Nursing Economics Journal - Featured Article

Volume 22, Number 5 **September/October 2004**

Essential Health Care: Affordable for All?

***Mary O. Mundinger, DrPH**, is Dean, Columbia University School of Nursing, New York, NY, and Director, UnitedHealth Group.*

***Edwidge Thomas, MS, ANP**, is a Clinical Director and Lead Clinician in Columbia University School of Nursing's Independent Nurse Practitioner Primary Care Practice, New York, NY.*

***Janice Smolowitz, EdD, ANP**, is a Clinician/Researcher, Department of Neurology, Columbia University School of Nursing, New York, NY.*

***Judy Honig, EdD, PNP**, is a Clinician/Researcher, Columbia University School of Nursing, New York, NY.*

Executive Summary

- *The number of Americans without health care insurance essentially equals the number of Americans covered by Medicare.*
- *Two-thirds of the funds used to pay for the new prescription drug benefit would pay for cost of the proposed plan to provide essential services to the uninsured.*
- *he faculty from the Columbia University School of Nursing propose a mandatory insurance plan that is "privately administered, community-based, affordable (in) cost by a broad group of employers or the public...(in) a risk pool mirroring the general population."*
- *The assumption behind normalizing the risk pool is rooted in the fact that many of the uninsured are children or young healthy adults.*
- *In addition to providing a base of essential services, the plan includes some thoughtful mechanisms to steer appropriate utilization such as low-cost generic drug benefits, low co-pays for preventative care, and higher co-pays for emergency services.*
- *Clearly, the benefits of preventative care and early intervention pale in comparison to the cost of treating acute or chronic illness and promise a much better outcome.*

Access to affordable health care has become a national crisis. Individuals and their families without insurance delay care, which results in hospitalizations and expensive treatment for conditions that could have been resolved with early access (Ayanian, Weissman, Schneider, Ginsburg, & Zaslavsky, 2000). The uninsured have many faces and many reasons for being uninsured. First and most crucial to the debate are those who cannot afford insurance. Second are those who could pay for insurance but choose not to, thinking they are unlikely to need

health care. Third are those who choose to rely on emergency room and charity care, knowingly foregoing an expensive premium for care they expect to need. The high cost of insurance causes many with low incomes to forgo insurance and care; disability, poorly controlled chronic illness, and a spiraling down of quality ensue. The nation cannot afford to sustain this broken system, not in terms of resources, nor in terms of the deteriorating health of the public.

In 2001, the annual cost for all care for those uninsured at least part of the year was $100 billion. (Hadley & Holahan, 2003). Approximately $62 billion was uncompensated care or self-pay by the uninsured, more than a third of the total cost of care for the uninsured for those covered by insurance for part of the year. The Institute of Medicine (2003) estimates that the uninsured incur other economic costs from their lack of coverage, including disability and lost work for additional aggregate costs of $65 to $130 billion. While complex issues of health economics, politics, taxes, and tradeoffs in public goods pose barriers to universal coverage (Reinhart, 2003), there is, nonetheless, an argument to be made for adopting an essential benefit plan. The plan proposed in this article would cost $86 billion in 2003 dollars for premiums for the 43 million individuals currently uninsured.

This cost could be borne in a number of ways; private, public or employer subsidy, or self-pay. The same benefits (at the same individual premium of $2,000 a year) could be available as an alternate option by employers to their currently insured employees. The major caveat for this level of benefits and premium requires that the insured cohort (employee unit or geographic region) reflect the same demographics in age/disease/burden/risk as those insured by other commercial insurer plans.

Universal coverage could offer a promising opportunity to begin to ameliorate the unsustainable use of expensive illness care now substituting for effective low-cost prevention and early detection.

Miracles of Modern Medicine

The miracles of modern American medicine have raised the hopes of every citizen for a healthier, longer life. The promise of the continuing cascade of scientific breakthroughs is real, but better health still relies primarily on the low-tech system of care that prevents crises, protects against the ravages of poorly managed chronic illness, and advances health through assisting individuals to adopt healthier lifestyles. Optimally everyone would have access to this valuable generalist care, and to sophisticated technologies when their use has a reliable chance of adding benefit. Not only can this country afford to engage in developing such a system, but it cannot afford not to. A catastrophic benefit plan may be appropriate for extensive care in a crisis, but preventing expensive, debilitating outcomes depends on the availability of essential health care services.

