

# Improving Fairness in Coverage Decisions: Performance Expectations for Quality Improvement

Matthew K. Wynia, American Medical Association  
Deborah Cummins, University of Illinois College of Medicine, Chicago  
David Fleming, University of Missouri—Columbia School of Medicine  
Kari Karsjens, American Medical Association  
Amber Orr, American Medical Association  
James Sabin, Harvard Pilgrim Health Care, Harvard Medical School  
Inger Saphire-Bernstein, Blue Cross and Blue Shield Association  
Renee Witlen, American Medical Association

**Writing for the Oversight Body of the Ethical Force Program\***

Patients and physicians often perceive the current health care system to be unfair, in part because of the ways in which coverage decisions appear to be made. To address this problem the Ethical Force Program, a collaborative effort to create quality improvement tools for ethics in health care, has developed five content areas specifying ethical criteria for fair health care benefits design and administration. Each content area includes concrete recommendations and measurable expectations for performance improvement, which can be used by those organizations involved in the design and administration of health benefits packages, such as purchasers, health plans, benefits consultants, and practitioner groups.

## Introduction

Today, each participant in the health care system can be strongly affected by the ethical standards of many others. In health care systems, medical, public health, business, personal, and professional ethical standards are working concurrently, and occasionally in conflict (see, e.g., JCAHO 1998; Ozar et al. 2000; Wynia 1999). Recognizing these necessary interconnections, the Ethical Fundamental Obligations Report Card Evaluations (Ethical Force) program was created in 1997 ([www.ethicalforce.org](http://www.ethicalforce.org))

in the belief that an effective and trustworthy health care system requires a “mutual and multilateral web of accountability for ethics” among all health care stakeholders (Emanuel and Emanuel 1996). That is, it is necessary to identify *shared* sets of fundamental ethical expectations that can be used by all participants in health care (see, e.g., Wolf 1994; Wynia 1999).

The Ethical Force program has since evolved into a collaborative effort to create organizational ethics self-assessment tools for use in quality improvement activities, based on shared expectations for ethical performance (see, e.g., Wynia 1999; Wynia et al. 2001; Eisenberg 2001). The program’s Oversight Body consists of leaders from health care delivery organizations, professional and patient organizations, government, accrediting bodies, unions, and the business community (see Appendix). In 2000, following a period of

## Keywords

health insurance  
benefits  
ethics  
coverage  
quality improvement  
performance

## Open Peer Commentaries

Richard D. Lamm, p. 101  
John J. Paris, p. 103  
Donald W. Light, p. 105  
Michelle K. Goldberg, p. 106  
Lauri Vuorenkoski, p. 108  
Mary Ann Baily, p. 110  
Mary Anderlik Majumder, p. 112  
Martin A. Strosberg, p. 114  
Jacquelyn Slomka, p. 115  
Rosamond Rhodes, p. 116  
Karen G. Gervais and  
J. Eline Garrett, p. 119  
David Steinberg, p. 122  
Jeffrey T. Berger, p. 123

## Author’s Response

Matthew K. Wynia, Deborah Cummins, David Fleming, Kari Karsjens, Amber Orr, James Sabin, Inger Saphire-Bernstein, Renee Witlen, p. W40

\*The views in this article represent the consensus of the Oversight Body for the Ethical Force Program. The report should not be construed as representing the policies of the organizations with which members of the Oversight Body, or Ethical Force program staff, are affiliated.

deliberation on issues that might best be addressed through establishing shared ethical expectations, the Oversight Body decided to focus on health care coverage decisions. The Oversight Body felt that difficult health care coverage decisions would always have to be made, and that trust in the legitimacy of these decisions is required for the health care system to be most effective and valuable (see, e.g., Daniels and Sabin 1998b; Mechanic 1998).

This article presents the results of a three-year process to create a workable framework for organizations to use to improve ethical quality and promote trust through fostering fair coverage decisions. It outlines five *content areas* for organizational self-assessment, including a set of *measurable expectations* within each content area. These expectations include specific actions that organizations can take in the design and administration of health benefits packages to demonstrate that attention is being given to core ethical values.

#### *Defining Terms: Access, Design, and Administration*

Resource allocation systems in health care are complex, and coverage decisions are made at multiple levels. In particular, questions about the fairness of coverage decisions tend to arise in three basic areas: access to care, benefits package design, and benefits administration. For the purposes of this report, we adopted the following brief definitions.

*Access* to health care is the degree to which individuals and populations can and do obtain health care despite financial, cultural, geographic, and other barriers.

*Benefits design* is the decision-making process that determines what assortment of health care services will be covered under an insurance package.

*Benefits administration* is the decision-making process that determines the insurance coverage of specific services for specific individuals within the scope and limitations of the benefits design.

This report addresses only the latter two areas: benefits design and administration. While some barriers to access are mentioned, the broader issue of access to insurance coverage—that is, the problem of the uninsured—poses unique and important ethical and social challenges, which deserve separate consideration beyond the scope of this consensus report.<sup>1</sup>

#### *Ethics and Coverage Decisions*

The fairness of the systems through which health benefits are designed and administered comprises an increasingly well-recognized domain of health care ethics (see, e.g., Daniels and Sabin 2002; Emanuel 2000; Eddy 1991b). Benefits package design and administration are central to health care delivery, and numerous parties are involved. Purchasers, insurance brokers, unions, health care financing and delivery organizations, practitioners, and patients all play important, sometimes overlapping, roles. But despite these overlapping responsibilities, each stakeholder in health care may recognize different competing demands on available resources and different ethical standards as to what is a “good” decision. Some even argue that ethical considerations play no meaningful role in benefits design processes, which are driven primarily by power relations and money, ethical considerations being merely a “cover” for economic self-interest (Wynia et al. 2004).

Facing these competing demands has caused tension between important stakeholders in health care and strained trust in the system. Coverage decisions vary widely, sometimes inexplicably (Steiner et al. 1997). Patients sometimes report not understanding, or not being told, the rationales behind coverage decisions. Both physicians and patients sometimes feel justified in “gaming” insurance company coverage decisions (see, e.g., Alexander et al. 2003; Freeman et al. 1999); some physicians report actually deceiving insurance companies to get services for their patients (Wynia et al. 2000). Amidst these rising tensions, there is a risk that some groups (such as health plans and practitioners) are becoming scapegoats for difficult rationing decisions, while others (such as purchasers, and beneficiaries themselves) may be escaping accountability.

---

1. While the problem of the uninsured is not directly taken up in this article, the framework proposed provides an ethical basis for benefits decision making that is applicable to any health insurance scheme, including a universal coverage system. In brief, the Oversight Body chose to address coverage decisions before addressing the problem of the uninsured based on the belief that creating legitimate means to make difficult coverage decisions might enable future expansions of insurance coverage and that it is necessary to have ethically sound means for decision making even in systems that provide universal coverage. For further discussion, see Wynia et al. (2004).

Despite these challenges, coverage decisions must be made. And because health care is a service that is of particular social importance, these decisions must be made as fairly as possible (Daniels 1984). Fair coverage decisions are of obvious importance to patients and practitioners, but a “business case” can also be made for ensuring fairness in coverage decisions. Among health plans, demonstrating careful attention to fairness in coverage decisions promotes customer satisfaction, might reduce risk of lawsuits, and can help retain plan members, since disenrollment can be related to coverage denials that appear irrational or unfair (personal communication, Chris Smith Ritter, Project Officer, Medicare CAHPS Disenrollment Surveys, May 29, 2003). For health care purchasers, such as employers, the perception of unfair coverage decisions can create enrollee/employee dissatisfaction. The costs associated with employee dissatisfaction, especially if it leads to changing health plans, can be enormous. Therefore, purchasers should seek proactive methods for evaluating the fairness of coverage decision-making processes as a means to avoid later appeals, unpleasant interactions with plan administrators, and benefits package changes (Hoffman, Wynia, and Balch 2001).

### **Methods**

The Ethical Force program has developed a three-stage framework for developing self-assessment tools for domains of ethics (Wynia 1999). This article is a product of the first stage, in which the Ethical Force Oversight Body (1) selects a particular domain of ethics for performance measures development, (2) works in an iterative process to develop a framework for assessing the domain, and (3) presents concrete steps that organizations can take to enhance performance.

In 2000, the Oversight Body appointed a national Expert Advisory Panel on Coverage Decisions (see Appendix). This panel reviewed existing ethical norms and performance standards regarding health care coverage and used this review to recommend potential content areas for this domain. These content areas were carefully reviewed, revised, and ultimately approved by the Oversight Body, which considered whether (1) any relevant considerations were being ignored and (2) all the areas being addressed were important. This review process was intended to ensure the content validity of the evolving framework and included the use of numerical rating scales (from 1 to 10) to assess each content area on its overall importance and relevance to the is-

sue of coverage decisions (Litwin 1995). Areas with marginal scores (mean <7) were reassessed, revised, or eliminated during face-to-face meetings of the Oversight Body.

