Investing in Long-Term Health

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The growth in spending on health care has slowed over the last decade, easing fears that Medicare would devour the federal budget, create crippling federal deficits, and cause precipitous jumps in tax rates.[1] This is good news insofar as it makes room in public and private budgets for other priorities, and is consistent with improving efficiency in health care delivery, such as the move toward substituting outpatient care for hospitalizations. This slowdown in spending, however, could also augur reduced innovation in new technologies, medications, and procedures; lower quality of care and less access to care; and lower life expectancy.

This raises the question of whether the health care system is aligned both to incentivize innovation and to have those innovations widely available to patients who could benefit from them. Insurance design is crucial for both.

When a new treatment becomes available, insurance plans have some latitude in covering it. Direct pressure to include coverage for new treatments comes from federal and state regulation, including how Medicare and Medicaid, which account for approximately 40% of national spending on health care, approach coverage decisions.[2] In many settings, regulation increases premiums by forcing insurers to cover treatments regardless of their cost or how much patients value them.[3] Requirements to cover medically beneficial care regardless of expense come with real costs: the decision to cover, for example, $1 million treatments that generate 1 month of additional life would raise premiums, making health insurance less affordable and leaving fewer resources for housing, education, food, and other priorities. Medicare prohibits the use of cost-effectiveness analysis,[4] which makes it hard for insurers to curtail the use of treatments that have cheaper substitutes. At the same time, Medicare does not cover many treatments and services, such as long-term care, which improve patients' quality of life and might prevent costly hospitalizations.

Pressure on what to cover also comes from enrollees and other purchasers of insurance who look for the best insurance plans they can find. Defining "best" is always difficult, and even harder when people value different things. Some enrollees value more generous, less restrictive coverage. Others may prefer lower premiums and thus choose plans with more cost sharing or narrower networks. These choices affect health as well as expenses.[5]

Employers serve an important function in the US health insurance system because employer-provided health insurance covers more than half of all individuals in the US. Employer-provided health insurance serves an important role in pooling risk and may be more nimble than public programs (though the financing of employer-provided health insurance is regressive),[6] and employers play an important role in curating the coverage options available to employees. This poses 2 challenges. First, some medical innovations may be very expensive for a single employer, and reinsurance may be limited. Second, employer-provided health insurance plans are less likely to gain from the benefits of long-term health because of employee turnover. About 25% of employees voluntarily leave their jobs each year, greatly reducing the incentives for employer-provided health insurance plans to invest in care that may only pay health dividends decades later.[7]

Insurers, even nonprofit ones, aim to minimize spending within any given insurance premium, generating a disincentive to cover treatments that increase costs in a way that is not fully valued by enrollees (and thus able to be incorporated into premiums). This approach may control spending on low-value care that is expensive and produces only minimal health benefits. However, it may also limit coverage of expensive high-value care that benefits relatively few patients.

The health plan choices that patients and enrollees face may also interfere with coverage generosity. First, enrollees may not be able to discern the generosity or quality of coverage until they are sick and need specialized care—when it may be too late to choose a different plan. Second, the benefits of the treatment may not manifest for many years. For example, statins taken by 50-year-olds may reduce the number of them who have myocardial infarctions in their 70s. This not only makes it harder for patients to put a value on future benefits, but also means that any future savings from reductions in spending would accrue to Medicare, not the private insurer, and thus not reduce premiums accordingly. (Of course, coverage of high-value treatments does not necessarily reduce spending. Some treatments, such as childhood immunization and counseling adults about low-dose aspirin to prevent coronary heart disease, may improve health and save money; but most high-value treatments that are highly cost-effective still increase spending.[8])

There are ways to counteract this disconnect. One mechanism would be to mandate full coverage (without co-payments or restrictions) of high-value treatments for patients, which would require the government to determine the treatments that rise to this value. There is some precedent for this, such as the minimum coverage requirements for nongroup insurance plans offered through health insurance exchanges. But there are reasons to be skeptical that these centralized decisions will be sufficiently responsive to rapidly evolving medical innovation and nuanced real-world evidence as seen in recent tensions over Medicare's coverage of new medicines. Although a single-payer approach might be administratively simpler in many ways, it is also affected by politics, appropriation constraints, and monopsonistic power if the government is the sole payer for health care.

One potential alternative mechanism to consider developing would be harnessing new data analytics to incentivize coverage of care that improves patient outcomes in the long run. Machine learning applied to granular data, which includes imaging, laboratory values, histology slides, and other longitudinal data, can improve predictions of future health risks and reduce future care costs. Regulations could generate payments between insurers based on how well insurers improve enrollees' predicted long-term health outcomes—making additional payments to insurers who improve those prospects and imposing penalties on those who do not. Such payments could be analogous to existing risk adjustment currently used to adjust payments for Medicare Advantage plans based on the initial health of their enrollees.

This augmented risk adjustment sounds like a technical detail, but risk adjustment is a crucial mechanism for combatting insurers' incentives for "cream skimming" (enrolling only the healthiest patients), and augmented risk adjustment could be a similarly powerful tool for combatting insurers' incentives to limit coverage of new treatments with short-term costs and long-term health benefits. Such a mechanism could not only improve the availability and affordability of care that improves health, but also incentivize the ongoing development of medical innovation.

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