Basic Health Benefits: Deciding What to Cover

BY JANE H. WHITE

The healthcare reform debate in Washington, DC, and across the country is remarkably wide-ranging; we seem to be leaving no facet of America's healthcare system untouched in the fervor of reform scrutiny. Yet one area stands out in its potential for significant change and political warfare: defining a standardized health benefits package.

Even before the release of President Clinton's healthcare plan, the notion of a standard, uniform, or basic health benefit (depending on your choice of language) had begun to stoke the fires of political and interest group passion. At stake is which provider services are covered and which are not by national health insurance. Rep. Fortney H. ("Pete") Stark said it "may well be one of the most complex and controversial components of any reform plan," in his opening statement for an April 22 House Ways and Means Subcommittee on Health hearing on the subject. Forty-three healthcare interest groups testified at the hearing.

This month I examine some of the ethical, scientific, and political issues surrounding definition of a standard health benefit. I also explore the varying definitions and consequences of a uniform benefit, as currently debated by leading health policy analysts.

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Why a Standard Benefit?

In the current healthcare system, health benefits vary widely across insurers and types of plans—health maintenance organizations, fee-for-service plans, and plans with some managed care. When people are offered a choice among health insurers and plans, true comparison of benefits becomes complex, if not impossible. As Linda Bergthold, chair of the president's working group on benefits, explains, consumers "may be reluctant to choose plans with lower prices for fear those plans have hidden exclusions buried in the fine print. Thus the uniform benefit package both clarifies the price differences among the plans and gives consumers greater confidence in picking plans with lower costs."[1]

Bergthold, who is a principal with William M. Mercer, Inc., a nationwide benefits consulting firm, also pointed to the problem of adverse risk selection when benefits are varied. "If plans can vary their benefits, they likely will modify them to attract low-risk enrollees and avoid those with higher risks. Thus, allowing plans to vary the package will tend to drive out the services that many sick people need most."

The problems associated with risk selection are a driving force behind the public's desire for health reform. People who are sicker have more difficulty finding comprehensive health insurance. Plans that do accept higher-risk patients may exclude preexisting conditions or limit covered services. Out-of-pocket costs to the high-risk consumer may be much greater than in the average health plan. Plans offering more generous benefits may take subtle or overt measures to avoid the high-risk patient, thus protecting their bottom line.

The Institute of Medicine (IOM), in its recent report *Employment and Health Benefits*, came out soundly against the current insurance practice of risk segmentation:

> This committee rejects the argument for risk segmentation on both philosophical grounds (believing that the least vulnerable should share the risk with the most vulnerable) and practical grounds (believing that competition based on risk selection should be discouraged in favor of competition based on effectiveness and efficiency in managing health care and health benefits).[2]

In mid-April the IOM held an invitational workshop, "Issues in Defining a Benefits Package for Health Care Reform," that further explored the issues raised in its report. Said health policy consultant Stan Jones at the meeting: "The benefit decisions made over the next one to two years will do more to set the [health] system in con-

crete than what we've done in the past decades." He called on policy analysts and decision makers to mine the data currently available in the Federal Health Employees Benefit Program, to do more outcomes research to determine what care is truly effective, and to undertake demonstrations using a uniform benefit package—before setting it in the concrete of national policy.

Ethical Issues

Defining a standard health benefit package raises numerous ethical issues. What is equitable coverage? Whose values do you use to make coverage determinations? How do you balance the needs of the individual with those of society? At the IOM meeting, Bergthold told participants that the president's working group on benefits had spent much of its time together sorting through issues of values and ethics.

The mere process of deciding what to include or exclude from a standard benefit package raises the specter of rationing. Rationing in the current healthcare system certainly exists, but is cloaked in the guise of ability to pay. With a standard benefit package, limits to care would be explicitly defined.

A Gallup survey conducted for the Employee Benefit Research Institute (EBRI) in late 1992 showed that most Americans would not accept limits on healthcare to hold down rising costs and increase access to care for the uninsured.[3] For example:

- Eighty-six percent of respondents found it unacceptable to reduce the amount of healthcare currently available to the elderly.
- Sixty-six percent opposed limiting types of services to low-income individuals.
- Sixty-one percent opposed limiting types of services health plans will cover.
- Fifty-seven percent said it was unacceptable to limit the introduction of new, expensive, high-technology equipment that saves lives but may increase costs.

An April 1993 EBRI report further examined rationing. "Care is rationed in our current system in several ways. The public policy issue is not whether we ration care, but can we find a more rational method of allocating resources?" noted EBRI's Bill Custer in the report.[4]

To date, Oregon has led the policy and ethical debate on explicit rationing with its proposed value ranking of healthcare services for its Medicaid population. As Mark Gibson, former chief of staff to the Oregon State Senate president, noted in the April EBRI report, "[The Oregon plan] baldly states the issues that must be resolved in health care resource allocation and imposes unrelenting accountability on policymakers for the decisions they make and the consequences of those decisions."