In 2002 the number of uninsured rose to an alarming 43 million — a 5% increase from the previous year (Mills & Bhandari, 2003), and this number continues to rise. Since most health insurance is an employee benefit, growing numbers of unemployed is a major cause, but the employed are also finding health care benefits deteriorating: more co-pays, escalating premiums, and higher co-insurance. Job-related health benefits declined 6% between 2001 and 2003 (Strunk & Reschovsky, 2004). Fifty-six percent of the uninsured are members of families where there is a full-time worker (Hoffman & Wang, 2003); the

loss of insurance for spouses and children is a major national problem. Young adults between the ages of 18 and 24 are less likely than any other age group to have health insurance coverage (Mills & Bhandari, 2003), a reflection of the low wage or temporary jobs available to them that do not usually offer health benefits (Collins, Schoen, & Tenney, 2003). And, as retiree health benefits erode, the newly disenfranchised are the under-65 retirees not yet eligible for Medicare.

Universal coverage for essential services offers enormous value to the system and to individuals. Preventive care and effective chronic illness management can be quite expensive to provide. Because patients change insurers often, there is a financial deterrent for any insurer to cover these services unless all insurers do so. If everyone were covered for prevention, chronic illness management, and early detection of potentially costly illnesses, then insurers would be less likely to limit coverage for these services. The benefits, universally provided, would accrue to all benefit plans regardless of patients switching between insurers. Individuals would bring with them the health benefits from earlier prevention/management/detection, and the aggregate costs to the system would decrease, perhaps dramatically. This is true for all populations, most of all the uninsured.

The uninsured more often present with health crises that are costly to themselves, as well as to the system. Many, if not most, of these crises could be prevented with early detection of new problems or effective management of existing ones. Even those with insurance are using the health care system ineffectively; care is most often prompted by symptoms, not prevention or management of asymptomatic health problems. Universal access to care would add a powerful incentive for payers to adequately cover prevention and chronic illness education and care, because all payers — and all beneficiaries — would reap the economic and health benefits. Understanding that the politics of the uninsured is far more complex than assuring essential coverage, the authors nonetheless believe that a program providing affordable care may facilitate the adoption of universal coverage.

Finding Balance

The RAND Health Insurance Experiment in the 1970s showed that individuals use health care in direct correlation to the cost they themselves will incur, regardless of whether or not the care is likely to help (Brook et al., 1983). Therefore, clinicians who are influential in patient acceptance of only care that has predictable benefit are crucial to cost-effective outcomes (Kosecoff et al., 1987; Mitchell & Bentley, 2000). Moving clinician behavior toward evidence-based practice has been slow to catch on although the country has many scientists, economists, and policy experts who have articulated the value of such a system for decades. Clinicians, however, still find it difficult to say no to patients' demands for care, drugs, testing, or new technology deemed (by the patients) as a health care right. The HMO act of 1973 (now 30 years old) was explicitly established to rely on clinicians' expert knowledge of what therapies were cost effective and therefore advisable to institute. It did not work then, and in the current environment of expanded choice and litigation triggered by denial of care, clinicians all too often defer to patient demands even though they may be fully aware that the treatment or tests have little chance of helping the patient or course of care. The emerging adoption of "pay for performance" by insurers may be a tool for success. Monitoring known beneficial process and outcomes of care is making its way into the mainstream, and as benchmarks are established, they are increasingly

hard to ignore.

Limited treatment choices with low cost-sharing tends to foster increased elective care after an out-of-pocket maximum is reached. Comprehensive care with high cost sharing has shown some indication of patients' delaying care that could have saved money (hypertensive treatment, for example) (Brook et al.,1983; Newhouse et al., 1981). The issue is to find the right balance of cost and choice to maximize use of beneficial care.

