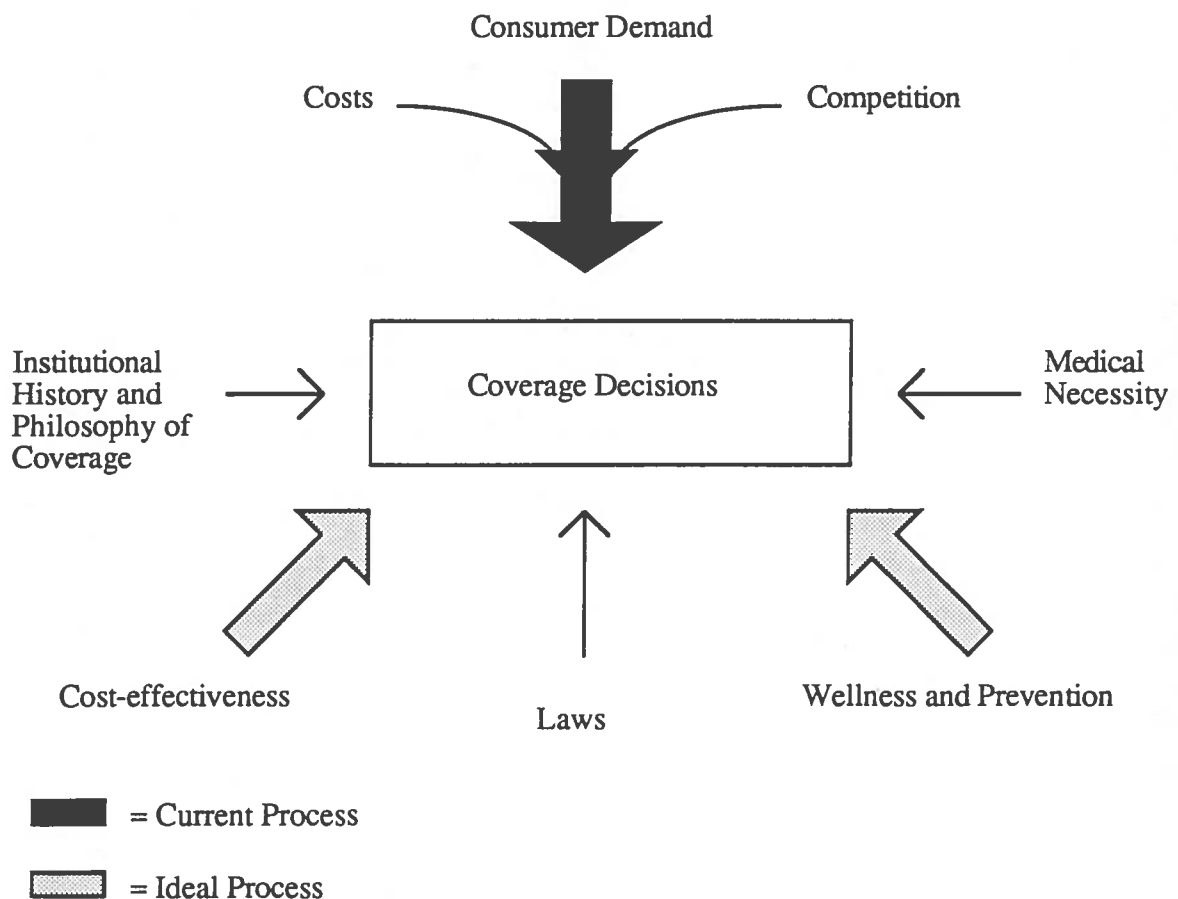
The California Medical Association was forming the California Advantage Plan when I conducted a phone interview with Jane. Jane stated that California Advantage did not plan to offer an individual product during its first year because of the adverse risk selection among buyers of individual health plans. Purchasers of individual health plans are usually older, because only older people can afford to buy health insurance, explained Jane. Also, the only younger people who choose to purchase an individual product are those planning to get pregnant, which then costs the plan substantial money and contributes to the adverse risk selection. Jane felt that someone looking for family planning does not think of herself as needing health insurance, because it is cheaper to buy family planning services directly than purchase health insurance. The cost differential between individual health insurance and family planning services leads this administrator to reason there is no overlap among those who choose to purchase and those who need these items.

2. The Coverage Decision Process For Family Planning Services

The interviews showed that several factors contribute to the development of family planning coverage policies: 1) consumer demand, 2) medical necessity, 3) institutional history and philosophy of coverage and 4) laws. Consumer demand is the dominant factor in most coverage decisions and includes issues of cost and competition. In contrast to the ideal coverage decision process outlined earlier which also incorporates wellness, prevention, and cost-effectiveness, participants did not cite these as affecting the policy process for family planning services. See Figure 6. for a diagram of current and ideal factors in the coverage decision process for family planning services.

Figure 6

The Coverage Decision Process: Current and Ideal Factors



Consumer Demand

Consumer demand appears to mold coverage decisions more decisively than any other factor. The variable coverage patterns observed in Section II. correlate with the broad range of perceived consumer demands among interviewees. Participants at Kaiser and the Tang Center felt that family planning services are in demand and needed. However, other participants viewed family planning services as low demand, which supports the marketing analysis that portrayed family planning services as low investment (see Section II.). The group of people who purchase individual policies does not perceive themselves as in need of family planning services according to Jane at California Advantage; the lack of demand means that family planning services do not need to be covered.

Similarly, Shannon at Blue Shield articulated that financial reasons dominate the process of coverage decisions and lead to the exclusion of family planning services. To paraphrase, she believed that money drives everything at the end of the day. Therefore, within Blue Shield's Individual Family Plan, family planning services are not covered routinely. Shannon provided four reasons for the exclusion of family planning services from the individual product: 1) provision of family planning services drives the cost of the product up; 2) family planning services only involve a small number of people; 3) Blue Shield is trying to stay competitive; and 4) family planning services are not medically necessary. The first three reasons represent different aspects of consumer demand. Medically necessary services are those needed for the treatment of active injury or illness; fertility includes no injury or illness and so family planning services do not qualify as medically necessary treatment. She characterized family planning services as benefits which are not burdensome and do not cost the individual much.

Kaiser participants reported a strong consumer demand for family planning services among their members, and the new Explanation of Benefits brochure released in the fall of 1995 expanded the individual health plan to include: drug plan options, IUDs, cervical

caps, diaphragms, injectable contraceptives and internally implanted time-release contraceptives. John described these brochure changes generically as:

Brochure changes occur in response to product changes. The Product design is usually crafted to respond to offerings made by the competition. Offerings are designed to respond to consumer preference.
The group that makes the product change is central marketing.

Many family planning services qualify as drugs and thus are covered through drug plans, not the individual health plan. As John explained, "Now the thing about oral contraception is that oral contraceptives are drugs and the state of California actually requires you to have a drug plan separate from a medical insurance plan.... Now the drug plans are variable and it is the client that buys the drug plan. It is not that the drug plan is a fixed item..... Now in the area of contraception it's pretty clear that all oral contraceptives are covered on all the drug plans except no drug plan. " IUDs, oral contraceptives, Norplant and other prescription contraceptive devices thus receive coverage hinging on the presence and richness of the drug plan, not the individual health plan.

...selling a drug plan separately is one way in which you can sell your primary product more cheaply because then you can call the drug plan an add-on. And then people don't see that in their decision making as easily 'cause you've separated that segment of the product. So in summary then, all contraceptives or family planning services have been covered for contraception and that the variation has been in the drug plan coverage.--John, Kaiser

Purchasers of Kaiser's individual product did not receive coverage for contraceptive devices or drugs until the drug plan was added in the fall of 1995. Sally outlined the situation, "So, actually, the only things that are new, new are the IUDs and the cervical caps. The rest of these had been covered under plans that included a drug plan. Individual coverage did not previously include a drug plan. So it's sort of like two things going on."

The addition of a drug plan to the individual product illustrates a coverage decision which depended mainly on issues of competition and affordability.

Again, looking at the marketplace and realizing that we really needed, in order to be competitive, to put a drug plan in. Additionally, we were able to because we decided to go towards an age-rated individual plan, we were able to provide coverage, affordable coverage, and also include that drug plan. We've been asked a lot of times in the past to include drug plan in the individual coverage, because of course, you know, you're going to sign up for health coverage, you want to have coverage for

your drugs.... In the past when we had been asked to it, I started to say, we realized that we just couldn't afford to add to the coverage because we would have been, it increased our premiums to such a point where we felt like people wouldn't really want to pay for it....it was really marketplace and affordability that allowed us to do that this year.

We have over the years done a lot of focus groups with members and actually, with non-members, people in the community, to find out what people wanted to have included in individual coverage, and one of the things that has consistently come up is drug coverage. --Sally, Kaiser

Since the addition of a variety of drug plans to the individual product, the individual purchaser may choose to buy a drug plan, which would then include some level of coverage of oral contraceptives and contraceptive devices. Sally explained:

we added, these changes that your referring to, in terms of IUDs and cervical caps wouldn't have applied to individual coverage at all if we hadn't added a drug plan. For individual coverage. Which we did last year. So prior to that, those changes wouldn't have had any bearing at all because they wouldn't have included drug plan coverage, it wouldn't have been part of the plan, so now it is....We just went to an age-rated plan in our individual markets. So that for younger and healthy, you're going to end up with a much lower rate, basically. So, and we also at the same exact time added drug plan coverage....