Five content areas were approved by the Oversight Body, which provided the working framework for subsequent steps. The Expert Advisory Panel next identified many potentially measurable expectations; these are specific expectations for action in each area that might be measurable within organizations in a valid, reliable, and feasible way. The Expert Advisory Panel and Oversight Body systematically reviewed each proposed expectation for its (1) overall importance, (2) universal applicability, (3) feasibility of implementation, and (4) potential for measurement. Again, each Oversight Body member gave each item numeric grades (from 1 to 10) for importance, universality, feasibility, and measurability. Items receiving marginal scores (mean score < 7) in any of these categories were reviewed and revised or eliminated.

The formal grading process was repeated three times over a period of two years, with extensive revisions between each iteration, to attain consensus among Oversight Body members. Then, as a penultimate step, in spring 2002 a draft of the report was mailed to more than 800 leaders in health care nationwide and posted on the program’s web site ([www.ethicalforce.org](http://www.ethicalforce.org)), soliciting feedback and comments. The report was then revised and reviewed again by the Oversight Body to address as many of these comments as possible.

### **Results**

There is no universally-accepted, coherent philosophical system for evaluating coverage decisions—nor was creating such a mythic ideal the aim of this consensus process. However, there is broad and deep consensus among many stakeholders in the health care system that processes for making coverage decisions ought to be (1) transparent, (2) participatory, (3) equitable and consistent, (4) sensitive to value, and (5) compassionate. These five core ethical criteria form the content areas for performance measurement that are outlined below and in Tables 1–5. They can provide a useful framework for organizational self-assessment with regard to the fairness of processes for making health care coverage decisions. Each area holds ethical importance, often for more than one reason, but each must also be considered in the context of the other areas. Potential synergies,

limitations, and conflicts within the areas are addressed in the discussion.

**Content area 1. Transparent**

The processes for designing and administering health benefits should be fully transparent to those responsible for and affected by these processes.

The ethical importance of transparency derives, naturally, from the importance of being honest, but also from the desire to hold both individuals and organizations accountable for their decisions. Increasingly, individuals are expected to accept coverage decisions as fair because, as informed consumers, they have agreed to a specified benefits package and set of administrative procedures for making these decisions (Robinson 2001). However, unless individuals have access to accurate information about covered services and how new services are evaluated for coverage, they cannot reasonably be held accountable for their choices. Conversely, organizations—both purchasers and providers—can only be held accountable through the market-

place when consumers make choices based on sound and complete information (Kizer 2001).

Transparency is important to those directly affected by coverage decisions and those considering whether to submit themselves to the process (such as potential new enrollees in medical practices and health plans or potential new employees/beneficiaries). Transparency regarding the results of coverage decisions is important (e.g., what is covered and what is not), but so too is transparency regarding who is involved in the decision-making process, what rationales underlie the decisions, what appeals mechanisms are available, and so on (Table 1). Furthermore, transparency requires active attention, not simply making documents available upon request. All enrollees/beneficiaries should receive a statement explaining the goals of coverage, defining who is included in the covered population, and describing the processes used and types of rationales that may be taken into account in making individual coverage decisions. These materials should be easy to understand, and a contact person, such as an ombudsman, should be available when

**Table 1. Expectations Regarding Transparency**

---

Expectations for designing covered benefits

- 1.1 The organization makes available written statements for beneficiaries/enrollees that, at minimum, include:
  - 1.1a A statement of the primary goals of the health benefits package
  - 1.1b A definition of the population to whom health benefits decisions apply (i.e., defining the “covered population”)
  - 1.1c A statement of the types of rationales and considerations that may be taken into account making health benefits decisions
- 1.2 The organization actively assists in educating beneficiaries/enrollees about covered services and how coverage decisions are made, including, at a minimum:
  - 1.2a Providing information on covered and uncovered services using language that is understandable for all relevant populations of beneficiaries/enrollees
  - 1.2b Providing an organizational contact person or office to whom beneficiaries/enrollees may turn with questions or concerns about their health benefits
  - 1.2c Making disclosures available regarding any conflicts of interest among those responsible for designing the health benefits
  - 1.2d Making information available about financial limitations that affect health benefits design decisions
  - 1.2e Disclosing the source of benefits coverage criteria, including the sources of information used to create guidelines

Expectations for the administration of covered benefits

- 1.3 The organization assists in educating beneficiaries/enrollees about administrative procedures such as appeals, including, at a minimum:
  - 1.3a Providing an organizational contact person or office (e.g., an ombudsman’s office) to whom enrollees may turn with questions or concerns about coverage disputes
  - 1.3b Making available information regarding personal, organizational, financial, or other incentives that affect decisions about coverage
  - 1.3c Providing to those directly affected by an appeals decision a written description of the decision that includes the rationale(s) used to arrive at the decision

questions or concerns arise. In particular, a clearly written description of the rationale(s) justifying the decision should be provided to individuals whenever coverage for a requested service is denied.

### *Content area 2. Participatory*

**Organizations should purposefully and meaningfully involve all stakeholders in creating and overseeing the processes for designing and administering health benefits.**

Building multistakeholder participation into benefits design and administration processes will be especially challenging, but is critical to developing political and ethical accountability in health care (Emanuel and Emanuel 1996). Transparency alone is sometimes sufficient for marketplace accountability mechanisms, which rely primarily on the consumer's ability to recognize and leave poor-quality organizations; that is, the power of consumers in the market to "exit" from an organization, taking their business elsewhere (Hirschman 1970; Rodwin 1997). But in health care, choice is often constrained and leaving may be impossible. Options may be limited (for example, an employer may offer only a single health plan, or multiple plans that are virtually identical in important respects) and the very nature of illness can constrain one's capacity to "shop around." In such settings, participatory processes can provide patients a "voice" in influencing the quality of care they receive (see, e.g., Hirschman 1970; Jennings 1991; Light et al. 2003; Rodwin 1997).

There are numerous practical benefits to developing mechanisms for all stakeholders to participate in making coverage decisions. Participatory processes play a role in quality improvement; when important stakeholders are given opportunities to express their views, decision-makers can assess proposed and existing benefits more effectively. Gathering this information can serve a dual educational purpose; while it informs purchasers and plans of the needs and priorities of their employees and members, it can simultaneously help to educate members/beneficiaries about coverage dilemmas faced by decision-makers. Promoting participatory processes also provides opportunities to discover alliances between beneficiaries, clinicians, health plans, purchasers, and others. In today's health care system, two or more parties may share similar views on an issue without realizing it, or mistrust and miscommunication may hinder working together. Participatory processes can open

communication channels between groups sharing common goals, leading to more collaboration and cooperative decision making.

Organizations can ensure and demonstrate the meaningful participation of all stakeholders by including relevant stakeholders on decision-making bodies, actively soliciting input from all stakeholders, and using the information gathered from stakeholders in decision making (Table 2). In addition, some participants in the health care system have special responsibilities to encourage the participation of others. In particular, practitioners should create clinical practice environments that foster shared decision making about treatments and that empower patients in managing their health. Benefits consultants and insurance brokers play a critical role in benefit design and should undertake special efforts to help employers/purchasers to solicit and incorporate the needs, values, and priorities of patients/enrollees when formulating health benefit packages (Hoffman, Wynia, and Balch 2001).

### *Content area 3. Equitable and consistent*

**Processes for designing and administering health benefits should result in similar decisions under similar circumstances.**

Consistency and equity are important to the ethical acceptability of any resource allocation system, based largely upon arguments against discrimination. It is unfair, discriminatory, and condemnable when similarly situated persons are not treated similarly due to factors irrelevant to the decision at hand. While health organizations build trust when they are evenhanded, systems that appear rigged, capricious, or otherwise discriminatory are ethically unacceptable.

Equity calls both for similar coverage for similar illnesses and conditions and also for differences in coverage when meaningful differences in health conditions are recognized. Consistency calls for the uniform application of coverage criteria to all members of a health care system. Equitable and consistent processes should seek to promote rational connections between the facts and the choice being made and should not be the result of "arbitrary or capricious" decision making (Chevron 1984). Organizations can attend to equity and consistency by making coverage criteria clear, easy to interpret, and based on nondiscriminatory rationales (Table 3).

**Table 2. Expectations Regarding Participation**

Expectations for designing health benefits

- 2.1 Key organizational stakeholders are included as members on decision-making bodies or committees that design health benefits packages and set general coverage rules.
  - 2.1a Organizational bodies or committees charged with designing health benefits designate a reasonable number of members who represent the beneficiaries receiving their health care coverage from the organization.
  - 2.1b Meetings of organizational bodies or committees charged with designing benefits hold meetings or other forums to provide all stakeholders an opportunity for input, and record the proceedings.
  - 2.1c Recorded decisions of organizational bodies or committees charged with designing benefits should demonstrate how the views of all stakeholders were considered in benefits design decisions.
  - 2.1d Designated members from each stakeholder group should be selected by a fair and unbiased means from each constituency.
- 2.2 The organization engages in outreach activities appropriate to the size of the organization to gather information from beneficiaries/enrollees on their needs, values, and priorities, through means that include but need not be limited to:
  - 2.2a Conducting interviews, random sample mail, phone, or e-mail surveys, and/or focus groups of beneficiaries/enrollees that address benefits design issues, such as additional services they would like covered, currently covered services they don't value, copayment and deductible structures, and service delivery mechanisms
  - 2.2b Providing open forums for enrollees/beneficiaries (e.g., open meetings, electronic forums, etc.) to address issues about health benefit packages (note: these are to address large-scale, general issues, not specific patients' cases)
  - 2.2c Encouraging beneficiaries/enrollees to participate in available forums by ensuring that such forums are well publicized and by monitoring the number and proportion of beneficiaries/enrollees attending
- 2.3 The organization uses its data on enrollee/beneficiary needs, values, and priorities to affect benefits design decisions, through means that include but need not be limited to:
  - 2.3a Providing regular feedback to organizational bodies or committees charged with designing benefits regarding beneficiaries'/enrollees' expressed needs, values, and priorities
  - 2.3b Providing for revisions of benefits design decisions over time as stakeholders' needs, values, and priorities evolve
  - 2.3c Providing feedback to enrollees/beneficiaries summarizing their input regarding benefits, access, and development of services

Expectations for administering covered benefits

- 2.4 The organization utilizes data on enrollee needs, values, and priorities when considering modifications of appeals and other administrative processes that include but need not be limited to:
  - 2.4a Providing regular feedback regarding beneficiaries'/enrollees' expressed needs, values, and priorities to organizational bodies or committees charged with overseeing appeals and other administrative processes
  - 2.4b Providing regular feedback to practitioners and providers on the expressed needs, values, and priorities of their patients

**Content area 4. Sensitive to value**

Processes for designing and administering health benefits should take into account the net health outcomes of services or technologies under consideration and the resources required to achieve these outcomes.

