

Why Well-Insured Patients Should Demand Value-Based Insurance Benefits

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VARIATIONS ON THE FAMILIAR REFRAIN “COSTS SHOULD not factor into decisions about health care” permeate contemporary discussions on the state of the US health care system.¹ The US populace seems to strongly agree with this proposition: a 2003 poll indicated that 86% of US citizens do not support the denial of health services for reasons of cost.² A significant part of this resistance can be attributed to the general feeling that health care services are a special good, the provision of which should not be “unfairly” influenced by costs.³ In particular, patients with good health benefits often suspect they personally have nothing to gain—and much to lose—by integrating costs into coverage determinations.

These beliefs are short-sighted and mistaken. Health insurance coverage uninformed by cost considerations already poses harms to insured patients and will pose an even greater threat as health care spending soars. All US citizens, even those with excellent health care insurance, should demand value-based insurance, in which health benefits are designed to reflect the underlying ratio of associated costs and benefits for the services covered.⁴

High Stakes of Health Care Costs

The need for value-based health insurance directly reflects the perilous situation of health care spending in the United States. Health care costs represented only 5% of the gross national product in 1950, but now account for 16% of the gross national product, or more than \$2 trillion; by 2016, these costs will consume \$1 of every \$5 of the nation's total output.^{5,6}

Although many complex factors play a role in these increases, the major contributor is the constant introduction of expensive new medical technologies, including new drugs, devices, and procedures.⁷ While some of these expensive new innovations represent significant advances in diagnosis and treatment, other new interventions may not be superior in any way to existing options or may provide only small, marginal improvements. Unlike other developed countries, the United States has no system in place to judge the clinical, cost, and comparative effectiveness of new technologies. Individual US health insurance companies and other private

entities have been likewise hobbled in efforts to distinguish useful new interventions from less useful ones. With very few exceptions, both public and private insurers in the United States cover and pay for any beneficial new technology without considering its cost in relation to the degree of additional benefit it provides over alternatives.⁸

Several examples illustrate this unacknowledged disconnect that often occurs between the marginal benefits and the costs of new technologies. A recent long-term study of schizophrenia medications indicated that second-generation antipsychotics, despite costing 3 to 9 times more than existing antipsychotics, were no more clinically efficacious on average than their predecessors.⁹ Cetuximab, a treatment for metastatic colorectal cancer, costs approximately \$40 000 for an average course of therapy that cures no one and extends median survival by only 1.7 months.^{10,11} Similarly, bevacizumab, also used to treat metastatic colon cancer, extends median survival for an additional 2 to 5 months at a cost of approximately \$50 000 for an average course of therapy.^{10,12} Despite their marginal value, these treatments are routinely covered by health insurance companies.

While some new medical innovations provide significant benefits to patients and even reduce overall health care costs, many new interventions do neither. By foregoing considerations of costs in relationship to benefits, current health insurance designs do little to distinguish health care interventions that are valuable from ones that offer little more than higher prices. Failing to explicitly include cost-benefit considerations in a framework for health benefits creates a pattern of imprudent and wasteful spending, fueling the escalation of health care costs.

High Stakes of Health Care Costs for Insured Patients

Many insured patients assume that this explicit inclusion of cost considerations will mean only the denial of services to which they were previously entitled; accordingly, they may believe it is in their best interests to fight for health insurance coverage that guarantees full access to every possible service, no matter how marginal its benefits or high its cost.¹³ However, this resistance to value-based insurance ignores the looming undesirable consequences for all US citizens, including the insured.

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See also p 2518.

Practical Consequences. First, there is the threat of losing insurance coverage. Higher costs force health plans to raise their premiums—for example, health insurance premiums for small firms are increasing at the rate of 15% annually, 6 times the rate of general inflation.¹⁴ This escalation reduces the ability of individuals to afford private coverage and leads employers to discontinue health benefits altogether. Thus, as health care costs increase, rates of insurance coverage decrease—for every 1% increase in health care premiums, an estimated 300 000 to 400 000 Americans lose coverage (John Sheils, MS, written communication, May 9, 2007).

Second, even for those individuals who retain health insurance, increased costs are leading to the elimination of family coverage, increases in deductibles and co-payments, and the abolition of entire categories of covered services.¹⁵ Between 1999 and 2005, workers' co-payment contributions for family coverage increased 75%, while the amount paid in deductibles increased 500%.¹⁶ These trends will make it increasingly difficult for many currently insured patients to obtain adequate health care in the future.