The changes within the drug plans at Kaiser provide an example of consumer demand influencing an expansion of coverage. John and Sally emphasized different factors in these decision processes. John focused on the historical context of IUDs and the financial risk they incurred, and Sally honed in on the specific case which led to these policy changes of IUDs and cervical caps within Kaiser.

Historically what happened with IUDs is that they were freely available and I used to be one of the many physicians that placed IUDs then the companies that produced IUDs stopped producing them for use in the United States because of litigation. And dangers. Even then Kaiser covered IUD insertions but the persons had to pay for the IUD.... And that was between about 1989 and 1995 and then somewhere in the middle of last year the company that was producing the IUD somehow got medical insurance coverage that would protect it from liability in excess of a million dollars. The problem was before that Kaiser used to think that if there was a litigation and the company didn't have insurance coverage then we would end up being the deep pocket. Now that the company that's making the IUD has adequate insurance liability coverage Kaiser doesn't feel that it's at a risk anymore. So starting January 1 of this year Kaiser started to cover IUD insertions as a drug plan again.... Norplant was the other one that came in very expensively. And in the case of Norplant we covered Norplant, again with the range.... So there's never been more than those fiscal restraints on IUD and Norplant and everything else is covered. --John, Kaiser

It was kind of a trend.... That particular person happened to get me on the phone. Which is not usual. Normally a member would not end up on my phone, but I talked with this member directly and she was very convincing. I mean, it's really an

interesting thing to talk to members directly. She was very smart; she was, you know, she was like a graduate student somewhere or something, and she was very smart and she had a lot of really good points to make and I asked her to follow up and to file a member grievance so that we would have a record of what she had, you know, described and the complaint that she had. And she did that. And she wrote another letter and thanked me for, whatever. So we spent a little time looking into it, talked to our, you know, chiefs of OB/Gyn services and any number of other people in pharmacy and tried to figure out if this even looked like something we wanted to consider.

....It depends on what it is. If it's something that seems really obvious, like it's totally medically appropriate, there's no reason not to cover the stuff, then if one person makes that point, and it causes us to then take a look at our policy, I mean frankly the only reason this was never included before is because we never did it. I mean, there's no, there's no reason.

....You know the contract was written probably, I don't know, 25 years ago, or more, I don't know. And we just never looked back and said well, gosh, should we consider adding this to all of our contracts. Certain groups had asked us to include it. So we'd been doing it on a kind of group specific basis for several really large groups. But it hadn't been an issue; no one had raised it. So it's not really volume. It's kind of like, you know, quality more than quantity, concept.

....And maybe it's also because I'm female and I saw this issue and I thought, yeah, this isn't right.

So I think that there's also probably an element of that [receptiveness] as well. I mean, some of this is of course subjective. We try to be, again we try to be as objective as we can in our processes in terms of like using the same elements each time to review any particular policy, in terms of accepting it or rejecting it, to even consider moving it forward as a proposal. So, you know, I mean clearly, this was one that has obvious merit. But it definitely caught my eye and it was also because the member called me directly. And you, she said, "Well, the only question I really want to ask you is why? Why don't you cover it? Can you just tell me why you don't do it?" And I thought, well, there is no answer to that question, except that we just haven't. -- Sally, Kaiser

Sally specified the changes as, "And you pointed out accurately that we changed our coverage and included IUDs and cervical caps in our coverage, whereas previously we had only, we had only included diaphragms." She continued on to outline the process that created the coverage changes:

So that one in particular came, it started out as a complaint from a couple different members just saying, why don't you cover this? Gosh, the FDA approved cervical caps, you know, ten years ago and you guys haven't put it into your coverage yet, what's the problem? So we sent that person, often we send people back when members complain. If it's something like that we will often send them back to their benefits manager, too and say, you know, your group could request specifically this kind of coverage, if they wanted to. In this case, we did that but then looked at the policy and then said this person's right, there's no reason. It should be covered. It's not going to be a big cost increase for us at all; it's just a tradeoff, one birth control

method for another. And let's take a look at it. And we looked and we found out, gosh the industry standard is that these things are covered, it's not going to really increase the cost of the plan at all, you know, on balance it doesn't have a big effect there. They're obviously safe and effective, you know, medically appropriate, let's add the coverage. So we look at a number of factors when we look at a benefits change.

The committee that we bring these things to is comprised of various different stakeholders throughout the program here in northern California. So there are physicians on the committee, there are people out in our facilities like, physician-in-chief, for example or medical group administrator who's like the operations administrator. There's also regional people who deal with policy, regional management, you know, like top level health plan management and medical group management. And so we try, it's really a kind of multidisciplinary committee that's takes a look at all of these changes and decides from various different aspects if it makes sense. It also includes Member Services. It also includes, especially if there's pharmacy issues being discussed, like this for example, we would bring in some pharmacy people and they would be on the committee and take a look at it. So, we look at all of those elements and then bring it to a multidisciplinary committee who will make a decision as to whether or not they're going to add that to coverage.

The committee arrives at its final decision by a vote, after which any new policy must be translated into contract language and added into the plans. Sometimes, as in the case of the recent contraceptive coverage expansion, the coverage decision originates from a group health plan, becomes a "global change" and then trickles into the individual plans as well.

When only individual contract changes are considered, the process simplifies, "because for individual contracts, because there's no marketplace employer group saying you have to do this a certain way because we're paying for it and this is what we want.... We're mostly looking at marketplace standards, you know, and what does our individual plan need to look like with regard to the rest of the marketplace. You know, is this a competitive plan? " A separate individual contract process is developing to evaluate coverage changes.

...we do have a group of people who are looking at just individual coverage and sort of what is our strategy with regards to individual coverage. They're looking at the big picture though obviously, family planning is just one little tiny piece of it. But that group this past year did make a decision that they would add a co-pay for infertility services of 50%, and like I said, that's because of the marketplace.... So we realized that we were putting ourselves in the position of having a more expensive plan, really, and richer coverage than other plans that were offering individual coverage. That doesn't really make sense for us to do. So we made that change there as well.

I think we are always refining our processes for how these things occur. Previous to maybe this past year when we really started looking at individual coverage and the

marketplace needs of individual coverage, we would have probably brought it to the same committee. Now we actually have a group of people who are looking at just individual coverage and deciding changes that need to apply to just individual coverage. -- Sally, Kaiser

Sally emphasized that, "...changes can arise from any number of sources so it could be that we're looking at specific individual coverage and it could be that we're looking at our broad policy, and it filters into individual coverage as well as everything else."

The Tang Center provides several examples of coverage decisions based mainly on demand. The Student Health Advisory Committee and the Student Health Insurance Advisory Committee, composed of and representing students, formulate much of the Tang Center's benefits package. As an example of the influence of the Student Health Insurance Advisory Committee, one interviewee (Dave) cited the recent addition of a drug plan:

For example, there was an outcry for improved pharmacy benefit a couple of years ago. So last year we were able to really improve, first of all add, and improve the pharmacy benefit package which has obviously helped out considerably because everybody has to buy medications at one time or another.... So that's one example of kind of lobbying through the Student Health Insurance Advisory Committee....

The recent expansion of the SHIP to include a drug plan parallels the course of drug plan development within Kaiser's individual product. Demand can determine coverage of family planning services as Dave explained: "And so, decisions around family planning, ... could really occur, one just based on sheer demand, so that if there's a large volume of a particular service we are able to incorporate it into the plan, and it depends on volume...."

The Student Health Plan was developed in 1987-88 by graduate students who organized and requested a group health plan sponsored by the university. Thus, mainly students designed the original benefits package. One participant narrated the history of the student health benefits package:

And we structured the entire benefits package...some graduate students, some members of the health service staff here and some insurance brokers, to bring in the technical expertise. And like every benefit, we listened to graduate students on what was important to them. ... And now women's health services were covered as any other medical expense and not held out separately.

So we got that feedback directly from the students, we constructed the benefits plan and as the years have gone on we have worked with different student advisory committees and every year check in about, you know, where are we with the

benefits? Do we need to make any changes? And no issue has ever come up since then about family planning or any women's health services because the way they were originally constructed worked well with what the student wanted. So they [the students] were lucky that way. --- Connie, Tang Center

Within the products California Advantage plans to market, all of which are group products, each purchasing group will determine the provision of family planning services: each group can demand what they like and will pay a corresponding premium. Thus, group demand substitutes for individual consumer demand. From the insurance point of view, Jane acknowledged that she is in favor of family planning because maternity services cost more. For group plans, oral contraceptives will add \$.50 per month per premium. The state associated HIPC program defines its benefits so that product will only offer the benefits which the state dictates. For companies operating under ERISA, the owner of the ERISA determines what benefits will be offered. Among the California Advantage designed products, a multi-level of benefits and corresponding prices will exist. These products will be offering many preventive programs and will include a cafeteria style of purchase within a group to accommodate individual needs. Through this, an employee will choose what he or she specifically needs. This concentrates the risk because each person will only take the services he plans to use, and the premium associated with each selected service increases.

Consumer demand also incorporates financial issues such as costs, trade-offs, and experience rating which impact coverage decisions at the policy level. The high cost of providing infertility services excludes them from most plans, except when mandated by law (see discussion of legal influences below). To limit the costs of family planning services, some insurance plans will cover the family planning procedure but not the device. According to Sara, a sale representative, PacifiCare often engages in this. For example, they cover the placement of an IUD but not the cost of the actual IUD; the same applies to Norplant and Depo-Provera. This policy reflects PacifiCare's concern that an individual may purchase coverage specifically to obtain an IUD or Norplant and then discontinue

coverage, although the individual will benefit from the contraceptive for another 5-10 years. This policy restriction avoids such abuse of the PacifiCare system.

