Ethical Issues:

Is ‘Let the Buyer Beware’ Ethical?

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About This Course

This course considers the ethical standard of 'let the buyer beware'. What does 'let the buyer beware' mean? Should health insurance brokers adopt this standard? What opposing ethical standards exist?

Some Background

We know that health insurance brokers have an ethical obligation to disclose several things:

First, they must honestly explain policy terms;
Second, they cannot leave out important information;
Third, they must honestly quote the price.

Does the broker's ethical responsibility end with these three obligations? Should an ethical broker disclose additional information? Specifically, **do health insurance brokers have a disclosure responsibility to educate their clients about the workings of our healthcare system…or should the broker 'let the buyer beware' of them?**

Let's remember that the ultimate product we sell is healthcare. *Insurance* is simply (simply?) the means of financing healthcare services. We know that our clients will ultimately purchase healthcare services – examinations, operations, medical treatments and the like. Our products facilitate access to, and use of, these services; health insurance is not an 'end' product in and of itself. The 'end' product is medical care.

This raises a key question: can brokers differentiate health *insurance* from health *care*? In other words, can brokers reasonably claim that their jobs involve *only* making financial resources available to clients for medical care, but not the end-use for which clients use this money?

In this Text, we will suggest that they cannot reasonably make this claim.

Instead, we will suggest that healthcare financing (insurance) is inextricably tied into medical care. The 'benefits advisor' should, in other words, advise on the benefits that clients will access.

We'll discuss this at great length, shortly. But in this Preface, let's look at a warning issued by Bernard Rosof, Chairman of Huntington Hospital in New York: [1]

[1] Washington Post, September 29, 2009, Connolly. Italics added

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> 'Often people with generous insurance plans can run up large bills and face life-threatening complications from unnecessary care. Those problems include back surgeries that result in wound infections when physical therapy might have been a more effective treatment.'

Rosof suggests several things here. **First,** that people with 'generous insurance plans' may receive different care from people with less generous plans.

Second, that some of the different care is 'unnecessary'.

Third, that this 'unnecessary care' can lead to patient harm.

Fourth, that this happens 'often'.

Does Rosof – the Chairman of a hospital - mean that patients with certain types of health insurance actually receive the wrong type of care *as a function of their health insurance* and get harmed as a result? Might some types of health insurance actually result in more patient harm than other types? Could you, as a broker, unintentionally cause some harm to your clients?

Rosof's quote raises a number of ethical questions for brokers. How should they respond when faced with evidence that their policies (i.e. the products that they sell) may lead to patient problems? Should they simply 'let the buyer beware'? Or should brokers live up to a higher ethical standard?

Key Idea: Patients sometimes get more care than necessary, and sometimes suffer poorer outcomes as a result.

The knowledgeable broker knows that we sometimes *overuse* our medical system. Researchers who have studied this phenomenon, however, suggest that above a certain level of care:

> There is just no evidence that doing more helps. At best you do the same, and in some cases you actually do worse [due to infections, errors, patient fatigue, etc] [2]

This is apparently the thrust of Mr. Rosof's comments.

We want our clients to receive the right care – not too little or too much.

[2] Jonathan Skinner, John E. Wennberg, How Much is Enough", NBER Working Paper 6513, 1998

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Too much care, or *overtreatment*, may lead to negative patient results. Indeed, some Dartmouth Medical School researchers, among others, have discovered that mortality rates go ***up*** as patients receive more and more medical care. Dr. Elliott Fisher, a Dartmouth Medical School researcher, did an exhaustive study of medical spending patterns and discovered that hospitals that *spent the most* and *did the most* for patients had a 2 – 6% *higher* mortality rate. [3] The reason:

> The additional medicine patients are getting in the high-cost regions is leading to harm. [4]

More care led to more patient risks from error, infection and fatigue, without any compensating medical advantages.

Key Idea: Mortality rates may rise if patients get excessive medical care.

Here's our potential patient cycle: patients with 'generous insurance plans' (Mr. Rosof's words) may receive unnecessary care. That care, according to Dr. Fisher, corresponds to higher mortality rates.

How should an ethical broker react to this kind of information? What should he/she do with this information?

What ethical disclosure standard should he / she adopt?

Disclaimer

We discuss various medical procedures, treatment protocols and outcomes in this course. We do so as insurance brokers and educators, not as physicians or medically trained professionals.

We at *HealthInsuranceCE, LLC* are not medically trained or licensed and provide no medical advice herein.

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[3] Elliott Fisher, et. al. The Implications of Regional Variations in Medicare Spending, Annals of Internal Medicine, 2003, several articles. See Shannon Brownlee, Overtreated, page 50 for a summary of relative mortality risks.

[4] ibid, The Implications of Regional Variations in Medicare Spending Part 2, Annals of Internal Medicine 2003:138, pages 292 - 293

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You should always consult your own physicians about medical care. You should not interpret anything contained in this course as medical advice, and you should not rely on anything contained in this course as a basis for medical decision making.

Education Differs from Advocacy and Advice

This is an education course. We do not advocate any particular ethical position. Nor do we advocate any particular approach to medicine.

Rather, our goal is to stimulate broker's thinking about these issues. We will present data, ethical dilemmas and alternative solutions. We hope this course will help you consider your own ethical standards, for in the end, you must make your own decisions about ethical behavior.

We will base our ethical positions on standards that have existed for hundreds (thousands?) of years. We will trace the origins of these standards and comment on their applicability to today's health insurance brokers.

Why do we take this approach? Most Western ethicists – the people who discuss what constitutes ethical behavior - have a strong background in historical ethical thought, often as articulated in traditional Judeo-Christian positions. Many of these positions have become codified in our laws and insurance regulations.

Our regulatory injunctions against theft, for example, may be seen as directly descending from Judeo-Christian ethical positions.

While some of the ethical positions discussed in this course are based on traditional Judeo-Christian ideas, we do not advocate any particular religion or even religion itself. Rather, we use these traditional ideas because they have served as the ethical basis of western civilization for thousands of years. Living according to Judeo-Christian teachings is generally synonymous in our society with living ethically.

We aim, in this course, to stimulate your thinking about ethical issues, rather than to direct brokers to act in any specific way. Certainly your own professional life will generate ethical dilemmas that differ from our Case Studies. We offer our ethical positions not dogmatically, but rather as a teaching guide.

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Table of Contents

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Introduction to the Problem
Medical Procedures Contain Risks as well as Benefits

Here are some examples. Note when reading these that we take no position on whether or not the benefits outweigh the risks, or whether the risks outweigh the benefits. We simply provide data here and pose questions about the broker's ethical responsibilities to inform his/her clients.

First, prostate surgery. A 2009 study of prostate cancer screening found that PSA tests identified approximately 48 times as many benign tumors as cancerous. In other words, only about 1 of 49 men who had prostate *treatment* actually suffered from life threatening prostate *cancer*.[5]

But all the men, including those who had unnecessary surgery, risked incontinence and impotence, both byproducts of the surgery. Indeed one study indicated that the majority of men were impotent and still wearing adult diapers a year after their prostatectomy. [6]

Providers got paid to treat all the men. But only a small percentage benefited from care. A larger percentage may actually have been harmed by medical care.

Who provides this data to your clients?

> Key Idea: In one study, only about 2% of men receiving prostate *treatment* actually had life threatening prostate *cancer*. Yet all risked incontinence and impotence – frequent byproducts of prostate treatment. Our question: should the broker educate his/her clients so they can shop for medical services more wisely?

Though this and the next couple studies discussed here are slightly dated, they remain relevant as subsequent studies did not negate their conclusions. Also the underlying message, that most patients under-estimate the risks associated with testing and treatment, remains valid.

Second, back surgery. Back pain can be debilitating and patients may seek any treatment offering relief including vertebroplasty, a procedure to inset medical grade cement into weak bones, ostensibly to reduce the pain. In 2008, the US market for vertebroplasty was about $245 million.

[5] Stephen Smith, Benefits of Screening Questioned, Boston Globe 3/19/09

[6] Shannon Brownlee, Overtreated, Bloomsbury Press 2008, page 202

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Then in 2009, the New England Journal of Medicine published 2 studies that compared vertebroplasty to a control or placebo group. Both studies showed no beneficial impact of vertebroplasty in terms of pain reduction over the control groups.[7]

Third, surgery for knee osteoarthritis Knee osteoarthritis is a degenerative disease that causes pain, stiffness and decreased knee function.

Arthroscopic surgery, including lavage (removal of particulate material such as cartilage fragments and calcium crystals) and debridement (surgical smoothing of articular surfaces and osteophytes) was the widely used treatment in the early 2000s despite the fact that, according to the New England Journal of Medicine in 2008 'scientific evidence to support its efficacy is lacking'.[i]

Estimates of the number of knee arthroscopies performed annually in the US vary, and not all address osteoarthritis so we'll have to estimate the size of this problem:

- A 2002 New England Journal of Medicine study estimated 650,000 procedures at $5,000 each, creating a $3.25 billion market.
- A 2014 NEJM study estimated the market at 500,000 knee arthroscopies at about $20,000, generating a $10 billion market.
- Vinay Prasad in his 2015 book Ending Medical Reversal estimated the market at 700,000 patients spending $4 billion.

How poorly does the scientific evidence support the efficacy of arthroscopic surgery to treat knee osteoarthritis?

- A 2008 New England Journal of Medicine published study concluded that they 'failed to show a benefit of arthroscopic surgery for the treatment of osteoarthritis of the knee.'
- This followed a 2002 comparative study which concluded 'At no point did [the] arthroscopic-intervention group have greater pain relief than the placebo group.'
- The 2002 study concluded 'This study provides strong evidence that arthroscopic lavage with or without debridement is not better than and appears equal to a placebo procedure in improving knee pain and self-reported function.'

Providers got paid to treat. Patients didn't get better – even while they accepted the various risks of surgery.

Again, who provides this information to your clients?

[7] For a good summary of these studies, see Sham-Wow by Walter Eisner, Orthopedics This Week, August 11, 2009.

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Fourth, cancer screenings. These contain a risk of 'false positives' from cancer screening tests. False positive test results indicate that a patient has cancer when, in fact he / she does not.

Key Idea: Screening tests sometimes accurately identify cancers. We call these 'true positive' results.

Sometimes, however, they see something that is *not* a cancer, but identify it as a cancer. We call these 'false positives.'

In both cases, the patient gets treatment or at least further investigation. These contain risks (infection, physician error, etc). Our question: are the benefits and risks always adequately considered? Does the broker have an ethical education responsibility?

Some within the cancer screening community favor extensive testing to find all potential cancers as early as possible. Others favor less extensive testing, taking a 'watchful waiting' approach.

Is one approach clearly better than the other? How do your clients learn about these issues? Do they always get unbiased information?

Here are some data as reported in the Journal of the American Medical Association in 2010, showing the results of mammogram screening **over a 10 year period, per 10,000 patients**: [8]

	Age 40 – 49	**Age 50 - 59**
Breast cancer deaths avoided	5 (out of 10,000 over 10 yrs)	7 (out of 10,000 over 10 yrs)
False positive results requiring a biopsy	600 – 2,000 (out of 10,000 over 10 yrs)	500 – 2,000 (out of 10,000 over 10 yrs)
Unnecessary treatment Including surgery	10 – 50 (out of 10,000 over 10 yrs)	10 – 70 (out of 10,000 over 10 yrs)

Biopsies and unnecessary care carry risks – infections, physician error, etc.

[8] This information comes from 'The Benefits and Harms of Mammography Screening' Journal of the American Medical Association, Jan 13, 2010

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Physicians weigh these risks differently. Some think that the risk of breast cancer death is greater than the risk of treatment complications arising from false positive test results. Others arrive at the opposite conclusion. The medical community is split. (We, of course, as non-physicians take no position on these issues.)

Here, for example is Dr. Otis Brawley, chief medical officer of the American Cancer Society: [9]

> We have definitive evidence that we certainly save lives by testing everyone. There are some [radiological findings] that may end up being treated but not needing to be treated. I can in good conscience encourage all women who have a diagnosis of breast cancer to get treated.

On the other hand, Dr. H Gilbert Welch of Dartmouth Medical School has titled his book-length critique of cancer testing **Should I Be Tested for Cancer? Maybe Not and Here's Why**. Welch suggests that the risks of false positives may be greater than the potential benefits of early screening.

He entitled Chapter 2 'You May Have a Cancer Scare and Face an Endless Cycle of Testing', and Chapter 3 'You May Receive Unnecessary Treatment'. Paraphrasing the old medical adage, the *cure* (including false positives) maybe worse than the *disease* of breast cancer.

Welch also titles his first chapter 'It Is Unlikely That You Will Benefit' from cancer screening, suggests that cancer screening tests actually save very few lives – a statistical viewpoint borne out by the JAMA study above.

The reason for this: the deadliest cancers are the fast-growing ones that screening tests typically miss because they grow and develop *between* tests. That's why the risks of false positive results may be greater than the chance that a screening test will positively identify a cancer.

Key Idea: Each patient needs to weigh the false positive risks from cancer screening tests against the mortality risks from cancer. Some patients may determine that the false positive risks are higher, so will opt for fewer cancer screening tests.

