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## ESSAY

### GENDER AND HEALTH INSURANCE

Steven Miles, M.D.<sup>†</sup>

There has been a lot of attention over the last several years on the question of gender and health care. There is the issue of women being neglected as research subjects; for example, women have been excluded in research about the benefits and risks of treating high blood pressure to decrease the risk of heart attacks. There is the belated recognition that we must study the physiological and anatomic differences between men and women so that doctors can provide the correct treatments for high blood pressure or perform cardiac surgery. There has been a large debate about the lack of investigation of breast cancer, which is so glaring that research funds were taken from the United States Army's budget to ensure that this common disease was adequately investigated. There had been belated attention to issues related to domestic violence as a public health problem and as a risk factor or reason for the use of many other kinds of health care services.

So, too, in looking at health care financing, it is important that we examine three different aspects of this problem: first, the difference between gender and sex; second, the differences between men and women's life-cycles approach (versus taking a slice in time approach); and third, the different health care needs of men and women.

"Gender" refers to the social worlds that are experienced by, allotted to, or enforced upon men and women. It refers to differences in marital worlds. It refers to different places in the economy. It refers to both the fact and the implications of different

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roles in the policy-making bodies of our society. It also refers to the effect of all of these differences in terms of access to power, choices, wealth, and health.

"Sex" differs from gender. Sex refers to differences that are biologically grounded. Men and women are different in fundamental, physiologic ways. Women live longer than men. Women are more likely to get osteoporosis than men. These differences in longevity and physiology translate into different needs for medical services. A health care system that provides one level of entitlement, or one type of service for all, may not treat each person the same.

It is also very important to take a "life cycle" approach in looking at men, women, and health insurance. Instead of looking at the question of men and women at one point in time (e.g., "working age women," "retired women," "poor women," or "women with kids"), it is very important to take a long view over the entire life cycle. First, work history greatly affects the types of financial resources that are available for health care in retirement. Second, various social programs have a significant impact; for example, the limited Medicaid program meets the needs of an increasing number of impoverished older women, as well as the increasing number of poor younger women who are single parents. It is possible for differences in social programs to create conflicts or disadvantages for women or men that become magnified because of life cycle effects. These differences are the topic of this Essay.

One of the interesting things about health care insurance and gender is that the aggregate numbers look about the same. About fourteen percent of women and sixteen percent of men are uninsured.<sup>1</sup> This is a total of around forty-one million Americans. The rates of private insurance are roughly the same for both sexes. However, the vast majority of women receive their private insurance as dependents on a man's policy. This means that they have a special kind of vulnerability to losing private health insurance in the event that they become widowed or divorced. The similarity between rates of the uninsured also does not reflect the fact that a greater proportion of women live to be older than age sixty-five, so they are more likely as a group to be supported on the Medicare program.<sup>2</sup> In addition, women are much more likely to receive

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1. See R.L. BENNEFIELD, U.S. CENSUS BUREAU, WHO LOSES COVERAGE AND FOR HOW LONG? *in* CURRENT POPULATION REPORTS: HOUSEHOLD ECONOMIC STUDIES 70-154 (May 1996) [hereinafter WHO LOSES COVERAGE? ] (stating that the reasons a

Medicaid, which is a wealth-tested insurance program for poor people, because women are more likely to be poor than are men.<sup>3</sup> So, as one begins to unpack what looks like similar overall statistics, one begins to get the hint that there may be more substantial differences in access to insurance than is immediately apparent.

In terms of the employment patterns, women work for less pay and in smaller companies.<sup>4</sup> That is, they are more likely to work in companies between two and fifty employees. Men, on the other hand, are more likely to work in larger companies, have more union participation, have higher salaries, and are much more likely to be working full time than women, who have a greater proportion of part-time work.<sup>5</sup> Furthermore, the greater health care benefits translates into more tax-free income for men,<sup>6</sup> as well as greater coverage in their health care insurance. Even after one corrects for skill level, education, pay status, and the type of jobs, men are still much more likely to have job-based insurance.<sup>7</sup> For example, if one looks at full-time workers, one sees that sixty percent of women receive job insurance versus sixty-eight percent of men,<sup>8</sup> and differences between men and women increase as one moves to part-time workers.<sup>9</sup> For people with punctuated work histories or discontinuous work histories, women are half as likely to be insured as men.<sup>10</sup>

A key feature of job histories in the United States is job mobil-

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greater percentage of men than women are uninsured are because (1) more women than men are over the age of 65 and, thus, are more likely to have Medicare coverage; and (2) women are more likely than men to be poor and, thus, are more likely to have public insurance such as Medicaid).