Competition and perceived market-place standards, other expressions of consumer demand, underlie all coverage decisions. The rapid changes of the health care industry in response to increasing competition manifests through new coverage policies. As discussed above, Kaiser's individual product has added a range of drug plan options (previously there was no drug plan); the drug plan has expanded to include cervical caps and IUDs within the last year, and PAP smear policies also have changed this year. John described the role of competition in his administrative work at Kaiser as:

We have been a long-term provider of a standard product to employers only, and more recently like the rest of the competition we've been forced to go out to individuals in the market and so the structure of the product has become much more flexible.

The individual market has grown in importance and competition:

...we have anything the competition is willing to offer to individuals or groups we are probably trying to match because the game now is market share. And because we are the largest market share the competition sees erosion of our market share as their goal. ... Now the others have been looking at the individual market, individual member market as being a potential area for growth... ---John, Kaiser

The increasing importance of the individual market has led to changes within how Kaiser views and handles coverage decisions related to its individual product: "And I think that given that they want to have more members now, that the flexibility is going to be greater than it had been in the past," stated John. Policy and the actual explanation of benefits have varied over time, mirroring the organization's need for individual members: "Up until about two years ago Kaiser was so oversubscribed that they were not taking any new members. But because the rule of the state is that you can't turn away a potential applicant what they did was they just made it very expensive for individuals to join so that it became a natural economic choice that they would not choose Kaiser," stated John.

Family planning services have been a focus of change in the current competitive market and provide an interesting look at how preventive and health maintenance services are treated. As one Tang Center participant explains, "Actually it's [family planning

services] a really good thing to look at 'cause when I study across insurance plans a lot of them are pulling back their family planning benefits and ... I've been looking at it for eight years and ... so it's surprising to me to see that it's eroding."

Within the context of a complete set of health care services, family planning services cost very little and play a minute role in competition and policy formulation. As Sally explained:

...we have this whole contract of benefits and family planning is like one little section, and there's just a lot of different stuff to try to get a handle on and figure out if your policy still makes sense. I mean, obviously medical care is really a moving target, and there are lots of very large looming issues that have to be resolved. So, it's like you sort of work your way, work your way to them, depending on what gets brought to your attention.

Because family planning uses so few resources and does not address an injury or illness it lands near the bottom of the priority list within a comprehensive coverage policy perspective. Infertility, however, because of its substantial financial and time investments is important to prospective members and to administrators and can differentiate plans.

Medical Necessity

Medically necessary and medically appropriate play important roles in determining what services are offered and what services are received. No clear difference exists between the two terms.

I tend to use these terms kind of interchangeably, but they probably do have different meanings. Medically necessary would imply to me do they need it at all? Does this serve a medical need? Does it prevent illness? Does it treat, you know, does it treat something? Does it make you get better? Actually we have a definition in our contract, if you wanted to see it, of medical necessity. But then beyond that, what is the most medically appropriate course of treatment for that member needs to be determined by the physician looking at the member and their specifics, you know, the specifics of their case.

Everything that's covered by Kaiser is as determined by our medical group physicians to be medically necessary or not.... So, all the decisions around what's going to be covered are going to be made by a physician or other health care provider.... --- Sally, Kaiser

Kaiser's definition of medically necessary states; " A service is medically necessary only if a Physician [refers to the Permanente Medical Group] determines that (1) its omission

would adversely affect the Member's health and (2) its provision constitutes a medically appropriate course of treatment for the member."

The practical meaning of medically necessary does not pertain to family planning services. When asked how medically necessary was defined, one participant (Connie) stated, "Oh, well they don't think about it in terms of women's health services, that's for sure. " The medically necessary concept allows the insurance to limit coverage so that patients do not "self-direct their own care" as Connie explained. The insurance plans conceive medically necessary as medical justification, an active injury or illness which needs treatment. Family planning does not fit this category:

See, family planning isn't a medical condition. You know, it's a, a life issue, I don't know. It's a, what would you call it? It's a lifestyle, it's a life it's your only life. So, we certainly never use it here as a way to exclude any services around women's services. ---Connie, Tang Center

Despite the concise published definition of medically necessary, participants indicated that in practice medically necessary has a nebulous meaning. One interviewee described his approach to the problem of determining medical necessity:

I try and enter into it as ... what did I learn in medical school, what's my training, and in some sense I'm looking at what is medically necessary, and what would I do if it was... my patient, what would I do if this was my family member, and so you know my idea of medical necessity might be broader than say an insurance person's,...there's ... I think differing opinions on what's medically necessary.... ...I guess a lot.
Each case is really different it's tough, there's no hard and fast rules or guidelines that I can immediately call upon to say what's necessary vs. appropriate vs. inappropriate and unnecessary.
---Dave, Tang Center

Dave further traced the difficult issues broached by cases of medical necessity as leading to the development of utilization review boards, so that a group rather than one person deliberates and decides the meaning of medically necessary in each case. He felt that this allowed the determination of medically necessary to "be somewhat of an objective process with more input and more opinions."

Sara emphasized that PacifiCare excluded all services which were experimental or investigational -- services for which medical safety and efficacy have not been shown.

Only services which are perceived as basic health care services will be covered. These categories are decided by a committee of five physicians and other professionals.

Therefore, Sara concluded that any uncovered family planning services fall into the two categories of exclusion: experimental and investigational or not a basic health care service.

The implementation of less frequent PAP smears at Kaiser, as mentioned in Section II., illustrates a coverage policy based on medical necessity. It occurred after several outside independent organizations recommended this practice, altering the medical necessity of yearly PAP smears: the American College of Pathology, the American College of Physicians, the American Cancer Society, the Canadian Medical Society, and the province of British Columbia. Kaiser then examined its data to evaluate the validity of such a PAP smear policy for its patients. John outlined the process of the PAP smear policy change, which is similar to the process used to evaluate and implement the contraceptive coverage changes discussed above.

...the way decisions are made by service, let's say by Obstetrics and Gynecology is that each department has a chief, and each department has a chief of quality, and there is a regional meeting where the eighteen facility representatives go to so there chiefs and chiefs of quality then review regional data compared with external benchmarks, in this case, American College of Physicians or the American Cancer Society. And then they look at the internal data to see how it matches with the external benchmark. And if we agree that the external benchmark seems valid, right, because if there's an incongruency between the external data and ours then we tend to rely on our data because that's our population. But if there is concordance between the external benchmark and us, then this group of chiefs will sit down and study it and make recommendations, which are then circulated back to the physicians for discussion and then the chiefs report back on what the general consensus is. And then once the consensus is established, then a policy directive is usually put in place and usually given some time for a reaction in the press or among the rest of the physicians in the group. And then it's applied. So this started in 1992, and it only got implemented ...[1995]

Even with the current recommendations to decrease frequency of PAP smears, any woman who wants one more often may have one. PAP smears are provided on demand, "...because the philosophy of the organization believes that, is that if people are adequately informed they will eventually make the right decision. And that even 10% of the people don't make what we consider the appropriate decision based on the facts, it's not a big

hassle, you know, it's not that we are so stretched to capacity level that we need to worry about that. And in time the behavior will move," explained John.

Institutional History and Philosophy of Coverage

Institutional history and philosophy of coverage set parameters for coverage decisions. Private health insurance historically has formulated coverage on the basis of "actuarial fairness," a concept which sorts individuals into smaller and more homogenous groups (Stone 1993: 287). Medical underwriting provides information about these specific groups which is used to assess risk and assign appropriate fees. One insurance agent who sells Blue Cross and Blue Shield described how this applies to the coverage of family planning: "Insurance plans are meant to cover sickness or accident. They don't cover preventive measures. They cover the unforeseen. HMOs cover preventive measures, too and elective procedures."

The insurance industry's philosophy of risk protection coverage has served as the base from which coverage decisions derive. Predictable and preventative services, such as family planning services, constitute a risk for which one can protect. When probed about the nature of exclusions around family planning services and whether exclusions occurred through an intentional process or a process of omission, the insurance industry's business philosophy was cited as an important force in the development of benefits packages. One interviewee, Dave (Tang Center), described this:

...the insurance industry is to really try and provide some protection in the event of something unexpected, something that is catastrophic,...that's where the origins of insurance started, in that say there's an earthquake or a hurricane or whatever, that it's something unanticipated or major medical illness, like heart attack, that there would be some protection of loss or reimbursement for that. ...prevention, family planning, proactive, you know, those type of things are really different from the insurance industry's original mission. ...I think that's where some of the reluctance to provide some of these prevention services, like immunizations...you know, a lot of plans didn't cover those initially because it was just really something that was different. It was something that was, you know, predetermined expense that was going to happen and it was just really different, a totally different mind-set.