A consequentialist ethical framework underlies the importance of attempting to maximize health benefits derived from resources used (Jonsen 1986). In this context, "value," by definition, includes consideration of both health benefits and costs. For example, one health service has greater value than another

service if it provides greater health benefits and costs the same, or if it has a lower cost but provides the same level of benefits.

The value of proposed services, broadly construed, should be a central concern in designing and administering health benefits. However, there are important practical limitations that affect how this is done. The analysis of value in health care should be a two-step process (Table 4). The first step involves estimating the clinical outcomes associated with the service or technology in question, that is, assessing the potential benefits, harms, and risks that result from use of the proposed service. At

Table 3. Expectations Regarding Equity and Consistency

## Expectations for designing covered benefits

- 3.1 The organization defines in writing (1) the principles and values that guide decisions about health benefits and (2) a general prioritization of different types of medical needs.
- 3.2 The organization provides for at least an adequate, basic set of health benefits that is consistent with local community norms.
- 3.3 Health benefits are provided equitably to all patients/enrollees with similar conditions, co-morbidities, and abilities to participate in the intervention, regardless of race, gender, socioeconomic status, and other factors lacking clinical relevance.
- 3.4 The organization helps to educate beneficiaries/enrollees in the covered population about the importance of:
  - 3.4a Providing *consistent* health benefits to all members of the covered population with similar diagnoses
  - 3.4b Providing *equitable* health benefits to the covered population so that similarly serious types of needs, based on impairment of function and risk of mortality, are treated similarly, while important differences are taken into account
  - 3.4c Recognizing that providing health benefits in certain areas of individual concern may or may not foster an equitable and consistent health benefit across the covered population

## Expectations for administering covered benefits

- 3.5 The organization maintains a retrievable record (electronic or paper) of adjudicated coverage decisions with enough information to facilitate subsequent equitable and consistent benefits administration.
- 3.6 The organization randomly or regularly audits adjudicated coverage decisions, such as appeals, to verify that no capricious, arbitrary, or discriminatory variations occur.
- 3.7 The organization uses standard and consistent methodologies to collect, analyze, and evaluate clinical evidence of effectiveness and other relevant information used in benefits administration.
- 3.8 The organization uses objective (i.e., not personally or financially involved) clinical experts in appeals and other adjudication processes.
- 3.9 The organization helps to educate beneficiaries/enrollees in the covered population about:
  - 3.9a Processes available to enrollees to appeal coverage decisions
  - 3.9b Options available when useful services are not covered
  - 3.9c An organizational contact person or office (e.g., an ombudsman's office) to whom enrollees may turn with questions or concerns regarding appeals or other adjudication decisions (see also Table 1, on Transparency).

this stage, “outcomes” means evidence-based outcomes measured in clinical practice or through research. Individual or group opinions or preferences are not part of the assessment of clinical outcomes, nor should consideration of costs be included in this stage of analysis. The second step involves incorporating information about costs and preferences, comparing potential outcomes for alternative services to determine whether benefits outweigh harms and justify costs for a specific population or patient.

*The Appropriate Use of CEA*

Cost-effectiveness analyses (CEA) deserve special mention, because they are often used by policy makers in the second step of a value analysis. CEA are generally used to compare different approaches to the same problem, and CEA results are often presented as a comparison of the cost of preserving

a “quality-adjusted” life-year (or QALY) using each available option (Gold et al. 1996). Using CEA to inform the design and administration of health benefits packages can be useful, and declining to cover services that are relatively ineffective may prevent harms, because such therapies can be dangerous and paying for them reduces the pool of resources available for other, more effective, services (Eddy 1991a).

There are, however, important limitations to using CEA to inform coverage decisions. Though CEA can contribute to decisions that improve the efficiency of the health care system in attaining its goals, it is essential to specify these goals. After all, whether a treatment is “effective” will depend on what the intended “effect” of the treatment is. Not all human goals are interchangeable or reducible to measurement in QALYs. For instance, a cost-effectiveness analysis based strictly upon years of life saved would be an inappropriate way to compare

**Table 4. Expectations Regarding Value**

Expectations for designing covered benefits

- 4.1 In determining whether to include proposed new services, technologies, or modalities in a health benefit package, the organization considers their value for the covered population by assessing:
  - 4.1a Their benefits, harms, and risks using the best available clinical and scientific data
  - 4.1b Their net health benefits compared to those of the best existing alternatives
- 4.2 When the net health benefit of a proposed new service, technology, or modality significantly exceeds that of the best existing covered alternative, the new service is covered.
- 4.3 When the net health benefit of a proposed new service, technology, or modality is comparable to that of the best existing alternative, the organization reviews (or performs, if necessary) cost-effectiveness analyses to compare the new service to the best existing covered alternative(s). Services that are more cost-effective are covered preferentially as first-line services for the population, but exceptions may be made in individual circumstances.
- 4.4 Cost-effectiveness analyses, when performed, are performed using standard and consistent methodologies.
- 4.5 When previously performed cost-effectiveness analyses are reviewed, they are assessed for whether they were performed using standard and consistent methodologies.
- 4.6 In assessing the overall cost-effectiveness of proposed interventions, the organization considers the health of all relevant communities, including communities outside the covered population.
- 4.7 The organization periodically reviews cost-effectiveness assessments when:
  - 4.7a Relevant new information arises that might significantly impact previous analyses
  - 4.7b A significant time (e.g., more than five years) passes.

Expectations for administering covered benefits

- 4.8 Financial and other costs and benefits that may lie outside the immediate organization (including costs and benefits to the patient, his or her caregivers, employer, family members, and so on) are considered in assessing whether to cover proposed interventions for individuals.
- 4.9 For conditions and categories of service that are included in the covered benefits, a specific technology or modality is covered when its net benefit significantly exceeds that of the best existing alternative for the given individual, taking the unique clinical and functional needs of the individual into account.

modalities for palliative end-of-life care. Other outcomes of interest for palliative care might be relief of discomfort or maintenance of human dignity. Good CEA are also difficult to perform. Necessary patient data are often unavailable and many factors can affect the data used, such as the populations studied and treatment(s) against which options are compared. These issues make CEA complex and susceptible to bias (Kassirer and Angell 1994). Performing CEA is also very expensive, and even high-quality CEA become outdated. An enterprise to perform and maintain independent, high-quality, frequently updated CEA for a comprehensive set of medical services would be very useful, though it would require massive and ongoing public/private investment (Reinhart 2004)

In addition to these practical issues, CEA can pose ethical concerns. Some outcomes of CEA have been intuitively unacceptable. For example, their use to develop the original Oregon Health Plan list of covered services suggested that capping teeth was a more effective use of resources than performing ap-

pendectomies (Nord 1993). Such outcomes were in part the result of flawed methodologies, but they also suggest that values other than simple aggregate costs and benefits must be included in making coverage decisions (Eddy 1991a; Hadorn 1991). CEA value efficiency, but tend to undervalue virtues such as compassion, equity, and equality of opportunity, which may be as or more important to society (Singer 1997). While CEA can be weighted to emphasize these virtues, such CEA can be criticized for being crafted to obtain desired answers (Nord 1999). Strategies to better address these concerns are being developed, but each strategy faces technical, organizational, and psychological hurdles to implementation (Nord 1999).

Patients and practitioners value the ability to customize treatments based on individual values and circumstances. Population-based assessments of value risk ignoring legitimate professional judgments and patient preferences. To address this, while the most cost-effective treatment should generally be the preferred treatment, coverage decisions

for individuals should take unique clinical and functional needs into account (Table 4). For a patient with comorbidities or other factors that would reduce the clinical benefit of one treatment option, an alternative treatment with higher initial costs might, in fact, provide greater value.

Finally, standardized methods have been developed for performing CEA (Gold et al. 1996). To ensure fairness, it is particularly important to use these standard methods and to recognize that CEA are of most value when comparing two treatments or tests that are expected to have similar efficacy but substantially different costs (Russell, Fryback, and Sonnenberg 1999). When one treatment is clearly much more effective than alternatives, especially for a serious condition, a cost-effectiveness analysis is unlikely to yield information that will alter decision making and is not warranted (Table 4).

