Is Choice of Physician and Hospital an Essential Benefit?

1. Robert H. Brook, MD, ScD

Author Affiliations

1. Author Affiliation: RAND Corporation, Santa Monica, California.

1. Corresponding Author: Robert H. Brook, MD, ScD, RAND Corporation, PO Box 2138, Santa Monica, CA 90407 (robert_brook@rand.org).

In the 1970s, health care was simpler. The fields of transplant surgery, clinical pharmacology, and clinical oncology, among others, were just emerging. The proportion of the gross national product spent on health care was in the low single digits. There were no preferred provider organizations, no publicly available data indicating which surgeon was better than another, no evidence-based medicine movement, or any other kind of information designed to help individuals make treatment choices. In the 1970s, it was reasonable for health insurance to cover the entire gamut of health care, from what currently would be called complementary and alternative medicine to traditional medicine. For those with health insurance, no matter what kind of service a physician and patient agreed to, the service was covered without either evidence that it was effective or prior authorization.

Forty years later, the Patient Protection and Affordable Care Act1 requires that the federal government define an essential benefit package for those individuals who will obtain insurance through the new health insurance exchanges. The Secretary of the Department of Health and Human Services has asked the Institute of Medicine to assist in this activity.2 What is an essential benefit package? One definition is a package that covers anything a physician and patient want, regardless of whether there is clinical evidence to support its use. Patients might be asked to share some portion of the cost of the package benefit, which would help to control use. Cost sharing is effective in reducing the amount of care used. But as the RAND Health Insurance Experiment of the 1970s demonstrated, cost sharing neither changed the quality of care that was delivered, nor did it change whether patients went to physicians for conditions that really required medical care.3 Stated another way, cost sharing exerted some control on the amount of care used, but it did not change the mix of appropriate or inappropriate care that was used, or improve the quality of care that was provided. Even free care did not affect the mix of care or quality.3 So how should an essential benefit be designed in an era when health care is far more expensive, the number of tests and procedures is significantly greater, and evidence-based medicine is the slogan of the day? In addition, consumers have access, at least in theory, to data describing the quality of hospitals, physicians, and health care facilities, complicating discussions regarding what is an essential benefit.

What do individuals want in health care? Obviously, they want to receive the treatment or procedure that can best help to improve their health status. Individuals do not want medical services that are not needed, but they do want those that are. Most individuals probably prefer not to travel very far to obtain needed care. Furthermore, many may ask whether, if given the opportunity, they should seek care from the physician they know or are referred to, or whether they should choose a “better”
physician in their local area, or even travel to a health facility such as one of the top-rated hospitals in the country to receive the required procedure, operation, or treatment. Whatever their choice, patients want to be treated humanely—to be respected as individuals and dealt with equitably and compassionately.

This is the complicated context in which health care reform is being implemented and an essential benefit plan is being defined. As the definition process moves forward, answers will be needed for questions that may be uncomfortable to discuss openly, such as whether expensive but marginally effective procedures or medicines should be covered. Another issue is whether an essential benefit package should allow patients to choose where and from whom they receive care with no financial consequences of their decision. Should an essential benefit plan allow this choice only if evidence shows that more expensive physicians and hospitals improve health status and outcomes more than those that are less expensive? What will happen if a patient has reliable information that a particular hospital provides a specific treatment better, or perhaps even far better, than the hospital covered in the patient's essential benefit plan? Will the patient have any recourse? How can patients be empowered and costs be controlled at the same time?

What are the precedents set elsewhere for essential health care benefits? Some countries that provide citizens with basic health care packages do not include choice of either physician or hospital as part of the essential benefit plan. In Israel, for example, a patient has to pay more for the privilege of choosing a specific surgeon.4 The following illustration makes these issues more concrete. A middle-aged man has a condition that meets evidence-based criteria for having coronary artery bypass graft surgery. If he undergoes the operation performed by the best surgeon in his local area or in his region of the country, he will be less likely to die. For example, depending on the patient's health, his expected death rate would be 1% not 2%.5 The patient’s health plan, in theory, allows him to make such choices, but the choice is associated with additional cost. After having had a quantitative decision-analytical conversation with his trusted, evidence-based practicing physician in his medical home or accountable health care organization about the adverse effects and the benefits of the procedure, and after reading information on a trustworthy publicly available Web site, the patient decides that he wants to undergo the operation performed by the better surgeon, as defined by available data. However, his health plan requires him to pay an additional $20 000 to have that surgeon do the procedure in the selected hospital, relative to his cost at the hospital in his essential benefit plan. Would this financial burden change the decision?

The Affordable Care Act will add a large number of US citizens to the Medicaid system. When the total number of Medicaid beneficiaries is added to the number of individuals whose health care will be provided by the new insurance exchanges, it becomes clear that what the government chooses to do in defining an essential benefit package will significantly shape both the public and private medical market. It is not sufficient to say that the package will only cover care that evidence shows will benefit the patient. If the available evidence compares one physician or hospital with another, will the same evidence-based principles be applied in defining an essential benefit package? Sports enthusiasts know that whenever a professional athlete is injured, the athlete will seek care for the injury from the best clinician at the best clinic. There is no question about who should perform the needed procedure. As health care reform is implemented, average US citizens will be asking: Is the essential benefit package
good enough to protect them and their family and help them live a healthy life? In other words, can the patient and family be certain that they can afford the best hospital or physician if the choice might make a meaningful difference in health?

Individuals cannot predict what procedures they will need, or whether receiving care from a better physician or hospital is potentially life-saving. But if an empowered individual takes the time to access reliable Web sites providing information about the quality of needed care, should acting on such information be discouraged by financial consequences that are part of an essential benefit plan? If the answer is yes, then the movement toward reporting results of surgeons and hospitals will probably lead to a society in which the wealthy receive care from the better hospitals and physicians, and they know it.