Other patients may decide that the mortality risks are higher, so will opt for more cancer screening tests. There is no universally right answer.

But only patients who understand these two types of risk can make wise and informed decisions.

[9] Boston Globe, Oct 25, 2010, Cooney page G7

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Dr. Brawley and Dr. Welch disagree on the relative risks and benefits of screening. Brawley thinks that the mortality risk outweighs the false positive risk. Welch thinks the false positive risks *may* outweigh the mortality risks.

Is Dr. Brawley right? Is Dr. Welch right? We certainly don't know. And neither does anyone else. The medical community is divided on this issue, though some members have strong feelings one way of the other.

Most Americans think that these treatment decisions are entirely up to the doctor and patient. Of course brokers are not physicians and cannot give medical advice. Indeed, any broker who is so foolish as to give medical advice would quickly run afoul of many laws.

But here we pose here a fundamentally different question**. Does the ethical broker have *any* disclosure or educational responsibility to inform clients about this type of medical discussion? Or should the broker simply *let the buyer beware* of any and all problems?**

An Implication of Your Ethical Position

One implication of *letting the buyer beware*: your clients visiting Dr. Brawley from the American Cancer Society will more likely *have* mammograms and risk the false positives. But your clients visiting Dr. Welch will more likely *not have as many* mammograms and risk the true positives. Is this all right with you?

Key Idea: Some physicians favor – while others do not favor – certain screening tests. Some see the benefits as overwhelming the amount of risk. Others see the risks as more significant. Their recommendations to patients differ.

Brokers know this (in part, because we just told you so.) Does the broker have an ethical obligation to inform his/her clients of ***two different issues***:

1. That a disagreement exists among physicians about how to deal with this type of cancer screening, and

2. That some physicians are more likely, and others less likely, to promote mammograms? Your choice of physician may, thus, include a higher or lower chance that you'll have a mammogram.

Are your patients aware of this? Should you, the broker, inform them?

Or should you just 'let the buyer beware'?

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Chapter 1:
A comparison of two ethical standards:
'Let the Buyer Beware' is unethical;
'Do You Fellow A Favor' is ethical

The Traditional View of Business Ethics: 'Do unto others as you would have them do unto you' and 'Love thy neighbor as yourself' are two fundamental ethical dictates of the Judeo-Christian tradition. We – Americans coming from these traditions and teaching – believe that we have responsibilities to treat others as we would want them to treat us.

Translating These Ideas to Product Sales and Business:
The Problem of Unequal Knowledge

One way that many of us would like to be treated: we would like people with expertise to share their expertise with us. Let's look at a simple example of 'treating others as you would want them to treat you' – an interaction with a car mechanic.

When I have a question about my car, I ask a car expert – i.e. my local mechanic. I seek his advice because he has had years of experience working with cars. He has an expertise that I do not share. He can differentiate serious from minor problems and advise me if and when to get my car fixed.

A good mechanic answers my questions when I ask them. He treats me as he would want to be treated were conditions reversed.

But here's a slightly more complicated case: when my mechanic changes my oil and notices a problem with my car, I expect him to inform me. My local mechanic recently told me, for example, that – since I was coming up on 100,000 miles - I should schedule a tune-up and install new brake pads. I appreciated his advice: he treated me well, which means 'he did unto me as I hope I would do unto him' were conditions reversed.

I would be very unhappy with a mechanic who told me after a serious accident 'Yes, I noticed that your brake pads were worn out, but I decided not to tell you'.

Here the 'expert' did not share his expertise. I thought that he would 'do unto me as I would do unto him' were conditions reversed and he let me down.

> Key Idea: An ethical expert shares his/her expertise with clients. An unethical expert does not.

Note some issues with this lack of disclosure:

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1. Since he did not tell me that there *was* a problem with my car, I assumed that there was, in fact, *no* problem;

2. The underlying issue here is definitional. I define a good mechanic as one who looks out for my interest. Part of his job is to be my 'car advisor' and offer advice about how best to maintain my car.

He, apparently, defines his job much more narrowly, simply as fixing hings that I ask him to fix, but no more.

3. His definition of 'good mechanic' puts an enormous burden on me. I must ask after every oil change for example, a number of specific questions about my car's operation. Are the brake pads good? Is the air filter working properly? Does the head gasket leak? Are the brake rotors in good condition? Are the tires balanced?

Unless I ask, he will not disclose.

4. My interest in developing a long term relationship with this mechanic is very weak. I don't trust him to look out for my interests. I worry that I may fail to ask the right questions and have an avoidable accident as a result.

5. As a result, I will probably switch to a different mechanic. After all, they just fix cars. They all use the same parts. They all – more or less – repair things that have broken.

I will switch because I define 'good mechanic' as someone who looks out for my interest, who helps me be proactive in maintaining my car and who fixes things that brake.

The fundamental issue between me and my mechanic: I want him to share his expertise with me, in addition to fixing my car.

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A Personal Case Study
Insurance Broker Ethical vs. Non Ethical Behavior

Several years ago I had a poignant interaction with an insurance professional over this *information disclosure issue*. The situation:

I had considered changing a liability insurance policy (written by an out-of-town agent) so got a quote from my long-term local P & C agent. He informed me by phone that he had a better policy at a lower price than my current plan. He summarized some key points and said he could bind it on my verbal approval. I trusted him, so agreed.

He also suggested that I cancel my existing policy, which I also did.

After a detailed policy review (a week or two later) I decided that the new policy was not as comprehensive as the previous one. I re-activated the old policy with the out-of-town agent and informed my long-term local agent by email that I wanted to terminate the new one.

He never cancelled my new policy. Instead, several months later, he told me that neither I nor the other broker had submitted the cancellation request on the correct form. (It then took numerous phone calls and significant upset to correct the problem.)

Note the different definitions at work here. My local agent defined his job as getting quotes, processing bills and filing the correct forms. He took the 'let the buyer beware' approach, apparently thinking that the burden of looking out for my interests fell on me or on others. He would sell me the policies that I requested, and nothing more.

I defined his job as 'looking out for my interests', or 'doing to me as I would do for him were roles reversed' - which included informing me that I needed to file a specific form to achieve my cancellation goal. I had no way of knowing which form to file absent his input; he had specific expertise and product knowledge that he failed to share with me. He 'let the buyer beware' to an upsetting end.

This destroyed my ability to trust his advice. What other information, I wondered, would he also leave out? What avoidable harms might I endure? What unnecessary problems would I face? In short, why should I pay him to advise me when he takes the 'let the buyer beware' approach?

Needless to say, he fairly quickly lost my home and auto insurance accounts!

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Unequal Knowledge about our Healthcare System

What does 'unequal knowledge about the healthcare system' mean?

Brokers typically know a great deal more about our healthcare system than do their clients. Among the areas of broker expertise:

- Underwriting guidelines
- Provider cost data (at least rough and crude measures)
- Outcome data (again, rough and crude measures)
- Treatment complication data (assuming a well informed broker)

Key Idea: Brokers typically know much more about our healthcare system than their clients do. Brokers, for example, read industry journals and understand underwriting practices. Their clients, typically, do not.

We will explore the broker's ethical responsibilities to share information with their clients. Is a health insurance broker like the car mechanic above, who has specialized knowledge? Is he like the P & C broker who failed to share his expertise with me? What disclosure responsibilities does a health insurance broker have?

In developing our overall position on the ethics of disclosure, we will rely on traditional Judeo-Christian ethical positions. These have served as the moral and ethical foundation of western civilization for thousands of years and can shed some light on ethical business transaction issues.

Some Judeo – Christian Business Ethical Positions on Disclosure: Abraham's first purchase

Let's start with the first commercial transaction in the Torah or Old Testament, in which Abraham laid down the 'full disclosure' commercial principle.[10]

Many commentators think that this ethical principle is of fundamental importance, given its prominent position in the Bible. They argue that if some other principle was more important, then *it* would have appeared first.

[10] This genesis of this discussion comes from www.torah.org Business Ethics: The Challenge of Wealth, *Parchas Chayei Sarah, Parchas Metzora, Parshas Shoftim* and *Responsa-Vayigash*

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The story of Abraham purchasing a burial plot for his wife Sarah shows the importance of full disclosure by the product seller to the product buyer. The haggling over land takes five steps in Genesis 23: 3 - 20:

> **Step 1:** Abraham explains what he needs in vague terms – a burial plot for his wife. He does not stipulate where or exactly what kind of burial plot;
> **Step 2:** The sellers offer 'the choicest of our burial places';
> **Step 3:** Abraham considers this (perhaps even goes on a guided tour of choice burial places) then asks for 'the cave of Machpelah…which is at the end of [the sellers] field', and offers to pay 'full price';
> **Step 4:** The sellers confirm that they have exactly what Abraham wants 'the field and cave that is in it';
> **Step 5:** The buyer and seller ultimately agree on the land and price and transact the purchase in public 'in the presence of the sons of Heth, before all who went in at the gate of his city'.

(Note the similarity with health insurance policy sales:

> **Step 1:** the Buyer explains what he/she needs in vague terms – a policy to cover my family's medical needs, perhaps with some specific issues in mind, or a policy to cover all our full time employees;
> **Step 2:** the Broker says 'we have many quality plans available' and explains them;
> **Step 3:** the Buyer considers several options, then stipulates what he/she wants;
> **Step 4:** the Broker confirms that a specified policy contains the desired benefits;
> **Step 5:** the Buyer enrolls by signing a contract.)

It was clear from Abraham's negotiations that he had the opportunity to view the land and cave prior to purchasing. The seller had helped him learn about the land, pointing out the choicest burial place. Indeed, the seller may even have warranted the land: 'none of us will withhold from you his burial place', thereby confirming that this was, in fact, burial property.

Key Idea: The story of Abraham's burial plot purchase shows that the seller has an ethical responsibility to educate the buyer about the product. Abraham was a foreigner, needing advice about local burial procedures and options, which plot to purchase, etc. The seller provided that education.

The message: sellers who educate buyers are ethical. This begins the ethical tradition of full disclosure.

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The seller apparently understood that Abraham – 'a foreigner and a visitor' – did not know all details about local burial plots. The seller therefore helped Abraham learn everything that he needed to know so he could
make a wise, informed purchase.

There was no ambiguity about the land, the location or the use. No confusion about exactly what Abraham bought…because the seller provided such a thorough and detailed education.

'Let the Buyer Beware' is Unethical

The lesson about this transaction? That in traditional Judeo-Christian ethics there is no concept of 'let the buyer beware'. The seller taught Abraham everything he needed to know about local burial plots, made very clear to Abraham exactly what he was buying and made his declarations publicly.

> Key Idea: According to traditional ethics, the principle of 'let the buyer beware' is unethical for two reasons. First, the buyer rarely has *as much* product information as the seller.
>
> Second, even if the buyer has the information, he/she generally *lacks the context* in which to understand the information.

'Let the buyer beware' assumes that all parties to a commercial transaction have the same information regarding price, quality, use, location, comparative markets, etc, etc. This was clearly not true for Abraham, the 'foreigner and visitor'. The seller could have taken advantage of his lack of knowledge to swindle him – but did not. The seller educated the buyer. This is the ethical business lesson of Genesis 23: 3 – 20.

'Let the Buyer Beware' Assumes that All Parties have Equal Abilities to Understand the Information Available

In the Biblical case, Abraham was only able to understand the intricacies of burial plots after being educated by the seller. Is this concept still valid today? Can 'let the buyer beware' serve as a valid basis for commercial transactions?

The answer is no. Traditional Judeo-Christian ethics remain valid today, for two main reasons.

Reason 1: Sellers and Buyers Rarely have Exactly the Same Information

The seller generally knows his / her products far better than the buyer, as was the case of Abraham's burial plot seller, our car mechanic, or insurance broker. The reason: the

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seller deals in this market – for this product – far more frequently than does the typical buyer.

This was clearly the case for Abraham, whose expertise did not include detailed knowledge of local burial plots. It's also the case in our industry, where the health insurance broker regularly reads industry information provided by carriers and regulators, for example, while the buyer only purchases health insurance one time per year.

Note how this information discrepancy played out in my interactions with my local P & C broker. He had access to information – details about the process of, and forms necessary to, terminate an insurance policy – that I lacked. In fact, I didn't even know that such a form existed…*rather like a health insurance broker's client who doesn't know that treatment variations exist among providers!* (See below if you're confused.)

Key Idea: Sellers have much more product information than buyers.

Reason 2: Sellers can *Understand Their Product Information* far better than the buyer can

This is primarily because the health insurance broker has studied healthcare issues in far greater depth than the typical buyer. Even if the buyer has very good *access* to information, he / she often *lacks the background and context* in which to place that information.

Key Idea: Sellers generally understand the context of information about their products better than buyers do.

Again, this is similar to Abraham's situation. He was a merchant, with expertise in his own arena – not in burial plots. He was not in a strong position to understand burial plot issues without additional education.

In fact, Abraham might not even know which questions to ask the burial plot seller. He needed guidance from a trusted source here.