#### *Content area 5. Compassionate*

**The design and administration of health benefits should be flexible, responsive to individual values and priorities, and attentive to those with critical needs and special vulnerabilities.**

This final content area reflects and in a sense summarizes the four prior content areas. Organizations attending to the preceding issues will demonstrate compassion and attention to vulnerable populations through clarifying how and why coverage decisions are made, involving all relevant parties in making these decisions, and providing benefits equitably and consistently and with a view towards maximizing the health benefits obtained from covered services given limited resources. In addition, however, this final content area makes the case for specific consideration of individual needs, values, and priorities and ensuring the provision of appropriate care to especially vulnerable populations.

Compassion dictates that health care resource allocation not be solely formulaic and population-based. Individuals seeking health care appreciate and rightly expect practitioners, providers, employers, and insurers to help them share in the decision-making processes of health care. When respect and choices are not offered or honored, patients may feel abused or violated by what they view as an uncaring system. This results in feelings of fear and mistrust, which have adverse effects on health outcomes (see, e.g., Kao et al. 1998; Safran et al. 1998; Thom, Bloch, and Segal 1999). Goals of organizational efficiency and social utility may sometimes

compete with the goal of responding to each individual's needs and values, but the moral sensitivity of individuals within health care organizations should foster a corporate sense of obligation to be responsive. Compassion is an innate human emotion, which creates a "rule of rescue" among us (Jonsen 1986). This term, coined by bioethicist Al Jonsen, describes our sense of duty to rescue immediately endangered life, an imperative that even strict utilitarians admit is firmly embedded in our collective moral conscience (Nelson and Drought 1992). As a result of this imperative, extraordinary expenses are borne by society to rescue trapped climbers, children who have fallen into wells, and seafarers caught in storms (Morreim 1994). Such rescues are not illogical or without a rational basis. They create in society a shared recognition that each individual is valued, building a safety net and promoting social cohesion and a sense of community reliability (Hadorn 1991).

In addition, there is great variability in individual response to illness and treatment. Decision-making processes that incorporate compassion will be flexible enough to adapt to this variability and thus may be more effective as well as more humane. Health care professionals have the opportunity to observe the human variability of illness and response to therapy and can learn to recognize subtle or indirect clues. Fostering the special role of professionals as patient advocates can capitalize on their accumulated knowledge and clinical insight during the process of designing and administering a health benefits package (Table 5).

Finally, compassion in coverage decisions is consistent with the purposes of health insurance. Insurance is expected to provide help in times of crisis, when there is great individual need and vulnerability. The public is not likely to perceive as adequate, or fair, health insurance that does not meet the needs of those in crisis due to catastrophic illness.

#### *Protecting Vulnerable Populations*

It is often when we are at our most vulnerable that we are also most reliant on health insurance benefits. Illness and financial stress can combine to reduce virtually anyone's capacity for self-help, but certain groups are especially vulnerable. Some patient groups—such as the physically or mentally disabled, limited English speakers or non-English speakers, the geographically or culturally isolated, the chemically addicted or dependent, the seriously/chronically ill, the homeless, the frail elderly, and children—confront substantial barriers

**Table 5. Expectations Regarding Compassion**

Expectations for designing covered benefits

- 5.1 The organization measures the health effects of benefits design decisions (including the use of exclusions, waiting periods, service caps, and copayments) on vulnerable populations.
- 5.2 The organization specifically addresses the priority given to services for the small percentage of cases that have catastrophic medical needs.
- 5.3 The organization monitors the level of satisfaction that practitioners and beneficiaries have with the availability of services and the interaction necessary for successful access.
- 5.4 The organization provides a choice of supplemental benefits options that are appropriate for individuals and groups within the covered population.
- 5.5 The organization provides information to enrollees/beneficiaries so that they can make informed decisions about supplemental benefits options.
- 5.6 The organization tracks the uptake and utilization of supplemental benefits options to inform revisions to the basic benefits package.

Expectations for administering covered benefits

- 5.7 The organization provides a process for the resolution of coverage disputes that is efficient and fair, with features that include but need not be limited to:
  - 5.7a Processes for adjudicating disputed benefits that are rapid and commensurate with the exigency of the case in question, according to the available information
  - 5.7b Professional practitioners who are encouraged to participate in the adjudication process with or on behalf of patients under their care
  - 5.7c Final adjudications of disputed coverage decisions involving determinations of medical appropriateness, effectiveness, or need, (e.g., medical necessity or investigational treatment decisions) that are decided by individuals and/or groups with appropriate clinical expertise
  - 5.7d Final adjudication of disputed coverage decisions involving determinations of medical appropriateness, effectiveness, or need (e.g., medical necessity or investigational treatment decisions) that are decided by individuals and/or groups with no direct personal or financial stake in the outcome of the dispute
- 5.8 Following adjudication of coverage disputes, regardless of the outcome, the organization provides a mechanism for all stakeholders to express their degree of satisfaction with the fairness of the process for handling the dispute.

to the safe and appropriate use of health care services. These groups are generally considered to be *vulnerable populations* because it is difficult and sometimes impossible for them to act to protect their own health care interests (President's Advisory Commission 1998). They are less likely to meaningfully participate in benefit design, pursue appeals, be aware of coverage limits, select thoughtfully from among benefit options, and perform other self-protective actions, compared to those with greater social, physical, mental, and financial resources.

Recommendations throughout prior sections reflect concern for vulnerable populations. For example, transparency can provide advocates for vulnerable populations with information necessary to make an effective case on their behalf and notes that it is unethical to describe a coverage exclusion so that it is intentionally unclear to vulnerable population(s) to which it is likely to apply (see, for example, Table 1, section 1.2a.). Table 5, however, calls for organizations to focus specific attention on

the needs of vulnerable populations, recognizing the ethical obligation every participant in health care holds towards ensuring their fair treatment (see especially sections 5.1, 5.2, and 5.7). Caring for vulnerable populations can be expensive and is often poorly reimbursed, since these populations generally have few financial resources. Yet, for the health care system to have ethical integrity, protection of vulnerable populations must receive specific attention. A health care system that does not protect its most vulnerable patients is failing medically, ethically, and socially at the most fundamental levels (Wynia et al. 1999).

**Discussion**

The Ethical Force Program brings together key representatives of practitioners, patients, health plans, government, unions, employers, and other stakeholders to create tools that promote attention to ethical values in health care. This report lays out a framework addressing perhaps the most contentious

set of ethical issues facing the health care system today: the processes by which coverage decisions are made and the criteria that should be used in making these decisions. The report describes a five-part ethical framework for designing and administering health benefits. And it goes beyond broad ethical principles to make recommendations for measurable actions that can be taken by organizations to demonstrate that attention is being given to core ethical values in the design and administration of health benefits.

In summary, health benefit packages should be designed and administered using processes that are (1) transparent, (2) participatory, (3) equitable and consistent, (4) sensitive to value, and (5) compassionate. There are prominent current needs in each area. For instance, coverage denials should always be explained in writing, including an understandable statement of the rationales used in the decision. Beneficiary/enrollee participation in the design of health benefits packages must be improved. And many organizations should monitor more carefully the health impact of their coverage decisions on vulnerable individuals and groups.

The framework presented is derived from numerous sources and rests on broadly accepted community norms for ethical behavior and fairness in decision-making contexts. Hence, some organizations that design and administer health benefits already live up to many of the listed expectations. But few organizations today can demonstrate that they attend well to all of these issues, and patient trust in the health care system suffers as a result. It takes only a few organizations to disrupt the entire system by eschewing shared ethical obligations. This report, coupled with the prospect of measuring whether organizations are meeting the listed expectations, should provide fresh impetus for organizations throughout the health care system to ensure the fairness of coverage decisions, develop a level-playing field, promote trust in the health care system, and improve the health and well-being of individuals and populations.

### *Limitations*

This consensus report has several important limitations. First, health care coverage decisions are complex and involve many considerations. This framework is based on ethical considerations, but does not address every issue related to health care resource allocation. Second, no single set of performance expectations can guarantee high quality. Organizations

that intend to use adherence to procedural norms as ethical “window dressing” will virtually always be able to do so. Third, the organizational entities involved in health care, and the role of each entity in making coverage decisions, may change over time. Ethical Force has worked to establish principles and recommendations that can guide coverage decisions regardless of who has the final say in making them. And finally, not all participants in today’s health care system are meeting the expectations we list. Indeed, if they were, this work would be irrelevant. But some organizations—in particular small purchasers, such as small employers—may feel that it is impossible to live up to all of the expectations listed in this document. This might not be an indictment of these organizations, nor an indication that the recommendations in this report are wrong; rather, it may reflect a health care system that literally asks the impossible of some of its key participants. Continuing work is required to address systemic problems of access and financing.