Columbia University School of Nursing faculty propose a plan that attempts to find that balance: a privately administered, community-based, affordable cost by a broad group of employers or the public offering the product through an in-network plan, and enrollment that has a risk pool mirroring the general population. This would be an essential benefit plan, providing cost-effective services required by the majority of the population, with reasonable premiums due to the benefit design, broad enrollment, and evidence-based decision making.

The ability to enroll a population reflecting a reasonable cross-section of risks is problematic. With no changes in federal law, carriers will accomplish this as they do now. Some carriers will perform medical underwriting; consequently some groups that want coverage and that pose a higher than average risk will be denied coverage or will be charged more. Groups with lesser risk than average, or individual employees and dependents that are healthier than average, might tend not to purchase coverage. One way to address this difficult issue is to require all individuals to have at least basic coverage (even the most healthy would join the risk pool). This mandatory coverage approach, similar to a requirement that drivers carry car insurance, is certainly not without significant social, financial, and policy implications. It will, however, make universal insurance affordable. As noted earlier, this issue will arise in any strategy to cover 100% of the population.

Plan the Essential Benefit Plan

Using 2003 data, the authors arrived at a plan with a premium of $172 a month ($2,074 per year) and out-of-pocket expenses capped at $1,500 a year, excluding co-pays for drugs. This premium includes a reasonable amount to cover the administrative costs of commercial insurers, which should encourage their participation in a broad national coverage plan. The illustrative premiums assume a cross-section of health care risks consistent with a typical insured group.

This plan would cover the great majority of essential health and medical needs of beneficiaries, rely on evidence in the literature to assure treatment based on scientific outcomes rather than patient demand or clinician preference, and would cover those services that a great majority of the insured pool would utilize. Only in-network charges would be covered. Since more than half of the uninsured are dependents of covered employees, the uninsured population includes children who are conventionally lower cost than the average enrollee, suggesting the cost of premiums could be even lower. Another large group of uninsured is the young healthy population (for example, nearly 40% of college graduates and one-half of high school graduates who do not go on to college had a period without health insurance in the year following graduation) (Collins et al., 2003). This group is also low risk for high utilization.

Fundamentally important to the success of this plan is the decision

making of the clinician acting in the best interests of the patient, assuring that care provided, drugs prescribed, and testing initiated are likely to be useful. By underpinning this benefit plan with the specific requirement that participating clinicians provide care within established evidence-based guidelines, fewer futile or unnecessary services will be provided. With the growth of evidence-based practice guidelines, and a growing awareness in the public that not all care is beneficial, this is more possible today than even a few years ago.

Questions

What exactly is an “essential” benefit plan as distinguished from a limited or comprehensive plan? Essential care is cost-effective care available to and needed by the large majority of the beneficiaries. Prior attempts at developing low-cost plans have relied on low premiums combined with extensive cost sharing. “Comprehensive” benefits, therefore, are often financially out of reach for the beneficiary. With a “limited” set of covered benefits and low cost sharing for those covered benefits, individuals have to pay out-of-pocket for a wide array of uncovered services.

All covered services require the beneficiary to pay either a flat co-pay or co-insurance, which is 15% percent of the contracted rate. The maximum out-of-pocket cost per year is $1,500, which would include the co-pays and co-insurance for all services except drugs. Once the out-of-pocket cost for the benefit year has reached $1,500 per member, the member does not have a co-pay or co-insurance for the remainder of that benefit year.

Coverage decisions were made by an experienced group of nurse practitioners who have a 10-year history of practicing independent primary care in New York City, with Medicaid and with commercially insured populations. The rationale for these coverage decisions follows.

Why in-network? Sufficient access to all necessary providers can be guaranteed through a contracting process; an essential plan that is cost effective requires close control of all costs. Recent quality assessment and improvement programs begin to identify cost-effective providers and institutions. These data and analyses are becoming more sophisticated and more widely adopted by the public and payers. Networks can also function to assure access to the most appropriate array and sources of care.

Why privately administered? Then economic forces function to assure that the product remains competitive and flexible within the major health insurance market. Employers will be less likely to withdraw from the market and patients less likely to switch to a publicly funded system.