Individual health plan development reflects the insurance company's concerns and provides for the risk that a person may become ill or suffer a catastrophe. Connie of the Tang Center outlined a generic model for benefits package development :

...the way that insurance is constructed is not based on what people need.... It's much more easy to understand the concepts of insurance if you think about car insurance or even house insurance. ... You're buying insurance against the risk that your car could get in an accident, get stolen, whatever. And the chances are it won't, but the 1/10,000 or 100,000 that it would, you're buying this insurance plan to cover that particular instance. Well, it was shocking to me when I became, in this field, to understand that health care was set up with that exact same mentality. So, the way that they develop health insurance plans is, you're a healthy person who's going to get through life and here's an insurance plan on the risk you could get sick. Not based on what you need to stay healthy. That's a very different way of looking at it.And more and more what I'm starting to see is preventative family planning services, starting to see limitations put on abortion services.... They literally just put that on there, based on controlling the plan in terms of cost. ---Connie

The car analogy also appears in other interviews with insurance administrators in Section II.

The attempt to control costs through limiting abortion services as mentioned here does not seem cost-wise. By law all health plans must cover pregnancy, and pregnancy care and delivery costs substantially more than an abortion. However, this participant has noted a trend to exclude or limit abortion coverage, for what she considers economic reasons, despite an obvious cost differential that would favor covering an abortion. When asked about this contradiction in costs and coverage, Connie agreed that factors other than cost may have created the abortion policies:

And, but, that is not to say there isn't some value laden stuff that's coming up about abortion and maybe because people think of it as choice, in the best case scenario, or that they don't want to in any way promote or treat it like any other medical, that they're starting to put restrictions around it. I think that you'd have a really hard time getting anybody to admit that, if you know.--- Connie, Tang Center

Kaiser's coverage philosophy and history have differed from much of the traditional insurance industry. The process through which coverage decisions evolve and become policy at Kaiser was characterized as a tradition of complete coverage by John and alternatively as a formal, objective committee process by Sally.

it's never been difficult for us to decide what we offer. Historically the program started as being a totally comprehensive program and if anything we've been working

over the years to carve out pieces that we have found are not appropriate so that we don't have to provide them. So ours has been a process of removing things from comprehensive coverage rather than building things up. --John

The way that we do that is that we have a whole committee that looks at benefit changes and we look at a number of factors: we look at largely, this one actually arose from complaints from members. So, the, proposals for change may arise from any variety of sources, like an employer group may ask us to do something, or members may complain about a certain thing, we may look at our policies, say gosh, good point, this doesn't make any sense or this needs to be fixed, or whatever. We may also just realize that we're out of sync with the marketplace. So there may be any number of reasons why we may change our benefit structure. We might also be looking at affordability and how can we shift our coverage in order to be more competitive. For example, a 50% co-pay in infertility is standard in the marketplace. We've added that to a lot of our coverages now, because it makes the plan more affordable and because it's consistent with the marketplace.

What we try to do is set up processes that are sort of, "This is the standard way we will make decisions about this thing." So that there's some consistency in the way that we're making decisions and so that we are sort of looking at the same factors each time and standardizing our decision making processes. -- Sally, Kaiser

Sally's statement above that "there's no reason" that specific contraceptives were excluded counters John's perception of comprehensive coverage with minimal intentional exclusions. John traced the original decision by Kaiser to offer completely comprehensive coverage to the organization's roots.

He [Stanley Garfield] was a physician and he didn't want to go into private practice. I guess he was just an entrepreneurial guy. And um, he wanted a steady income and he went to uh, the, a project in southern California and set up his shop nearby a construction project. And when he set up his construction project he realized that all of the workers were coming into him for similar complaints and that their families were coming in for similar complaints and that they couldn't pay, they used to pay him a little bit and want to, you know, pay the next installment when they got the next paycheck. And so he got this idea that he would just go to the company and offer them "I'll take care of any illness," because they were out in the sticks, "I'll take care of any illness of any person that works for you and or their family, if you give me 10 cents per person that works here." And that was the beginning of HMOs. So he got a lump sum from the company and then he provided full services and what services he couldn't provide he would send the patient to the appropriate facility and he would take care of the bill. And, which is a referral out thing, and those were obviously to cover those things that he couldn't do in a small practice. Then it came upon him that if he got a lot of people coming in with fractures to him and he asked how, why were you fracturing your bone, they were all falling off ladders that were poorly maintained. So he made an investment in going in and making sure that the rungs on the ladders were well nailed in. I mean, it's funny how the economics drives behavior.

Comprehensive coverage then included everything; the first exclusions came in the mid-1960s. John felt that cosmetic surgery, IVF and hip replacements early on had been the

main exclusions. The paucity of exclusions reflected a model of care not based on curative medicine according to John:

...it was a capitated model in the original sense, where they had already collected up front the money for the services and so what their major role was to try and keep you healthy and not do things together because every time they did something it was going to cost them some more and so the profit margin would, um, would erode. Of course it's a non-profit organization so eroding of profit margins meant not having capital to grow.

Legal Influences on Family Planning Coverage Decisions

Laws can affect the coverage decision process. Three examples within family planning services are presented here: mandatory pregnancy coverage, in vivo fertilization, and the absence of gender-rating. Pregnancy care is unique among family planning services because all health plans cover it, although most assess an additional deductible or fee. This ubiquitous coverage of pregnancy has resulted from the Pregnancy Discrimination Act of 1978 (PL 95-555) which mandates that pregnancy be treated like any other illness. This differentiates pregnancy care from other coverage decisions about family planning services. Because of its legal definition as an illness, pregnancy receives coverage through health insurance. The law requires coverage of pregnancy services in health plans which serve employee groups of fifteen or more; however in practice this applies to individual health plans as well.

In Vivo Fertilization (IVF) presents an unusual case among family planning services: unlike most family planning services, IVF costs a lot and is less commonly performed. Several factors lead to exclusion and minimal coverage of IVF: the high cost, the diminishing success after multiple trials, and infertility's lack of any intrinsic injury or illness. Originally Kaiser did not cover IVF because it was experimental; however, Kaiser later added an exclusion clause for IVF which was then contestable by law. Kaiser did not cover IVF until forced to by legal action as John detailed:

...IVF has never been fully covered. And even in those, even now that we are covering IVF, there are limitations to the number of procedures that can be done.... It came about as part of a class action suit that was initiated in 1988 and I think was resolved in 1990. And it was a strong enough class action response on the part of the legal people who handed down the ruling so it was retroactive for about six years.

So anyone who had had infertility work-up at Kaiser for the previous six years, I think, and who was still interested in becoming pregnant, or had not been able to become pregnant, were then eligible for up to five or up to four, I think it's four or five, IVF procedures.

In all the plans reviewed premium rates do not vary by gender. The absence of gender-rating seems inconsistent with actuarial practices: other forms of insurance (such as car insurance) do incorporate gender-rating, and women use health services more than men yet premiums do not reflect this. Differences exist by gender in health and health care utilization in part because the average life-span of a woman in the U.S. surpasses the average life-span of a man by 7.1 years (Mann 1995: 767). Two of every three U.S. health care dollars are spent on women, according to the Department of Health and Human Services (Mann 1995: 767). Even excluding pregnancy care, more health care dollars are spent on women than men. Women have more appointments with doctors, more hospital care, and more operations than men (Mann 1995: 767). However, women do not pay higher premiums. Sally at Kaiser did not know the reason for the lack of gender rating either at the time of the interview:

I don't know if that's a legal issue or just a policy issue that we decided to do it, to do it that way. We don't tend to want to discriminate on the basis of gender. So I don't know of any other rating policies where we have done that. I think we probably could have. I don't know though.

However, she agreed to research this issue further and discovered that Kaiser is restricted by law from considering gender in its rate analysis and methodology for age-rated small group plans. She indicated that AB 1672 probably regulates this.

3. The Role of Cost-effectiveness in Coverage Decisions

Cost-effectiveness on a global, plan wide scale assessing costs and outputs of various programs does not exist. One participant at Kaiser cited two areas which have received some cost-effectiveness interest or analysis: IVF and teenage pregnancy. This correlates with the paucity of literature on cost-effectiveness evaluations of private family planning services (see Section I.). More limited cost analyses based on location, an individual case by case approach, and prevention also received mention. The prevention

approach results from the postulate that prevention saves money and therefore is cost-effective. The location approach focuses on the relative costs of providing a service in-house versus off-site at the health plan level:

that [cost-effectiveness] enters into the decision making process in that is it more cost-effective to provide service here on-site.... So, if we have a high enough volume of say, gynecology services, which we do, here, given our population.... It's much more cost-effective to hire a full-time gynecologist and have the bulk of that care provided on-site, here. And so, we save the Student Health Insurance Plan a significant amount of money. So that sort of where those things would enter into. --- Dave, the Tang Center

Informal and individual cost analyses are performed more often than formal analyses at the program level. The individual approach to cost-effectiveness depends on evaluating each case for its medical necessity, which Dave at the Tang Center emphasized as the most important factor in the coverage decision process. In describing how Kaiser applies cost-effectiveness approaches to coverage, Sally discussed decisions made informally at the individual patient and physician level, not at the policy or benefits package level.

...they're [the health care providers] not going to be doing a formal cost-effectiveness analysis, but they're clearly going to look at those factors, right. ... say all things being equal medically, you'd want to consider cost, right and you'd want to consider the cost to the member and you'd also want to consider the cost to us. And in terms of making a decision. So in that sense, I mean there's some kind of a process that goes on. But it's not formal, really.

The informal role of cost-effectiveness facilitates the elimination of services which are too expensive. However, it does not allow for the inclusion of services which save money.

