

In Focus

The Odds Have It

Benefits managers have long dealt with uncertainty in meeting one of their core responsibilities, how to decide what services their plans should cover and what services they will exclude or cover to a lesser degree. They have been reluctant to cover every service just because a doctor wanted to provide them. In applying this reluctance, benefits managers have usually relied on the concept of “medical necessity”. Take a look at the following definition of medical necessity excerpted from a standard health plan booklet used by one national health plan:

Medically Necessary Covered Services and Supplies are those determined by our Medical Director to be:

- 1) required to diagnose or treat an illness, injury, disease or its symptoms; in accordance with generally accepted standards of medical practice;
- 2) clinically appropriate in terms of type, frequency, extent, site and duration;
- 3) not primarily for the convenience of the patient, physician or other health care provider; and
- 4) rendered in the least intensive setting that is appropriate for the delivery of the services.
- 5) Where applicable, our Medical Director may compare *the cost-effectiveness* Of alternative services, settings or supplies when determining the least intensive *setting*.

Most benefits managers are familiar with the first four elements of this definition. It's the fifth element that contains a relatively new and additional coverage criterion. We mean, of course, the introduction of cost-effectiveness into the definitional mix.

Cost-effectiveness can be boiled down to answering the question raised by the old phrase “Is the juice worth the squeeze?” We didn't use to see cost-effectiveness in definitions of medical necessity. Its inclusion in the definition above reflects not only concern about rising costs but also the fact that studies assessing the efficacy of alternative forms of diagnosis and treatment are increasingly available. The growing body of evidence enables benefits managers to make plan coverage decisions that discourage the use of relatively ineffective, costly and even harmful services.

Nevertheless, the evidence does not always produce easy, unequivocal conclusions. Judgment is required in some cases. The fields are still ripe for informed, active management.

Benefits managers have several places to look for guidance about plan coverage optimization. Here are several:

- The Cochrane Collaboration, <http://www.cochrane.org>. This is an excellent international source of validated medical procedure efficacy.
- Of recent prominence ranking the efficacy of preventive measures is the U.S. Preventive Service Task Force: <http://www.uspreventiveservicestaskforce.org/recommendations.htm>.
- Health care reform is bringing us comparative effectiveness research and the Independent Payment Advisory Board.
- The Institute of Medicine has recently urged that cost-effectiveness be one of the key criteria for “the list” of Essential Health Benefits

They Said It

“Screening is always a double-edged sword. We need to be more cautious in our advocacy of these screening tests.”

Dr. Otis Brawley,
 Chief Medical Officer, American
 Cancer Society,
 New York Times,
 October 30, 2011

Making plan coverage decisions based on the data does not take place in a vacuum. Assertive benefits managers should prepare for potential disagreement, often based on fear and an attachment to conventional medical approaches to diagnosis and treatment. We've certainly seen this in the recent past:

- The outrage directed at the U.S. Preventive Service Task Force when its research up-ended conventional views about the frequency and efficacy of mammograms
- Thanks to new research by U.S. Preventive Task force, "to PSA or not to PSA" is now a good question for men to ask themselves.
- The controversy a couple years ago over vaccinating pre-teen girls with Gardasil. Now we have a similar concern directed at the recommended vaccination of boys against HPV.

It will help benefits managers, their HR colleagues and perhaps employees in general to read the *New York Times* article on cancer screening that appeared in the October 30, 2011 edition:

http://www.nytimes.com/2011/10/30/health/cancer-screening-may-be-more-popular-than-useful.html?_r=1&ref=health. The article encapsulates the whole dilemma.

At the same time, some highly visible plan coverage changes based on objective evidence are taking place, for example, United Health Care's decision to drop coverage of Nexium.

One way to deal with these plan coverage decisions is to default to the government and tell your people, "It's required. We have no choice." Experience shows that this strategy requires a willingness to wait for studies to be conducted, vetted, and recommended, and then survive (or not) the political wrangle that frequently will follow. One consequence of this strategy is that more of your employees and family members will, in the meantime, undergo diagnosis and treatment that is questionable, harmful and costly.

There is a better path - the path set forth by the Preponderance of Evidence. In the real world, we have an example of how reliance on the data can shape plan-wide coverage without denying coverage for services whose efficacy and cost-effectiveness raise questions.

The example is the State of Oregon and how this employer is making coverage decisions based on evidence, (and they are doing it amidst emotion, labor unions and state-house politics). We wrote about Oregon in last month's In Focus. Very simply, Oregon applies special deductibles and copayments to services that research shows to be of questionable efficacy and cost-effectiveness. Oregon also provides online educational content and coaching which addresses the personal risks attendant to listed tests and procedures.

Plan coverage decision-making should reflect independent and rigorous scientific research. Leaving these decisions solely to the government, insurance companies, doctors or employees is not in the long term best interest of your plan members. Making these decisions won't always be easy. If "change agent" wasn't in your job description when you hired on, it may become your Number 1 priority.

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