Humanistic and Biophysical Care

Essential health care satisfies the health needs of the majority of the population. It is care that is cost effective, appropriate, necessary, and achieves a positive effect on the health status of the individual and population served. Essential care preserves or prolongs life, leads to cure or effective prevention of disease, and relieves suffering; essential care, therefore, is “humanistic” as well as biophysical.

The essential benefit plan described in this article attempts to fulfill this description. The drug benefit embedded in this plan is also an essential plan. Generic drugs are accessible with an $8 co-pay and formulary brand name drugs with a $40 co-pay. The formulary is designed with

the same criteria as for the other medical services: cost effective, appropriate, necessary, with a projected positive effect on health status. The formulary covers brand-name drugs only when a generic with benefit for the same condition is not available. While we recognize the advantages of many new generation drugs for many individuals, it is clear that not everyone, and not even the majority, requires these newer drugs. There will always be patients who need but are not covered for the more expensive drugs. We would rather see generic drugs available for all those who need them, especially because of the growing concern over effective chronic illness management, than the few instances where only the newest drug is required for a few individuals. This could be a good beginning to rationalizing drug coverage, but the essential drug benefit needs significantly better definition in the future. There is evidence that in some instances a newer generation or more expensive drug will, in effect, save money if covered, even though a generic is available for the same conditions (Craig, Davey, Malek, & Murray, 1996; Ofman, Yamashita, Siddique, Larson, & Willian, 2000; Smith & McBurney, 2003). The outcome achieved with the more expensive drug may save more money in care dollars than the initial cost of the drug. As evidence in the scientific literature identifies these cost-effective choices, the essential formulary should adopt these drugs.

In reviewing the covered and noncovered services listed in Table 1, several questions arise. The emergency room (ER) co-pay of $75 per visit is relatively high. We believe this higher financial barrier to utilization is warranted, as most inappropriate ER visits are due to insufficient access to generalist care. With a plan that provides adequate primary care, nonemergency use of an ER should have a significant penalty.

Table 1.
Proposal for an Essential Health Plan

Type of Services	Covered	Non-Covered	Co-Pay/Co-Insurance
Hospital Inpatient			
Medical	X		15%
Surgical	X		15%
Deliveries	X		15%
Mental Health	X		15%
Hospital Outpatient			
Emergency Room	X		$75
OP Lab	X		15%
OP Radiology	X		15%
OP Surgery	X		15%
OP Observation	X		15%
Primary Care Services			
Surgery	X		15%
Venipuncture	X		15%
Radiology	X		15%
Pathology Lab	X		15%
E&M - Office Visits	X		15%
E&M - Preventive Visits	X		$15
E&M - Inpatient Visits	X		15%
Immunization/Injections/Infusions	X		15%
Referral Services			
Surgery - Nonmaternity	X		15%
Inpatient	X		15%
Outpatient	X		15%
Office	X		15%
Assistant	X		15%
Surgery - Maternity - Non-Deliveries	X		15%
Venipuncture	X		15%
Anesthesia	X		15%
Radiology	X		15%
Lab/Pathology	X		15%
E&M - Office Visits	X		15%
E&M - Inpatient Visits	X		15%
E&M - Consultations	X		15%
E&M - Emergency Room/Critical Care	X		15%
Medicine Non-Surgical			
Psychiatry	X		15%
Ophthalmology – Exams	X		15%
Ophthalmology – Services	X		15%
Cardiovascular	X		15%
Chemotherapy	X		15%
Physical Medicine	X		15%
Other Services			
Transplant		X	
Home Health Care: Post Hospital Only	X		15%
Ambulance/Transportation	X		15%
Appliance/DME		X	
Chiropractic Care		X	
Eye Wear (Cataract and Glaucoma)	X		15%
Eye Wear (other)		X	
Optometry Exams		X	
Generic Drugs	X		$12
Formulary Drugs	X		$40
Dental Care		X	
Cosmetic Surgery		X	
Podiatry		X	
Hearing Testing and Hearing Aids		X	