Clearly if there's something that we're covering, that just doesn't make any sense to cover, because it's just really not a cost-effective service. We will look at it, and decide, oh this, we need to stop doing this. But the thing is that there are lots and lots and lots of things that we could provide, we could cover, that we don't actually mention specifically in our health plan contract. Like it's not written in there, right. So a lot of this stuff isn't really documented. It's more about how physicians practice medicine. -- Sally

Again, the expensive nature of IVF differentiates it from other family planning services and has resulted in the use of cost-effectiveness analysis to determine extent of coverage. Sally explained:

One sort of exception to that [the absence of cost-effectiveness analysis] is in the area of infertility. We actually do have a group of reproductive endocrinologists who have

worked with a national group in developing guidelines for infertility services and they're sort of nationally accepted standards there....

There was a national group that was formed to look at guidelines for infertility services to determine things like, you know, the sort of cutsize name that we put on it was, "Enough is enough." Sort of like at what point do you reach complete diminishing returns in terms of artificial insemination and how many cycles you're going to do.... Sort of, you know, after, you know, the first cycle X% of women tend to get pregnant, and you're sort of looking at this curve. And you want to get people up at a certain point on the curve. But at a certain point, you're like, way down there somewhere and it's not worth it anymore, right. The chances of them getting pregnant are like next to none. And from a cost-effectiveness standpoint it makes no sense to continue doing it....But, you know, on all of the other family planning services, um I don't know of any real formal cost-effectiveness analysis that we're doing now.

The other family planning specific example which applied the cost-effectiveness approach to coverage issues involves teenage pregnancies.

I have heard from a number of physicians over the last few years that one of the things they looked at is teen pregnancies. And if we have teens that don't have coverage for birth control pills or even if they have coverage, but it's covered at a co-pay, like \$5 or \$10, whatever their drug plan coverage is, they may not want to go and get it, right. So we end up dealing with unwanted pregnancies. So this issue definitely has come up. -- Sally, Kaiser

Several participants indicated that family planning services possessed limited economic and policy interest to their organizations. When questions arise about the cost-effectiveness of a specific family planning policy such as teenage pregnancies and the cost of birth control pills, administrators perceive these issues as of too little importance and urgency to merit immediate attention.

We haven't in any formal way addressed it [teen pregnancies], at least at this point, we haven't been able to find a way to address it. And largely, frankly, it's a matter of resources and being able to really, there's just so many things that you could try to target. And so you really have to prioritize and then like work your way down the list. -- Sally, Kaiser

The process of coverage decisions at the policy level currently does not utilize formal cost-effectiveness analysis. Sally at Kaiser explained, "We in general, in terms of coverage, don't do sort of your classic cost-effectiveness analysis." However, informal cost-effectiveness factors influence services at the level of the individual physician and what care is selected as most appropriate. Decisions about coverage of family planning

services do not constitute an exception to this: they, too, usually do not incorporate formal cost-effectiveness analysis.

Sally promised at the end of our interview to investigate the uses of cost-effectiveness, especially through the Department of Quality. She did not discover any examples of cost-effectiveness analysis. The reported lack of cost-effectiveness analysis in the coverage decision process may indicate that it is a novel and unfamiliar tool for the private health care context. This absence may also reflect an unwillingness of the organization to discuss with an outsider such privileged information as costs and benefits; perhaps some cost-effectiveness analysis is conducted, but it is regarded as a confidential trade secret or it is feared that an outsider will perceive it critically.

Several participants attributed the small impact that cost-effectiveness has on coverage decisions to its newness and its poor development for use within private health care organizations. The literature supports this assessment (see Section I.). Few have attempted to assess cost-effectiveness of private family planning services (Trussell et al 1995; Trussell, Koenig, Ellertson, and Stewart 1995), and none of these analyze specific private organizations or programs. Similarly, only one of the participants interviewed knew of any uses of cost-effectiveness to evaluate family planning services within their institutions, and that one person only knew of the IVF and teenage pregnancy examples.

a lot of this kind of stuff is sort of new in the field of medicine.... But it strikes me that at least in this kind of an environment, it's new to be developing guidelines and really nailing down, what do you mean by medical necessity? And what's, guidelines for care, etc. And so we're at a point where we're looking at kind of the heavy hitters, like, you know, heart disease, asthma, diabetes, things that are like really big.... And so, I think that probably family planning isn't, it's just not up there. -- Sally, Kaiser

Another participant attributed the difficulties of assessing cost-effectiveness to the problems of proving the impacts of prevention: "you're getting into the whole realm of trying to actually get real hard data on prevention, which is really hard to do," explained Connie (Tang Center). She then referred to the Office of Family Planning as an organization which may have a better understanding of the cost-effectiveness of family

planning services because it "has to prove, in order to get the funding that they [the Office of Family Planning] get from the state, they have to describe what the impact of their services does. And so they're in a position of having to make those arguments about how much their prevention is working." This has motivated the various studies on the cost-effectiveness of public family planning in California (Forrest 1990a and 1990b; Brindis 1995). However, the private sector has no mandate to prove the impact of services. Connie summarized the contrast between the public and private sector approaches: "...public sector is justifying getting government money to do prevention. Private sector is trying to spend the least amount of money and isn't trying to improve health status.... it's totally a business."

A lack of data on costs or benefits complicates attempts at cost-effectiveness analysis. John stated, "We don't actually have a good accounting system for tracking individual costs because again, our business is not driven by billing, our business is driven by managing health care." Kaiser assesses and estimates costs, such as the cost of overhead and the annual cost to treat a patient. However, Kaiser does not have a process to evaluate this cost for its output or effectiveness. John described this:

And you ask yourself well how can I know it's [the annual cost to treat a patient] OK? And there's no way to answer that question. Most people answer that question by saying, well can someone else do it cheaper? Not knowing exactly what they are doing, you just say, if someone else is doing it cheaper than maybe I can too. And then you look inside and see what you can fix inside to make it cheaper. And if there's no competitive pressure to make it look any cheaper you're certainly won't because you will go and do something else.... With competition increasing in the last many years, two years or so, everybody's looking for more cost-effective ways of delivering the same product for a lower price.

The organization's lack of control over patient demand complicates cost analysis, impeding Kaiser's evaluation of any dimension beyond price of services.

In the United States you really have very little leverage in determining demand. When a patient's, because the patients have so many different options available to them they can more or less demand what they want and get it. Now the other question when they can get what they want is, what is the price? And to the extent that the price is prohibitive, you really don't have to respond to the threat. But if the price is not prohibitive, then your only requirement then is to match the price, which is what we've just talked about. So, so I don't think there's much in the way of a proactive strategy on the part of health maintenance organizations to measure

effectiveness as much as it is their , their behavior is driven by their, their, the necessity for them to respond to competition....So I guess what I'm saying is that I don't think the organization can drive the process to efficiency; it's still a consumer driven activity. --- John, Kaiser

Current cost analyses focus exclusively on costs: program outputs and program comparisons do not receive consideration. In the coverage decision process and with issues of cost analysis the underwriters determine much of the policy. Their work as described by Connie (Tang Center) focuses on costs and does not explore the benefits or impact of services:

...underwriters, by the way, use financial formulas to determine what they do.... But they [underwriters] know what adds cost and they know what they're trying to protect the plan against. They're the ones that study all the things that impact a plan negatively, cost-wise. And so then when they look at your group, ... they look at demographics and make a lot of analysis based on demographics. That's why a lot of insurance plans, including individual plans, are age-rated.

The health industry's focus on costs to the exclusion of output and alternative programs appears in the explanation of benefits brochures. Despite the name, the benefits do not differentiate the brochures clearly. As observed in conducting the review of the five individual products, the literature provided by all five plans showed a high degree of similarity. Women's health, cute photos of babies, easy accessibility to an obstetrician/gynecologist, and annual PAP smears and pelvic exams appeared as frequent motifs in all the marketing. Sally at Kaiser observed the likeness as well:

Generally speaking if we can, we'll draw from what else is out there, in other brochures. I mean of course, it's interesting because if you look at other health plan brochures, they look in a lot of areas very similar to ours. And also, a lot of other health plans have used ours as their model....Because you read it and it's like, oh, this is exactly, let's what, our health plan does. And it's like, oh, this is the same thing as ours says.

Similarity among the informational packets may foster an impression among consumers that the plans can not be differentiated by services or coverage and that the only distinguishing dimension is price.

The rough cost analysis approach described by John at Kaiser considers only the costs of the product; the effectiveness is equated with the cost, with a lower cost indicating a higher effectiveness. Benefits or outcomes from the product do not enter into this

approach to cost analysis. Family planning, like all health services, is subject to the same considerations of cost-cutting. One method of decreasing costs for family planning services consists of a sourcing strategy through which Kaiser shifts the cost of drugs, such as oral contraceptives, to the pharmaceutical company by demanding low bulk prices. The decision to fund IUDs exemplifies the desire to decrease costs:

So, in the case of family planning services I guess that everybody is looking at ways in which they can do that more cheaply. And I think that that's one of the reasons why they decided to fund IUDs because when you figure it's a more effective way of providing contraception than anything else, and it has the lowest up front costs and it has the least requirement in terms of equipment to put it in place. It is really low technology and product. And it's actually turned out that you could put in an IUD cheaper than it would be to provide birth control pills. -- John

All the approaches to cost analysis which John discussed focused on targeting the costs and decreasing the costs of services. Major portions of the cost-effectiveness equation -- the output and program comparisons -- do not appear. John indicated that in another five to ten years that part of the cost-effectiveness analysis will evolve and be applied. For now, the focus is on costs which implies an assumption of equality in outcomes and benefits for alternative services or treatments. Thus, the value of spending \$500 on IUDs as compared to the value of spending \$500 on abortions or another service which prevents parenthood is not compared.

