Payors, Data, and Nudges to Improve Care

Wendy Netter Epstein

Health care spending in the United States is bloated by payments for expensive, yet unnecessary and ineffective treatments. The Institute of Medicine estimates that we waste approximately $210 billion per year on such services.[1] Unnecessary care not only raises systemic costs, ultimately raising premiums and pricing some patients out of the market, but it can also harm patients who are exposed to unnecessary radiation, surgeries with the risk of complications, infections, and emotional harm.[2]

Unnecessary care is not caused by a single player. Doctors prescribe it. Patients consent to it. And payors pay for it. The role of doctors and patients in creating this problem has received considerable attention in the literature. Economic incentives, cultural norms, and legal incentives stemming from the medical malpractice system cause doctors to over-test, over-prescribe, and over-treat.[3] Patient decision-making is also subject to informational deficits and cognitive biases that lead many to err on the side of more treatment.[4] Further, moral hazard makes patients inefficiently price sensitive and lack of price transparency impedes their ability to take cost into account in making decisions.[5] Attempts to address the doctor and patient contributions to the unnecessary care problem are underway, and yet challenges persist.

But payors' contribution to the problem is just as important. After all, private insurers and government payors alike are paying for high cost, low value care. Of all the actors in the complicated web that is health care, payors would seem best situated to act as a check on patients and doctors. A rational, profit-maximizing insurance company (or even government payor), should be motivated to refuse reimbursement for costly, unnecessary care that not only does *not* improve patient health but might even harm it. While insurers do sometimes refuse such coverage, and extensive efforts at payment reform are underway, more often than not they now defer decisions on the medical necessity of treatment to physicians.[6]

There are reasons for this. For one, it can be hard for insurers to identify with requisite certainty just which expensive procedures are likely to be ineffective.[7] And the possibility of error in these determinations could have dire consequences. Consider, for example, the insurer that refuses to pay for a certain cancer drug, and it later turns out that the drug would

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The Journal of Law, Medicine & Ethics, 46 (2018): 927-930. © 2018 The Author(s)
DOI: 10.1177/1073110518821991
https://doi.org/10.1177/1073110518821991 Published online by Cambridge University Press

have saved the patient's life. Insurers also might lack adequate incentive to incur the administrative costs of a stricter medical necessity review, particularly when insurers can instead raise premiums in an ineffectively regulated market when claims costs increase.[8] In some cases, state law prohibits insurers from challenging physician decisions about reimbursable care.[9]

But perhaps the biggest hurdle is the norm of patient and physician autonomy. Public outcry against Health Maintenance Organizations (HMOs) has centered largely on their use of utilization reviews to turn down reimbursement.[10] Doctors and patients have argued that each individual patient is different, medicine is more of an art than a science, and doctors employed by insurance companies should not be able to override the decision of a doctor who has actually examined and developed a relationship with the patient. Further, a patient's right to self-determination is considered particularly strong in health care where patients are charged with making very personal decisions that affect their own bodies.[11]

In a world where most policymakers agree that reducing unnecessary care is essential to both bringing down systemic costs and improving quality, and where payors have both the incentive and the power to effect positive change, we should be focusing more on how payors can effectively use that power.

While respecting patient and physician autonomy is undoubtedly important, it is only part of the story. When patients consume unnecessary care that is reimbursed by a private or government payor, the patient's decision not only impacts the individual patient's well-being — it also has consequences for all other members of the risk pool who ultimately must bear the reimbursement cost.[12] The time has therefore come to revisit the role of payors in addressing the unnecessary care problem.

As a threshold matter, payors cannot simply be tasked with making reimbursement decisions absent input from physicians. There are too many land mines. Insurer financial motivations are likely to prompt denial of reimbursement for profit maximization reasons and not the betterment of patient health. Individual circumstances and doctor intuition do certainly still matter. And political headwinds against "death panels" are too strong to even contemplate that much payor power.