2. See J.K. Iglehart, *The American Health Care System – Medicare*, 327 NEW ENG. J. MED. 1467-72 (1992).

3. See J.K. Iglehart, *The American Health Care System – Medicaid*, 328 NEW ENG. J. MED. 896-900 (1993).

4. See HEALTH INSURANCE COVERAGE, *supra* note 1, at 218.

5. See *id.*

6. See *id.*

7. See generally AGENCY FOR HEALTH CARE POLICY & RESEARCH, *National Medical Expenditure Survey No. 43, in EMPLOYMENT-RELATED HEALTH INSURANCE IN 1987* (Apr. 1995).

8. See generally L. Beghley & K. Seccombe, *Gender and Medical Insurance: A Test of Human Capital Theory*, 6 GENDER SOC. 283-300 (1992); R. Block & J.R. Tallon Jr., *Changing Patterns of Health Insurance Coverage: Special Concerns for Women*, 12 WOMEN'S HEALTH 119-36 (1987); N.S. Jecker, *Can an Employer-based Health Insurance System Be Just?*, 18 J. HEALTH POL. POL'Y L. 657-73 (1993); K. Seccombe, *Employer Sponsored Medical Benefits: the Influence of Occupational Characteristics and Gender*, 34 SOCIAL Q. 557-80 (1993).

9. See HEALTH INSURANCE COVERAGE, *supra* note 1, at 218.

10. See *id.*

ity. About twenty percent of the work force changes jobs each year. While men and women are equally likely to lose insurance during a job transition,<sup>11</sup> women are more likely than men to change jobs for childbearing or family reasons. This makes them vulnerable to becoming ineligible for private insurance or to facing higher premiums for conditions acquired during interrupted private policies, and it adversely affects eligibility for pension-based insurance.<sup>12</sup> Though women and men between twenty-five and fifty-four years old are as likely to lose employer-based insurance in shifting to new jobs,<sup>13</sup> women's new jobs pay less than men's: The median pay for women is \$306 per week, versus \$459 for men.<sup>14</sup> One-fourth of men's and one-half of women's new jobs pay wages below the poverty line.<sup>15</sup> The effect of this income difference in job transfer means that women are less likely to be able to pay their portion of premium purchase for employers who offer a voucher for purchasing health care insurance.<sup>16</sup> Or it means that women are less likely to be able to purchase private insurance when a new employer does not offer insurance at all, which is increasingly common. Women are, however, more likely to become eligible for Medicaid. The net result is that after a job transfer, fifty-one percent of men are uninsured versus only thirty-five percent of women.<sup>17</sup> When you look within the group of women who are changing jobs, women who make transfers in the context of being continuously married have a much lower likelihood of becoming uninsured over the course of a job transfer.<sup>18</sup> On the other hand, men – regardless of their marital status – have a much greater likelihood of main-

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11. See *id.* (stating that although about 49% of men and women are insured before a job change, the number drops to about 30% after the change).

12. See *id.* (noting that family reasons, such as childbearing, often force a greater percentage of women to change jobs).

13. See A.L. Schor, *Job Turnover – A Problem with Employer-based Healthcare*, 323 NEW ENG. J. MED. 543-45 (1990). See generally AGENCY FOR HEALTH CARE POL'Y AND RESEARCH, *National Expenditure Survey No. 4*, in RETIREES: EMPLOYMENT-RELATED HEALTH INSURANCE COVERAGE I (Feb. 1992).

14. See HEALTH INSURANCE COVERAGE, *supra* note 1, at 218.

15. See *id.*

16. See U.S. DEP'T OF COMMERCE, DYNAMICS OF ECONOMIC WELL-BEING: LABOR FORCE 1991 to 1993 tbl.7 (Aug. 1995). However, women will be more likely to be eligible for Medicaid, especially if they have children. See *id.*

17. See generally WHO LOSES COVERAGE?, *supra* note 1, at 70-154.

18. See N.S. Jecker, *Can an Employer-Based Health Insurance System be Just?*, 18 J. HEALTH POL'Y L. 657-73 (1993). However, a divorced woman or one whose husband has an "adverse" change in job is vulnerable to becoming uninsured. See Beghley & Seccombe, *supra* note 8, at 283-300.

taining continuous insurance during job transfers.