Each content area also has limitations. For example, adopting certain participatory structures, such as direct democratic decision making (one person, one vote), in benefits design and administration processes, might not lead to appropriate decisions (Daniels and Sabin 1998a). Voting often skews toward those already empowered and can leave minority groups susceptible to the effects of majority rule, marginalizing those with significant but unpopular health concerns. Overemphasis on consistency might hinder progress if decision-makers hesitate to cover new technologies in efforts to adhere closely to past decisions; consistency must therefore be balanced against compassion, or flexibility, and incorporation of new data in value analyses. On the other hand, some treatments and services requested by individuals might not be consistent with evidence-based standards of care; such requests need to be considered with compassion, but realistically in light of medical evidence, the patient’s clinical situation, and expected outcomes. Compassion can even backfire: providing unique and expensive services to those with special needs might create a sense of inequity and mistrust if it appears that others will not receive attention to their basic health care needs as a result. In the end, these limitations highlight the importance of balancing attention across all five areas.

### *Conclusion*

Quality improvement in health care should incorporate measures of ethical performance, because

health care is a moral enterprise grounded in patient trust (Wolf 1994; Crawshaw et al. 1995; Wynia 1999). Yet health care today is also an interconnected web of complex relations. For quality measurement to address domains of ethics will require a *shared* set of expectations for ethical behavior, applicable across the full range of health care participants. Health care delivery organizations, purchasers, patients, and clinicians must be accountable to each other for identifying and then implementing these shared expectations. This report represents a unique effort to advance the quality agenda in this direction, by bringing together multiple stakeholders in health care to create a framework for evaluating and improving the fairness of health care coverage decisions, including a set of specific, measurable expectations for performance. ■

Received 15 December 2003; accepted 25 December 2003; posted for peer commentary 5 February 2004.

#### Competing Interests Statement

The authors declare that they have no competing financial interests.

#### References

- Alexander, G. C., R. M. Werner, A. Fagerlin, and P. A. Ubel. 2003. Support for physician deception of insurance companies among a sample of Philadelphia residents. *Annals of Internal Medicine* 138:472–475.
- Chevron v. Natural Resources Defense Council*, 467 U.S. 837 (1984).
- Crawshaw, R., D. E. Rogers, E. D. Pellegrino, et al. 1995. The patient-physician covenant. *Journal of the American Medical Association* 273:1553.
- Daniels, N. 1984. *Just health care*. New York: Cambridge University Press.
- Daniels, N., and J. Sabin. 1998a. The ethics of accountability in managed care reform. *Health Affairs* 17:50–64.
- Daniels, N., and J. E. Sabin. 1998b. Last chance therapies and managed care: Pluralism, fair procedures and legitimacy. *Hastings Center Report* 28:27–42.
- Daniels, N., and J. E. Sabin. 2002. *Setting limits fairly: Can we learn to share medical resources?* New York: Oxford University Press.
- Eddy, D. M. 1991a. Oregon's methods: Did cost-effectiveness fail? *Journal of the American Medical Association* 266:2135–2141.
- Eddy, D. 1991b. What care is "essential"? What services are "basic"? *Journal of the American Medical Association* 265:782–788.
- Eisenberg, J. M. 2001. Can you keep a secret? Measuring the performance of those entrusted with personal health information. *Journal of General Internal Medicine* 16:132–134.
- Emanuel, E. J. 2000. Justice and managed care: Four principles for the just allocation of health care resources. *Hastings Center Report* 30:8–16.
- Emanuel, E. J., and L. L. Emanuel. 1996. What is accountability in health care? *Annals of Internal Medicine* 124:229–239.
- Freeman, V. G., S. S. Rathore, K. P. Weinfurt, K. A. Schulman, and D. P. Sulmasy. 1999. Lying for patients: Physician deception of third party payers. *Archives of Internal Medicine* 159:2263–2270.
- Gold, M. R., J. E. Seigel, L. B. Russell, and M. C. Weinstein. 1996. *Cost-effectiveness in health and medicine*. New York: Oxford University Press.
- Hadorn, D. C. 1991. Setting health care priorities in Oregon: Cost-effectiveness analysis meets the rule of rescue. *Journal of the American Medical Association* 265:2218–2225.
- Hirschman, A.O. 1970. *Exit, voice and loyalty: Responses to decline in firms, organizations, and states*. Cambridge, MA: Harvard University Press.
- Hoffman, M. K., M. K. Wynia, and G. Balch. 2001. *Focus groups with employers and insurance brokers to discuss issues that shape decisions about health benefits*. Chicago: Institute for Ethics at the American Medical Association.
- Jennings, B. 1991. Possibilities of consensus: Toward democratic moral discourse. 1991. *Journal of Medical Philosophy* 16:447–463.
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO). 1998. *Ethical issues and patient rights: Across the continuum of care*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations.
- Jonsen, A. 1986. Bentham in a box: Technology assessment and health care allocation. *Law, medicine and health care* 14:172–174.
- Kao, A. C., D. C. Green, A. M. Zaslavsky, J. P. Koplan, and P. D. Cleary. 1998. The relationship between method of physician payment and patient trust. *Journal of the American Medical Association* 280:1708–1714.
- Kassirer, J. P., and M. Angell. 1994. The *Journal's* policy on cost-effectiveness analysis. *New England Journal of Medicine* 331:669–670.
- Kizer, K. W. 2001. Establishing health care performance standards in an era of consumerism. *Journal of the American Medical Association* 286:1213–1217.
- Light, D. W., R. Castellblanch, P. Arredondo, and D. Socolar. 2003. No exit and the organization of voice in biotechnology and pharmaceuticals. *Journal of Health Politics, Policy and Law* 28:473–507.

- Litwin, M. S. 1995. *How to measure survey reliability and validity*. Thousand Oaks, CA: Sage Publications.
- Mechanic, D. 1998. The functions and limits of trust in the provision of medical care. *Journal of Health Politics, Policy and Law* 23:661–686.
- Morreim, E. H. 1994. Of rescue and responsibility: Learning to live with limits. *Journal of Medicine and Philosophy* 19:455–470.
- Nelson, R. M., and T. Drought. 1992. Justice and the moral acceptability of rationing medical care: The Oregon experiment. *Journal of Medicine and Philosophy* 17:97–117.
- Nord, E. 1993. Unjustified use of the quality of well-being scale in priority setting in Oregon. *Health Policy* 24:45–53.
- Nord, E. 1999. *Cost-value analysis in health care: Making sense out of QALYs*. Cambridge, UK: Cambridge University Press.
- Ozar, D., J. Berg, P. H. Werhane, and L. L. Emanuel. 2000. *Organizational ethics in health care: Toward a model for ethical decision making by provider organizations*. Chicago: Institute for Ethics at the American Medical Association.
- President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. 1998. *Quality first: Better health care for all Americans*. Available from: <http://www.hcqualitycommission.gov/final/chap08.html>.
- Reinhart, U. E. 2004. An information infrastructure for the pharmaceutical market. *Health Affairs* 23:107–112.
- Robinson, J. C. 2001. The end of managed care. *Journal of the American Medical Association* 285:2622–2628.
- Rodwin, M. A. 1997. The neglected remedy: Strengthening consumer voice in managed care. *The American Prospect* 8. Available from: <http://www.prospect.org/print/V8/34/rodwin-m.html>.
- Russell, L. B., D. G. Fryback, and F. A. Sonnenberg. 1999. Is the societal perspective in cost-effectiveness analysis useful for decision makers? *Joint Commission Journal on Quality Improvement* 25:447–454.
- Safran, D. G., D. A. Taira, W. H. Rogers, et al. 1998. Linking primary care performance to outcomes of care. *Journal of Family Practice* 47:213–220.
- Singer, P. A. 1997. Resource allocation: Beyond evidence-based medicine and cost-effectiveness analysis. *American College of Physicians Journal Club* 127:A16–A18.
- Steiner, C. A., N. R. Powe, G. F. Anderson, and A. Das. 1997. Technology coverage decisions by health care plans and considerations by medical directors. *Medical Care* 35:472–489.
- Thom, D., D. Bloch, and E. Segal. 1999. An intervention to increase patients' trust in their physicians. *Academic Medicine* 74:195–198.
- Wolf, S. M. 1994. Quality assessment of ethics in health care: The accountability revolution. *American Journal of Law and Medicine* 20:105–128.
- Wynia, M. K. 1999. Performance measures for ethics quality. *Effective Clinical Practice* 2:294–298.
- Wynia, M. K., D. S. Cummins, J. B. VanGeest, and I. B. Wilson. 2000. Physician manipulation of reimbursement rules for patients: Between a rock and a hard place. *Journal of the American Medical Association* 283:1858–1865.
- Wynia, M. K., S. S. Coughlin, S. Alpert, D. S. Cummins, and Emanuel, L. L. 2001. Shared expectations for protection of identifiable health care information: Report of a national consensus process. *Journal of General Internal Medicine* 16:100–111.
- Wynia, M. K., D. Cummins, K. Karsjens, and A. Orr. 2004. Appendix C: Ethics and Access to Care. In, *The Ethical Force Program, Ensuring fairness in health care coverage decisions: A consensus report on the ethical design and administration of health care benefits packages*, 36–38. Chicago: Ethical Force Program, American Medical Association.
- Wynia, M. K., S. R. Latham, A. C. Kao, J. W. Berg, and L. L. Emanuel. 1999. Medical professionalism in society. *New England Journal of Medicine* 341:1612–1616.