Despite the challenges of cost-effectiveness analysis, the interviewees indicated that this approach would progress and expand. As Connie (Tang Center) stated:

Because in trying to quantify the cost-effectiveness and how they've prevented unwanted pregnancy, um and you know, you can't quantify the quality of life that that brings. So it's the weakness of the whole issues is that it's not an area that's well developed and well-qualified. But people are trying, very hard.

The HMOs have just begun. Certainly nobody in the traditional insurance plans, the indemnity plans, the HMOs are stumbling around at it. And Kaiser's probably the best at it.

CONCLUSION

Among the five plans surveyed, coverage variation correlated with plan type (HMO vs. PPP) more than any other factor; HMOs offered more comprehensive coverage of family planning services than other models. Previous research into large group and employer based insurance coverage of family planning services also supports this (Costello 1994; Uneven and Unequal 1994; Burns 1993). Cost and payment structure varied more than coverage inclusion and exclusion, complicating any attempt to estimate the subscriber's cost of receiving any service. The range may reflect other aspects of benefit richness in the plans or different levels of operating efficiency. The variation observed can be interpreted as spotty and inconsistent or as responsive to diverse consumer demands.

Accessibility and availability of interview participants, and thus information, followed a descending continuum from public to non-profit to for-profit. This, along with other factors such as my credibility and perceptions, has biased the data gathered through the qualitative interviews: the participants over-represent non-profit organizations.

As revealed through the interviews four factors affect coverage decisions: demand, medical necessity, institutional history and philosophy of coverage, and laws. The importance of each factor varies with the service and context of the coverage decision. Cost-effectiveness, as addressed and assessed in the interviews, impacts very little on private coverage of family planning services. However, several statements anticipate a larger role for cost-effectiveness in future coverage decisions. In part this may reflect the questions I asked and my initial interest in cost-effectiveness evaluations of family planning services. Ideally, the coverage decision process will someday expand to include cost-effectiveness and wellness and prevention considerations.

The literature also indicates that formal cost-effectiveness does not contribute to family planning coverage decisions within the private sector. Some health insurers and small businesses represented by the organization CAHR feel contraceptives are not cost-effective (Zaremborg 1995), but no published studies prove this. The interviews suggest

that no individual plan has performed cost-effectiveness analyses of contraceptives or most other family planning services; some work has been done with IVF and teenage pregnancy at Kaiser.

The need to perform formal cost analyses of family planning services varies according to the importance of family planning services within a program or organization. As explained by one interview participant, the Office of Family Planning and other public administrators must prove the impact of their services, and several studies do find publicly provided contraceptives and family planning to be cost-effective (Brindis 1995; Forrest and Singh 1990a and 1990b; Trussell 1995). Many public providers focus all their resources on family planning services and so the need to evaluate impact becomes very important. In contrast, the relative insignificance of family planning for private sector providers has condemned costs analyses of family planning services to very low priority.

Issues for Future Research

Several issues for future research arise from the discussion of coverage and coverage decisions. How does coverage or lack of coverage affect women's access to family planning services? One Arizona study suggests that coverage of family planning services specifically, not simply insurance status, impacts on access (Kirkman-Liff and Kronenfeld 1994). A comparison of insurance plans which do cover family planning services with those that do not would address this issue.

On the cost-effectiveness front several issues remain to ponder and explore. Trussell's evaluation of contraceptive methods raises some questions. Would an expansion of contraceptive coverage impact on the insurer's bottom line? Do third party payers already transfer the savings of contraception use to consumers through, for example, lower premiums? Increasing contraceptive coverage could raise payer costs or it could decrease costs if it resulted in greater access and use of contraception, thus decreasing pregnancies (Trussell et al 1995: 500). A potential use of cost-effectiveness applied to family planning services would evaluate the following question: given that insurance plans all cover

pregnancy, and using unwanted pregnancies as an outcome measure, would provision of family planning services be more cost-effective through the insurance plan or through out-of-pocket consumer purchases?

The role and importance of medical necessity in coverage decisions provides another topic for future work. How is medical necessity determined and who defines it?

Medical necessity and the diverse coverage patterns observed both stimulate discussion of a standard benefits package. Medical necessity provides a minimal baseline for the benefits package in most plans. However, medical necessity is an ambiguous concept left for further definition and interpretation by each plan, which explains the variety in coverage despite a common cited standard of medical necessity. Should there be a more clearly defined standard benefits package or does the nebulous concept of medical necessity suffice for this? The current system honors consumer choice and preferences, and any changes should work to maintain this aspect of the benefits package. The problem with the current use of medical necessity as a criterion of the standard benefits package is that the process through which medical necessity is determined remains open to abusive interpretations. A committee or provider may decide that services that a consumer had perceived as medically necessary are not necessary, without justifying this decision to the consumer. Rather than a mandated standard benefits package which would remove much consumer choice, the process which defines and determines medical necessity should be structured in a more specific and concrete manner so that consumers and providers know what it includes.

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Appendices

Appendix 1: Blue Cross Premiums

HMO

Area 1 includes Amador, Butte, Calaveras, Colusa, Humboldt, Kings, Lake, Lassen, Monterey, San Benito, Sutter, Tehama, Tuolumne, Yuba and Yolo. Several other Area 1 counties have limited network availability: Alpine, Del Norte, El Dorado, Glenn, Inyo, Mendocino, Modoc, Mono, Nevada, Placer, Plumas, Modoc, Mono, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Trinity, and Tulare counties. Area 2 extends complete network availability to Fresno, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Louis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus, Santa Barbara (three zip codes) and San Bernadino (one zip code); limited network availability in Area 2 includes Imperial and Kern counties. Area 3 covers Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, and Los Angeles (eleven zip codes). Orange, Santa Barbara (all other zip codes), Ventura, and Los Angeles (six zip codes) counties pertain to Area 4. Area 5 is the remaining Los Angeles zip codes. Area 6 includes Riverside, San Bernadino (except as listed in Area 2), San Diego and Los Angeles (four zip codes).

Premiums

<u>Age</u>	<u>Subscriber</u>	<u>Area 1</u>	<u>Area 2</u>	<u>Area 3</u>	<u>Area 4</u>	<u>Area 5</u>	<u>Area 6</u>
15-18	One	\$51	\$51	\$58	\$62	\$68	\$57
19-29	One	81	81	94	102	113	93
	Couple	153	153	177	193	215	177
	Family	207	207	240	261	290	238
	Subscriber & Child	122	122	141	154	171	140
	Subscriber & Children	164	164	189	205	228	188
30-39	One	105	105	121	131	145	120
	Couple	201	201	232	249	277	229
	Family	275	275	318	343	381	315
	Subscriber & Child	146	146	169	182	203	167
	Subscriber & Children	200	200	231	250	278	229
40-49	One	130	130	151	165	183	151
	Couple	251	251	289	316	351	290
	Family	341	341	393	430	478	394
	Subscriber & Child	172	172	198	217	241	198
	Subscriber & Children	242	242	280	305	339	279

Preferred Provider Option

Personal Prudent Buyer Classic Plans

\$2000 Deductible

<u>Age</u>	<u>Subscriber</u>	<u>Area 1</u>	<u>Area 2</u>	<u>Area 3</u>	<u>Area 4</u>	<u>Area 5</u>	<u>Area 6</u>
15-18	One	\$27	\$27	\$30	\$38	\$40	\$36
19-29	One	31	31	41	48	50	43
	Couple	62	62	82	96	100	78
	Subscriber & Child	55	55	64	85	89	77
	Family	98	98	131	140	163	134
	Subscriber & Children	74	84	98	124	145	117
30-39	One	44	45	57	66	79	62
	Couple	88	90	102	130	148	124

<u>Age</u>	<u>Subscriber</u>	<u>Area 1</u>	<u>Area 2</u>	<u>Area 3</u>	<u>Area 4</u>	<u>Area 5</u>	<u>Area 6</u>
30-39	Subscriber & Child	64	70	79	91	118	95
	Subscriber & Children	94	108	120	164	168	144
40-49	One	56	56	64	79	113	72
	Couple	106	108	118	153	201	138
	Subscriber & Child	80	77	93	117	152	107
	Family	127	146	159	203	278	191
	Subscriber & Children	102	117	130	173	190	156

\$1000 Deductible

<u>Age</u>	<u>Subscriber</u>	<u>Area 1</u>	<u>Area 2</u>	<u>Area 3</u>	<u>Area 4</u>	<u>Area 5</u>	<u>Area 6</u>
15-18	One	\$31	\$33	\$38	\$49	\$58	\$44
19-29	One	41	43	51	64	77	54
	Couple	82	86	95	124	149	108
	Subscriber & Child	64	94	86	101	122	94
	Family	121	130	161	193	223	176
	Subscriber & Children	96	100	127	149	183	140
30-39	One	51	61	75	88	102	82
	Couple	102	119	149	172	193	161
	Subscriber & Child	72	87	107	125	147	114
	Family	156	173	200	250	289	229
	Subscriber & Children	114	127	139	185	224	148
40-49	One	75	80	99	109	155	109
	Couple	150	156	196	210	298	193
	Subscriber & Child	98	70	114	146	200	142
	Family	204	205	229	281	385	253
	Subscriber & Children	131	134	152	196	245	164