One of the most significant trends in employment health insurance over the last several years has been the dropping of coverage for kids altogether. At the present time, coverage for the children of single parents – child dependent policies – has become rare for women who work in low-paying service jobs.<sup>19</sup>

There are also differences in coverage, particularly with regard to reproductive services, which women use and men do not. Seven percent of insured women (about five million women) have no obstetrics coverage.<sup>20</sup> Twenty-five percent do not have coverage for mammograms,<sup>21</sup> and about ten percent are not covered for abortion services.<sup>22</sup> Coverage varies greatly for job-based health insurance and is much better for women who work for large firms, where coverage for mammograms and obstetric care is a universal part of the benefit set.<sup>23</sup> There are minimal federal standards that mandate benefits for job-based health insurance; however, the Employee Retirement and Income Security Act (ERISA) allows self-funded health insurance plans to get around state requirements for coverage of services. In addition, about one-quarter to one-half of all insurers ask women on the insurance forms whether they have been victims of domestic violence. Apparently, being such a victim is a kind of a medical disease. One female public relations agent for a large insurer justified excluding, or charging higher premiums to, women who were victims of domestic violence by saying that they are just like diabetics who do not take their medicine. What we have there is a failure of empathy and a mistake about who is ill.

As one looks at women who are approaching the age of retirement, there are some general features that are important to keep in mind. This group of people – which represents fourteen percent of elderly adults – has a much higher than normal incidence of acute and chronic disease. They use one-third of all hospital beds,<sup>24</sup> and they are using somewhere around twenty percent of all health care costs. During this age period, women are twice as

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19. See J.S. Banthin & P.F. Short, *New Estimates of the Underinsured Younger Than 65 Years*, 274 JAMA 1302-06 (1995).

20. See HEALTH INSURANCE COVERAGE, *supra* note 1, at 218.

21. See generally ALAN GUTTMACHER INSTITUTE, UNEVEN AND UNEQUAL: INSURANCE COVERAGE AND REPRODUCTIVE HEALTH SERVICES 1 (1993).

22. See *id.*

23. See HEALTH INSURANCE COVERAGE, *supra* note 1, at 218.

24. See *id.*

likely as men to become uninsured,<sup>25</sup> largely because a woman's job history is more likely to be punctuated with job interruptions that are related to non-disabling chronic diseases.<sup>26</sup> When this happens, especially among women who are unmarried, their household income dramatically falls and they become uninsured. When their income goes back up, they repurchase health care insurance but the insurance that they then purchase often has a smaller benefit set, with greater co-payments and deductibles than they had before. The uninsured spells have a particularly adverse affect on women as they approach retirement. These spells also have a particularly adverse affect on acquiring seniority in jobs, so that women can be eligible for pensions.

Because of the prevalence of costly chronic disease in older women, there is a regressive relationship between an older woman's health care insurance as she experiences greater longevity and declining resources.<sup>27</sup> Older women are disproportionately likely to be poor but, more importantly, they are older and poorer for a longer period of time than men. Women are half as likely as men to have pensions, and their pensions are half as big,<sup>28</sup> making them much more likely to depend on spouses' pensions. Understandably, a woman is three times as likely to be impoverished when her husband dies than is a man whose wife dies.<sup>29</sup> One other interesting consequence of a woman's greater longevity is in the case of the provision of home-care services: Women are more likely to have to purchase home-care services, whereas older men are more likely to receive such services from their spouses.<sup>30</sup>

Differences in financial situations and longevity profoundly affect health care insurance for women and men. First, the Medicare system, which is universal health care insurance for people over 65 years of age, has a benefit set that is better designed to fit a man's older life cycle than a woman's older life cycle.<sup>31</sup> For example, women have more chronic disease and, therefore, more need for

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25. *See id.*

26. *See* G.A. Jensen, *The Dynamics of Health Insurance Among the Near Elderly*, 30 MED. CARE 598-614 (1992).

27. *See* R.N. Butler, *On Behalf of Older Women – Another Reason to Protect Medicare and Medicaid*, 334 NEW ENG. J. MED. 794-96 (1996).

28. *See* J. Dimeo, *Women Receive the Short End When It Comes to Their Retirement Pension Incomes*, PENSION WORLD, Oct. 1992, at 1.

29. *See* HEALTH INSURANCE COVERAGE, *supra* note 1, at 218.