The situation may therefore be ripe for what Richard Thaler and Cass Sunstein have described as a "nudge."[13] Nudges steer people toward better decision-making without mandating a particular choice.[14] When it is important to protect decisional autonomy, but the exercise of autonomy alone results in suboptimal decision-making, nudges can be particularly useful.

Payors might be able to steer doctors and patients away from unnecessary care without going so far as refusing to reimburse for it entirely. Specifically, payors could nudge providers by requiring that providers receive automated warnings when they try to order a test that is known to be overused or a treatment that evidence suggests may often be ineffective. Essentially, a message would come up when a doctor puts in an order that asks, "Are you sure you want to prescribe this test?" There is at least preliminary evidence that such nudges can move the needle in significant ways, without overriding decisional autonomy.[15]

What makes this approach particularly salient, now, is that the data on which to base such warnings has significantly improved. While there will always be circumstances where knowledge of the individual patient is important, there is also much to be learned from the data that applies across broad categories. We can now identify at least some common tests and procedures that are over-used and the circumstances in which such overuse is likely. Over time, we will be able to identify more circumstances and to make these determinations more personalized.[16] There are many organizations — private and governmental — gathering this data, and while there is still a tremendous amount of work to be done, there has been much progress.[17]

One interesting example is the work being done by the Choosing Wisely campaign.[18] In 2012, the American Board of Internal Medicine Foundation (ABIMF), Consumer Reports, and nine medical specialty societies launched the Campaign.[19] Its purpose was to promote quality, evidence-based care that was "truly necessary."[20] It tasked medical societies with preparing lists of five tests or procedures in their clinical domains that are performed too often. The initial set of lists was well-received, and the campaign has grown from there, with more than 70 societies now involved.[21]

Also, there is precedent for the use of automated warning systems in medicine in the form of clinical decision support systems (CDSSs).[22] CDSSs were originally designed to try to prevent medication errors

The Journal of Law, Medicine & Ethics, 46 (2018): 927-930. © 2018 The Author(s)

https://doi.org/10.1177/1073110518821991 Published online by Cambridge University Press

by screening for drug doses, allergies, and drug interactions, and by employing alerts and warnings.[23] Some CDSSs now also go beyond the medication error realm to screen for problematic treatment.

But CDSSs as currently implemented are both over and under-inclusive. They have been criticized for the abundance of alerts that pop up when providers try to enter orders, many of which are not useful. Overuse of alerts leads to alert fatigue, where providers end up just ignoring the alerts.[24] Also, where CDSSs are currently deployed, they are still mostly used for prescribing and not for other types of orders and interventions.

A more effective alert system might be based on the lists that the Choosing Wisely campaign has assembled. This approach offers a number of advantages. First, the lists are driven by the providers practicing in the area, which might facilitate provider buy-in to the system and more effectively nudge provider decisions. Second, the Choosing Wisely lists are simple to translate to warnings and are not so numerous as to overwhelm. Third, they do not contain a lot of "close calls" but rather focus on the big ticket sources of overuse. Finally, they establish a national standard — which might even be helpful to physicians in malpractice litigation — and could promote uniformity in approach.[25]

There are admittedly hurdles to implementing this approach. For one, the nudge is paternalistic in the sense that it does attempt to influence behavior. Yet doctors and patients are ultimately free to make their own decisions absent repercussion. Common alternatives to the nudge, such as tying compensation to the likely effectiveness of treatment, are far more coercive.[26]

There are also concerns to still be addressed about the quality of the data, the cost of implementing the system, and the timing with which alerts must be deployed to have the desired impact on decision-making.[27] But in a world where most policymakers agree that reducing unnecessary care is essential to both bringing down systemic costs and improving quality, and where payors have both the incentive and the power to effect positive change, we should be focusing more on how payors can effectively use that power.

Note

This paper is adapted from W.N. Epstein, "The Health Insurer Nudge," *Southern California Law Review* 91, no. 4 (2018): 593-656. The author has no conflicts to declare.

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https://doi.org/10.1177/1073110518821991 Published online by Cambridge University Press

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