Type of Services	Covered	Non-Covered	Co-Pay/Co-Insurance
Hospital Inpatient			
Medical	X		15%
Surgical	X		15%
Deliveries	X		15%
Mental Health	X		15%
Hospital Outpatient			
Emergency Room	X		$75
OP Lab	X		15%
OP Radiology	X		15%
OP Surgery	X		15%
OP Observation	X		15%
Primary Care Services			
Surgery	X		15%
Venipuncture	X		15%
Radiology	X		15%
Pathology Lab	X		15%
E&M - Office Visits	X		15%
E&M - Preventive Visits	X		$15
E&M - Inpatient Visits	X		15%
Immunization/Injections/Infusions	X		15%
Referral Services			
Surgery - Nonmaternity	X		15%
Inpatient	X		15%
Outpatient	X		15%
Office	X		15%
Assistant	X		15%
Surgery - Maternity - Non-Deliveries	X		15%
Venipuncture	X		15%
Anesthesia	X		15%
Radiology	X		15%
Lab/Pathology	X		15%
E&M - Office Visits	X		15%
E&M - Inpatient Visits	X		15%
E&M - Consultations	X		15%
E&M - Emergency Room/Critical Care	X		15%
Medicine Non-Surgical			
Psychiatry	X		15%
Ophthalmology – Exams	X		15%
Ophthalmology – Services	X		15%
Cardiovascular	X		15%
Chemotherapy	X		15%
Physical Medicine	X		15%
Other Services			
Transplant		X	
Home Health Care: Post Hospital Only	X		15%
Ambulance/Transportation	X		15%
Appliance/DME		X	
Chiropractic Care		X	
Eye Wear (Cataract and Glaucoma)	X		15%
Eye Wear (other)		X	
Optometry Exams		X	
Generic Drugs	X		$12
Formulary Drugs	X		$40
Dental Care		X	
Cosmetic Surgery		X	
Podiatry		X	
Hearing Testing and Hearing Aids		X	

The co-pay for preventive services is $15, which would include screening, counseling, education, immunizations, and chemoprophylaxis determined by the evidence in the scientific literature for that age group. Annual assessment and counseling by a primary care clinician will be provided for risk related to smoking, physical activity, nutrition, alcohol or drug abuse, and periodic assessment and monitoring of the beneficiary's chronic illness, thereby reducing complications. A flat $15 fee for preventive care visits rather that a percentage co-pay is an attempt to encourage preventive care visits.

Several services are not covered at all, requiring full self-pay or alternative insurance. Transplant services are not covered under this plan. Individuals at risk for this service (and most of the need is predictable from long-standing cardiac, diabetic, or kidney disease) might choose additional coverage, or rely on Medicare if age or disability (at any age) provided eligibility. Socializing the added premium for transplants would make it much higher in order to cover the small number of those who might need a transplant. Only brand name drugs listed in the formulary are covered for the same reasons.

Summary

In this essential benefit proposal, we have attempted to develop an affordable plan that covers the medical needs most relevant to the current demographics of the uninsured population. Many uncovered services are either utilized primarily by the Medicare population (podiatry, hearing aids, durable medical equipment) and are therefore already covered for those individuals, or are needed by a minority of beneficiaries (transplant, the newest generation of drugs), or are of questionable medical value (cosmetic surgery). While we believe dental care, eyeglasses, many new drugs, and other uncovered services are indeed beneficial, coverage was eliminated in order to develop a plan that could have broad adoption for 43 million people who, today, have no coverage at all. Employers, or the individuals themselves, can make the financial decisions (or at times the sacrifices) to access these additional services.

