Practical Reform For The U.S. Health Insurance System

by John P. Cookson

Health Coverage—Some Background

Continuing cost increases for health coverage represent a major problem for many if not most of us. However, the long-term continuation of the excess growth rate of the health care economy versus the rest of the economy has the potential makings of a major crisis.

A key problem with affordability is the lack of flexibility in health insurance. Some of this is due to legislated mandates such as mental health and maternity coverage, and court or regulatory rulings requiring coverage of services like bone marrow transplants for breast cancer, for example. In effect, buyers—employers and other premium payers—have little say in what they do and do not want to cover. And, once something becomes a covered service, it is more or less covered for everyone. This process exaggerates the affordability issue because the purchaser cannot choose what services they cannot afford and/or are unwilling to cover. The only alternative to some employers is to drop coverage altogether.

Changing the dynamics of the system could have a significant effect on lowering the future costs of health care. This would primarily require two actions: 1) a significant improvement in the measurement of cost, quality and efficacy of medical treatment and dissemination of this information to consumers; and 2) a change in the insurance structure to reduce or eliminate the third-party payment for high-cost, low quality providers and treatments that are of unproven or dubious efficacy, and allowing buyers to select coverage based upon the perceived cost of services in relation to the outcomes. This would likely require the establishment of a health care research organization that provides unbiased information on the cost, quality and efficacy of providers and treatments.

Non-Scientific Based Medical Care And The Supply Driven Health Care System

The health care system is a supply driven system, and physicians are responsible for control of and ordering most medical care services. Contrary to what many might think, much of the health care delivered is not based on hard scientific studies and sometimes is even based on fallacious interpretations of statistical data.

Some studies indicate that as much as 35 to 45 percent of prescriptions may have no effect on the disease for which they are prescribed and that as little as 10 percent of diseases are significantly influenced by modern treatment. Substantial portions of recoveries or physical improvements during treatment are likely due to the placebo effect or our bodies' natural healing processes.

The diagnosis and treatment of high cholesterol illustrates these problems. A substantial portion of the adult population is considered borderline high risk or above in total cholesterol and could be considered lifetime candidates for statin drugs. However, for otherwise healthy individuals with high or borderline high cholesterol and no other cardiac risk factors (the vast majority of those with high cholesterol): 1) their cardiac mortality risk is really lower than the public is led to believe; 2) the potential reduction in mortality from taking statins is quite minimal in absolute terms; and 3) any mortality reductions are not statistically significant. On the other hand, for those who have had a previous heart attack, reductions of 3 to 3.5 percent in total mortality over a five-six year period have been found.

Another area of questionable use of scientific evidence relates to the high percentage of false positives occurring during preventive screenings. These false positives necessitate additional testing or procedures on the patient, which can lead to significant anxiety and cost for those wrongly diagnosed. The claimed benefits of undergoing these screenings are generally based on assumed reductions in relative mortality risk (for example, 30 or 40 percent reduction, or some other large number, in dying from breast cancer). However, absolute mortality risk reductions—for those of average risk—are fractions of 1 percent over a decade. In effect, the statistics show large percentage reductions in what are otherwise very small numbers.

Finally, the fact that much of medical care is still reimbursed on a fee-for-service basis sets up an inherent vested interest by providers in recommending more frequent and more expensive services, or services that are more convenient for the provider, irrespective of the presence of any evidence of efficacy.

Variation In Health Care Cost And Quality

Significant variability of costs by area has been demonstrated, even when controlling for differences in illness burden. In these studies the variation is often attributed to excess supply of hospital beds and specialists, and higher cost is often associated with lower quality. For years, my own research about variation in efficiency and pricing of hospital services shows significant variation at the provider specific level, even within geographic areas, and the results show that the lower quality hospitals tend to receive higher relative reimbursement and also tend to be less efficient at delivering care. The marketplace is effectively rewarding inefficiency and lower quality.

The Solution

The identification of the problems contributing to excess health care costs also represents the potential framework for the solution. Consumers must be made more responsible for their own care and must be provided the tools and information they need to choose wisely. The providers must then adapt to the new realities by becoming more efficient and focusing on improving quality. Some details of the needed changes are as follows:

1. Development and Dissemination of Information to Consumer and Payers

   This process is important and has two key requirements:

   a. An independent agency (independent of politics, as well as health care providers and insurers), such as a Consumer's Bureau for Healthcare, needs to rigorously review the scientific and statistical bases of both old and new treatments to classify those which are truly efficacious, and those that are less so and/or harmful. Evidence-based medicine and valid statistical techniques should be the primary drivers of such determinations. Such an agency should also be the repository for quality information on providers. This agency is necessary so that payers can obtain the evaluations from an independent agency on which to base their coverage decisions. Such an agency needs to be independent of government influence because of the tendency for governments to mandate coverage for many medical services of unproven value and efficiency.

   b. Provider's performance must be compared to each other on a case-mix, severity-adjusted basis on the variables of cost, quality, efficiency and outcomes.

2. Plan Designs and Coverage

   Changes in plan design need to incorporate the proper incentives for consumers to use care wisely and spend effectively. These changes will force providers to compete in new, more appropriate ways.

   a. Truly efficacious medical care treatments should be covered generously by insurance and third-party payments. These could form the core of insurance coverage. Care that is speculative and/or harmful should not be covered, or covered to a much lesser degree at the option of the premium payer. Controlled clinical studies or other experimental procedures could also constitute an additional monitored class, with its own method of perhaps pooled reimbursement.

      Traditional out-of-pocket insurance limits need to be removed on the non-efficacious services. Otherwise, these services will be overused once the out-of-pocket limits are met.

b. In addition, insurance/third-party payment levels must also recognize cost, quality and efficiency differences by provider. The consumer must be made to bear the economic consequences—through the reimbursement mechanism—of choosing higher cost, less efficient and/or low quality providers.

These actions would more directly involve consumers in their health care decisions, and level the playing field on the knowledge gap between consumers and payers vis-a-vis the providers. Furthermore, this would change consumer behavior and put tremendous pressure on the inefficient, lower quality/higher cost providers to compete. Such action would also reduce the costs of health care while improving quality and should help control the long-run rate of growth, because efficiency, cost effectiveness and quality will become the focus of competition by providers.

Let's assume that half of current medical services will satisfy that high quality, cost effective and efficacious level of care. Also, assume one-fourth would be classified at a low level and one-fourth at the middle level. Let's also assume the first level would be covered at 90 percent, the middle level at only 50 percent and the low level would be covered at only 20 percent. Not only would the payment levels be lower, but utilization on the lower two levels would also decrease, while perhaps increasing on the higher level. Let's further assume the following: mid-level coverage utilization is reduced by 20 percent; low-level utilization is reduced by 80 percent; and the high coverage level increased by 20 percent. This scenario could reduce claims cost levels by 30 percent from what they would be under current typical plan designs. Furthermore, additional savings would accrue from the improved quality and cost transparency. These are only hypothetical assumptions, and demonstrate the potentially significant impact of such changes.

This demonstrates that reasonable changes to the health care system that align incentives with quality and efficacy can produce significant savings to the system.

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