\$500 Deductible (\$25 co-pay)

<u>Age</u>	<u>Subscriber</u>	<u>Area 1</u>	<u>Area 2</u>	<u>Area 3</u>	<u>Area 4</u>	<u>Area 5</u>	<u>Area 6</u>
15-18	One	\$45	\$46	\$59	\$74	\$90	\$64
19-29	One	54	54	68	93	113	74
	Couple	101	105	134	185	224	145
	Subscriber & Child	84	87	109	141	169	126
	Family	163	167	209	267	336	250
	Subscriber & Children	114	128	159	196	241	191
30-39	One	74	74	101	134	147	114
	Couple	141	141	192	261	285	225
	Subscriber & Child	104	107	142	182	203	166
	Family	208	217	280	344	408	304
	Subscriber & Children	147	161	187	236	291	222
40-49	One	80	85	111	150	186	130
	Couple	157	167	211	293	355	247
	Subscriber & Child	110	118	152	198	242	182
	Family	214	222	295	380	456	326
	Subscriber & Children	158	170	213	264	325	247

\$250 Deductible (\$20 co-pay)

<u>Age</u>	<u>Subscriber</u>	<u>Area 1</u>	<u>Area 2</u>	<u>Area 3</u>	<u>Area 4</u>	<u>Area 5</u>	<u>Area 6</u>
15-18	One	\$58	\$58	\$75	\$96	\$120	\$83
19-29	One	72	73	93	119	149	106
	Couple	140	143	180	232	299	208
	Family	218	218	280	344	418	330
	Subscriber & Children	173	174	209	266	330	250
30-39	One	87	88	117	147	183	129
	Couple	165	165	219	283	354	243
	Subscriber & Child	137	138	175	221	272	191
	Family	250	252	356	418	547	371
	Subscriber & Children	206	207	261	314	381	278
40-49	One	110	112	145	184	235	160
	Couple	210	216	279	358	452	306
	Subscriber & Child	160	162	203	258	324	222
	Family	289	298	409	476	637	438
	Subscriber & Children	226	228	293	358	442	324

Appendix 2.: Blue Shield Premiums

HMO

<u>Age</u>	<u># Subscribers</u>	<u>Northern</u>		<u>Southern</u>			
		<u>Region 1</u>	<u>Region 2</u>	<u>Region 3</u>	<u>Region 4</u>	<u>Region 5</u>	<u>Region 6</u>
15-18	One	\$52	\$52	\$58	\$45	\$49	\$54
19-29	One	113	113	120	86	99	101
	Two	204	204	214	172	185	193
	Family	285	285	299	234	248	260
30-39	One	136	136	144	104	123	136
	Two	244	244	257	205	221	243
	Family	339	339	357	289	309	339
40-49	One	174	174	183	135	158	173
	Two	311	311	328	259	282	310
	Family	436	436	458	368	393	432

Region 1 includes El Dorado, Fresno, Merced, San Joaquin, Stanislaus, and Yolo counties, and Region 2 covers Kern, Napa, Nevada, Placer, Sacramento, Santa Cruz, Solano, and Sonoma. Region 3 is Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara. Region 4 covers Riverside, San Bernadino, San Diego, Santa Barbara, and Ventura. Region 5 is Orange, and Region 6 is Los Angeles county.

Preferred Provider

Region 1 includes all the counties listed for the HMO plan, plus: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, San Joaquin, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, and Yuba. Region 2 adds San Luis Obispo and Monterey counties to those already listed for HMO coverage. Regions 3, 4, 5, and 6 remain the same.

<u>\$250 deductible</u>		<u>Northern</u>			<u>Southern</u>		
Age	# Subscribers	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
15-18	One	\$36	\$36	\$44	\$51	\$65	\$76
19-29	One	73	74	94	107	120	150
	Two	141	144	181	209	233	300
	Family	219	219	281	331	345	419
30-39	One	88	89	118	130	148	184
	Two	166	166	220	244	284	355
	Family	251	253	357	372	419	548
40-49	One	111	113	146	161	185	236
	Two	211	217	280	307	359	453
	Family	290	299	410	439	477	638

<u>\$500 deductible</u>		<u>Northern</u>			<u>Southern</u>		
Age	# Subscribers	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
15-18	One	\$32	\$32	\$37	\$41	\$48	\$56
19-29	One	55	55	69	75	94	114
	Two	102	106	135	146	186	225
	Family	164	168	210	251	268	337
30-39	One	76	76	102	119	135	148
	Two	142	142	193	226	262	286
	Family	209	218	281	305	345	409
40-49	One	81	86	112	131	151	187
	Two	158	168	212	248	294	356
	Family	215	223	296	327	381	457

<u>\$1000 deductible</u>		<u>Northern</u>			<u>Southern</u>		
Age	# Subscribers	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
15-18	One	\$24	\$24	\$30	\$31	\$33	\$37
19-29	One	39	41	51	57	60	72
	Two	76	80	101	106	115	138
	Family	112	120	149	165	178	205
30-39	One	48	58	70	76	82	95
	Two	96	110	138	149	159	178
	Family	145	166	204	218	237	276
40-49	One	74	75	92	101	101	143
	Two	144	144	181	187	193	279
	Family	189	189	237	252	262	366

<u>\$2000 deductible</u>		<u>Northern</u>			<u>Southern</u>		
Age	# Subscribers	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
15-18	One	\$15	\$30	\$19	\$19	\$21	\$24
19-29	One	30	30	39	41	44	52
	Two	59	60	77	85	93	108
	Family	91	91	121	124	129	150
30-39	One	43	43	55	57	62	74
	Two	86	86	108	114	120	137
	Family	119	120	156	167	175	212
40-49	One	53	54	66	69	74	107

Age	# Subscribers	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
40-49	Two	98	100	125	128	141	185
	Family	134	137	168	176	190	259

Appendix 3.: Foundation Health Premiums

HMO Monthly Premiums

Cheaper Region: Sacramento, North Central, Delta and South Central

Option:	Premier			High			Standard		
#Beneficiaries:	1	2	3+	1	2	3+	1	2	3+
Age									
5-18	\$56	--	--	\$48	--	--	\$39	--	--
19-29	121	218	296	105	190	257	86	156	210
30-39	145	248	351	126	215	305	104	177	248
40-49	186	316	465	162	275	404	133	224	331

Higher Rate Region: Bay and Stanislaus

Option:	Premier			High			Standard		
#Beneficiaries:	1	2	3+	1	2	3+	1	2	3+
Age									
5-18	\$66	--	--	\$57	--	--	\$49	--	--
19-29	123	241	329	107	209	286	92	179	246
30-39	149	276	392	129	240	340	110	205	291
40-49	190	321	472	165	279	411	141	238	352

Copayment Annual Maximum

	Premier	High	Standard
individual	1000	1,500	2,500
family	2,500	3,000	5,000

Preferred Provider Product: Monthly Premium Rates

Los Angeles County

Deductible	\$250			\$500			\$1,000		
# Beneficiaries:	1	2	3+	1	2	3+	1	2	3+
Age									
15 -18	82	--	--	66	--	--	50	--	--
19-29	140	279	411	106	208	331	68	131	198
30-39	174	341	526	135	265	409	90	171	268
40-49	222	435	603	165	323	454	125	245	342

Deductible	\$2,000			\$5,000		
# Beneficiaries:	1	2	3+	1	2	3+
Age						
15 -18	36	--	--	30	--	--
19-29	49	100	145	43	84	138
30-39	70	135	208	58	114	178
40-49	89	174	244	74	145	203

Northern California: Higher Rate Region: Bay and Stanislaus Region

Deductible	\$250			\$500			\$1,000		
# Beneficiaries:	1	2	3+	1	2	3+	1	2	3+
Age									
15 -18	46	--	--	40	--	--	30	--	--
19-29	89	174	267	68	133	209	49	96	151
30-39	115	225	332	88	172	260	68	133	198
40-49	143	280	377	110	216	296	88	172	231

Deductible	\$2,000			\$5,000		
# Beneficiaries:	1	2	3+	1	2	3+
Age						
15 -18	19	-	-	14	-	-
19-29	33	65	102	27	53	81
30-39	50	98	141	41	80	113
40-49	67	131	170	57	112	142

Cheaper Region: Sacramento, North Central, Delta and South Central

Deductible	\$250			\$500			\$1,000		
# Beneficiaries:	1	2	3+	1	2	3+	1	2	3+
Age									
15 -18	36	-	-	33	-	-	25	-	-
19-29	71	140	212	57	112	172	42	83	126
30-39	92	173	253	74	138	201	59	111	156
40-49	115	215	293	92	173	229	77	146	185

Deductible	\$2,000			\$5,000		
# Beneficiaries:	1	2	3+	1	2	3+
Age						
15 -18	15	-	-	12	-	-
19-29	28	63	87	22	49	67
30-39	43	81	114	33	62	88
40-49	59	105	140	45	81	108

Appendix 4.: Kaiser Premiums

1995

Monthly rates

Subscriber only	\$134.67	\$117.80
Subscriber and one dependent	\$267.34	\$233.60
Subscriber and two or more dependents	\$354.91	\$310.03

Area A includes the following counties: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Yolo (zip codes 95607 and 95694 only). Area B encompasses the following counties: Amador (zip codes 95640 and 95669 only), El Dorado, Fresno, Kings, Madera, Placer, Sacramento, San Joaquin, Sonoma, Sutter, Tulare, Yolo (except 95607 and 95694), and Yuba.