30. *See id.*

31. *See id.*

adaptive aids like wheelchairs. Women have more outpatient care needs, including things like physician visits for mammograms. They tend to be on a greater number of outpatient medications for conditions like arthritis and depression. They have a much greater use of community services and nursing home care. At the same time, these are the services and treatments that Medicare substantially under-covers.<sup>32</sup> On the other hand, older women are less likely to rely on hospital care, which is where the Medicare benefits are centered.<sup>33</sup> Men use about five percent more hospital care than women. The net of this can be looked at either in terms of service patterns or in terms of an economic allocation of resources per beneficiary year: Medicare pays out twelve percent more for a male beneficiary than it does for a female beneficiary.

One of the main features of insurance for older people is that people often will buy a supplemental policy to cover some of the holes in Medicare coverage – physician payments, direct payments, and so forth. There are two primary sources of health supplements to the Medicare benefit: so-called “Medigap” policies and pension-based insurance policies. Men, as we have seen, are twice as likely to have pension-based benefits.<sup>34</sup> Furthermore, they have more financial resources to take into retirement, so they are more likely to be able to purchase Medigap policies if they do not have pension services. Women, with fewer personal resources, are both less likely to have pension-based services and more likely to need to purchase out-of-pocket Medigap policies.<sup>35</sup> Hence, though the number of older people without Medicare supplemental policies is increasing, it is increasing faster for women than for men.

Medigap and pension policies differ. Pension policies determine eligibility for health care services with the same criteria as conventional insurance uses, whereas the Medigap policies use a much tighter Medicare-based determination of eligibility.<sup>36</sup> Thus, in terms of determining eligibility for the same service, men are more likely to receive coverage for that service from a pension-based policy than women are from a Medigap policy. This means that the woman either must buy that service privately or go without.

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32. *See id.*

33. *See id.*

34. *See* M.A. Morrissey, *Retiree Health Benefits*, 14 ANNUAL REV. PUB. HEALTH 271-92 (1993).

35. *See id.*

36. *See* G.A. Jensen & M.A. Morrissey, *Employer-Sponsored Post-retirement Health Benefits: Not Your Mother's Medigap Plan*, 32 GERONTOLOGIST 693-703 (1992).



Furthermore, the Medigap policies have less outpatient care coverage and are much less likely to cover drugs without a very large premium adjustment.<sup>37</sup> They also do not cover things such as eyeglasses, hearing aids, and dental services.<sup>38</sup>

There are two fascinating studies that look at gender and the Medicare payment system itself. One was done by the American College of Obstetrics and Gynecology, which is a group of surgeons who perform reproductive surgery. They studied Medicare reimbursement for procedures of comparable difficulty in men and women: external genital biopsies and surgery on internal pelvic organs.<sup>39</sup> They found that Medicare reimbursement was substantially higher for the procedures of comparable difficulty that were done on men than on women.<sup>40</sup> This affects the quality or range of surgeons that women can go to, and it affects the amounts women pay when they have procedures with deductibles. Additional studies of reimbursements for other conditions that are of comparable treatment difficulty for men and women need to be done but have not yet have been undertaken. Another study looked at the ten most common conditions that were treated within Medicare in which there was consensus on the appropriate treatment. Three or four of the highest out-of-pocket costs after Medicare/Medigap reimbursement were conditions that are seen more frequently in women – conditions like arthritis and depression.<sup>41</sup> On the other hand, of the five conditions with the lowest out-of-pocket costs, four happened to be conditions in which the disease was more common in men, such as hypertension.<sup>42</sup> These studies suggest that there is a problem with the way that Medicare reimbursement is structured, in addition to the overall way that Medicare is designed for men's and women's life cycles.

Medicaid is where the gender drama of these differences between health care access for men and women is finally played out. In contrast to the Medicare system, which is paid for by federal dol-

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37. *See id.*

38. *See id.*

39. *See id.*

40. *See* P. Cherouny & C. Nadolski, *Underreimbursement of Obstetric and Gynecologic Invasive Services by the Resource-based Relative Value Scale*, 87 *OBSTETRIC GYNECOLOGY* 328-31 (1996); W.B. Harer, Jr., *Gender Bias in Healthcare Services Valuations*, 87 *OBSTETRIC GYNECOLOGY* 453-54 (1996).

41. *See* E. Abel & S. Sofaer, *Older Women's Health and Financial Vulnerability: Implications of the Medicare Benefit Structure*, 16 *WOMEN'S HEALTH* 47-67 (1990).