Third, spiraling health care expenses lead to reduced spending for programs that affect other aspects of patients' lives. Because more must be spent on Medicare, Medicaid, and government employee coverage, states compensate by reducing public education budgets, scrapping construction projects, and generally cutting funding for nonhealth initiatives. Given increasing Medicaid costs, for instance, policy analysts see no end to hikes in state university tuition such as those seen in North Carolina, where in-state tuition increased more than 71% in less than a decade as Medicaid costs increased by \$1 billion each year.¹⁷⁻¹⁹ Even individuals unpersuaded by eroding health care benefits should be concerned with the potential for health care costs to displace other valuable public projects.

Ethical Consequences. Beyond self-interest reasons, insured patients also have a moral responsibility to endorse value-based insurance benefits. Loss of coverage due to increasing insurance premiums disproportionately affects low-income individuals who are least able to pay for health care on their own, further increasing the inequitable income and resource disparities in US society.

In addition, there is a moral imperative to work toward providing essential health care for all US residents. With current spending patterns, it becomes increasingly unlikely that the United States will ever marshal the resources necessary to extend coverage to its 46 million currently uninsured residents.²⁰ Refusing to discriminate by value in health benefits severely limits efforts to build a sustainable infrastructure of universal coverage for the United States.

Designing Value-Based Insurance Benefits

Given the serious threats posed by rapidly increasing health care costs, all Americans, insured or not, ought to demand the use of value as a basis for health insurance benefits. This demand can be translated into action only with a trustworthy process

to determine the value of health technologies and to integrate these findings into the design of health insurance benefits.

The United States currently lacks an authoritative, independent entity specifically charged with determining the value of health care services by assessing their comparative clinical effectiveness and cost-effectiveness. International examples, such as the National Institute for Health and Clinical Excellence in England and the Pharmaceutical Benefits Advisory Committee in Australia, have demonstrated how this task can be successfully managed with rigor, objectivity, and transparency.²¹

But how should insurance benefits be modified to reflect comparative value information about a new technology? To many, this path raises the specter of rationing, which is often vilified for its absolute denial of specific services. However, data on the value of new interventions need not be used for dichotomous, all-or-nothing coverage decisions. Instead, such information could guide the creation of a system of financial incentives, which would promote the use of high-value interventions but discourage—but not prohibit—the use of low-value, marginal interventions.

On one end of the spectrum, interventions that are highly effective and that reduce overall health costs could be covered without co-payments or deductibles.²² This would make ultra-cost-effective interventions—such as β -blockers used following myocardial infarction or angiotensin-converting enzyme inhibitors used for congestive heart failure—even more accessible than they are now.

At the opposite end, low-value services that provide only marginal benefit at high cost, such as spinal fusion surgeries for herniated disks,²³ would have high co-payments or other forms of cost-sharing to reflect their limited value in the patient population. This strategy has already been incorporated into many drug formularies: insurers often assign minimal co-payments for generic drugs while implementing greater cost-sharing for brand-name versions of the same drug. Comparable drugs, with comparable benefits but largely differing costs, are among the most obvious and legitimate situations in which value should be made part of insurance benefit design. But this approach also can be extended to procedures, diagnostic services, and medical devices.

By incorporating comparative value, insurers would be able to create a variety of coverage packages, ranging from “gold” essential services packages, which would chiefly cover treatments of proven high value, to more expensive “platinum” packages, which also would provide coverage for services of marginal value. Individuals would still be able to purchase coverage for marginally beneficial interventions via the platinum plan, but would have to use their own money to do so. Thus, the real costs of low-value treatments would be transferred to subscribers in the form of higher premiums.

Objections to Demanding Value-Based Insurance

Several objections to the demand for value-based insurance must be considered. One objection is that “value-

based health benefits results in inequitable, 'tiered' health care access, in which the rich can purchase treatments that are unavailable to the poor."

Value-based tiering is more ethically justifiable than the current situation, in which millions of less privileged members of society lack access to essential health care. Additionally, given that public resources are scarce, justice does not require providing everyone in society with access to every possible health technology. Justice does, however, require freedom for individuals to spend their resources as they see fit, provided they do not harm others. As long as the services offered in the essential benefit package represent quality care, with the higher tier(s) adding only services of marginal benefit and high cost, a tiered system adheres to the principles of justice.²⁴ Already in the United States, this view is incorporated in many drug formularies without moral worry.

Another potential objection is that "making value assessments based on population data may result in depersonalized health care." In certain situations, the value of an intervention could be low for most patients but high for a particular individual, given the patient's unique clinical and personal characteristics. The clinical features of a particular patient with schizophrenia, for example, could make a second-generation antipsychotic agent substantially more beneficial and valuable than for the average patient.

Having more data on clinical and comparative effectiveness will allow physicians to pinpoint more precisely the type of patients for whom certain new technologies represent a significant value, thereby avoiding the inappropriate application of generalized assessments to the individual. Furthermore, in cases of continuing disagreement, good appeals processes should be able to address this issue, just as they do for tiered drug formularies. Generally, however, while acknowledging a heterogeneous population, value-based insurance benefits must fundamentally rely on the argument that patients should be willing to pay more out of their own pocket for services that they personally value but that represent a poor value for the population.

