Coverage and Payment for Healthcare Services: Narrower Options for All?

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That the U.S. health care system is in “crisis” seems to be a foregone conclusion. A lack of access to insurance and healthcare coverage is one of the main features of the current healthcare crisis according to health policy experts. Although there was little disagreement among the major Presidential candidates that something needed to be done about the fact that more than 40 million Americans had no health insurance, there was also an unfortunate tendency to collectively talk about uninsured Americans as if they were a homogeneous group of individuals. The 40 million Americans with no health insurance are an extremely heterogeneous group, with very different reasons for being uninsured. Some can afford health insurance but chose not to purchase it (e.g. healthy young people); some want health insurance but can’t afford it (the working poor earning too much to qualify for Medicaid and but not enough to purchase employer-based insurance); some are simply unable to obtain insurance because of pre-existing medical conditions which exclude them from coverage; and, at least compared to the relative costs in other countries, healthcare insurance coverage is expensive in the U.S.

The situation is also aggravated by the fact that, unlike almost all other Western countries. The U.S. has no government-sponsored universal health insurance plan. Outside of federal health coverage such as Medicare or combined federal-state coverage such as Medicaid, almost all other health insurance in the U.S. is employer-based, whether it is family, or group health insurance coverage. Even without the added pressure of the current economic downturn in the U.S. economy, the costs for group health insurance have become increasingly burdensome for even large employers. The costs of health pension plans for its workers is cited as a major reason why the U.S. automobile industry is no longer as competitive as it used to be, and recent efforts by General Motors and others to survive the current economic downturn revolve around efforts to curtail the long-term health care insurance obligations they have to their former employees. Even corporations with good economic prospects feeling the burden of trying to provide

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4 William Snyder, What Do We Really Know About the Uninsured?, THE WALL STREET JOURNAL, November 21, 2008 at A23.
5 Alain C. Einthoven, Wynand P.M.M. van de Ven, Going Dutch – Managed Competition Health Insurance in the Netherlands, 357 N. ENGL. J. MED. 2421, (2007).
employer-based health insurance system, and are now offering workers fewer healthcare plans to choose from, often with higher deductibles.\(^7\)

President-elect Obama and his team of health policy advisors clearly recognize the gravity of the situation. Yet, it is not clear whether their approach is necessarily the correct one, as the major difference between the health plans proposed by Senator Clinton and then-Senator Obama was over the issue of whether everyone should be required to have and maintain health insurance.\(^8\) Although President-elect Obama has indicated that he wanted to be certain that insurance was both affordable and available to all before considering a mandatory health insurance requirement,\(^9\) Senator Clinton may have been right. Certainly, the recent change in position by the insurance industry reflects this reality: only by expanding the risk pool to its maximum size will the insurance industry be able to more readily offer health insurance to all without regard to pre-existing conditions.\(^10\)

**The Problem of Cost**

The enormous and growing number of people without health insurance is not the only thing which sets the U.S. apart from all other industrialized countries; the U.S. is also distinguished by its high health care expenditures.\(^11\) Thus, the second part of the crisis in the U.S. healthcare system is that of cost control. Even if the problem of access were solved in some way – whether by having a federally-sponsored single payor healthcare plan with mandatory participation for everyone regardless of age, income, or health status; a modification of our current employer-based health insurance system so that all workers could obtain affordable health insurance; or some combination of the two, with expansion of eligibility for existing government programs and subsidies for employer-based insurance programs – any program or combination of programs is still going to have to deal with the issues of cost and cost control. Even if access were universal someone would have to pay for the benefits.

Both Presidential candidates were more than a little reticent to talk about the concept of controlling runaway healthcare costs by no longer paying for some of the healthcare services U.S. citizens have gotten used to. Perhaps this was because no one had the nerve to ask such a blunt question even in a televised debate. On the other hand, the recent medical literature\(^12\) on health care reform has not shied away from this issue. Health policy experts have begun to seriously address the issue of run-away demands for

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\(^9\) Id.

\(^10\) Id.