Our clients are similar to Abraham. They are accountants, schoolteachers, fishermen or others, with expertise in their own fields, not healthcare. Lacking the broker's healthcare education and background, they are less able to understand healthcare details and issues than the broker.

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Key Idea: Today's broker is much like Abraham's burial plot seller – and, according to traditional ethical considerations still relevant today, responsible to educate the client.

Thus for these two reasons – that the broker has better *access* to product information and a better *ability to understand* that information – today's health insurance salesperson has an ethical responsibility to educate the client. Just like my car mechanic. Or like Abraham's burial plot seller.

Do Your Fellow A Favor

Traditional ethics goes even further. *Parshas Shoftim*, a commentary on ethical principles, stipulates that 'He who does not ***do his fellow a favor***, is not of the sons of Abraham' for 'we force one to act contrary to the selfishness of Sodom'.

This places an even greater ethical burden on the seller. Not only must he / she educate the buyer and make full disclosure, but the seller must ***do his fellow a favor*** and highlight problems with the healthcare system that may occur.

Key Idea: Traditional ethics goes even further, requiring the seller to 'do his fellow a favor' and highlight problems that may occur.

Why would traditional Judeo-Christian ethics place such a burden on sellers?

There appears some thinking that these burdens ultimately work to the advantage of the *seller*. If all sellers act ethically as described above, then it becomes very easy to sell products to buyers. The reason: buyers would have a very high degree of confidence in the seller's representations.

Business Ethics = Business Efficiency
Ethical Practices = Good Customer Service

Key Idea: Traditional ethics equates business ethics with business efficiency. Its ethical standards are really instructions for successful businesspeople.

This approach follows directly from the two fundamental ethical dictates of Judeo-Christian religions described above: 'Do unto others as you would like done to yourself' and 'Love thy neighbor as yourself'.

Effectively, this means sellers should give clients excellent advice about the products they are selling.

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In doing this, traditional ethics advises us to educate our clients as we would like them to educate us, were conditions reversed.

If everyone followed these ethical principles, in other words, we would have a very well functioning business economy. They can be seen as a manual for how to prosper in business. We'll read its various ethical teachings in this light.

Ethical sellers – i.e. those who follow these traditional principles - would not have to prove their honesty or credibility. They could concentrate, instead, on selling products. This is very efficient: sellers could focus on their income generating activities (i.e. sales) rather than spending time explaining or justifying their personal ethical standards, or establishing personal credibility. They would thus generate higher incomes.

Ethical practices, as we have discussed above, also equal good customer service. Would you prefer to purchase something from a seller who 'lets the buyer beware?' Or would you prefer that the seller 'do you a favor?'

Abraham apparently preferred the latter. His burial plot sellers were, apparently, credible, as there is no mention of him searching for other plot sellers. He did not shop around for a 'better deal'. He was – apparently – satisfied with his seller's ethical positions, and the quality of education they offered, so chose to do business with him.

My car mechanic – the one who advises me that my brake pads are thin or that I need a tune up at 100,000 miles – also takes this ethical position. He 'does his fellow a favor' by advising of problems that may occur, so I can fix them promptly. When I find a mechanic like this – who looks out for my interest – I stay with him.

Not so for my long ago, local P & C agent. He did not share the mechanic's business approach. He chose to offer the minimum client education and not to inform me of the specific policy cancellation process. He ended up operating his business less one client.

As with burial plot sellers, car mechanics and P & C agents, so with health insurance brokers. Brokers who 'do their fellow a favor' act ethically; those who 'let the buyer beware' do not.

Is it enough simply to describe the health insurance policy in detail?

Such a description would include a discussion of copayments and deductibles, pre-existing condition exclusions if any, available providers, prescription drug coverage, price etc and then show alternative products and describe them.

Though this may satisfy some customers, it does not satisfy all the ethical dictates discussed above.

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Key Idea: Simply describing the insurance policy in detail does not satisfy the traditional ethical dictates discussed above.

The broker also has an ethical responsibility to describe policy implications and healthcare systemic problems that may harm the customer.

How Much Should Brokers Disclose?

The question posed in Parchas Shoftim above, in the discussion of ***do the fellow a favor*** remains: ***How much* should a seller disclose about a product to a customer?**

It is unclear from Genesis 23 exactly *how much* information Abraham's burial plot seller provided. He apparently provided a great deal, and probably all that was necessary in that circumstance. But we get into a gray area when applying the lessons of Genesis to more complicated transactions, like health insurance policy sales.

How Should the Broker Educate the Buyer?

Clearly a broker should not give medical advice. That's outside the realm of his / her licensed authority. For example, in this course we take no position on the use of mammograms. We do not endorse or dispute either Dr. Brawley or Dr. Welch above, the doctors who disagreed about having annual mammograms above.

Rather, we suggest that health insurance brokers have an educational responsibility to offer clients information indicating that there is a disagreement over the use of mammograms in the medical community.

Key Idea: The ethical broker can advise clients that educational resources exist.

The ethical broker's goal in educating the client: help the client become an informed consumer of medical services. The ethical broker becomes a resource for his/her clients.

Some Samples

Just as a public library makes information on a wide range of subjects available to the general public, so the ethical broker can make information on medical care available to clients.

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We have tried this is out in our live classes. One telling example: we distribute information on the rates of Caesarian births by local hospital.

I often start the discussion by asking 'How do you decide which hospital to use for child delivery?' Most women respond that they use the hospital recommended by their obstetrician.

'When do you choose an obstetrician?' I then ask. Answers range from 'I use my gyn for obstetrics, and I've known my gyn for years', to 'I use the obstetrician recommended by my friends, relatives or primary care physician.' In any case, women report that they generally have an obstetrician on board quite early in their pregnancy.

I then present data on the various rates of caesarian births in different local hospitals. Here's a partial list of hospitals located within about 50 miles of Boston reported in 2019: [11]

Hospital Name	Rate of Caesarian Births
Haywood Hospital, Gardner	10.8%
Cambridge Health Alliance, Cambridge	18.7%
Newton Wellesley, Newton	27.8%
Winchester Hospital, Winchester	29.4%
Parkland Memorial, Derry NH	41%

The next comment that typically arises in live classes: there must be medical differences among the patients in those hospitals. For example, women at high risk will use Winchester more frequently than Cambridge Health Alliance located just a few miles away.

But wait, I caution. You said that you use the hospital where your obstetrician has admitting privileges. You choose your obstetrician before you had any delivery complication issues (generally). Now you've changed your story!

In fact, the analysis of these treatment rate differences *does not* indicate that women presented with such different medical needs. Rather, according to Dr. Lauren Smith, medical director of the Massachusetts Department of Public Health, the reason for the rate differences include:

> A complex array of factors….including how they organize the staffing of their labor and delivery units, what are the resources that might be available. [12]

[11] Kumler, Do You Know Your Hospital's C-Section Rate?, Boston Magazine, 4/25/2019

[12] Boston Globe, 6/7/10

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Interestingly, Dr. Smith made these comments in 2010. But the rate discrepancy continued years after, and likely until today and into the future.

Patient need differences played a minor role and *did not explain the vast differences in Caesarian rates.*

Indeed, Smith, the Massachusetts DPH Medical Director, went on to say that in a similar analysis performed from 2004 – 2006 – *where hospitals were divided into three groups based on the complexity of obstetrical care they provided* – the caesarean rates varied widely within the groups. Exactly as we saw in the most recent data.

State analysts want to know why the rates differ so markedly.

Might physicians at some hospitals perform the procedures with which they are the most comfortable – and ignore patient presentations that suggest a different treatment is more appropriate?

If so, here's the scary thought: *it's unclear which hospitals are most attentive to patient differences!* Parkland that perform Caesarians on almost half of their deliveries? Or Haywood that performs Caesarians on only about a 10th?

One hospital might overperform a treatment with which it feels comfortable, while another might underperform one with which it feels uncomfortable! Hospitals might staff up and organize their resources around a particular treatment and then gain a comfort level with it – just as Dr. Smith of the Mass DPH suggests.

Why might a hospital organize itself to perform more or fewer Caesarians? A number of factors may impact on this decision, including financial incentives, religious or philosophical orientations or entrenched hospital bureaucratic interests. Patient need differences, according to the analysis by the Mass DPH, play a relatively minor role in all this. Interestingly multiple other studies support this conclusion.[13]

Brokers learning this information in our live classes – especially the pregnant ones – are generally quite astonished. I often ask 'do you think your clients would like to know this?' The typical answer: Yes, of course.

In our ethical terms, these brokers would like to treat their clients as they would like to be treated.

[13] See for example 'A commercial study of vaginal delivery and cesarean section rates in New Hampshire hospitals', 2011 from the NH Insurance Department and Kozhimannil et al, Cesarean Delivery Rates Vary Tenfold Among US Hospitals, Health Affairs, March 2013

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An Objection

Occasionally a broker disagrees. Objections generally reference fear of a lawsuit.

Typically this objection comes in the following form: if I provide data about providers and my client then uses this data to help make a decision about which provider to use, I may be liable for a poor medical outcome.

This is a relatively rare objection that, I submit, does not stand up well to scrutiny. (I'm not a lawyer and thus do not give legal advice.)

I generally respond to this objection as follows:

> Do you think that I'm at risk for quoting – in live lectures or in this course - articles in the Boston Globe, New York Times or Washington Post? Or studies conducted by the Massachusetts Department of Public Health or New Hampshire Insurance Department?
>
> *The typical response: no, not if you quote articles or studies with attribution and present the information fairly and objectively.*
>
> Do you think I'm at risk for quoting studies in peer reviewed, learned journals like the New England Journal of Medicine, the Journal of the American Medical Association or Health Affairs?
>
> *The typical response: no, not if you quote articles with attribution and present the information fairly and objectively.*
>
> Do you think I'm at risk for referencing published studies authored by academics at Dartmouth Medical School or Harvard Business School? Or research published by the US government? Or studies commissioned by the Institute of Medicine or Commonwealth Fund? Or publicly available books?
>
> *The typical response: no, not if you quote with attribution and present the information fairly and objectively.*

In short: if you advise your clients that there is publicly available information which may help them, then you likely have little to fear from a lawsuit. (Disclaimer: anyone can sue anyone for anything and I'm still not a lawyer.)

A longer version: if you are at risk for disclosing publicly available information to your clients, then so are all the journals and organizations listed above that disseminate this information, along with many, many more. They continue to research and publish.

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Key Idea: Brokers can inform their clients that information exists to help them make medical decisions. Brokers can also tell their clients how to access this information, for example by referencing reports by a state department of public health.

Brokers cannot, however, provide medical advice (unless they are licensed to do so).

It's important that brokers understand the difference between these two forms of client advising.

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Chapter 2
Treatment Variation
Or *Where You Live Influences What You Get*

What Ethical Responsibilities Does the Broker Have to Advise Clients About This?

Treatment Variation means that the *same* patient, with the *same* medical condition, might receive *different* care in *different* geographical regions of a state or of our country.

In other words, a retiree living in Fort Myers, Florida and experiencing lower back pain, for example, is about twice as likely to have back surgery than the same person living in Miami.[14]

Or a person suffering from angina might be 70% more likely to have angioplasty in Elyria, Ohio, than the same person living in Akron – about 50 miles away. [15]

Or a person living in Florence, South Carolina with a chronic medical condition may be 47% more likely to be hospitalized than the same person, with the same medical condition, in Charleston, SC. [16]

How can this be?

Key Idea: Treatment variation exists among different regions of the US. Treatment variation means that the same patient, with the same medical condition, might receive different care in different geographic regions.

Treatment Variation and the Broker's Ethical Advisory Role

Below, we'll explain why Treatment Variations exist. But first, we seek to make two key points to brokers:

1. No region of the US suffers from a lack of medical resources, though in some rural areas people need to travel longer to receive care than do urban dwellers.

[14] http://www.dartmouthatlas.org/data/table.aspx?ind=74&tf=6&ch=35&loc=143,221&loct=3&fmt=99

[15] http://www.dartmouthatlas.org/data/table.aspx?ind=80&tf=6&ch=35&loc=54,94,112,119,132,332,358&loct=3&fmt=105

[16] http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=24

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> This suggests that treatment frequencies above the minimum may be unnecessary and wasteful, potentially causing more harm than patient benefit. (We'll explain this in more detail below.)
>
> 2. No entity in the US healthcare distribution system has a specific responsibility to inform patients of this situation. Indeed, many healthcare providers are either ignorant of this or have financial incentives (fee for service) to provide more care.

The broker, interestingly, may be the only actor whose long-term financial incentives parallel the consumers'. The broker seeks a long term relationship with his/her client. The client may switch carriers and providers while staying with the same broker.

As such, the broker wants his/her clients to receive the best medical care, at the best possible price, over the long term.

Thus the broker may have an ethical reason ('do your fellow a favor') and a financial reason (remember how Judeo-Christian teachings equate business ethics with business efficiency) to advise patients about the risks of treatment variation.

Why Treatment Variations Exist

Perhaps the key source of Treatment Variation data is the Dartmouth Atlas of Healthcare, which uses Medicare data to determine the amounts of medical care received in different regions of the US. The Atlas describes and documents the vast variations in medical care available to patients in the US. You can access this information at www.DartmouthAtlas.org.

