

1986

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Anthony Shaw

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Recommended Citation

Anthony Shaw, *Commentary: Effects of Cost Containment on Health Care Services for Infants and Children*, 36 Case W. Res. L. Rev. 1221 (1986)

Available at: <https://scholarlycommons.law.case.edu/caselrev/vol36/iss4/24>

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COMMENTARY: EFFECTS OF COST CONTAINMENT ON HEALTH CARE SERVICES FOR INFANTS AND CHILDREN

*Anthony Shaw**

INTRODUCTION

SINCE THE PASSAGE of Medicare and Medicaid in the mid-1960's, much has been learned about the effects of *increased* funding of health services for families and children. During this fifteen-year period, generous funding of federal and state health initiatives has resulted in the following: production of increased numbers of needed pediatricians, family practitioners, and obstetricians through the financing of graduate medical education under Medicare; an accelerated decline in infant and postneonatal mortality rates; immunization programs which virtually eliminated polio and measles; and increased availability to economically disadvantaged families of the benefits of new technology for pregnant women and newborn infants, thus reducing the inequities of a two class medical system. In addition to these programs having direct impact on child health, federal initiatives in maternal and pediatric *nutrition* have had positive effects on child health. In this milieu, the cost of medical care for infants and children has soared, largely as a result of the successful application of expensive new technologies requiring the skills of highly trained professional personnel.

This Commentary will not address the question of the *need* for cost containment of children's health services and programs. Whether there is such a need for cost containment is actually unclear. No one would support spending for health-related programs or services that do not in fact improve health or prevent disease. However, the degree of benefits gained for the amounts spent is often controversial, and people of good will as well as those with personal biases argue endlessly over interpretation of data which are largely murky and unable to pass rigid tests of significance. None-

* Chief, Division of Pediatric Surgery, Los Angeles County-Olive View Medical Center, and Professor of Surgery, UCLA School of Medicine. B.A., Harvard College (1950); M.D., N.Y.U. College of Medicine (1954).

theless, the perception on the part of government, business, and the insurance industry is that health care costs are out of control. Once one accepts the need for cost containment as a given, the inquiry then must focus on its impact on children's health care.

Can one expect current and projected cost-containment measures to reverse many of the gains of the past fifteen to twenty years? There is abundant evidence to demonstrate that this may be so. But to say that we are simply back-pedaling to where we were in 1960 is to greatly oversimplify the effects of cost containment on pediatric health care in the very different and much more complex medical environment of the 1980's. One cannot overstate the dramatic effects of the tremendous pressure on physicians who are trying their best to supply the fruits of modern medical science to their young patients in a climate of reduced financial support for children's programs, the increased competition resulting from the superabundance of pediatricians and pediatric specialists, escalating liability costs, confusing and contradictory statutes in many areas of medical decisionmaking, and the rise of corporate medicine. This Commentary considers the various cost-containment devices and their effects on child health under three major categories, namely: 1) employers and health insurers; 2) government; and 3) physicians and hospitals.

I. EMPLOYERS AND HEALTH INSURERS

The American worker in the decades after World War II became the envy of the industrialized world because of his high standard of income, which included increasingly comprehensive health benefits for him and for his family.¹ However, by 1985, when health costs in the automotive industry, for example, amounted to ten percent of the cost of manufacturing a new car, it became obvious that health costs had to be curtailed. In many cases this was done by reducing health benefits for employees' families, including dependent children, and by raising co-insurance and deductibles, thus reducing the costs of insurance to the employer and placing a

1. Many of the family policies of the 1950's and early 1960's, however, excluded coverage of congenital conditions and conditions requiring treatment in the first 30 days of life. Furthermore, they would not pay for many relatively simple, although major, operations, such as repair of hernias in infants, unless the patient spent a night in the hospital. It thus rewarded hospitals for keeping their beds full and encouraged empire building among physicians for whom the number of occupied beds was directly related to clout with department chairmen and boards of directors.

greater burden for insuring the family's health on the worker.² As a result, many children of working parents who cannot afford the deductibles or co-insurance are uninsured or underinsured, because their parents have sufficient income to render the children ineligible for government health benefits from programs such as Medicaid.³

Some large employers are looking for innovative solutions so as to continue services to employees' children while concomitantly cutting costs. Central to these efforts are such mechanisms as employer coalitions to pressure providers. These groups have negotiated directly with hospitals and even operated their own health programs; offered employees competing health plans (including HMOs and PPOs); instituted wellness programs, substance abuse treatment and weight reduction programs, and claims analysis; required second opinions for elective surgery; provided pre-admission testing, and more.⁴ Most employers, however, still contract through private insurers, such as Blue Cross/Blue Shield, although that tendency is changing rapidly in the larger industries.