\(^11\) Id.


expensive medical technologies with negligible or marginal benefits.\textsuperscript{14} The fact is that without a determined effort to address the topic or wasteful medical care and run-away medical technologies, efforts to control healthcare costs are likely doomed to failure.

One major reason why the aggregate health costs in the U.S. for private, employer-based insurance as well as for government entitlement programs such as Medicare and Medicaid keep rising is because all of these programs continue to cover progressively more, and more costly, goods and services even though the benefit of such services may be small, marginal, or non-existent. Though technological innovation is only one of several reasons why costs of healthcare are rising faster than income, it may be the main driving force.

Viewed in the harsh light of medical economics,\textsuperscript{15} there really are only three basic ways of dealing with the upward spiral of healthcare costs: spend less on the same items, spend the same on fewer items, or spend less on fewer items.\textsuperscript{16} One proposed solution which is part of all three of these approaches is to decrease costs by controlling “waste” in the U.S. healthcare system, i.e. by delivering more efficient and cost-effective healthcare. Ideally, talk about reducing healthcare costs by getting rid of “wasteful spending” should primarily be about reigning in payments for non-beneficial technology and medical care, but instead tends to devolve into talk about eliminating administrative costs. The primary way President-elect Obama would do this is by eliminating unnecessary paperwork and switching to a system based on electronic health records.\textsuperscript{17} Unfortunately, this is at best only a partial solution, and one which fails to focus on increasingly expensive new drugs and medical technologies.

In Europe, assessing the comparative cost-effectiveness of drugs, medical devices, diagnostic tests, and surgical services is an established fact of life, and a political reality.\textsuperscript{18} Even when direct comparative effectiveness of new, or even established, medical technologies and services is not available, coverage and payment decisions will be made anyway based on whether the health benefit is below a certain threshold such as $50,000 per quality-adjusted life-year.\textsuperscript{19} By any measure, this approach rations healthcare. In the U.S., no one, particularly elected government officials, has wanted to talk about rationing healthcare or even use the word rationing. But, at the end of the day talking about cost containment and regulation of medical technology is ultimately about making coverage and payment decisions which are nothing more than rationing decisions. The reluctance to ration may be changing.

\textsuperscript{18} David, \textit{supra} note 12.
\textsuperscript{19} \textit{Id.}
In the past the Center for Medicare and Medicaid Services (CMS) routinely covered and paid for all new drugs, services, and medical technologies either approved by FDA or adopted by the medical profession. Recently however CMS has stated that FDA approval alone is not sufficient to assure coverage. CMS has stated that it does not consider “cost” of medical technology directly in making its decisions, but CMS decisions are actually a two-step process which do indirectly deal with cost. First there is the coverage decision, then the reimbursement decision. Until CMS determines that a medical service is one it will cover, the issue of payment is not on the table. The standard for coverage is that of “reasonable and necessary”, i.e. items and services will not be covered by CMS if they are not reasonable and necessary for the diagnosis and treatment of illness or injury.\(^\text{20}\)

But, even if CMS decides to cover a service or drug, it has the option of either refusing to pay for it, or to set its reimbursement rate at a level it feels is justified, not at the price sought by the sponsor. There have already been several high-profile instances where companies marketing expensive biological drug products for treatment of cancer were simply told their products were too expensive and would not be reimbursed at the sought-after rate. Under a new administration in D.C faced with a $1 trillion federal debt, this trend will certainly continue, and private insurers will likely follow the federal government’s lead. This approach, coupled with new proposed Congressional legislation\(^\text{21}\) sponsoring comparative effectiveness studies, could actually edge the federal government towards the long-established approach of other industrialized Western nations of considering both price and relative value of medical products and services. Absent this sea-change, even solving the access to care problem of the U.S. healthcare system will not be enough to salvage it.

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\(^{20}\) SOCIAL SECURITY ACT, 42 U.S.C. § 1395y(A)(1)(A). “…no payment may be made under Part A or Part B of this subchapter for any expenses incurred for items or services -1(A) which…are not reasonable and necessary for the diagnosis or treatment of illness or injury…”