One reason for variations in medical treatment between regions is the supply of medical resources – i.e. hospital beds per capita, radiological equipment per capita, specialists per capita, etc.

Here's how the Dartmouth Atlas describes this situation: [17]

> Regional variation in capacity reveals the irrational distribution of valuable and expensive health care resources. Capacity represents the capital investments and labor that permit the delivery of medical services.
>
> Two types of capacity determine the majority of health care costs.

[17] http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=24 . Emphasis added.

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> The **first is hospital capacity**, including the number of general and intensive care beds, imaging devices, and procedure suites like operating rooms and cardiac catheterization labs.
>
> **Health care labor is the second** and related component of capacity, and includes the physicians, nurses, allied health professionals and administrative staff who work in hospitals and physician practices.
>
> Unfortunately, the distribution of capacity fails to reflect the regional need for health care, either for beds or for physicians and hospital staff.
>
> Even after controlling for differences in age and sex, some regions had more than twice the number of beds per capita than other regions.
>
> **More beds means that patients are more likely to receive their care during a hospital admission, with greater costs, and a higher likelihood of hospital-acquired infections and medical errors.**
>
> **Higher physician supply offers little benefit in population health or in patients' satisfaction with access to care and with the care received.**

In other words, as the supply of hospital beds increases, the number of patients admitted also increases…but outcomes, as measured by mortality rates, speed at which patients return to functional status or patient satisfaction with medical care **do not improve**.

Key Idea: Regions that have more hospital beds per capita also have higher rates of hospitalization per capita. But they don't have better medical outcomes!

In fact, the mortality rates go ***up*** as patients receive more medical care, not down!

Here's Elliott Fisher of Dartmouth Medical School, describing how regional spending rates vary, along with mortality rates:

> For every 10% increase in spending [comparing one US region to another], relative risk of death in 5 years increased.[18]

The reason, again: above a certain amount of care (say, the US regional minimum), additional medical care increases risks of error, infection or patient fatigue with no concomitant benefit increases.

[18] Fisher, Implications of Regional Variations in Medicare Spending Part 2, 2003

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Note that Fisher and the other Dartmouth studies work primarily with Medicare data, as that's the most comprehensive US healthcare data source available.

How Much Impact Does The Local Supply of Medical Resources Have On Medical Treatments and Costs?
Roemer's Law

Researchers have studied the impact of bed supply on hospitalization rates since the 1950s, at least. The pioneer of this research, Dr. Milton Roemer, first studied the impact of expanding the bed supply in a study of an upstate New York town in 1957 – 8.[19]

Here's what Roemer found: in 1957 this town (Roemer doesn't name it, so unfortunately, we can't verify his data) had one general hospital with 139 beds. The average daily occupancy was 108 (78%) suggesting some excess bed capacity.

The hospital was apparently satisfying the medical needs of this community reasonably well. Roemer based this conclusion on his reading of the local newspapers, which reported few, if any, stories about inadequate hospital resources.

In 1959, the town opened a new general hospital with 197 beds. Roemer doesn't explain why, but notes that there was no population change, no new industries moving to town and no major disease epidemics. Apparently the town took advantage of some financing available to build a new hospital and close the old one.

Almost overnight, the hospital occupancy grew to 137 – a 26% increase!

Roemer suggested that physicians responded to this increased bed supply by hospitalizing patients in 1959 that they would not have hospitalized in 1958.

His conclusion: 'the supply of hospital beds in a community or state is the major determinant of the hospital utilization.' The amount of treatment variation due to bed supply: about 26%.

> Key Idea: Roemer's Law – that a hospital bed built is a hospital bed occupied – suggests that the availability of excess hospital beds may account for 26% of all US healthcare spending.

Other Studies Reinforce Roemer's Conclusion

Fisher, in his major 2003 studies, concluded that

[19] Milton Roemer, Bed Supply and Hospital Utilization: A Natural Experiment, Hospitals, 35 (1961)

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> Up to a third of medical care is devoted to services that do not provide any detectable benefit.

He studied the distribution of medical resources by region and compared patient treatment patterns and mortality rates. His studies have not been refuted. Indeed, other researchers have found the same expenditure patterns.

Here, for example, is a comparison of Medicare spending in El Paso and McAllen, Texas: [20]

> Average Medicare spending/capita, McAllen: $14,900
> Average Medicare spending/capita, El Paso: $7,500

McAllen Medicare beneficiaries had, compared to El Paso:

> 50% more specialist visits
> 20% more abdominal ultrasounds
> 30% more bone density tests
> 60% more stress tests with echocardiography
> 2/3 times more pacemakers, cardiac bypass operations and coronary artery stents

Yet the McAllen demography appeared virtually identical to the El Paso demography, with no significant mortality or longevity differences:

	McAllen	El Paso
Average household income	$40K	$36K
Poverty rate	27%	27%
% Hispanic	80%	77%

Why do McAllen Medicare recipients get more medical care than El Paso folks? The answers appear to include (a) regional treatment norms and (b) the availability of medical specialists.

Impact of Specialists on Patient Risk, Price and Outcomes
Would Your Clients Like to Know This?

The number of specialists varies significantly by region, even if the population demographics do not!

[20] Atul Gawande, Cost Connundrum, New Yorker, September 2009

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Here, for example, is the distribution of physicians in 'high spending regions' vs 'low spending regions' (spending levels calculated on a per capita basis) per 1000 Medicare beneficiaries: [21]

	High Spending Region	Low Spending Region
	Rates per 1000 Medicare beneficiaries	
Specialists	78	57
Sub Specialists	44	27
Surgeons	56	44
GPs / Family practitioners	27	36

High spending regions have more specialists per capita and fewer primary care physicians. They enjoy (enjoy?) higher medical costs.

But researchers who have studied the medical outcomes suggest that this additional spending generates no better medical outcomes. Here's Fisher, again, from his same studies:

> we found **no evidence** that the pattern of practice observed in higher spending regions led to **improved survival, slower decline in functional status or improved satisfaction with care.** (Emphasis added)

Thus the type of medical care received by people in the higher spending regions – defined as having more beds and more specialists – does not impact positively on patients.

Key Idea: As a region gets more hospital beds and more medical specialists, the medical costs increase. But patient outcomes do not improve.

Two other researchers from Dartmouth's economics department, Katherine Baicker and Amitabh Chandra, arrived at an even stronger conclusion:

> Researchers have found that underlying population risk (i.e. disease factors) **does not** seem to drive the presence of specialists and that **outcomes are not improved by increased access to these specialists**. [22]

[21] Maggie Mahar, Money Driven Healthcare, page 170

[22] Baicker and Chandra 'Medical Spending, the Physician Workforce and Beneficiaries Quality of Care' Health Affairs, April 7, 2004

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Specialists don't set up their shops based on the disease epidemiology in a region – in other words, based on patient demand for their services. They set up their shops in regions where the local medical culture indicates that patients will access their services.

But for patients, having easy access to a greater number of specialists does not generate better outcomes. Yet – often – this is exactly what your clients want in a health insurance policy: easy access to a wide range of specialists.

Kenneth Thorpe of the Rollins School of Public Health at Emory University takes this one step further. He suggests that having access to more specialists means that patients will use more specialists and that this process may lead to *unnecessarily high mortality rates*. Dr. Thorpe was Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Human Services from 1993 to 1995. His research shows that

> A typical Medicare beneficiary sees two primary care physicians and five specialists working in four different practices…who rarely coordinate the care they deliver. Because of this structural deficiency, patients with chronic illnesses receive only 56% of clinically recommended medical care. That gap in care may explain a nontrivial portion of morbidity and excess mortality. [23]

Why the 'excess mortality'? We'll turn to the final researchers in this section (sorry, there are still more to come later in this course), Peter Muennig and Sherry Glied, both of the Mailman School of Public Health at Columbia University. Muennig and Glied asked 'What Changes in Survival Rates Tell Us About US Health Care' and conclude that:

> Unregulated fee-for-service reimbursement and an emphasis on specialty care may contribute to high US health spending, while leading to unneeded procedures and fragmentation of care…Fragmentation of care leads to poor communication between providers sometimes conflicting instructions for patients, and higher rates of medical errors. [24]

Here's our summary:

> 1. As we provide a higher supply of hospital beds and specialists, we generate higher utilization (Roemer's Law);

---

[23] Thorpe, et al, Chronic Conditions Account for Rise in Medicare Spending from 1987 – 2006, Health Affairs Web First, April 2010

[24] Muennig and Glied, What Changes in Survival Rates Tell US About US Health Care, Health Affairs, November 2010, page 2105

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2. This does not improve outcomes or generate higher patient satisfaction with care (Fisher);

3. Indeed, specialist location decisions are not a function of patient need, or the demand for specialist services (Baicker);

4. But the availability of excess beds and specialists leads to systemic fragmentation and excess mortality (Thorpe);

5. The reason for excess mortality is poor communication between and among the excess supply of specialists (Muennig).

Should You Inform Your Clients?
How Would an Ethical Broker Behave?

Armed with this type of information, an ethical broker would inform his/her clients (a) that treatment variations exist and (b) some ways the client can protect him/herself from receiving excessive and unnecessary care that may pose unnecessary risks and generate unnecessary costs.

One way for the client to protect him/herself: access information from the Dartmouth Atlas, Medicare or other sources to determine if he/she is *likely* to receive unnecessary care.

Your client can then discuss this with his/her physician(s). The client and physician can, together, review the available data and then discuss appropriate treatment strategies.

Alternatively, of course, you can let your client beware…

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Chapter 3
A Case Study in Massachusetts

If you were a customer, would you want your broker to advise you of this?

We have, so far in this course, made two fundamental points.

> First, that traditional business ethics requires brokers to 'do their fellow a favor', which, in the health insurance brokerage arena, means to advise their clients about various systemic risks;
>
> Second, we've discussed one of those systemic risks: treatment variation, or the chance that people will receive excessive and unnecessary care in certain regions, and have higher medical risks as a result.

In this Chapter, we will look at three types of medical care in Massachusetts to see the role that local treatment orientations play. You can find the same situation in all other states.

Do you think your clients would like to know this?

Some Geographic Background:
Case studies in Massachusetts

> The information here is specific to Massachusetts. The methodology applies to all states. Brokers can get the most recent available data for their own locations on the Dartmouth Atlas website www.dartmouthatlas.org.

Massachusetts is broadly divided into 5 hospital referral regions by the Dartmouth Atlas of Healthcare.

Dartmouth defines hospital referral regions as 'regional health care markets for tertiary medical care that generally require the services of a major referral center.'

Among the 5 Massachusetts hospital referral regions, 2 use out-of-state hospitals for tertiary care: extreme western Massachusetts uses the Albany, New York hospitals, and extreme southern Massachusetts uses Providence, Rhode Island hospitals. These two regions contain relatively small populations. As such, and for simplicity here, we will focus on the 3 most heavily populated regions in Massachusetts: the **Boston** area, the **Worcester** area and the **Springfield** area.

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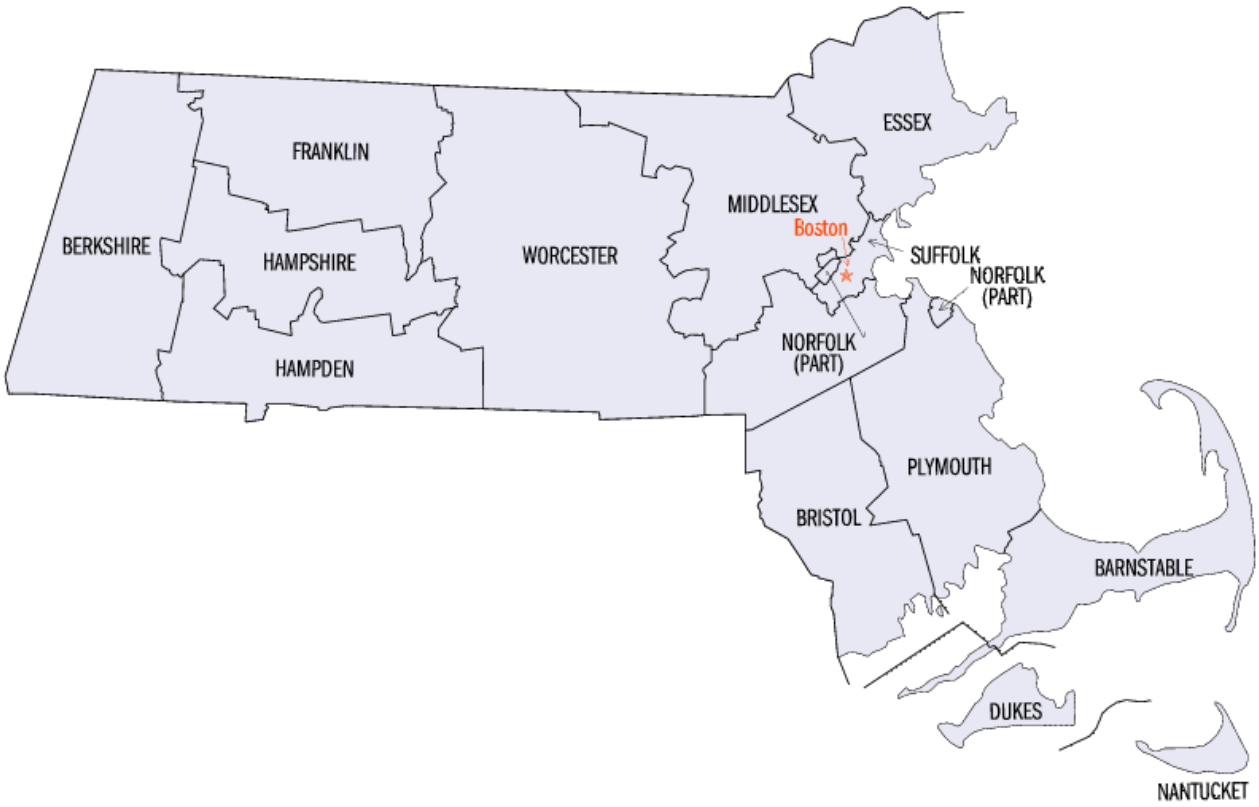

The **Boston area** is generally defined by patients living in, or east of, Middlesex and Norfolk counties. This population tends to use the downtown Boston teaching hospitals – Massachusetts General Hospital, the Brigham and Women's Hospital and the Beth Israel Hospital – for major tertiary care.

