Getting the Right Services Covered by Health Insurance

Dean G. Smith, PhD

Quality care has been defined as providing the right services to the right patient at the right time and place. Health insurance can support the provision of quality care by offering meaningful coverage of the right services for the right patient—perhaps even at the right time and place. Defining what's "right," however, is a critical step in the process.

Health insurance traditionally has offered coverage for services that are generally accepted to be associated with improved outcomes. The advent of managed care brought about a greater scrutiny of the association between medical services and health outcomes, and evidence-based medicine has started to provide a knowledge base from which to examine this association.[1] We have made substantial progress in offering coverage for services that are generally associated with improved outcomes.

The value-based insurance design (VBID) movement seeks to push traditional coverage on 2 fronts: (1) beyond yes/no decisions on coverage to gradients based on value and (2) beyond generalities to specific expectations of outcomes for the right patient. If a treatment is impressively effective in improving health outcomes, but is not provided or adhered to because of health insurance reasons, VBID suggests that enhanced coverage should be provided to encourage patients to do the right thing. Recent evidence shows that this enhanced coverage is possible in specific instances.[2] Conversely, if a treatment has little effect on outcomes, limited coverage should be provided to discourage patients from doing the wrong thing. Beyond yes/no decisions (and within the constraints of avoiding unreasonably complex plan designs), coverage should match the value offered by the service to a patient with a particular condition.

A good examination of the available information doesn't bring us much closer to the goal of providing a complete matrix of coverage for a given treatment based on value and patient conditions.[3,4] Comparative effectiveness research (CER) is much more likely than prior clinical research to include comparisons across treatments that are meaningful to payers. Ensuring that comparisons consider patient conditions and stratify outcomes will require vigilance.[5]

Comparative effectiveness research recognizes the importance of costs, although ensuring that analyses include costs also will require vigilance. The recent Institute of Medicine report on priorities for CER included cost comparisons for 19 of the 100 conditions.[6] A further requirement of research for the VBID application of CER will be identification of treatments that are sensitive to patient cost sharing.

At a high level, VBID may be applied to a yes/no coverage decision. Applying gradients of coverage based on value requires that patients respond to cost sharing at meaningful levels. A clearly high-value or low-value treatment that already has 95% or 5%, respectively, selection and adherence would not benefit from a VBID approach. Although development of a clinical and economic information base will take time and resources, it is feasible. Tuft's Center for the Evaluation of Value and Risk in Health is a public service aimed at making such information available (https://research.tufts-nemc.org/cear/Default.aspx).

Successful implementation of VBID requires both information and courage. I suggest that the larger challenge is finding the courage to conduct the research and to implement coverage based on the findings. Among the elephants in the room is the relationship between the profitability of treatments and their outcomes. Administrators would be loath to talk about it publicly, but certain services are more profitable than others. Even before the seminal work of Siu et al,[7] we knew that a considerable percentage of hospitalizations are unnecessary. Strict adherence to the evidence-based medicine that is encouraged through VBID may require rethinking our delivery systems. Our delivery systems may not be prepared for VBID.

Nearly a decade ago managed care was making yes/no coverage decisions and moving beyond generalities to assigning expectations of outcomes for specific patients. Granted, the information base for those decisions may not have been ideal and the tools may not have been in the right hands. The backlash against managed care highlighted the limitations of our information. More notably, that backlash highlighted our discomfort with making difficult decisions.[8] A new era of VBID may require that medical directors contact patients about coverage, as opposed to speaking only with physicians.

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Making coverage decisions on the basis of value for specific patients involves many challenges. Yet we must go down that road. With increased expenses for health insurance, pressures for reforming not only the availability but also the nature of coverage will rise. I hope that we find the courage to provide quality healthcare that is covered in a quality way.

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Address correspondence to: Dean G. Smith, PhD, Department of Health Management and Policy, University of Michigan, 109 Observatory, Ann Arbor, MI 48109-2029. E-mail: deans@umich.edu.

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