General Motors (GM) provides 2.1 million individuals, or about one percent of the United States population, with health care coverage and is thus challenged to come up with a health package which provides affordable coverage to its employees and their minor dependents while, at the same time, keeping the price of their product competitive. In a recent presentation to the American Academy of Pediatrics, GM representative Richard O'Brien described the efforts his company is making with so-called "managed health care systems," including HMOs, PPOs, and more traditional types of insur-

2. One controversial Article reported that varying the portion of co-payment paid by parents for medical services to their children from zero (free care) to 95 percent, although reducing the use of medical services by up to a third as co-payment increased, had no measurable effect on health outcomes during the study period (three to five years). Valdez, Brook, Rogers, Ware, Keeler, Sherbourne, Lohr, Goldberg, Camp & Newhouse, *Consequences of Cost Sharing for Children's Health*, 75 PEDIATRICS 952 (1985). Some find fault with the design of the study and thus are critical of its conclusions, especially with respect to the effects of cost sharing on poor children. See, e.g., Haggerty, *The Rand Health Insurance Experiment for Children: Commentary*, 76 PEDIATRICS 969 (1985); Starfield & Dutton, *Care, Costs, and Health: Reactions to and Reinterpretation of the Rand Findings*, 76 PEDIATRICS 614 (1985).

3. See Butler, Winter, Singer & Wenger, *Medical Care Use and Expenditure Among Children and Youth in the United States: Analysis of a National Probability Sample*, 76 PEDIATRICS 495 (1985); CHILDREN'S DEFENSE FUND, A CHILDREN'S DEFENSE BUDGET: AN ANALYSIS OF THE FY 1987 FEDERAL BUDGET AND CHILDREN.

4. Address by Edwin C. Husted, *The Reasons for Major Health Care Premium Increases in 1981 Through 1984 and Employer Responses to the Increase*, presented to the American Public Health Association (Nov. 19, 1985); Goldbloom & MacLeod, *Impact of Pre-admission Evaluations on Elective Hospitalization of Children*, 73 PEDIATRICS 656 (1984).

ance plans, all of which have in common a mechanism for monitoring cost and utilization.⁵ GM encourages its employees to select the PPO option, expecting it to be the most cost effective (although it is not clear as yet whether any of GM's managed-care settings will contain costs of medical care more effectively than more traditional benefit packages with private insurers). The PPO option focuses on wellness and preventive care, including home and office visits, well-baby coverage during the first year of life, standard immunizations to age six, and treatment of speech disorders. Co-payments are required for many of these services.

Private insurance plans are primarily available through employment. During the years of "usual and customary" fee for service, long the basis for physician remuneration under Blue Shield and other private insurance plans, the cost of private health insurance rapidly escalated. Benefits under them to children of employees are among the "fat" trimmed in cost-containment measures. Low-paid workers often cannot afford the over \$3000 premiums per year for private comprehensive family plans. Even when they do have family coverage, many such plans are deficient in providing for important preventive and therapeutic benefits for children.

As a result of spiraling costs and due to pressure from private insurance companies, supported by government efforts, the "usual and customary" fee for service mentioned above may be moribund in the name of cost containment. In Massachusetts, for example, all physicians, not only those participating in the Blue Shield plan, are required by act of the Massachusetts legislature to accept the Blue Shield fee as payment in full without co-payment. In that same state physicians are required to accept Medicare fees as full payment; doctors who bill for co-payments risk loss of license.

II. GOVERNMENT

Lester C. Thurow, in his 1985 Shattuck Lecture, pointed out that "the federal government used to view health care as a social problem. Today it views it almost solely as a budget deficit problem."⁶

As a fledgling pediatric surgeon in private practice in New York City in the middle 1960's, I welcomed Medicaid for two reasons:

5. Address by Richard F. O'Brien, *General Motors Corporation—Health Care Cost Containment Efforts*, presented to the American Academy of Pediatrics, Chicago, Ill. (Jan. 18, 1985).