The **Worcester area** is generally defined by patients living in Worcester county. This population tends to use the University of Massachusetts Medical Center in Worcester for major tertiary care.

The **Springfield area** (Springfield is in Hampden County) is generally defined by patients living in Franklin, Hampshire and Hampden counties. This population tends to use the Springfield hospitals for major tertiary care.

We'll evaluate the treatment tendencies of each region for three common acute procedures: mastectomies, leg amputations and coronary angioplasty.

Mastectomies

Dartmouth's raw data indicates the following rates for mastectomies in these three Massachusetts hospital referral regions:

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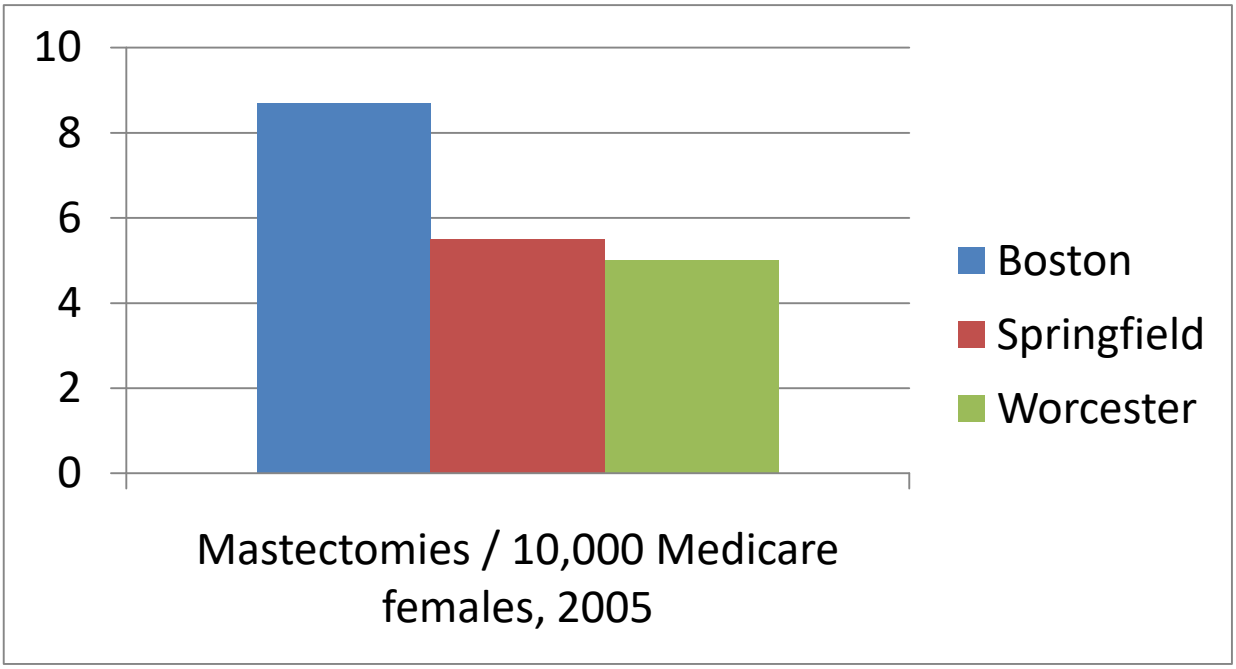
Boston area --- 8.7 per 10,000 female Medicare beneficiaries
Springfield area – 5.5 per 10,000
Worcester area – 5.0 per 10,000

Here's a graph showing the differences.

Regional Treatment Tendencies:
Mastectomies
Source: Dartmouth Atlas. Data downloaded Feb 2011



(If you're seeing this in black and white, Boston is the left bar, Springfield is the center bar and Worcester is the right bar.)

This data shows that Boston area female Medicare beneficiaries have about a 60% greater likelihood of having a mastectomy than Springfield women, and about a 74% greater likelihood of having a mastectomy than Worcester women.

Key Idea: Boston area female Medicare beneficiaries have a higher likelihood of having a mastectomy than do their counterparts in Springfield or Worcester.

This, claim many, is not particularly surprising. The Boston area hospitals include several Harvard Medical School affiliated teaching hospitals and the world famous Dana

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Farber Cancer Hospital. It is not unreasonable to think that women living only an hour or two away and suffering from breast cancer would visit one or more of these highly respected hospitals for care.

Or that the very sickest women, in general, will travel to Boston for care.

Thus, they claim, the Boston area data might pick up sick women living in the Worcester or Springfield areas also, thus skewing this graph. Maybe…

There are two alternative theories that fail to stand up to critical analysis:

- Some people might suggest that there is 60 – 70% more breast cancer in the Boston female population, due, perhaps, to environmental factors. No data supports this proposition. [25]

- Others might suggest that the sample size is too small to generate any statistically significant conclusions. This doesn't stand up to the historical data, which indicates that these proportional variation trends have existed over a very large population for many years.

The only other potential explanation suggests that Boston area oncologists operate on the same population (from an epidemiologic perspective) more frequently than do Worcester or Springfield area oncologists.

Which analysis is correct? **Do women at risk for mastectomies travel from Worcester and Springfield to Boston for care? Or do Boston area oncologists perform mastectomies on patients who would not have this treatment in Worcester and Springfield?**

We'll test both theories by reviewing the leg amputation data and the coronary artery stent data. If we find that the Boston area physicians perform these procedures more frequently than Worcester or Springfield physicians, then we can hypothesize that sick patients travel to Boston for treatment.

But ***if Worcester or Springfield physicians perform more leg amputations or insert more stents, then we will suspect that local medical treatment preferences are more important.*** (No one in the Massachusetts medical community or medical research community argues that massive numbers of patients travel from Boston to

[25] There is some data to indicate that more rigorous cancer screening *identifies* more cancer in some regions than in others, but not that there is a significant regional difference in cancer incidence rates. Also, some data indicates that a specific environmental contaminant may affect cancer rates in a very small region, but not in regions as geographically diverse as the three we are considering here.

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Springfield for tertiary medical care. Also, my casual perusal of the local media over the past 20 years suggests that there are no stories in the local press indicating this trend either.)

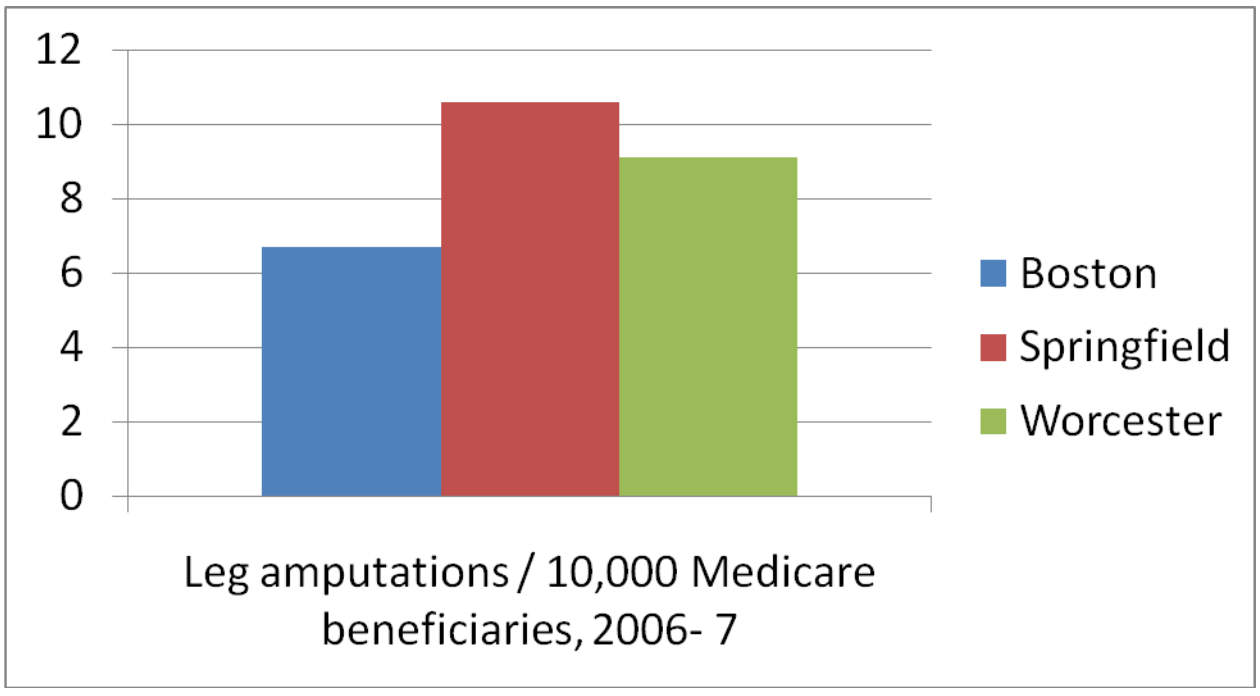
Leg Amputations

Dartmouth's raw data indicates the following rates for leg amputations in these three Massachusetts hospital referral regions:

Boston area --- 6.7 per 10,000 Medicare beneficiaries
Springfield area – 10.6 per 10,000
Worcester area – 9.1 per 10,000

Now Boston has the lowest rate of treatment and Springfield the highest.

Regional Treatment Tendencies:
Leg Amputations
Source: Dartmouth Atlas. Data downloaded Feb 2011



(If you're seeing this in black and white, Boston is the left bar, Springfield the center bar and Worcester the right bar.)

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This data shows that Springfield area Medicare beneficiaries have about a 60% greater likelihood of having a leg amputated than Boston area beneficiaries.

Key Idea: Springfield area Medicare beneficiaries have a higher likelihood of having a leg amputated than their counterparts in Boston or Worcester. In fact, Boston area beneficiaries had the lowest likelihood of the 3 regions.

How can this be?

No one in Greater Boston seriously suggests that Boston area Medicare beneficiaries at risk for leg amputation travel to Springfield for medical care – at least, not in the numbers required to skew this data.

Indeed, those who believed that Medicare females suffering from breast cancer travel from Springfield to Boston, must now believe that Boston folks go to Springfield for orthopedic or vascular treatments. This simply doesn't make sense. Where would a women suffering from breast cancer *and* at risk of a leg amputation go for treatment?

There are virtually no stories in the local press suggesting this migration of people needing leg amputations to Springfield.

It's beginning to look like the treatment variation argument will prevail.

Inpatient Coronary Angiography

Dartmouth's raw data indicates the following rates for inpatient coronary angiography in these three Massachusetts hospital referral regions:

Boston area --- 16.7 per 1,000 Medicare beneficiaries
Springfield area – 11.9 per 1,000
Worcester area – 20.4 per 1,000

Now Worcester has the highest rate and Springfield the lowest.