A third objection is that "limiting access to marginal interventions should wait until entirely wasteful spending in the system has been eradicated." Efforts to identify and limit wasteful health care spending will help reduce unnecessary uses of collective health resources. However, the United States cannot afford to wait for the elimination of wastefulness before implementing value-based health insurance. The ill effects of unchecked spending are already burdensome and will worsen before such a process can be completed. Even in an ideal, perfectly efficient health care system, collective resources will always be finite, and most of the escalation of health care costs is attributable to spending on expensive new technologies, not to wastefulness.⁸ Moreover, eliminating waste results in a one-time savings that would lack a long-term impact on cost inflation. Accordingly, the elimination of waste and the elimination of spend-

ing on low-value, marginally beneficial care are complementary and should occur simultaneously, not sequentially.

Conclusions

It is becoming increasingly apparent that there are limits to the amount of money that can and should be spent on health care, and that bypassing these limits has significant negative consequences for many groups, including insured patients. Rather than railing against these limits, insured patients ought to embrace ways that allow those finite resources to be used efficiently. Encouraging the assessment of the value of interventions and the integration of this information into transparent insurance benefit designs will enable the expansion of health insurance to all US citizens and ensure the best health care for every dollar spent.

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Managing Medical Resources Return to the Commons?

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THE INEXORABLE INCREASE IN HEALTH CARE COSTS, seemingly impervious to most market-based attempts at amelioration, has led to a growing interest in measuring efficiency of health care as a key component of quality of care.¹ Although there have been creative attempts by the insurance industry to develop meaningful efficiency measures, physicians are suspicious that payers are concerned only about the cost component and not about the quality component when measuring efficiency.² But, in addition to questions about the method and accuracy of measurements of efficiency, an underlying set of concerns have been expressed by the physician sector of the health care provider community regarding their role in managing health care resources, concerns that stem from the deep and profound roots of medical ethics.

The Physician's Charter on Medical Professionalism maintains that among other responsibilities, physicians must be committed to managing medical resources.^{3,4} This responsibility is controversial largely because it can be seen as in conflict with the more traditional altruistic commitment of the physician to the patient. Moreover, control of cost is inextricably linked to the business interests of insurers. Physicians ask, is this really our responsibility?

The answer is yes. Physicians cannot afford to ignore the profound logic of the link between care for individual patients and the costs of care. The more care costs, the more likely many individuals will be without good insurance, and research clearly shows their health will suffer.⁵ It is impossible to avoid the fact that physicians live and work in a medical commons and bear responsibility for it.

Ethics of the Medical Commons

The traditional core value of medicine is the primacy of the patient's well-being over the self-interest of the physician and implicitly over other social concerns as well. This is desirable, if one realizes the proprietary potential of the patient-physician relationship and the fundamental inequality of knowledge and power when a patient who is very ill seeks help from a physician. When in dire situations, most patients would like their well-being to be at forefront of their physicians' concerns.

In the United States, this disconnect between responsibility over the management of resources and responsibility to the individual patient is made even greater by the historical disconnect between the public health sectors and the world of medical practice. This is no accident: as Starr⁶ pointed out more than 20 years ago, the allopathic profession worked hard to assert its control over medicine and eschewed public health models while championing fee-for-service payment.

In addressing the fundamental ethical conundrum of managing resources, Hiatt adapted in 1975⁷ Hardin's "Tragedy of the Commons"—which posited that the commons would be destroyed should every farmer let his or her livestock graze freely—as an analogy for the erosion of the health care system under the fee-for-service model, powerless to curb the unrelenting increase in health care costs. However, he believed that physicians should not be the ones setting limits on resource utilization; rather, that task should fall to "society." He believed—even as a public health physician—that the individual patient-physician relationship should take primacy, acknowledging that although limits do need to be set, these limits should be set by some larger social force—perhaps by establishing a global budget for health care or guidelines for utilization.

A decade later, but still well before the managed care revolution and counterrevolution, Daniels⁸ suggested why saying no in the United States is so difficult. He argued that physicians do not have "moral agency." The fee-for-service model does not allow physicians to affect where saved resources go, so why would they try to avoid costly interventions in the name of helping other patients? The key insight is that the physician is not part of a commons. Indeed, the physician has no assurance that any money saved would even go into expanding health care but rather might go to paying off the deficit (in a publicly funded system), or to profit margins of corporate entities (in a privately funded system). This is one of the pitfalls of what Daniels called "bedside rationing"—that restricting marginally effective imaging studies will not allow that physician to ensure that more children are immunized or that health insurance is made more available to the uninsured.

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