6. Thurow, *Medicine versus Economics*, 313 *NEW ENG. J. MED.* 611 (1985).

first, it allowed many poor children access to hospitals, private offices and medical services previously available only to those who could pay for them; second, it paid me for treating patients for whom I was previously providing free clinic care. Although the term was not in common use in 1965, "cost containment" was built into Medicaid in a way all physicians are unhappily familiar with twenty years later—fees are far below what most physicians charge (even by pediatric standards, which have always been at the bottom of the specialists' heap), and reimbursement of physicians by Medicaid was and is a time consuming, frustrating process by which payment can be delayed by ingenious Medicaid staff for up to a year. Out of frustration with the low fees and the mountainous and escalating paper work, many physicians refused to see Medicaid patients. Others saw them free of charge after concluding that the extra office time and staff required to process Medicaid forms, including long and exasperating follow-ups of appeals, was not cost effective. But, on the whole, Medicaid provided the benefits of modern medicine to millions of poor, chronically ill, and handicapped children. Medicaid, as well as other federal and state government initiatives, including the Title V maternal and child health block grant, community and migrant health centers, Title X family planning program, and federal immunization grants, have allowed many children of the poor to partake of these medical blessings. The dramatic success of Medicaid and other federal- and state-mandated programs are shadowed by gaps in services to many poor children because of limited funding and seemingly arbitrary eligibility requirements (varying widely from state to state). Such practices may, for example, exclude children from poor but employed families (especially from two parent families) from benefits, no matter how poor they are. The small amount of money available for treatment of the most needy disabled and handicapped children under state crippled children grants through Title V often runs out in the spring of each year in many states, requiring postponement of needed surgery until the pot is refilled at the beginning of the new fiscal year in July.

Although the wish of all child advocates is for an increased government role in funding comprehensive health services for needy infants, children, and pregnant women (but hopefully in a more consistent manner), the opposite has occurred, as we all know. Over the past four years, at national and state levels, eligibility standards have been tightened for Medicaid (and Medicaid-related programs such as Aid to Families with Dependent Children). In

addition, funding for Medicaid, immunization programs, Title V, and community health centers, among other programs, has been reduced or maintained at 1981 levels, even though the percentage of children living in poverty has increased to twenty percent of the nation's children.⁷ Moreover, many federal health programs, formerly in the form of categorical funding of targeted groups in states and communities, have been jelled into block grants, leaving agonizing choices regarding how to allocate this limited sum (between handicapped children and pregnant teenagers, for example) to local program administrators. The needs of one needy group are thus pitted against those of equal need (including elderly and handicapped adults), with eligibility of children for such programs even more dependant than before on where they live and on local state political pressures from groups with greater political clout than children.⁸ Cuts in federal programs proposed by the President for 1987 would lead to much more drastic cutbacks in health services for children administered on the state and local level.⁹ A cap on Medicaid funding, for example, would sharply limit the ability of states to expand services and to encourage physician participation in Medicaid by increasing fees.¹⁰

Over the past five years, the national decline in infant mortality has slowed appreciably, especially among black infants, and has even increased in some areas of the country. The former steady decline in premature births, postneonatal mortality, and the percentage of pregnant women receiving late or no prenatal care has been reversed.¹¹ It would be a gross oversimplification to blame these phenomena completely on cutbacks of medical and nutritional services to infants, children, and expectant mothers, but the reduced availability of preventive and medical services to these vulnerable groups during a time of national economic depression, high unemployment, increased immigration of poor Asian and Latino populations, soaring birth rates among poverty stricken immigrant groups and among unwed teenagers, clearly exacerbates the unmet health needs of antenatal and postnatal pediatric populations.

Of particular concern in the current climate is the immunization

7. See CHILDREN'S DEFENSE FUND, *supra* note 3, at 5.

8. See Miller, *The Health of Children, A Crisis of Ethics*, 73 PEDIATRICS 550 (1984).

9. See CHILDREN'S DEFENSE FUND, *supra* note 3.

10. See *id.* California is caught in a special bind in that restrictions on real estate taxes imposed by the Proposition 13 Referendum limits the ability of local government to raise money to supplement the shrinking federal contribution to health programs for children.

11. See Miller, *supra* note 8.

program (diphtheria, whooping cough, measles, polio, etc.) which is threatened by a combination of proposed funding cuts, critically low national vaccine stockpiles, and soaring vaccine costs. The increased costs are directly related to the increasing premiums for liability insurance, which have driven all but two pharmaceutical companies out of the vaccine business and currently threaten to drive the remaining two out of production altogether. The American Academy of Pediatrics supports proposed legislation which would establish a national no-fault vaccine-injury compensation program to ensure prompt and equitable compensation for victims of adverse immunization reactions. Such a program would reduce the liability of vaccine manufacturers, making immunizations affordable, as well as spare families of victims years of expensive and frustrating litigation in the courts.¹²

Although Medicaid and some of the other major federal programs providing direct and indirect health benefits to children are exempt from the ax of the Gramm-Rudman sequestrations, it is already evident that the President and Congress are considering cost cutting in these areas in order to prevent the across-the-board cuts mandated by Gramm-Rudman (assuming the law is modified to cure the constitutional infirmities found by the Supreme Court).¹³

Although Medicaid has not as yet adopted the Diagnosis-Related Groups (DRG) approach to hospital reimbursement, it may well soon follow Medicare's lead. However, the payments through Medicaid are already so low, the eligibility requirements already so restrictive, and hospitalization time allowances already so minimized, that it is hard to see how switching to a DRG form of reimbursement will save much money. Its major advantage might be the imposition of some regional and national uniformity on what is now a completely arbitrary patchwork "nonsystem."