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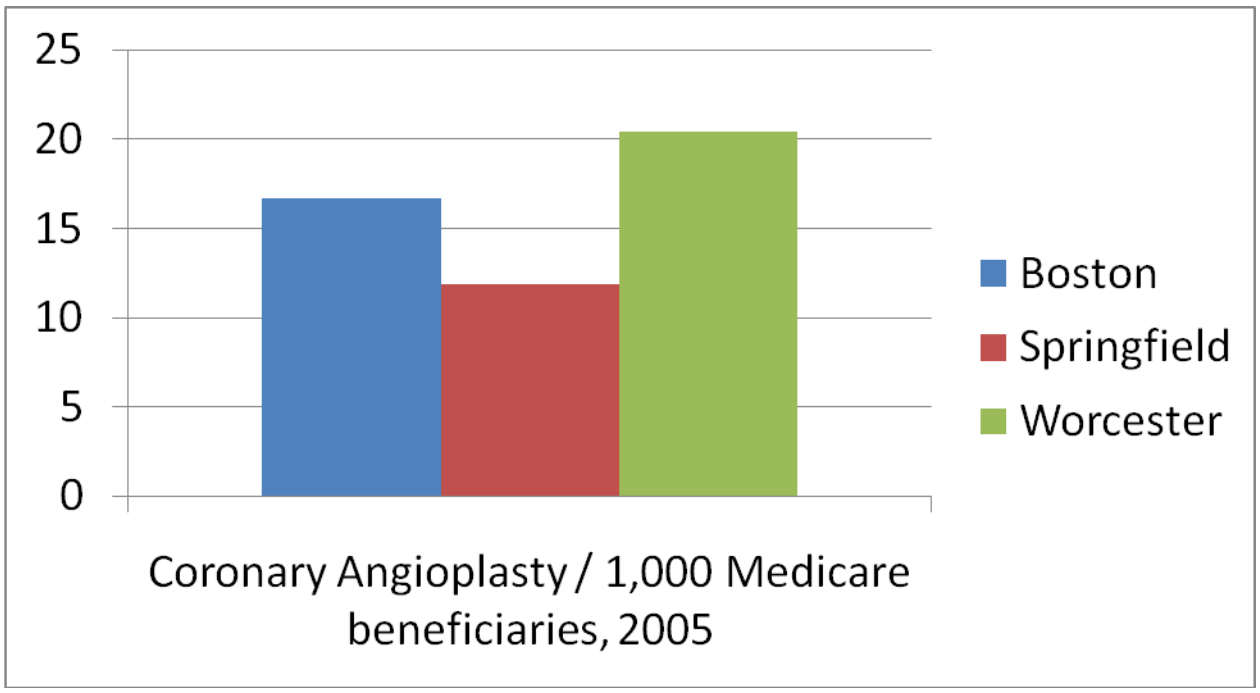
Regional Treatment Tendencies:
Inpatient Coronary Angiography
Source: Dartmouth Atlas. Data downloaded Feb 2011



Again, if you're seeing this in black and white, Boston is on the left, Springfield in the center and Worcester on the right.

This data shows that Worcester area Medicare beneficiaries have about a 70% greater likelihood of having a coronary artery stent inserted than Springfield area beneficiaries, and a 22% greater likelihood than Boston area beneficiaries.

Key Idea: Worcester area Medicare beneficiaries have a higher likelihood of having a coronary artery stent inserted than their counterparts in Boston or Springfield.

Again, there is no evidence of significant underlying population medical differences (remember, all Medical beneficiaries are 65+, and no one suggested that those with coronary conditions move to Worcester, while those with poor leg circulation move to Springfield).

Rather, these three charts suggest quite strongly that the impact of local treatment preferences is quite strong.

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Jack Wennberg, the founder of Dartmouth Institute for Health Policy and Clinical Practice, ties all this treatment variation information together. He suggests that treatment protocols vary more based on *medical supply differences and the regional medical culture* than based on *patient medical differences*. He suggests that your chance of having surgery can be predicted by the rate of surgery in your region 10 years prior:

> The really fascinating thing to me is to think that what predicts your risk of surgery today in a particular region is what it was ten years ago in the same region. [26]

Key Idea: The best predictor of your likelihood of having a specific medical procedure in a region is the rate of that procedure in that region 10 years ago, according to Jack Wennberg of Dartmouth Medical School.

The reason: physicians in a region develop 'medical cultures' that get transmitted to new doctors entering the area. Young docs learn from more senior partners in their practice. Career advancement may mean accepting the senior's approach. After all, what senior partner wants a junior partner who very often disagrees with him?

It seems, from the data presented in this Chapter, that Wennberg is right. Your chances of having a particular medical procedure may vary up to 70% by region in Massachusetts for any one of these three procedures: mastectomy, leg amputation and coronary artery stent insertion.

Extending This Analysis to Other States

Brokers interested in learning about the treatment variation risks in their own state may visit the Dartmouth Atlas website and do their own research.

Here are some of the (astonishing) things they will find:

In Florida, rates of inpatient back surgery vary almost by a factor of 3 by Hospital Referral Region

Back Surgery Rates, Florida
Data from Dartmouth Atlas, downloaded Feb 2011

[26] Brownlee, op cit, page 41

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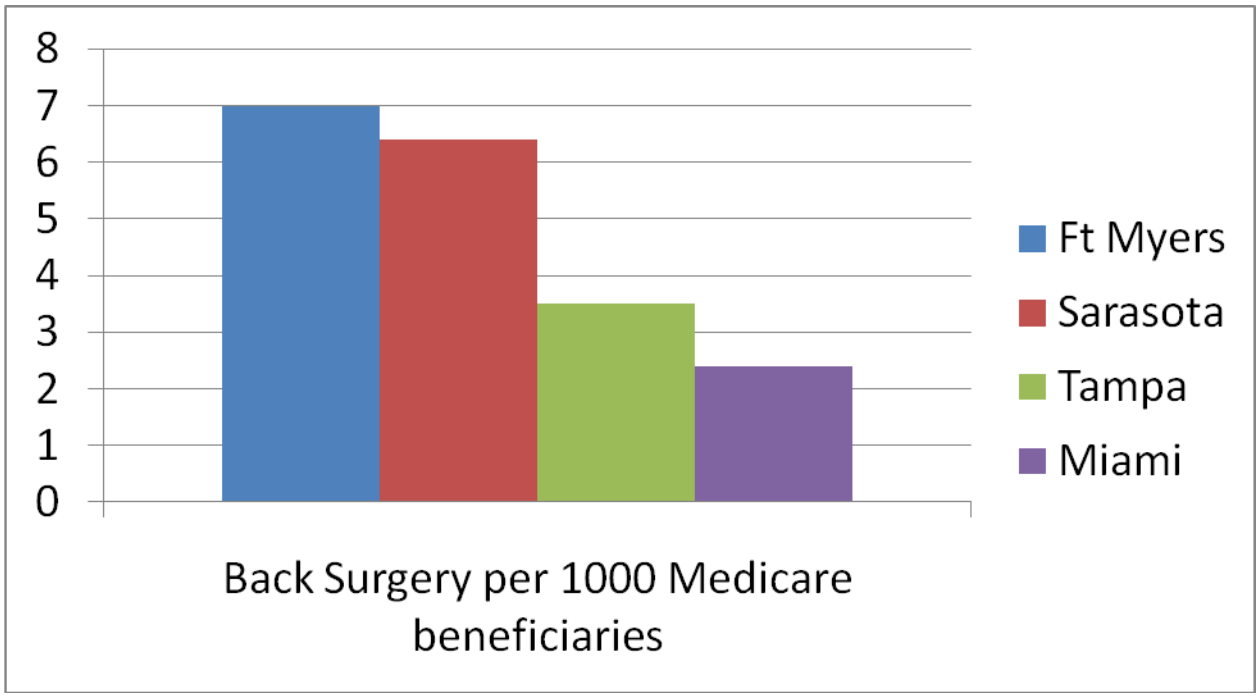

These bars are ordered, from left to right, Ft. Myers, Sarasota, Tampa and Miami.

The Medicare populations in these 4 cities are quite similar. Interestingly, Sarasota is about an hour drive from Tampa and Ft Myers. Yet the treatment protocols vary quite significantly.

Why Do These Rate Discrepancies Exist?

The Washington Post ran a series of articles in July, 2005 to celebrate the 50th anniversary of Medicare. One article in the series, *When Geography Influences Care Options*, addressed the issue of treatment variation. [27]

Among the Post's findings:

- The rate of back surgery over the previous 10 years had increased by more than half;
- There is no clear-cut science for treating back pain. 'Some doctors favor surgery, while others recommend exercise, rehabilitation and other conservative approaches';

[27] Gaul, When Geography Influences Treatment Options, Washington Post, July 24, 2005

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- Had Fort Myers's surgeons operated at the more conservative Miami rate, ‘there would have been 4,800 fewer back surgeries from 1992 to 2001 and Medicare would have saved millions of dollars’.

How many millions might Medicare have saved? About 200! That’s 4800 surgeries at an average cost of $40,000, or $192 million, plus doctor’s fees.

"It's highly improbable that Medicare retirees living in Fort Myers prefer back surgery two times as often as residents of Miami," according to James Weinstein, chairman of the Department of Orthopedic Surgery at Dartmouth Medical School. Weinstein has tracked variations in the number of spine surgeries in South Florida for a decade.

Rather than understanding this phenomenon as a function of patient demand, researchers look for ‘surgical signatures’ of physicians. Some back specialists prefer surgery while others prefer medication and therapy. Lacking clear outcome data, the patient is likely to receive the type of care preferred by the specialist…exactly as Wennberg suggests, above.

Unfortunately, clinical preferences are sometimes influenced by economics. The Post notes that back surgery can be very profitable. In 2001, spine surgery accounted for more than half of all profits from orthopedic procedures in hospitals but only 21 percent of the volume, according to a study done for the American Academy of Orthopedic Surgeons.

One hospital chain located in Fort Myers saw its Medicare payments for back surgeries grow by 50% over the previous 5 years.

Are Miami Medicare beneficiaries underserved by back specialists? Do they get an insufficient number of back surgeries? Are they harmed as a result of having fewer back surgeries, per capital, than Fort Myers beneficiaries? There’s no evidence to support any of this.

Instead, Fort Myers Medicare beneficiaries seem to get more back surgeries than necessary, pay more than necessary and possibly put themselves at greater risk of error or infection than their Miami compatriots.

Our underlying ethical question: ***do you think your clients would like to know this?***

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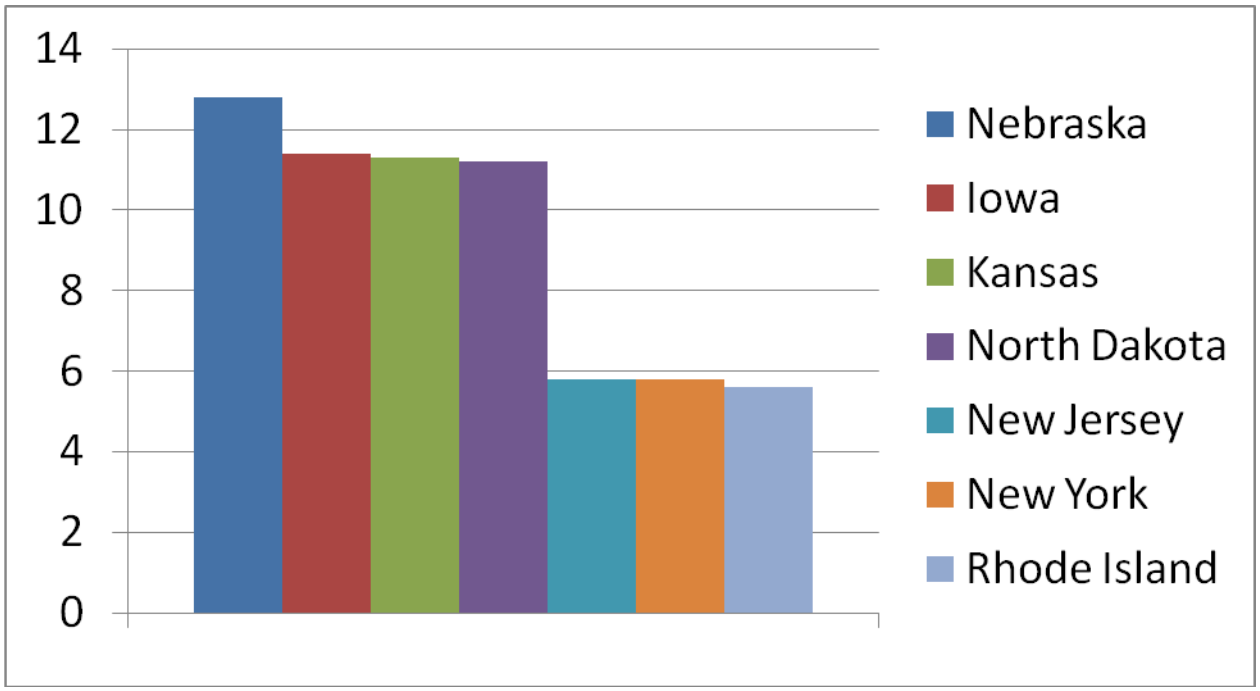
Mid-Western states have 2+ times more inpatient knee surgeries than some other parts of the country

Inpatient Knee Replacement
Data from Dartmouth Atlas, downloaded Feb 2011



Left to right: Nebraska, Iowa, Kansas, North Dakota, New Jersey, New York and Rhode Island.

Again, it appears that the specialist preferences and local medical norms best describes this data. There are no data to suggest that New Jersey, New York or Rhode Island perform too few knee replacements on their Medicare beneficiaries.

Of course, there's an alternative theory: less healthy mid-western retirees stay in Nebraska, Iowa and Kansas, while healthier retirees move to…New Jersey, New York and Rhode Island? Sorry, doesn't pass the laugh test.