At $89 billion a year in premiums, Columbia Nursing's plan approximates only 60% more dollars than the conservative estimate for a very limited drug benefit for the elderly ($540 billion over 10 years). Isn't a program of broad essential health care for individuals who today have no insurance worth $1.60 for every $1.00 of a limited drug benefit

for individuals who already have extensive comprehensive health coverage? This proposal does not advocate public payment of the premium for the uninsured, nor does it argue for funding one program over another. This comparison is simply a way to view, in context, the fact that the uninsured population is approximately the same size (43 million) as the Medicare population (44 million), and yet a Medicare drug benefit would cost two-thirds as much as a full array of health services, including drugs, for the same number of uninsured. Savings to those already insured would be significant. Hidden in the premiums of the insured is the cost of care of the uninsured. This subsidy would no longer be needed if everyone were covered. The savings, therefore, would accrue to the currently insured, to employers who carry much of the cost, and to all the uninsured who today suffer from avoidable illness and disability. Essential health care is eminently affordable, and the business case, as well as the social one, demands that we take action.$

NOTE: Reden & Anders, a Subsidiary of UnitedHealth Group, provided actuarial analysis.

References

Ayanian, J.Z., Weissman, J.S., Schneider, E.C., Ginsburg, J.A., & Zaslavsky, A.M. (2000). Unmet health needs of uninsured adults in the United States. Journal of the American Medical Association, 284(16), 2061-9.

Brook, R.H., Ware, J.E., Rogers, W.H., Keeler, E.B., Davies, A.R., & Donald, C.A., et al. (1983). Does free care improve adults' health? Results from a randomized controlled trial. New England Journal of Medicine, 309(23), 1426-34.

Collins, S.R., Schoen, C., & Tenney, K. (2003). Rite of passage? Why young adults become uninsured and how new policies can help. New York: The Commonwealth Fund, Task Force on the Future of Health Insurance.

Craig, A.M., Davey, P., Malek, M., & Murray, F. (1996). Decision analysis of Helicobacter pylori eradication therapy using omeprazole with either clarithromycin or amoxicillin. Pharmacoeconomics, 10(1), 79-92.

Hadley, J., & Holahan, J. (2003). How much medical care do the uninsured use, and who pays for it? Health Affairs. Retrieved March 12, 2004, from http://www.healthaffairs.org

Hoffman, C., & Wang, M. (2003). Health insurance coverage in America: 2001 data update. Washington, DC: Kaiser Family Foundation.

Institute of Medicine. (2003). Hidden costs, value lost: Uninsurance in America. Washington, DC: The National Academies Press.

Kosecoff, J., Kanouse, D.E., Rogers, W.H., McCloskey, L., Winslow, C.M., & Brook, R.H. (1987). Effects of the National Institutes of Health Consensus Development Program on physician practice. Journal of the American Medical Association, 258(19), 2708-2713.

Mills, R.J., & Bhandari, S. (2003). Health insurance coverage in the United States: 2002. Washington, DC: U.S. Department of Commerce,

Economics and Statistics Administration, Bureau of the Census.

Mitchell, J.B., & Bentley, F. (2000). Impact of Oregon's priority list on Medicaid beneficiaries. Medical Care Research and Review, 57(2), 216-234.

Newhouse, J.P., Manning, W.G., Morris, C.N., Orr, L.L., Duan, N., & Keeler, E.B., et al. (1981). Some interim results from a controlled trial of cost sharing in health insurance. New England Journal of Medicine, 305(25), 1501-1507.

Ofman, J.J., Yamashita, B.D., Siddique, R.M., Larson, L.R., & Willian, M.K. (2000). Cost effectiveness of rabeprazole versus generic ranitidine for symptom resolution in patients with erosive esophagitis. American Journal of Managed Care, 6(8), 905-916.

Reinhardt, U.E. (2003). Is there hope for the uninsured? Health Affairs. Retrieved March 12, 2004, from http://www.healthaffairs.org

Smith, D.G., & McBurney, C.R. (2003). An economic analysis of the Atorvastatin Comparative Cholesterol Efficacy and Safety Study (ACCESS). Pharmacoeconomics, 21(Suppl. 1), 13-23.

Strunk, B.C., & Reschovsky, J.D. (2004). Trends in U.S. health insurance coverage, 2001-2003. Washington, DC: Center for Studying Health System Change.

Anthony J. Jannetti, Inc.
East Holly Avenue Box 56 Pitman, New Jersey 08071-0056
Phone: (856) 256-2300 Fax: (856) 589-7463