---

*Appendix. Members of the Ethical Force Program Oversight Body and the Expert Advisory Panel on Fair Coverage Decisions*

*(Affiliations listed for identification only)*

**Oversight Body Members 2001–2003**

- Myrl Weinberg (chair), *National Health Council*  
 Robert Alpert, *United Auto Workers\**  
 Ron Anderson, *Parkland Health and Hospital System*  
 Laurie Badzek, *American Nurses Association*  
 Robert Carr, *GlaxoSmithKline*  
 Jordan Cohen, *Association of American Medical Colleges*  
 John Combes, *American Hospital Association*  
 Ronald Davis, *American Medical Association*  
 Michele Dennis, *American Federation of State, County and Municipal Employees Union\**  
 John Eisenberg, *Agency for Healthcare Research and Quality, \*¶*  
 Ezekiel Emanuel, *National Institutes of Health\**  
 Linda Emanuel (Ethical Force Program Founder), *Northwestern University*

Mary Jane England, *Washington Business Group on Health*\*  
Arnold Epstein, *Harvard School of Public Health*\*  
J. Michael Fitzmaurice, *Agency for Healthcare Research and Quality*¶  
David Fleming, *University of Missouri—Columbia School of Medicine*  
Larry Gage, *National Association of Public Hospitals and Health Systems*\*  
Stephanie Harrison, *American Federation of State, County and Municipal Employees*\*  
George Isham, *Health Partners*\*  
Stephen Jencks, *Health Care Financing Administration*¶  
Allan Korn, *Blue Cross and Blue Shield Association*  
Catherine Kunkle, *National Business Coalition on Health*\*  
Mark Levine, *The AMA Council on Ethical and Judicial Affairs*  
John Ludden, *Tufts University*  
Beverly Malone, *American Nurses Association*\*  
Karen Milgate, *American Hospital Association*\*  
Mary Mologne, *American Hospital Association*\*  
Peggy O’Kane, *National Committee for Quality Assurance*  
William Plested III, *American Medical Association*\*  
Thomas Reardon, *American Medical Association*\*  
Frank Riddick, *The AMA Council on Ethical and Judicial Affairs*\*  
James Sabin, *Harvard Pilgrim Health Care/Harvard University*  
Inger Saphire-Bernstein, *Blue Cross and Blue Shield Association*  
Neil Schlackman, *Aetna—US Healthcare*\*  
Paul Schyve, *Joint Commission on Accreditation of Healthcare Organizations*  
Linda Shelton, *National Committee for Quality Assurance*\*

Drew Smith, *American Association of Retired Persons*\*  
David Tennenbaum, *Blue Cross and Blue Shield Association*\*  
Reed Tuckson, *UnitedHealth Group*  
Gladys White, *American Nurses Association*\*

**Expert advisory panel on health care coverage decisions†**

Gail Agrawal, *University of North Carolina School of Law*  
Robert Alpert, *United Auto Workers*  
Mary Jane England, *Washington Business Group on Health*††  
Bruce Jennings, *The Hastings Center*  
Allan Korn, *Blue Cross and Blue Shield Association*  
Donald Light, *University of Medicine and Dentistry of New Jersey*  
Russell Massaro, *Joint Commission on Accreditation of Health Organizations*  
Rick Miller, *Blue Cross and Blue Shield of Tennessee*  
Thomas Morley, *General Motors*  
James Sabin, *Harvard Pilgrim Healthcare/Harvard University*  
Inger Saphire-Bernstein, *Blue Cross and Blue Shield Association*

---

\*Not a current member of the Ethical Force Oversight Body, but membership overlapped with the development of this report. Noncurrent members were not asked to approve the final report.

¶Governmental representatives serve as advisors.

†The Expert Advisory Panel served as a resource for the Oversight Body but was not asked to approve the final report.

††Affiliation at the time of service on the Expert Advisory Panel. Dr. England is now at Regis College.

*Transparency* is a word that is used widely in the health care system, has many meanings, and polls very favorably with the public. Encarta World English Dictionary defines transparent as being “completely open and frank.” The Oversight Body of the Ethical Force Program in a recent article on coverage decisions states, “the ethical importance of transparency derives, naturally, from the importance of being honest, but also from the desire to hold both individuals and organizations accountable for their decisions.” The article goes on to state that “transparency requires active attention, not simply making documents available upon request.”

In the public arena, most notably, the President signed an Executive Order last summer to help increase the transparency of America’s health care system and empower Americans to find better value and better care. The order directs federal agencies that administer or sponsor federal health insurance programs to increase transparency in pricing and quality. The Department of Health and Human Services has developed a web site devoted to this initiative, it is entitled “Value-Driven Health Care”. The subtitle is “Transparency: Better Care Lower Cost”.

The push for price transparency will continue to grow from both government and private payers as more of the financial burden for health care costs is shifted to the consumer through the growing number of uninsured, as well as the move toward high-deductible health insurance coverage and HSAs. Physicians need to help determine how this transparency will take shape, rather than wait and have it mandated/legislated upon them.

In addition to price transparency, the government is also working with private payers to develop standards to measure the overall costs of treatment for an *episode of care*. This issue is much more complex and practicing physicians should be directing these discussions. Physicians have already “suffered” the black box efficiency ratings of some private payers, if nothing is done this could very easily become the industry standard.

Question for the Physicians’ Congress:

1. How should the medical profession in Colorado position itself on fee/payment/price transparency? (See language in Reactor Reform Proposals)

# National Health Care Update

An ongoing analysis of today's political environment



## Pricing transparency: Show me theirs

Kimble Ross, CMS consultant

Even a blind health care lobbyist can see this one coming. "Transparency" is the health care idea du jour, medical necessity notwithstanding, and will be the top priority for the usual suspects in the next legislature. Here are just a few of the neon signs flashing, "here it comes, ready or not:"

- The litany of commercial payers using proprietary software to evaluate the so-called "efficiency, value and quality" of physicians continues to grow. We all know about United's Premium Designation Program, which at least attempts to put quality in front of efficiency (aka cost savings). Cigna's new Care Network lumps both cost and quality measures together to develop a tiered network program, while Anthem's Value Networks doesn't even feign interest in quality and instead focuses exclusively on cost. We're on pins and needles waiting for Aetna's Aexcel program that appears to be another blended approach at transparency using problematic methods. All these "transparency" programs are running on Ingenix's (owned by UnitedHealth Group) proprietary episode treatment grouper computer program called Symmetry.
- The august Institute of Medicine just published a report essentially endorsing an idea that the Medicare Physician Advisory Committee (MedPAC) endorsed months earlier – phasing in a pay-for-performance payment program for fee-for-service Medicare.
- Congress has actually conducted hearings on the transparency in health care and the Colorado legislature has precedent on the books with various hospital report card initiatives.

Nobel Prize economist Joseph Stiglitz isn't exactly bedside reading, but his work, for which he nailed the Nobel, pretty much says that markets don't work without sufficient

information between purchasers and suppliers. To really oversimplify, transparency as an economic principle is life-or-death essential to health care markets being functional, insofar as we want price to be a factor. However, as also previously noted, health care markets have some anomalous economic characteristics that frustrate the market purists—add to supply/stimulate demand, the limits on making one patient-at-time treatments "efficient," the inelasticity of demand for health care, the relative technical exclusivity of medical knowledge, etc.

In the short-term, this falls under the no-good-deed-goes-unpunished category. Congressional and Executive Branch action will accelerate the need for more transparency in all these transactions; health information technology (HIT), the lynch pin in delivering "transparent" data, is reaching center stage with the adoption of safe harbor regulations for the donation of EMRs and other software to physicians and physician groups and key bills awaiting reconciliation in Congress (see story on page 313). More and more patients will be buying their health care with cash, either as working uninsured, coverages with high deductibles and co-pays, or as a result of the liberalization of HSAs. Current focus group research by several payers is reaffirming that John Q. Citizen may not know yet what he's looking at, and thinks transparency is some kind of cross gender family matter, but you can bet he's more engaged since it's mostly his money. This is probably a good thing, eventually. There is a more pernicious flip side to a price-informed consumer, and that is the avoidance of necessary, preventive care.

It doesn't take a Nobel economist to understand that there's more to health care purchasing than price.

Posting physician fee schedules in and of itself should raise eyebrows, since most physicians haven't seen a fee schedule that wasn't modified, bundled, blended, down-coded or cannibalized, usually without notice or consent. The claim edits will most assuredly be exempted as proprietary, a time-honored dodge in every lawsuit and legislative fight. And don't get physicians started with silent PPOs and other pricing games where the physician never even had a shot at negotiating a fair fee for their services.

The price transparency absurdities list goes on. Consider hospitals and how they calculate charges. The hospital "chargemaster" is legal fiction, right up there with MSRDP, UCR and AWP. What about drug prices? Talk about voodoo economics. Then there are the payers themselves. How much of that administrative budget is corporate jets, offensive advertising and senior management compensation? And how much of the perversely named "medical loss ratio" is actually patient care? What in fact are the fee schedules, the coding edit criteria, and what is their definition of network adequacy?

When it comes to transparency, I think most physicians I know would say, "I'll show mine, but they gotta show me theirs." That is a game of chicken I'd pay to watch from the front row.