Rates of Coronary Artery Bypass Graft exhibit huge discrepancies in next door Hospital Referral Regions

Coronary Angiography
Rates Per 1,000 Medicare Beneficiaries
Data from Dartmouth Atlas, downloaded Feb 2011

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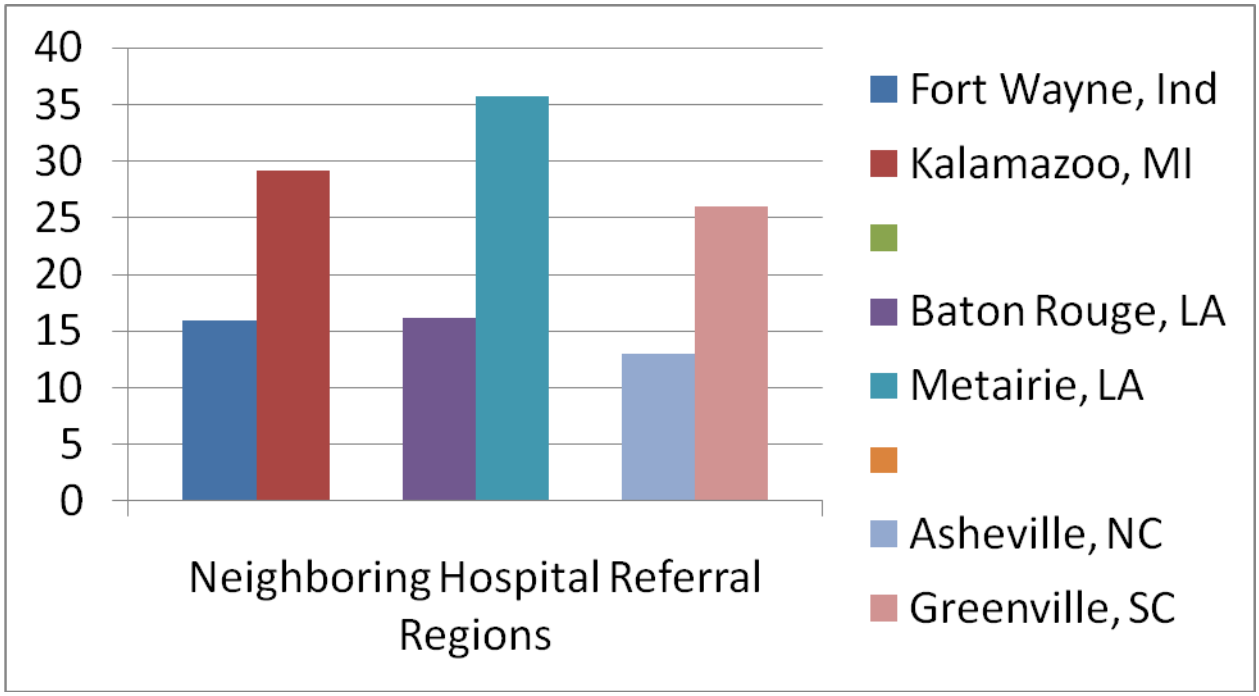

Left to right, if you're seeing this is black and white: Fort Wayne and Kalamazoo, Baton Rouge and Metairie, Asheville and Greenville.

These pairs of Hospital Referral Regions border each other:

> Fort Wayne, Indiana borders the Kalamazoo, Michigan region,
> Baton Rouge, Louisiana borders the Metairie, Louisiana region, and
> Asheville, North Carolina borders the Greenville, South Carolina region.

Again, no one claims that Fort Wayne, Baton Rouge or Asheville are underserved by cardiologists. Nor that their populations are sicker than Kalamazoo, Metairie or Greenville.

Rather, it appears that local medical treatment preferences define these variations.

The Ethical Broker's Role

Your clients may find this type of information interesting or useful when considering medical care. Some may prefer more aggressive care – a mastectomy, for example, rather than watching and waiting.

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Others may prefer more conservative care – watching and waiting, for example, rather than a mastectomy.

In any case, they may appreciate learning about the treatment tendencies in their area. This may well give them something useful to discuss with their physicians.

Our underlying point here: **most patients do not know that these treatment variations exist.** The broker who 'does his fellow a favor' may help people avoid inappropriate care.

The broker who 'let's the buyer beware' may not be protecting his/her client as well.

> Key Idea: Most consumers / patients do not know these treatment variations exist. Out of ignorance, they may fail to discuss certain systemic issues with their providers and receive unnecessary or inappropriate care as a result.
>
> The ethical broker would advise his/her clients about this phenomenon and help them avoid unnecessary care that carries risks but little benefit.

Remember also that no regions in the US suffer from insufficient medical care, or widespread *undertreatment* of patients. The data presented here may suggest that some regions, rather, *overtreat* patients by providing excessive or unnecessary care.

We, in this country, believe that decisions about care – undertreatment, overtreatment or other – should be made by the patient and physician. The broker has no role in treatment advising.

But the broker may have a role in client education and data distribution. By helping to educate the client about systemic risks, the broker may help the client have a more detailed and fruitful discussion with his/her physician.

Brokers who 'do their fellow a favor' may aid in this process.

Brokers who 'let the buyer beware' probably do not.

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Chapter 4
A Discussion with a Benefits Administrator: Let the Buyer Beware vs. Do Your Fellow A Favor

A Benefits Administrator for a large company puts the company's benefits out to bid. Two brokers respond. Both offer similar plans at similar prices. Both are experienced. Both are professional. Both offer all the standard services – 401(k) administration, FSA administration, wellness programs, etc.

The Benefits Administrator tries to find some reason to choose one broker over the other. Since they appear to be mirror images of each other, he has little to choose. So he asks both brokers 'why should I choose you?'

Broker A talks about experience: 20 years in the business, a good customer service reputation, intimate knowledge of carriers and plenty of references. Broker A talks about his commitment to clients and interest in helping clients. He even offers to meet with the Benefits Administrator quarterly to provide policy and regulatory updates.

Certainly, thinks the Benefits Administrator, Broker A is fine. There's nothing wrong with him.

Then Broker B comes along. This broker also has years of experience, a good customer service reputation, good relations with the various local insurance carriers and plenty of references. This broker also offers to meet quarterly to discuss policy and regulatory updates. (Both brokers, it seems, value face time with the Benefits Administrator.)

But in addition to all these services, Broker B makes a surprising statement:

> My company has a clear business standard that defines our relationship with clients. The ethical standard that we embrace is called 'Do Your Fellow A Favor'. I've studied business ethics and decided that I want my company and my employees to live up to this standard.
>
> Many of my competitors use a different ethical standard. They 'let the buyer beware.'

Intrigued, the Benefits Administrator asks Broker B to continue.

> I won't save you any premium money in the short term as compared to Broker A. She's a fine broker who is perfectly capable of running rates and showing alternative policies.

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> I won't show you any plans that she doesn't. And I offer all the same services as she does.
>
> But in addition to offering everything that she offers, under my 'do your fellow a favor' standard, I'll also educate your employees about how to use our healthcare system more wisely.
>
> I'll tell them things about the healthcare system that they probably won't learn from their doctors but that may help them interact with their doctors. I'll help them become wiser consumers of medical care.

The Benefits Administrator started to yawn as Broker B continued:

> Better educated consumers, who shop more wisely, use medical resources more efficiently. In the long run, this may save you money….maybe quite a bit.

The Benefits Administrator suddenly perked up:

> You'll save us money? Explain. Give me an example.

Broker B then summarizes:

> We know, for example, that the rate of Caesarian births varies among hospitals in this state almost 3 to 1. The infant mortality rates and maternal mortality rates, though, are about the same among all in-state hospitals. [28]
>
> Researchers have not identified any significant health differences among women delivering at the various hospitals. Instead, they found that the main causes for this Caesarian birth rate variation are hospital staffing and organizational differences, not patient epidemiological differences.
>
> *This means that the same woman will more likely have a c-section at some hospitals than at others. Her choice of hospital may have an impact on her likelihood of having a caesarian delivery.*

'I didn't know that' exclaims the Benefits Administrator. Broker B continues:

> I have no opinion about whether Caesarian births are better or worse than natural births. But some of your employees might. They may find this information useful when planning their delivery.

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[28] This discussion uses real data from Massachusetts hospitals. See Boston Globe, Why Caesarian Birth Rates Differ at Area Hospitals, 6/7/2010, Cooney

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> At the very least, it may give them something to talk with their obstetrician about.

'So,' suggests the Benefits Administrator, 'having this information available may reduce my employee's rate of unintended Caesarian deliveries. That could affect our Experience Modifier and save us some premium money in the future. Interesting.'

Broker B continues:

> Here's another example of what we discuss with employees. It's an analysis of the rate of angioplasty procedures performed in Smithville and Jonesville, the two largest cities near here.[29]
>
> People in Smithville have about 3x the rate of angioplasties as people in Jonesville, and about 4x the national average. Researchers have not discovered any major epidemiological differences among people in the two towns.

The Benefits Administrator: 'Why are there such stark differences?'

Broker B:

> I don't know for sure, but it seems that the physicians in Smithville favor angioplasties in cases where the physicians in Jonesville would not. The researchers seem to suggest that the Smithville physicians use angioplasty more aggressively than the Jonesville physicians.

Benefits Administrator: Why is that?

Broker B:

> I don't know for sure, but it seems that studies of the usefulness of angioplasty present a confusing picture. Some studies show that angioplasty is a useful and necessary procedure that helps a great number of people. Other studies indicate that it is useful in only a much smaller number of circumstances.
>
> Some physician groups embrace this treatment protocol and use it widely; others seem to shy away from it.

[29] I have changed the town names, but use actual data as presented in the New York Times, Heart Procedures is Off the Charts, 8/18/2006

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'Interesting,' comments the Benefits Administrator. 'That seems to suggest that our employees living in Smithville will have higher rates of this procedure than our employees living in Jonesville. Let me check my claims data and get back to you.'

The Administrator, who has a remarkably good computer system, immediately compares claims data and, sure enough, notes this discrepancy. 'I wonder how many Smithville angioplasties would not have been performed on Jonesville residents. I wonder what the cost differences would be.'

Broker B continues:

> I do not know whether angioplasty is a good treatment protocol or not; I'm not a doctor. I can't give medical advice or opinions. Neither can you.
>
> But your employees in Smithville and Jonesville might be interested to see this data. We can present it to them in one of our classes. It may help them discuss their treatment options with their own physicians.

The Benefits Administrator then pauses and thinks for a couple of minutes.
'Giving us data like this is a good thing. But it may be too specific for many of my employees. They may not need Caesarian or coronary treatment information. But they may need information about other treatments. What can you do for us there?'

Broker B responds:

> We offer classes on our healthcare system. One class, for example, addresses issues of 'treatment variation' – like the data I just presented. We explain what it is, why it exists and how your employees can learn more. We use local examples for medical procedures ranging from mastectomies to leg amputations to back surgeries.
>
> We want to help your employees become sophisticated healthcare consumers. We want to provide them with data to discuss with their physicians.
>
> **We never advise people whether or not to seek treatment.**
>
> Instead we teach them how our healthcare system works. We try to give them tools to negotiate the system better, and to protect their own interests better.
>
> In short, we inform them of systemic problems that they may not have realized exist.

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In the end, the Benefits Administrator considers the two brokers. One who takes the 'let the buyer beware' approach about dealing with our healthcare system. The other who 'does his fellow a favor'. Which will help my employees the most, he wonders.

In the end, the Benefits Administrator chooses…..

Well, who would you choose?

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Chapter 5:
If the Broker 'let's the buyer beware', then who will 'do his clients a favor'?

Background: Demand for Health Services
Americans want all the medical care available

In the 1990s, carriers restricted access to medical care as part of their cost containment programs. Patients needed referrals – which were not always accepted by the carrier. Carriers limited access to expensive specialists, limited the number of physician visits / condition, or limited the types of medications covered.

The American public perceived this as an attempt to improve carriers' financial positions rather than to improve patient outcomes – and objected to these inappropriate restrictions.

Key Idea: Americans want all the medical care available. We strongly resist restrictions imposed on us by carriers or the government.

One result: today's insurance policies allow easier, even unfettered (the 'generous insurance plans' described by Mr. Rosof in our Preface) access to the hospital or specialist of choice. Many carriers have acquiesced to consumer demands for easier access to care. Today many insured Americans can get access to all the medical care available.

Is this always a good thing? Not necessarily, suggests Mr. Rosof in our Introduction.

Patients delegate medical decision making to physicians
Purchasing medical services is different from purchasing most other services:
The Impact of Trust

John Wennberg, the founder of the Dartmouth Institute for Health Policy and Professor Emeritus at Dartmouth Medical School addresses the underlying issue here. Purchasing medical services, he suggests, is vastly different from purchasing goods and services in most markets. 'The doctor-patient relationship is different,' he suggests 'because of the asymmetry of information.'

The consumer – your client:

> Does not know what he or she truly needs; it is the physician who knows the nature of the patient's illness and can select the right treatment…[as a result] patients delegate decision making to the seller of the services. [30]

[30] Wennberg, Tracking Medicine, page 23

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Key Idea: Purchasing medical services differs from purchasing most other services. In medicine, the service supplier (physician) knows far more about the technical aspects of our problem than we do, due to his/her extensive training.