Eli Ginzberg has pointed out a very important difference between current cost cutting and true cost containment:

Health analysts and health managers . . . must not assume that legislative or financial gimmickry, such as reducing the Medicaid rolls, using certificates of need to deny hospitals the right to buy new equipment, insisting on more copayments from patients at hospitalization, and placing a ceiling on reimbursements for Medicare and Medicaid, will result in effective cost containment Reductions in expenditures that result in lowering the level

12. See AMERICAN ACADEMY OF PEDIATRICS, GOVERNMENT ACTIVITIES REPORT (April 1985).

13. See *Bowsher v. Synar*, 106 S. Ct. 3181 (1986).

and quality of health care, particularly for the poor, should not be confused with cost containment.¹⁴

III. PHYSICIANS AND HOSPITALS

When I completed my residency in pediatric surgery in 1962, newborn babies who could not breathe spontaneously died; babies who could not feed died; most babies who weighed less than three pounds died. Generous federal funding of research in neonatology, coupled with grants to support training of the new breed of neonatal physicians, surgeons, and intensivists, brought increased survival. Expansion of benefits under private and government insurers paid for this increasingly expensive care, thereby making it financially feasible—even profitable—for hospitals to convert their old premature nurseries into modern newborn intensive care units. Now comes both “cost containment” and a confusing and contradictory bundle of legislation and court decisions posing a host of economic, legal, and ethical dilemmas for families, doctors, and hospitals. The most cost-effective programs for reducing neonatal mortality and prematurity are not achieved through the dramatic intensive-care-unit technology. They are those more mundane preventive programs of prenatal care, nutrition, family planning, genetic counseling, and so on—the very programs under greatest threat of funding rescissions and budget cuts by the administration and Gramm-Rudman.

Cutbacks in federal and state reimbursements for perinatal services to mother and baby will reduce incentives for innovative programs enhancing neonatal survival. Reduction in funding for residency training in intensive care and for research will reduce the pool of scientific and clinical expertise required to take us to new plateaus of newborn survival. Physicians are squeezed between the increasing costs of liability insurance and diminishing reimbursement under private and government fee schedules. Additional pressures on physicians have been generated by the succession of Baby Doe regulations, the most recent of which are the federal guidelines outlining physician responsibilities under the 1984 amendment to the Federal Child Abuse and Neglect Reporting Act.¹⁵ Under the new federal guidelines, medical neglect is defined as failure to provide all “medically indicated treatment” to impaired newborns. The definition of “medically indicated treatment,” in the opinion of

14. Ginzberg, *Cost Containment—Imaginary and Real*, 308 NEW ENG. J. MED. 1220, 1223 (1983).

15. Child Abuse Amendments of 1984, Pub. L. No. 98-457, 98 Stat. 1749.

many, requires by implication an unconscionable expenditure of financial and human resources on many infants who cannot benefit in any meaningful way.

The child abuse laws provide additional dilemmas for physicians required to report child neglect in a time when health benefits for poor families are being curtailed in both private and public sectors. The reported incidence of abuse and neglect continues to rise along with the percentage of the children who live in poverty and who are born to unwed teenage mothers. Neglect and inadequate parenting are likely to increase, resulting in increased health problems for infants and children with additional pressures on physicians and hospitals, both of which are inadequately reimbursed for providing these services.¹⁶

IV. CONCLUSION

As one looks down the road, it is clear that society, through its government, is not prepared to pour unlimited resources into programs benefiting the health of infants and children. Programs for the elderly, the fastest growing segment of our population, will compete strongly for the health dollar, and children and young parents will clearly be at a political disadvantage in this competition. With curtailing the health dollar spent for children, choices will have to be made between spending on increasingly expensive technology benefiting a relatively small segment, the most egregiously impaired of the pediatric population, and spending on those programs that although less glamorous than heart and liver transplantation and fetal intensive care, are likely to yield the greatest benefit to the largest number of babies and children. A humane society, truly committed to its children, will try to maintain both.

16. The superabundance of pediatricians (along with the increasing glut of other specialists), resulting from the capitation grants to medical schools made by the federal government in the 1970's, has led to intense competition for patients and an increased willingness to accept low Medicaid fees. This development may be an important factor in maintaining access of poor children with Medicaid coverage to medical care.