*Editor's note: Transparency programs are rolling out across the nation. Below is an excerpt from a September 5, 2006 Boston Globe article that effectively highlights physician concerns both nationally and in Massachusetts about these initiatives.*

## Measuring quality in health care

The world is becoming more transparent, from the public sector to the private, from non profits to for-profit companies, and health care is no exception. That can be a good thing for patients, providers, and society in general. Transparency fosters trust, drives efficiency, and advances quality.

Health care is a notoriously complex field – much more so than many consultants and self-appointed advocates would lead people to believe. Unlike many businesses, where success is ultimately measured by the bottom line, success in medicine cannot solely be measured in terms of dollars and cents, but in terms of saved lives and improved health.

But does that mean it's impossible to measure success, or better yet, quality in health care? Of course not. Physicians and hospitals have been doing it for years. They have to push hard on transparency for their patients and to produce accurate, relevant information. And that's where they often differ from those who are trying to overlay untested business school profit-and-loss models on a fundamentally human enterprise...

"Good enough" has never been acceptable in health care, and it shouldn't be on this issue either. Physicians are trained to be careful with information. Accuracy is everything. If they act on incorrect or incomplete data, they risk harming the patient...

(P)otentially inaccurate, confusing, or conflicting information may cause a patient to pay (more). It might prompt a patient to look for another doctor based on false information, disrupting years of trust and continuity with that physician or that practice. And it can unfairly and inaccurately label a doctor as "inefficient," affecting the physician's

reputation and standing in the community.

The data provided by any organization that operates physician-rating programs need to be transparent, too. Currently, physicians have little ability to respond effectively to those results. Good data, provided in a meaningful way, show physicians and their staffs where they can improve their care or the operation of their practices. But data that are difficult to understand, interpret, or take action on become meaningless.

Transparency must cut both ways. Yes, patients need and deserve

good information on which to make informed decisions. But physicians who are ready to work collaboratively with the...health plans, and others who drive such programs, believe that the entire rating process should be open for public inspection. Physicians deserve a reasonable chance to review, understand, and correct information before it's published. Equally important, patients deserve this kind of transparency as well.

*Kenneth R. Peelle, MD, President of the Massachusetts Medical Society*

## CLIENT-FOCUSED INVESTMENT MANAGEMENT

*J. V. Bruni and Company*

- Placing clients first ... always.
- Providing fee-only management with a long-term focus.
- Managing over \$600 million for investors in Colorado and nationwide.

- Not compensated by product sales or commissions.
- Ask about our reputation—we currently serve over 50 active and retired Colorado physicians.
- Learn more about investing at our educational web site.

*www.jvbruni.com*

*J. V. Bruni and Company*



1528 North Tejon Street  
Colorado Springs, Colorado  
(719) 575-9880 • (800) 748-3409



Press the print button on your browser.  
[Click here to return to the previous page.](#)

## **Nation's leading physician groups join together to announce principles for reforming the U.S. health care system**

**For immediate release**  
**January 11, 2007**

Washington, DC –Ten of the nation's leading physician associations speak with one voice to release principles to reform the U.S. health care system. This unity among physician groups is intended to help provide the impetus for bipartisan Congressional action to cover the uninsured. Recognizing that many newly elected Members of Congress campaigned on fixing the health care system, the Principles serve as a guide for Congress to improve both individual health and the collective health care system in the U.S.

The Principles For Reform of the U.S. Health Care System released today call for the following actions:

1. Health care coverage for all is needed to ensure quality of care and to improve the health status of Americans.
2. The health care system in the U.S. must provide appropriate health care to all people within the U.S. borders, without unreasonable financial barriers to care.
3. Individuals and families must have catastrophic health coverage to provide protection from financial ruin.
4. Improvement of health care quality and safety must be the goal of all health interventions, so that we can assure optimal outcomes for the resources expended.
5. In reforming the health care system, we as a society must respect the ethical imperative of providing health care to individuals, responsible stewardship of community resources, and the importance of personal health responsibility.
6. Access to and financing for appropriate health services must be a shared public/private cooperative effort, and a system which will allow individuals/employers to purchase additional services or insurance.
7. Cost management by all stakeholders, consistent with achieving quality health care, is critical to attaining a workable, affordable and sustainable health care system.
8. Less complicated administrative systems are essential to reduce costs, create a more efficient health care system, and maximize funding for health care services.

9. Sufficient funds must be available for research (basic, clinical, translational and health services), medical education, and comprehensive health information technology infrastructure and implementation.
10. Sufficient funds must be available for public health and other essential medical services to include, but not be limited to, preventive services, trauma care and mental health services.
11. Comprehensive medical liability reform is essential to ensure access to quality health care.

"Doctors want Congress to take action on health system reform this year," said Rick Kellerman, MD, president of the American Academy of Family Physicians and a practicing family physician in Wichita, Kansas. "Physicians are coming together to support these principles because they want the best care for their patients and if these principles are adopted, patients will be the main beneficiaries."

"As orthopaedic surgeons, we see the successes – but also the dilemmas, strains and unmet needs – in American healthcare on a daily basis," said Richard F. Kyle, MD, president of the American Academy of Orthopaedic Surgeons and a practicing physician in Minneapolis, Minnesota. "The American Academy of Orthopaedic Surgeons strongly supports the Principles for Reform of the U.S. Health Care System for its multi-faceted approach to significant lapses of access and funding. We recognize the strong clinical, educational and research foundation on which to base the prescribed improvements. These principles reflect the mandate we feel as physicians, and we are committed to making certain that all Americans enjoy the healthcare they deserve, no matter their economic resources."

"All patients deserve access to quality care, and national efforts to address health care quality must proceed in parallel to efforts to expand coverage and access," said Steven E. Nissen, MD, FACC, president of the American College of Cardiology (ACC). "We have an obligation to improve health care by delivering appropriate and quality medical services using evidence based medicine. The ACC is committed to this fundamental principal and, in turn, ensuring that all employers, individuals and families have access to affordable health coverage."

"Emergency physicians serve as the safety net for America's troubled medical care system, and we see firsthand how the lack of health insurance coverage affects everyone, not just the uninsured" said Brian Keaton, MD, FACEP, president of the American College of Emergency Physicians. "In June, the Institute of Medicine issued reports on the future of emergency care and found a fragmented system, unable to respond to disasters. The causes included the lack of health insurance for 46 million Americans as well as the medical liability crisis. The need for change is urgent, which is why the American College of Emergency Physicians strongly supports the Principles for Reform of the U.S. Health Care System."

"Nearly 13 million reproductive-age women, and 13% of all pregnant women, in the US are without health insurance, which prevents them from receiving critical preventive care and screening tests," said Douglas W. Laube, MD, MEd, president of the American College of Obstetricians and Gynecologists (ACOG). "ACOG believes that providing pregnant women and infants with full insurance coverage and access to care is an important step in providing health care for all Americans."

"As osteopathic family physicians, we believe that every American should have appropriate health care, and these principles certainly support that goal," said Thomas N. Told, DO, FACOFP dist., president of the American College of Osteopathic Family Physicians. "It is our duty to make sure only the highest quality of care is being delivered

in the health care marketplace, and we hope to work with Congress this year on making these principles a reality."

"The American College of Physicians believes that immediate steps must be taken to expand health insurance coverage, with the goal of providing coverage to all Americans. Proposals to expand health insurance coverage should also assure that patients have access to a core set of benefits," said Lynne M. Kirk, MD, FACP, president of the American College of Physicians.

"These principles are consistent with the position of the American College of Surgeons that all parties concerned – physicians, other health care providers, payers, and patients – must share responsibility for the appropriate provision and financing of quality health care," said Thomas R. Russell, MD, FACS, executive director of the American College of Surgeons. "The American College of Surgeons sincerely supports these principles and the future efforts of the coalition to provide Congress with viable options for providing all Americans with quality health care."

"Providing health care coverage to the uninsured is a top priority of the American Medical Association, and we are proud to join together with other physician organizations to present a cohesive set of principles to guide reform of the U.S. health care system," said Jeremy Lazarus, MD, board member of the American Medical Association.

"Congress must address the growing problems facing the nation's health care system," said John A. Strosnider, DO, president of the American Osteopathic Association. "We are pleased to join with our physician colleagues in putting forth these principles for health system reform. We believe that they provide the framework for all stakeholders – patients, physicians, payers, employers, and the federal government – to come together to improve the health care system."

Mollie E. Turner  
Public Information Officer  
American Medical Association  
(202) 789-7430  
Fax (202) 789-7472

Last updated: Jan 11, 2007  
Content provided by: Media Relations

---

[Privacy Statement](#) | [Advertise with us](#)

Copyright 1995-2007 American Medical Association. All rights reserved.



New York Times  
OP-ED COLUMNIST  
**Golden State Gamble**  
By PAUL KRUGMAN  
Published: January 12, 2007

A few days ago Gov. Arnold Schwarzenegger unveiled an ambitious plan to bring universal health insurance to California. And I'm of two minds about it.

On one side, it's very encouraging to see another Republican governor endorse the principle that all Americans are entitled to essential health care. Not long ago we were wondering whether the Bush administration would succeed in dismantling Social Security. Now we're discussing proposals for universal health care. What a difference two years makes!

And if California - America's biggest state, with a higher-than-average percentage of uninsured residents - can achieve universal coverage, so can the nation as a whole.