42. *See id.*

lars, the Medicaid system is paid for by much more constrained state dollars on a matching basis. About sixty percent of people on Medicaid are women,<sup>43</sup> and there has been a spectacular growth in the number of people on Medicaid in the last several years. Some of that is due to an increase in pregnant women with kids,<sup>44</sup> and some is due to the growing numbers of uninsured or “dis-insured” women in the working age population. As employers have become less and less inclined to offer health insurance to their employees, Medicaid has expanded.<sup>45</sup> Furthermore, the rate of private insurance for children is deteriorating even faster than the rate for adults – reflecting the singular drop out in terms of coverage for dependents. But, this “access-expanding” piece of Medicaid, as it is sometimes called, is not the primary cost inflator. The cost inflation in Medicaid is occurring largely due to the expanding number of chronically-ill elder people, including nursing home residents, who are impoverished because of their diseases.<sup>46</sup>

This dynamic has a particular implication for women in health care insurance in the United States: Non-elderly women face shrinking insurance and regressive premiums, particularly for dependents. They also face the increasing likelihood of being single parents and not being carried as dependents on men’s health care insurance. Meanwhile, an increasing number of chronically-ill and poor, older women are coming into the Medicaid system. These older women are poorer because of their job histories and widow-ing. They are being driven onto Medicaid by regressive financing in Medigap policies and Medicare coverage. Thus, younger women – mainly those working in the service industry and having children – are competing with older, aging, and impoverished women within a Medicaid budget that is fixed and finite, because it is constrained by states’ rather than a federal budget.

One could ask of any health care reform, to what extent does it reduce unequal access to adequate insurance? To what extent does any new effort of private system health care reform reduce the vulnerability to cuts in public programs?

For example, consider medical savings accounts (MSA). A

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43. See generally Steven Miles & Kara Parker, *Men, Women, and Health Insurance*, 336 NEW ENG. J. MED. 219 (1997).

44. See *id.*

45. See generally J. HOLOHAN ET AL., *THE CHANGING COMPOSITION OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES I* (1994).

46. See J. Holahan et al., *Explaining the Recent Growth in Medicaid Spending*, 12 Health Aff. 177-93 (1993).

medical savings account works like this: I, the employer, would insure you, the employee, with a \$3000 to \$5000 deductible policy. You would have the option of putting some of your salary into a tax-free savings account which, if you did not spend it for health care, you could keep as a tax shelter and essentially an IRA-type account. From the standpoint of a richer, more likely male workers, there would be an incentive to maximize the tax savings and to maximize the degree to which they could put assets that can grow into a tax-sheltered account, while using extra personal income to continue to purchase out-of-pocket health care services. On the other hand, a low-income, more likely female worker would be unable to use the service in that manner, and she would be using money from that account to pay for primary health care. If you are working at \$6.00 per hour and your child gets a \$60.00 ear infection, you take the money out of the medical savings account. If you earn \$60,000 per year, you pay cash and allow the account to grow tax-free. A low-wage worker who wants to build a nest egg has an incentive to risk her child's ears. Thus, the MSA magnifies, rather than amends, the relative disadvantages that women already face in work-based health insurance.

Gender-based inequalities within the United States' health care system can be attributed to three main features of the system. First, health care is provided through separately-financed sub-systems for providing health care rather than within some sort of overarching framework. Within these sub-systems, the coverage inequalities reflect a gender-based insensitivity to the life perspectives of women as seen by those who designed employer benefits, by those who are in charge of unions, and by the largely male legislators who designed the Medicare benefit set. Second, these inequalities exist because the health care system is tied so strongly to the voluntary contributions of employers in a system where men and women do not have equal income opportunities. Unequal access to health insurance is a natural consequence. A third feature relates to gender categories in various insurance structures themselves. In many areas of the country, women must pay more than men for health care insurance which means that proportionately fewer women are insured.<sup>47</sup> Equal access to health care depends

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47. Five years ago in Minnesota we noticed that women of working age were charged forty to sixty percent more than men for individual and small group policies – ostensibly because women got pregnant and men did not. Since these pregnancies were largely cooperative endeavors, that type of insurance structure

upon the confrontation and resolution of these issues by the health care system and by policy-makers.

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basically represented state-permitted abandonment of pregnancies and of fathers' responsibilities. When we proposed a law to prohibit the practice, one legislator asked, "Don't you think that will make insurance harder to get for men?"