1996

\$5 Copay Level

Age	<u>Single</u>		<u>Subscriber & Spouse</u>		<u>Subscriber & Child</u>		<u>Subscriber, Spouse & Children</u>		<u>Subscriber & 2+ Children</u>	
	<u>Area A</u>	<u>Area B</u>	<u>Area A</u>	<u>Area B</u>	<u>Area A</u>	<u>Area B</u>	<u>Area A</u>	<u>Area B</u>	<u>Area A</u>	<u>Area B</u>
19-29	\$79	72	156	142	145	131	254	231	210	191
30-39	\$104	95	205	186	169	154	303	275	235	213
40-49	128	116	254	231	193	175	353	320	258	235
50-59	\$146	146	289	289	217	217	397	397	289	281
60-64	\$146	146	289	289	217	217	397	397	289	289

\$15 Copay Level

<u>Age</u>	<u>Single</u>		<u>Subscriber & Spouse</u>		<u>Subscriber & Child</u>		<u>Subscriber, Spouse & Children</u>		<u>Subscriber & 2+ Children</u>	
	<u>Area A</u>	<u>Area B</u>	<u>Area A</u>	<u>Area B</u>	<u>Area A</u>	<u>Area B</u>	<u>Area A</u>	<u>Area B</u>	<u>Area A</u>	<u>Area B</u>
19-29	\$59	52	116	103	108	95	189	167	156	138
30-39	\$78	69	152	134	126	111	225	198	175	154
40-49	\$95	84	189	167	144	127	262	231	192	169
50-59	\$130	115	257	229	181	160	335	296	230	203
60-64	\$130	115	257	229	193	178	353	332	250	220

Appendix 5.: PacifiCare Premiums**HMO Monthly Premiums****Northern California Counties****HMO15**

<u>Beneficiaries</u>	<u>Single</u>	<u>Subscriber & Spouse</u>	<u>Subscriber & Child</u>	<u>Subscriber & Children</u>	<u>Subscriber, Spouse & Children</u>
<u>Age</u>					
0-29	\$85	166	153	191	254
30-39	\$107	199	175	257	327
40-49	\$132	254	200	283	373
50-54	\$171	327	239	291	418
55-59	\$207	395	275	334	476
60-64	\$225	450	293	334	513

HMO 10

<u>Beneficiaries</u>	<u>Single</u>	<u>Subscriber & Spouse</u>	<u>Subscriber & Child</u>	<u>Subscriber & Children</u>	<u>Subscriber, Spouse & Children</u>
<u>Age</u>					
0-29	\$93	183	168	210	280
30-39	\$118	220	193	284	360
40-49	\$145	280	221	312	411
50-54	\$188	360	264	321	461
55-59	\$228	436	303	368	525
60-64	\$248	496	323	368	565

Santa Barbara and San Luis Obispo Counties**HMO 15**

<u>Beneficiaries</u>	<u>Single</u>	<u>Subscriber & Spouse</u>	<u>Subscriber & Child</u>	<u>Subscriber & Children</u>	<u>Subscriber, Spouse & Children</u>
<u>Age</u>					
15-18	\$66.47				
19-29	\$82.09	161.11	148.51	185.62	247.3
30-39	\$103.64	193.94	170.06	250.49	318.11
40-49	\$128.27	247.3	194.69	275.12	363.26

HMO 10

<u>Beneficiaries</u>	<u>Single</u>	<u>Subscriber & Spouse</u>	<u>Subscriber & Child</u>	<u>Subscriber & Children</u>	<u>Subscriber, Spouse & Children</u>
<u>Age</u>					
15-18	\$73.26				
19-29	\$90.48	177.57	163.69	204.59	272.58

<u>Beneficiaries</u> <u>Age</u>	<u>Single</u>	<u>Subscriber</u> <u>&Spouse</u>	<u>Subscriber</u> <u>&Child</u>	<u>Subscriber</u> <u>&Children</u>	<u>Subscriber, Spouse &</u> <u>Children</u>
30-39	\$114.23	213.76	187.44	276.09	350.62
40-49	\$141.38	272.58	214.59	303.24	400.38

Point of Service Products
Northern California Counties
POS 1000 = \$1000 deductible

<u>Beneficiaries</u> <u>Age</u>	<u>Single</u>	<u>Subscriber</u> <u>&Spouse</u>	<u>Subscriber</u> <u>&Child</u>	<u>Subscriber</u> <u>&Children</u>	<u>Subscriber, Spouse &</u> <u>Children</u>
0-29	\$98	191	176	220	293
30-39	\$123	230	202	297	377
40-49	\$152	293	231	326	430
50-54	\$197	377	276	336	482
55-59	\$238	455	317	385	549
60-64	\$259	518	337	385	591

POS 500 = \$500 deductible

<u>Beneficiaries</u> <u>Age</u>	<u>Single</u>	<u>Subscriber</u> <u>&Spouse</u>	<u>Subscriber</u> <u>&Child</u>	<u>Subscriber</u> <u>&Children</u>	<u>Subscriber, Spouse &</u> <u>Children</u>
0-29	\$102	199	184	229	306
30-39	\$128	240	210	310	393
40-49	\$159	306	241	340	449
50-54	\$206	393	287	350	503
55-59	\$249	475	331	402	573
60-64	\$270	541	352	402	617

POS 250 = \$250 deductible

<u>Beneficiaries</u> <u>Age</u>	<u>Single</u>	<u>Subscriber</u> <u>&Spouse</u>	<u>Subscriber</u> <u>&Child</u>	<u>Subscriber</u> <u>&Children</u>	<u>Subscriber, Spouse &</u> <u>Children</u>
0-29	\$106	208	191	239	318
30-39	\$134	250	219	322	409
40-49	\$165	318	251	354	467
50-54	\$214	409	299	365	524
55-59	\$259	495	344	418	597
60-64	\$281	564	367	418	643

Child Only, Age 1-18*

<u>Plan</u>	<u>1 Child</u>	<u>2 Children</u>	<u>3+ Children</u>
HMO15	\$69	114	173
HMO 10	\$76	126	191
POS 1000	\$79	132	200
POS 500	\$82	138	209
POS 250	\$86	143	217

* No provision to add dependents.

Santa Barbara and San Luis Obispo Counties
POS 1000 = \$1000 deductible

<u>Subscribers</u> <u>Age</u>	<u>Single</u>	<u>Subscriber</u> <u>&Spouse</u>	<u>Subscriber</u> <u>&Child</u>	<u>Subscriber</u> <u>&Children</u>	<u>Subscriber,</u> <u>Spouse& Children</u>
15-18	\$76.60				
19-29	\$94.60	185.65	171.14	213.9	284.99
30-39	\$119.43	223.49	195.98	288.66	366.58
40-49	\$147.81	284.99	224.36	317.04	418.61

POS 500 = \$500 deductible

<u>Subscribers</u> <u>Age</u>	<u>Single</u>	<u>Subscriber</u> <u>&Spouse</u>	<u>Subscriber</u> <u>&Child</u>	<u>Subscriber</u> <u>&Children</u>	<u>Subscriber,</u> <u>Spouse& Children</u>
15-18	\$79.93				
19-29	\$98.72	193.74	178.59	223.21	297.39
30-39	\$124.63	233.23	204.51	301.23	382.54
40-49	\$154.25	297.39	234.12	330.85	436.83

POS 250 = \$250 deductible

<u>Subscribers</u> <u>Age</u>	<u>Single</u>	<u>Subscriber</u> <u>&Spouse</u>	<u>Subscriber</u> <u>&Child</u>	<u>Subscriber</u> <u>&Children</u>	<u>Subscriber,</u> <u>Spouse& Children</u>
15-18	\$83.27				
19-29	\$102.84	201.82	186.05	232.53	309.8
30-39	\$129.83	242.96	213.04	313.8	398.5
40-49	\$160.69	309.8	243.89	344.65	455.06

Appendix 6. General Letter Sent on Request to Interviewees to Specify Interview Topics

Neva Phair
939 Shattuck Ave.
Berkeley, CA 94707
526-4340 • FAX: 643-8771

January 15, 1996

Dear Ms. X:

Thank you very much for agreeing to meet with me and discuss family planning coverage and costs. I am a graduate student in the Health and Medical Sciences at the University of California, Berkeley and am studying how family planning services are provided to individual purchasers of health insurance.

This interview will be completely confidential and voluntary. Your name will not be recorded nor will it ever be linked with the information given. You can refuse to answer any question(s) and can choose to terminate the interview at any point. I will tape record the interview unless you wish for any portion(s) to not be recorded.

I would like to discuss with you how Z (name of your organization) makes decisions about the coverage of family planning services and through what process coverage decisions are made.

The role of cost-effectiveness in determining coverage of family planning services also interests me. How does Z (name of your organization) assess or calculate the costs and benefits of family planning services (how is cost-effectiveness perceived), and how does any cost-effectiveness analysis influence coverage decisions? What are perceived costs and what are perceived benefits for family planning services such as an abortion or oral contraceptive pills for example? Some other questions I would like to discuss if there is time are: what is the cost of services to the enrollee, and how are these costs are determined.

I can be reached at (510) 526-4340 for any questions or clarifications. Thank you for your time and help.

Sincerely,

Neva Phair