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Oregon's process for ranking its Medicaid service priorities included large-scale involvement of the state's citizens through surveys, public hearings, and town meetings to add their value preferences to the rankings set by the medical community. The controversial process has garnered much national attention. The Bush administration denied Oregon the waiver necessary to proceed with its plan on the grounds that it discriminated against people with disabilities. Conversely, the Clinton administration approved the state's renewed waiver request on March 19, 1993. However, under "special terms and conditions," the administration has required that Oregon redo its priorization list to ensure it does not discriminate against the disabled. Several other specific benefits-related concerns were highlighted in Health and Human Services Secretary Donna Shalala's letter to Oregon (March 19, 1993).

Scientific Issues

The difficulty Oregon has faced in defining and prioritizing health benefits is due in large part to the ever-shifting scientific base on which medical care rests. Medicine has a vast gray area between procedures that are widely acknowledged as effective and cost-efficient and those which are deemed "unnecessary." The clinical practice guidelines developed to date are a thin base on which to build an explicit benefit package.

As medical ethicist Daniel Callahan explains:

> It seems clear enough that there is neither now nor ever likely to be some simple, utterly clear, purely medical standard of "need" such that a basic set of benefits could be developed out of that objective knowledge alone. . . . So to solve the problem . . . we turn to a political process, recognizing not only the need to consider

things other than need, but also because we understand that they will all remain contestable.[5]

Policy analysts at the April IOM meeting devoted much time to defining "medical necessity" and arguing whether the data exist to make objective determinations of which medical services to cover. George Thibault, MD, chief of medicine at Brockton–West Rosbury V.A. Medical Center in Massachusetts, argued, "Neither outcomes research nor medical practice guidelines will write the benefit package. The constantly changing terrain and incomplete data are a major problem." He suggested that a benefit package is rather "a statement of philosophy and goals." The data and outcomes research, however, "will have an extraordinary role in the *implementation*" of a benefit package in a reformed system, he added.

Simeon Rubenstein, MD, of Group Health Cooperative of Puget Sound, pointed out the dilemma of choosing between a simple, broad-based, philosophical health benefit package and a more complex, explicitly defined plan. "There is a clear benefit of going with the simplistic benefit plan, except for one factor—lawyers." Indeed, the litigious nature of American culture is cause for concern to reformers who would set a standard health benefit. As soon as an individual is harmed by limits imposed by a new basic health benefits package, the lawyers are sure to be involved in the case.

Stan Jones called on healthcare providers to take an active role in determining the scientific base for medically necessary care and ultimately the benefits that are covered. "The day is here when clinicians need to get seriously involved in research for better definition of services, harder headed determination of priorities, to determine sites of delivery, and to help produce a clinically better insurance product." He said that clinicians and insurers need to "sit down at the table together to work out joint risk arrangements." Such deliberations mean "giving up that arm's length luxury for clinicians" in the current reform debate, he added. But such involvement is necessary to improve the scientific basis for defining benefits and successfully reforming the healthcare system.

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Political Issues

Beyond issues of science and ethics, defining a standard health benefit is ultimately a political exercise. As Bergthold notes, "Many aspects of health system reform may end up being decided in the marketplace. Defining a core benefit, however, must be a rational, visible, public decision."[6] Involving the public and the myriad healthcare interests in defining benefits is critical, but also may stall reform on the political front.

In addition to reaching agreement on services, there is the matter of benefit package cost. "The real debate should be at what point do the benefits begin to take effect," suggested economist Gail Wilensky, former adviser to President Bush and now senior fellow at Project HOPE. She argued at the April IOM meeting that people of different economic means should enter a standard benefit plan at different levels (via higher or lower copayments and deductibles).

At the end of the IOM meeting, Jerome Grossman, chief executive officer of the New England Medical Center, tried to find the points of agreement. He noted that most of the analysts agreed on the context and framework of a standard benefit and that the tendency was toward a comprehensive benefit package rather than a "bare bones" plan. In sorting out the differences that will plague the political process in the coming months, he urged the health community: "Remember why we're moving away from the current system." □

NOTES

1. Linda A. Bergthold, "Benefit Design Choices under Managed Competition," *Health Affairs*, Suppl., March 1993, pp. 99-109.
2. Marilyn J. Field and Harold T. Shapiro, eds., *Employment and Health Benefits: A Connection at Risk*, Institute of Medicine, National Academy Press, Washington, DC, 1993.
3. Employee Benefit Research Institute, "Public Attitudes on Setting Health Care Limits, 1992," Washington, DC, October 1992.
4. Employee Benefit Research Institute, "Making Choices: Rationing in the U.S. Health System," Washington, DC, April 1993.
5. Daniel Callahan, "Ethical Considerations," in David C. Hadorn, ed., *Basic Benefits and Clinical Guidelines*, Westview Press, Boulder, CO, November 1992.
6. Bergthold.