As a result, we rely on our physician to (a) diagnose the problem; (b) design a treatment program; and (c) implement that treatment option. We often delegate decision-making responsibility to him/her.

Arnold Relman, Professor Emeritus of the Harvard School of Public Health and a former editor of the New England Journal of Medicine, echoes Wennberg on the asymmetry of medical information between patient and physician: [31]

> Patients usually know much less about the diagnosis and treatment of their disease or injury than their doctors do. Furthermore, because of illness or injury they may be in no condition to evaluate their options.
>
> As a consequence they cannot independently decide what medical services they want in the same way consumers choose services in the usual market…
>
> The penalties for making a mistake in the health care market are usually higher than in others.
>
> Patients must therefore trust their physicians to decide what services they need.

Imagine doing this with your home repair contractor! We might call it 'license to steal' if the homeowner said 'tell me what I need and I'll buy it all.'

Key Idea: In our fee-for-service environment, the physician has an economic interest in the advice he/she gives us.

In other words, the physician to whom we have delegated decision making authority for our medical care stands to gain or lose economically from his/her advice.

But in medicine we accept that the service seller (physician) will identify the problem, design the solution, implement the solution, get paid for his/her efforts and that the patient will agree.

Physicians are Human

[31] Arnold Relman, A Second Opinion, 2007, pages 22 - 23

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Various factors may affect their advice, consciously or subconsciously

Dartmouth's Wennberg provides a cautionary note.

> Physician decisions…are strongly influenced by the capacity of the local medical market - the per capita number of…medical specialists, and hospital or ICU beds, for example. [32]

In other words, physicians in areas with *greater medical services available* are likely to design more expensive and more generous treatment programs than physicians in areas with *fewer medical services available*…for the same patient. And often generating the same outcomes.

(Remember that in the US, no regions have *insufficient* medical resources as, for example, do many foreign countries. This is, in part, due to Medicare's payment system. We do not have significant regional mortality rate differences that researchers attribute to a lack of medical resources. All US regions have at least a sufficient level of medical resources available.)

Here is Wennberg's startling suggestion: treatment protocols vary more based on *medical supply differences and the regional medical culture* than based on *patient medical differences*. He suggests that your chance of having surgery can be predicted by the rate of surgery in your region 10 years prior:

> The really fascinating thing to me is to think that what predicts your risk of surgery today in a particular region is what it was ten years ago in the same region. [33]

As a result, a Medicare beneficiary moving from Tampa Florida to Fort Myers Florida – about 2 hours away - increases his/her chance of receiving back surgery by 60%. [34]

Or residents of Elyria, Ohio are about 3 times more likely to have an angioplasty procedure than are residents of Cleveland, about 20 miles away. [35]

Do Harvard and Yale Med School Graduates Practice Medicine the Same Way?
An Embarrassing Live Example

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[32] Ibid. page 11

[33] Brownlee, op cit, page 41

[34] Ibid.

[35] Heart Procedure is Off the Charts, NY Times, 8/18/2006

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Wennberg and his colleagues at Dartmouth Medical School tested this Treatment Variation idea on physicians practicing in Boston and New Haven. [36]

Their reasoning: the Boston medical landscape is dominated by Harvard Medical School, its affiliated teaching hospitals and its alumni. The New Haven medical landscape is similarly dominated by Yale Medical School. Both are outstanding and prestigious academic medical centers. Both publish widely. Both read each other's research studies.

We would expect both to treat similar patients similarly. Wennberg wanted to explore this idea and determine if the supply of medical resources affected the physician's judgement.

Here's what Wennberg's team did. First, they counted the number of hospital beds available in the Boston and New Haven areas. They then divided the number of beds by the number of Medicare beneficiaries to get a ratio. (They used Medicare beneficiaries because Medicare provides sufficient data for this research study.)

Boston had 55% more beds per 1000 Medicare beneficiaries than did New Haven. And, just as Roemer had predicted in his Law some 25 years earlier, Boston area Medicare beneficiaries spent about 40% more time in the hospital than did New Haven beneficiaries.

This meant that a patient in Boston had a 40% higher likelihood of being hospitalized for something that a similar patient in New Haven would not be hospitalized for!

Yet, as Shannon Brownlee summarized the situation:

> Patients in Boston weren't any sicker than those in New Haven; they were just more likely to be hospitalized – and admitting them more often to Boston hospitals did not appear to improve their outcomes.

Wennberg's initial publication of this phenomenon was entitled 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?' [37]

He continued his research. He discussed standard admission decisions with physicians in Boston and New Haven. He asked physicians in New Haven if they felt like they were forced to ration care, and they said no. He asked physicians in Boston the same

[36] This story comes from Brownlee, Overtreated, pages 111 - 112

[37] Lancet, 1987

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question and got the same answer. Physicians in both cities felt that they had sufficient medical resources available and hospitalized patients at the right rate.

He then presented his findings to physician groups in Boston and New Haven. But he played a trick: **he reversed the labels on his slides!**

He labeled Boston admission rates 'New Haven' and labeled New Haven as 'Boston'. He then showed Boston area physicians that 'New Haven' doctors were admitting patients 40% more often than they were. And he showed New Haven doctors that 'Boston' physicians were admitting 40% less.

He then asked the Boston group to comment on how New Haven docs practiced medicine. The result, according to Megan McAndrew, editor of The Dartmouth Atlas: The Boston audiences

> Would come up with all these reasons why those guys down in New Haven were admitting too many patients.

This group, being highly trained physicians, would explain in detail which admission errors the New Haven docs made – by disease type, etc. Wennberg dutifully wrote everything down.

He then showed the correctly labeled slides and went through the reasons given for poor admission decisions in New Haven. He discussed item-by-item the treatment differences and hospital admission differences, by patient presentation and disease, for Boston and New Haven. This made a big impression on the physicians.

The lesson here, according to Brownlee:

> Doctors were blithely, astonishingly unaware that the supply of hospital beds was affecting their clinical decisions. They thought they were putting patients in the hospital entirely on the basis of what would help the patients…

Not based on any external supply factors.

I – that author of this course - have no idea whether Boston admission rates or New Haven admission rates were correct. I only know that they differ. As a consumer, I would like someone to inform me of this discrepancy.

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Key Idea: Our physician sometimes has a bias. He/she may not even be aware of this. After all, physicians are only human.

Sometimes physicians may be influenced by regional or cultural factors, such as the availability of medical resources.

These factors may influence the advice we receive. Should the broker point this out to clients?

Our ethical question returns: *do you think your clients should be advised of this information? Would you like to be advised of this if you were a client? If so, how would you know that this information exists? Who, in our healthcare system, would tell you?*

The Average Doctor's Visit Lasts 20 Minutes

How Much Patient Education Can Doctor's Provide?

The average doctor's visit only lasts about 20 minutes. [38] During this time, the physician needs to diagnose the patient's problems, describe the treatment options and help the patient make a decision – that's plenty to do in 20 minutes.

The physician doesn't also have time to (a) explain the treatment variation issues, (b) research the likelihood of excess care for a particular medical problem in a specific region, (c) research the treatment tendencies of each hospital in the region for that particular medical problem (see our example, above, of Caesarean deliveries by hospital) and (d) answer all the patients questions. That's too much information for the poor patient – who may be emotionally upset by the diagnosis in the first place!

Our physician, thus, is unlikely to 'do your clients a favor' during the short office visit…even if the physician understands the treatment variation issues.

.

But even worse, from a patient education point of view…

Our medical system does not pay anyone to disagree with the physician

By analogy, our legal system requires both a prosecution and defense attorney to question witnesses. That way neither has too much power.

In our medical system, however, patients only get one point of view ---from providers who earn money by providing care. This is Wennberg's key point. Your doctor plays the equivalent roles of police investigator, prosecutor, defense attorney and judge. This puts

[38] Chen, et al, Primary Care Visit Duration and Quality, Archives of Internal Medicine, November 9, 2009

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enormous advisory power in the hands of one person – and, interestingly, a person who has an economic interest in the patient's decision.

Our system does not pay anyone to oppose the provider's point of view.

Carriers might also play that role – but the managed care experience of the 1990s has turned popular opinion against trusting carriers too much.

Second opinions might fulfill the role…but probably do not. Physicians in the same group practice, hospital or region tend to treat patients with similar protocols, and disagree far less than perhaps they should. This is very well documented in the healthcare literature.

Also, physicians may have informal – perhaps even unconscious – motivations to support each other.

Key Idea: Second opinions may have less value than we expect. Researchers have discovered that physicians in the same practice or in the same region are likely to design similar treatment protocols.

But the treatment protocols may vary by region. A Medicare beneficiary living in Fort Myers Florida might get back surgery, while an identical beneficiary living in Tampa might get physical therapy.

The first and second opinions from Fort Myer's physicians may agree. It may make more sense to get a second opinion from a physician in a different geographic region….with different treatment tendencies!

No one, it seems, will do your clients a favor….except you, the broker!

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Chapter 5
How Should an Ethical Broker Proceed?

In this concluding chapter we'd like to offer some general advice for how best to ***do your fellow a favor***: [39]

We offer some general advice for ethical brokers. **First**, educate yourself about our healthcare system, so you understand both *insurance policy and regulatory details* and *healthcare system operational issues*.

1. Educate yourself about our healthcare system.

   The ethical broker has a responsibility to 'do your fellow a favor'. The more you know about our healthcare system, the better you can educate your clients.

   Today's bookstores are full of insightful and useful books about healthcare. Some that we have found particularly useful (also quite engaging and easy to read):

   Overtreated, by Shannon Brownlee;
   Complications, by Dr. Atul Gawande;
   Better, by Dr. Atul Gawande;
   Best Care Anywhere, by Phillip Longman;
   Should I Be Tested for Cancer?, by Dr. H. Gilbert Welch;
   Overdiagnosed, by Dr. H. Gilbert Welch;
   Know Your Chances, by Dr. Steven Woloshin, et al
   Tracking Medicine, by Dr. John Wennberg

   Here's typical feedback from our students who have read these books: they contain fascinating and very useful information. Ethical brokers use that information their normal professional work.

2. Help your clients ask questions.

   Patients sometimes are intimidated by specialists; sometimes awed by specialists; or sometimes tongue-tied in front of specialists. The better you educate your clients about the inner workings of our healthcare system, the better they'll be able to ask important questions of their physicians.

[39] Some of this advice comes from the Afterward of Overtreated. See Brownlee, op cit pages 308 - 310

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Second – provide your clients with good information so they can ask good questions of their physicians.

3. Give general, but not client specific advice. Do not play the role of doctor or give medical advice. This is illegal unless you are licensed to practice medicine.

Third – give general advice about our healthcare system's operations, not specific medical advice (unless you are licensed to do so).

Rather than give specific, detailed advice to a client about his / her specific medical condition, we encourage you to offer general education about the workings of our system.

You can, for example, use the Dartmouth Atlas of Healthcare (www.dartmouthatlas.org) to see comparisons between your region / state and other states or national averages.

Some other useful websites include the Kaiser Family Foundation site (www.KFF.org) , the Centers for Disease Control site (www.cdc.gov) and the Agency for Healthcare Research and Quality site (www.ahrq.gov) and the Commonwealth Fund (www.commonwealthfund.org) .

These sites provide extensive data about the operation of our healthcare system.

Conclusion

In this course, we have suggested that ethical brokers educate their clients. An ethical broker adopts the 'do your fellow a favor' standard rather than 'let the buyer beware'.

In this Conclusion, though, I would like to extend this idea, and suggest that *adopting the ethical standard of 'do your fellow a favor' is good customer service.* The more you treat your clients as you would like them to treat you (were conditions reversed), the more satisfied they will be with your service.

'Customer service' in this regard is much more than answering telephones promptly, responding to emails and processing the myriad of forms that health insurance brokers process. It is also more than generating quotes for health, life, disability and dental coverage.

Customer service begins to mean 'help your customers navigate our healthcare system.' This may be far more important than answering phones promptly.

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Imagine how satisfied a client will be with your service when she learns from you about the relative risk of Caesarian births at local hospitals. Absent that knowledge, she might have had an (unwanted) Caesarian; her lack of information may have reduced her ability to plan and increased her risk of a procedure that she did not want. Armed with information, however, she can make more informed decisions about where and how to deliver her baby.

Alternatively, imagine how pleased a different woman may be to learn that some hospitals perform very low rates of (desired) Caesarian births. She may use your information in discussions with her obstetrician, and alter her choice of delivery hospital as a result.

Imagine how satisfied another client will be when they begin a conversation with their cardiologist armed with data about the relative rates of angioplasty performed in your region compared to the national average.

Now ask yourself the chance that a client who is so satisfied with your services will switch to another broker at the next policy renewal. I suggest that your client retention rates will increase as you embrace the 'do your fellow a favor' ethical standard.

Good ethics is good customer service. We have an ethical tradition of full disclosure and 'do your fellow a favor' extending back to the time of Abraham. I hope that today's health insurance brokers will embrace this tradition, and practice both good ethical behavior and good customer service as a result.

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