Politics Trumps Science
Rethinking State-Mandated Benefits

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Consumer frustration in the health insurance marketplace and difficulty influencing the coverage decisions of health insurance companies and employer health benefits have ultimately led to the definition of mandated benefits by state legislatures to cover specific services. In late 1997, a population-based survey of insured adult Californians found that 13% reported that important benefits they needed were not covered by their health plan. In this same year, approximately 3% of California’s insured adult population (or ≥200,000 people) reported contacting their elected official about the problems they were experiencing with their health plans, including important benefits not being covered. It is no wonder that state legislatures all over the country have taken on the task of regulating the benefit package for group-sponsored health insurance through coverage mandates.

As Rathore et al. conclude in the article, “Mandated Coverage for Cancer Screening Services: Whose Guidelines Do States Follow?” in this issue of the Journal, the practice of mandating coverage for cancer-screening tests by states is widespread and continues to grow. The first cancer-screening tests mandated were for breast and cervical cancer screening, followed by prostate cancer screening, and most recently colon cancer screening. The mandates included in this paper applied to traditional insurers, including indemnity health insurance and preferred provider organizations. State mandates that applied only to health maintenance organizations were not included. In this respect, the article underestimates the extent of cancer-screening mandates in the United States.

It seems remarkable that in the year 2000, cancer-screening benefits, which have been empirically demonstrated as both effective and relatively cost-effective, require acts of state government to ensure their coverage. Historically, traditional health insurance has not covered preventive care because these services were not considered “insurable” or medically necessary. They were not considered insurable because they were neither unpredictable (one needs them periodically) nor catastrophically expensive (they are relatively low in cost). Health insurance was originally designed to protect individuals against the high costs of hospitalizations. In fact, under Section 1862 of the Social Security Act—the Medicare program, which was modeled after the early Blue Cross programs—prohibits payment for preventive care. Only as exceptions to this provision has the U.S. Congress incrementally mandated coverage for specific preventive services for Medicare beneficiaries. Preventive services by definition are not considered medically necessary because they are not needed to treat illness, but are provided to seemingly healthy people.

What is perhaps most disturbing, however, is the fact that most state legislatures are not using evidence-based guidelines and recommendations as the basis for defining cancer-screening benefits. Policymaking in state legislatures seems influenced more by interests with a direct stake in the outcome and the desire for everyone to be screened for everything every year, regardless of the cost, effectiveness, or relative cost-effectiveness of the cancer-screening tests. Allowing politics to trump science in the design of benefit mandates results in potential overuse of screening services, is an inefficient use of health care resources, and produces an even greater divide in access to preventive care between those who have health insurance coverage and those who do not.

For example, in its comprehensive review of the scientific evidence on the efficacy and effectiveness of Pap tests, the U.S. Preventive Services Task Force (USPSTF) concluded that conducting annual Pap tests, instead of screening every 3 years, produces very little additional benefit at approximately three times the cost. If women between the ages of 20 and 64 are screened every 3 years, the reduction in the incidence of invasive cervical cancer is 91%, with an average of 15 tests for women ≥45 years. Annual screening of these same women reduces the incidence of invasive cervical cancer by 93%, with an average of 45 tests for women ≥45 years. To mandate screening every year is a very inefficient use of resources, tripling the costs of screening the more than 71 million insured women at risk in the United States, with very little added benefit. In a 25-year period, more than 3.2 billion Pap tests would be...

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The full text of this article is available via AJPM Online at http://www.elsevier.com/locate/ajpmonline.
performed on insured American women if screening were required annually, compared with less than 1.1 billion if screening is mandated every 3 years. The resources spent to provide the extra 2.1 billion tests under annual screening would be more than six times the amount needed to provide Pap tests every 3 years to every single one of the 21 million uninsured women in the United States.

Similarly, Rathore et al.² found that 18 states mandated prostate-screening coverage in 1999, despite the fact that the USPSTF recommended against routine screening for prostate cancer. In fact, “there is currently no evidence that screening for prostate cancer results in reduced morbidity or mortality.”² A great deal more research that prospectively examines the health outcomes of screening for prostate cancer is warranted before any widescale mandates for prostate screening are adopted. The only explanation for mandating this benefit is the result of political pressure on policymakers.

Not a single state in the survey conducted by Rathore et al.² had based its coverage mandates on the USPSTF recommendations. One obvious reason is that there is no lobby for the USPSTF recommendations. It is highly likely that most legislative staff members at the state and federal levels are not even aware of the guidelines and their scientific validity, or that the guidelines differ substantially from those made by cancer advocacy groups and health care providers. Given ongoing concerns about the growing costs of health care and the widening disparity in access to preventive services for those with and without health insurance coverage, the current approach of state legislators mandating coverage for unproven cancer screening tests or at intervals that dramatically increase the cost for little incremental benefit is wasteful, inefficient, and ineffective.

A fundamental dilemma is how to make the political process of producing mandated preventive benefits more rational? And if it cannot be made more rational, what alternative strategy is available to increase coverage for preventive care? I believe that the policymaking process at the state level can be made more rational by (1) working to increase the awareness of evidence-based guidelines among state legislative staff members and their elected officials, and (2) establishing ongoing relationships between preventive medicine experts in universities and research centers in each state with key legislative staff to the health committees in the state legislature. The objective of such an effort would be for legislative staff to rely increasingly on preventive medicine experts for policy advice on preventive benefit mandates, in addition to hearing from advocacy and other interest groups.

However, there is certainly no guarantee that attempts to increase rationality will win out over politics. Interest-group pressure, constituent pressure, and campaign financing are powerful forces in the political arena. Perhaps one of the most politically effective arguments for relying on evidence-based guidelines as the basis for defining mandated preventive benefits is an economic one. To provide ineffective preventive services or to mandate screening more often than needed is wasteful and unnecessarily increases the costs of health care and the price of health insurance. The health insurance industry is a powerful ally in the political process that will most likely support an argument for a more efficient and effective benefit design. One of the major arguments the industry has used to fight mandates is that they increase cost, which in turn exacerbates the growing rate of uninsured. To the extent that the industry would support mandated cancer-screening benefits, it is more likely to support evidence-based benefits.

Another approach to mandating preventive benefits would be to move away from a political decision-making process to the creation of health benefits commissions at the state level whose job it is to review evidence-based guidelines every 2 to 3 years and to update a basic benefit package that, at a minimum, all health insurers in the state must cover. This would take decision making out of the realm of electoral politics and political bargaining in the legislative arena and move it into the hands of experts who are charged with making decisions based on the scientific evidence of a particular service’s or drug’s efficacy, effectiveness, and cost-effectiveness.

The issues raised by Rathore et al.² are important ones for the field of preventive medicine to tackle. To allow the present political process and associated outcomes of mandating benefits to continue may in the long run lead to increasing disparities in access to preventive care and leave us even further from achieving our goals of increasing access to effective and cost-effective preventive care for all Americans.

References