On the other side, Mr. Schwarzenegger's plan has serious flaws. Maybe those flaws could be fixed once the principle of universal coverage was established - but there's also the chance that we would end up stuck with those flaws, the way we ended up stuck with a dysfunctional system of insurance tied to employment.

Furthermore, in the end health care should be a federal responsibility. State-level plans should be seen as pilot projects, not substitutes for a national system. Otherwise, some states just won't do the right thing. Remember, almost 25 percent of Texans are uninsured.

To understand both what's right and what's wrong with Mr. Schwarzenegger's plan, let's compare what he's proposing with the plan he rejected. Last summer, the California Legislature passed a bill that would have created a single-payer health insurance system for the state - that is, a system similar to Medicare, under which residents would have paid fees into a state fund, which would then have provided insurance to everyone.

But the governor vetoed that bill, which would have bypassed private insurance companies. He appears to sincerely want universal coverage, but he also wants to keep insurance companies in the loop. As a result, he came up with a plan that, like the failed Clinton health care plan of the early 1990s, is best described as a Rube Goldberg device - a complicated, indirect way of achieving what a single-payer system would accomplish simply and directly.

There are three main reasons why many Americans lack health insurance. Some healthy people decide to save money and take their chances (and end up being treated in emergency rooms, at the public's expense, if their luck runs out); some people are too poor to afford coverage; some people can't get coverage, at least without paying exorbitant rates, because of pre-existing conditions.

Single-payer insurance solves all three problems at a stroke. The Schwarzenegger plan, by contrast, is a series of patches. It forces everyone to buy health insurance, whether they think they need it or not; it provides financial aid to low-income families, to help them bear the cost; and it imposes "community rating" on insurance companies, basically requiring them to sell insurance to everyone at the same

price.

As a result, the plan requires a much more intrusive government role than a single-payer system. Instead of reducing paperwork, the plan adds three new bureaucracies: one to police individuals to make sure they buy insurance, one to determine if they're poor enough to receive aid, and one to police insurers to make sure they don't discriminate against the unwell.

The plan's supporters say that it would save money all the same. Those who are currently uninsured would receive preventive care, which is often cheaper than waiting until they show up in emergency rooms. Insurers would spend less money trying to weed out high-risk clients and more money actually paying for health care: the plan would require that insurers spend at least 85 percent of premiums on health care, considerably more than most insurers do now.

Still, why all the complexity? The smart, well-intentioned economists who devised the plan think they're being more politically realistic than single-payer advocates - that it's necessary to placate the insurers. But that's what Bill and Hillary Clinton thought, too - only to find that their plan's complexity confused the public, while the insurance industry went all-out to defeat it anyway.

So am I for or against the Schwarzenegger plan? That's a tough question. As a practical matter, however, I suspect that the real question is what to do after the plan founders from its own complexity. And the answer is, damn the insurers - full speed ahead.



# California Medical Association

1201 J Street, Suite 200, Sacramento, CA 95814-2906

Phone: (916) 444-5532 • Fax: (916) 444-5689

*Physicians dedicated to the health of Californians*

---

## GOVERNMENT RELATIONS

---

### CMA Analysis of Governor's Health Care Reform Plan

January 2007

#### **Governor Schwarzenegger Announces Health Care Reform Proposal**

The Governor announced his new health care proposal on January 8, 2006. The proposal focuses on the themes of prevention, coverage and affordability. Specifically, the proposal includes a Medi-Cal and Healthy Families expansion, an individual mandate, employer mandate, insurance market reforms, easing of licensure requirements for physician extenders, tax system reform and a physician/hospital tax. Details of the proposal are described below.

#### ***Medi-Cal and Healthy Families Expansion***

The proposal would expand publicly funded health coverage to all children under 300 percent of the Federal Poverty Level (FPL) (about \$50,000 annually for a family of three.) This would not only increase eligibility in Medi-Cal and Healthy Families from the current 250 percent of FPL to 300 percent of FPL, but would also cover undocumented immigrant children in these programs (who are not currently covered.) In addition, no-cost Medi-Cal coverage would be expanded to adults under 100 percent of FPL (\$9,800 annually.)

#### ***Medi-Cal Increases Through a Pay for Performance System***

Acknowledging that Medi-Cal rates are unsustainably low, the proposal would include a significant increase (an estimated \$4 billion) in Medi-Cal rates. However, the increases would be tied to participation in a new and unspecified pay-for-performance program, cost-containment and adoption of health IT.

#### ***Physician and Hospital Tax***

The Governor's proposal would impose a "provider tax" on hospitals and doctors. The plan requires physicians to pay a tax of 2 percent of total gross receipts, and all hospitals to pay a tax of 4 percent. The administration believes that by increasing Medi-Cal rates and lowering the number of uninsured, physicians and hospitals can pay a new "coverage dividend."

#### ***Insurance Market Reforms***

The Governor's plan would require plans to limit the amount of money insurers can spend on administration and profits to 15 percent of the premium paid. Health insurers would also be required to offer community rated products where rates can be based only on age and geographic location. They would also be required to offer "healthy incentives" such as gym memberships.

#### ***Employer Mandate***

The proposal requires employers with 10 or more employees to contribute to the cost of insurance for their employees. Under the Governor's proposal, employers would be required to offer insurance or pay 4 percent of payroll into a purchasing pool made available only to

individuals with income less than 250 percent of FPL. All other workers would be responsible for purchasing coverage on their own. Employers will also be required to offer section 125 plans to allow employees to make pre-tax contributions to their health care premium. This would require employers to facilitate (but not fund) Section 125 plans, which would help workers save up to 40 percent on their insurance premium by taking advantage of federal tax breaks.

***Individual Mandate***

Individuals would be required to secure health insurance for themselves and their dependents. The individual mandate will be enforced by withholding wages and through the tax code.

Californians with family incomes between 100 and 250 percent (\$16,600 and \$41,500 respectively) of the FPL will be eligible to purchase insurance in the state purchasing pool. Participants in the pool will be responsible for contributing to their premium, based on income and family size (see chart below for maximum contribution schedule.)

Percent of FPL	Income (family of three)	Percent of Gross Income	Maximum Annual Out-of-Pocket
100 - 150%	\$16,600 - \$24,900	3%	\$498 - \$747
151 - 200%	\$24,901 - \$33,200	4%	\$996 - \$1,328
201 - 250%	\$33,201 - \$41,500	6%	\$1,992 - \$2,490

***Prevention and Wellness***

The Governor’s plan includes incentives for individuals to make health lifestyle choices, reduce obesity, stop smoking, and control chronic conditions. The plan also would require providers to implement a paper-less e-prescribing and electronic health records system by 2010. This would include mandatory hospital and physician reporting requirements and the use of unspecified evidence based medicine guidelines.

***Expand the Scope of Practice for Physician Extenders***

The Governor’s plan proposes to remove statutory and regulator requirements for physician extenders such as nurse practitioners and physician’s assistants, such that they could practice without physician supervision.

***“24-Hour Coverage”***

The Governor’s plan also proposes to implement a “24-Hour Coverage” program whereby worker’s compensation and traditional health insurance coverage. The 5-year pilot program would be voluntary for employers.

***HSA Conformity***

The Governor’s plan also includes a proposal to conform state and federal law by allowing deposits made into a Health Savings Account (HSA) to be tax deductible. Currently, these contributions can be deducted from federal, but not state, tax liability.

## **CMA Comments**

The CMA is very encouraged by the Governor's commitment to providing all Californians with access to health insurance. However, we are concerned with specific aspects of the proposal.

We are excited about the Governor's plan to cover all Californians. We also applaud the Governor's plan for containing costs by limiting excessive health insurance plan profits and administrative costs. In addition, as an organization dedicated to promoting health and wellness, we appreciate the Governor's emphasis on promoting healthy lifestyles and disease prevention.

We are concerned that allowing non-physicians to expand their practice beyond what they are trained and licensed to do will compromise quality of care. This part of the Governor's plan creates a two-tiered system of care, where only some people have access to physician services. We believe that all Californians, rich and poor, rural and urban, should have access to a doctor when they need it.

The CMA is also concerned about the Governor's proposed doctor and hospital tax, which would require physicians to pay a 2 percent tax on gross revenues. This tax is essentially a tax on sick people when they can least afford it. By taxing providers, the plan is able to offer conditional increases in Medi-Cal rates. These increases would only be available to providers who meet certain pay-for-performance, IT and cost-containment requirements. CMA is concerned that the requirements to obtain these long-overdue Medi-Cal rate increases will be onerous and require substantial investment in new computer systems and employee training. We are also concerned that any pay-for-performance system allow physicians to help patients make the best decisions for the individual needs of their patients.

Finally, we are concerned that the mandatory employer contribution is too modest to adequately fund the system the proposal creates and generates incentives for employers to drop coverage in favor of the lower-cost option of paying just 4 percent of their payroll. Currently, the median amount that an employer who offers any coverage pays is 7.7 percent, and 25 percent of employers who offer coverage pay more than 15 percent of payroll. Since almost all employers who currently offer coverage pay far in excess of 4 percent of payroll, the new proposal creates an incentive for employers to drop coverage.

*For more information contact CMA Government Relations at 916-444-5532.*