# Health Insurance Broker Ethics 1

Mass CE course #C60661, 9 ethics credits

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**Health Ins Broker Ethics I**
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## Introduction

This course considers the ethical standards related to health insurance policy sales and disclosure.

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.

But 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, surgeries, 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 good health.

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. The 'ethical benefits advisor' will help clients understand the likely impact of using various services.

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]

> '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.'

[1] Washington Post, September 29, 2009, Connolly. Italics added. Many other commentators have made similar suggestions.

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 harm.
- Fourth, that this happens 'often'.

Does Rosof – the Chairman of a hospital - mean that patients with certain types of health insurance actually receive unnecessary and harmful care ***as a function of their health insurance***? 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 and harms?
- Should they simply 'let the buyer beware'?
- Or should brokers live up to a higher ethical standard?

The knowledgeable broker knows that we sometimes *overuse* our medical system. Researchers like Professor Jonathan Skinner of Dartmouth Medical School who have studied this phenomenon 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. Too much care, or *overtreatment*, may lead to poorer 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 and Director of the Dartmouth Institute for Health Policy and Clinical Practice, 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] concluding

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

[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.

> 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.

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?

**New Health Insurance Plans and the Medicare Modernization Act of 2003**
make broker ethical disclosure even more important

Two trends over the past 20 +/- years highlight the need for brokers to disclose likely medical impacts ethically.

**First,** deductibles have increased dramatically. In the early 2000s, a 'high deductible' plan might include an annual $250 deductible. By 2020, many (most?) plans include a $1000 annual deductible with some exceeding $3000. This places an increased economic burden on clients who want to avoid wasting their own money on unnecessary care.

In the past brokers might have considered the 'unnecessary care' problem a minor issue. Yes, they may have thought, some excessive care may be unnecessary but other so-called excessive care might prove useful to patients. No individual actually paid for it since virtually all plans included first dollar coverage and the harms from excessive care were not widely known or understood.

Today's high deductibles, though, create an economic cost to patients. Each *unnecessary* MRI can waste several hundred dollars, money more usefully spent in other ways. This makes the broker more responsible for helping clients identify and avoid unnecessary care today than ever previously.

**Second,** more companies try self funding, with some carriers offering self funded or partially self funded plans to groups as small as 50. In self funded arrangements, each wasted dollar of medical care comes directly from the company's bottom line.

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

These two trends have fundamentally changed the broker's responsibilities. Not only must the broker assemble an appropriate benefits package for each client and keep clients in compliance with state and federal regulations, but brokers today must try to control healthcare spending at both the corporate and individual levels. Among the ways to do this: teach people how to identify and avoid unnecessary medical care.

### Disclaimer

We discuss various medical procedures, treatment protocols and outcomes in this course. We do so as insurance brokers, economists 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. 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 ethicists – the people who discuss 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. We offer ethical positions not dogmatically, but rather as a teaching guide.

**Review Questions**

Correct answers on next page

1. What ethical advisory role do brokers have according to this course?
    a. They should explain policy terms only
    b. They should quote prices only
    c. They should answer specific client questions only
    d. They should explain policy terms, quote prices, answer client questions and educate clients about the workings of our healthcare system

2. What is the ultimate product that health insurance brokers sell, according to this course?
    a. Healthcare
    b. HMOs
    c. Deductibles
    d. Health savings accounts

3. What function does *insurance* play in our healthcare system?
    a. Insurance is a mechanism of financing healthcare
    b. Insurance covers deductibles and copayments
    c. Insurance applies to employed children up to age 26
    d. Insurance identifies appropriate medical treatments

4. What is one potential risk of having a generous health insurance plan, according to Bernard Rosof, Chairman of Huntington Hospital in New York?
    a. People with generous insurance plans can run up large bills and face life-threatening complications from unnecessary care, including back surgeries that result in wound infections when physical therapy might have been a more effective treatment
    b. Generous health insurance plans are far more expensive than less generous plans, which can create stress for people paying the premiums
    c. Generous health insurance plans generate greater profits for insurance carriers, which they use to fund lobbying and political activities that ultimately work against the policy holder's interests
    d. People with generous health insurance plans may disregard healthy lifestyle advice and turn to medical care instead when they get sick

**Correct answers in bold**

1. What ethical advisory role do brokers have according to this course?
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# Part 1:
# Disclosure Ethics

## Introduction to the Problem

Some information that an ethical broker should disclose

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

**First, an overview.** A profound and massive 2013 study and important 2015 book concluded that 40% of established medical practices are 'ineffective or harmful'. [5] This study wasn't published in some unknown or disrespected journal, by unknown researchers. Instead it was published in the Mayo Clinic Proceedings, a highly respected medical publication, written by lead author Dr. Vinay Prasad, a Senior Fellow at the National Cancer Institute and National Institutes of Health at the time, and reviewed in the New York Times.[6]

Prasad and his team reviewed every article written in the New England Journal of Medicine between 2001 and 2010 and found 363 that examined an established medical practice. 146 of them, about 40%, were found to be ineffective or harmful when put to a rigorous comparative test, 38% were beneficial and 22% unknown. Examples include:

- Prolonged antibiotics for patients with persistent symptoms and history of Lyme disease
    - No benefit found in, 2 randomized, placebo-controlled, double blind studies
- Low calcium diet for patients with history of kidney stones vs. diet low in animal protein and salt (but normal calcium)
    - After 5 yrs, low calcium group had double rate of kidney stones
- Intensively lowering blood sugar in Type 2 diabetics to reduce cardiovascular events
    - Low blood sugar group (A1c < 7%) sustained for 3.5 yrs increased mortality without fewer cardiovascular events compared to more permissive goal
- And about 140 more

Dr. Prasad summarized his findings this way in a You Tube video attached to the Mayo article:

> Patients who are embarking on procedures, screening tests or diagnostic tests should really try to ascertain whether or not those tests are based on good evidence. Of all those things we're doing that lack good evidence, probably about

[5] Prasad, A Decade of Reversal, Mayo Clinic Proceedings, August 2013 and Ending Medical Reversal written with Adam Cifu

[6] Bakalar, Medical Procedures May Be Useless or Worse, NY Times, July 26, 2013

> half of them are incorrect.

The fundamental problem, he said to the New York Times, edited for space here: Medical procedures

> ‘all sound good if you talk about the mechanisms. You have cholesterol-clogged arteries, it makes sense that if you open them up it will help. But when that was studied, it didn’t improve survival.”
>
> Patients, like to talk about mechanisms. “They tend to gravitate toward the nuts and bolts — what does it do, how does it work? But the real question is: Does it work? What evidence is there that it does what you say it does? What trials show that it actually works? You shouldn’t ask how does it work, but whether it works at all.”

Our ethical dilemma starts here.

- Who discloses this type of information – that about half of all established medical treatments are ineffective or harmful – to your clients?
- Should brokers ‘let their clients beware’ and assume that physicians and other medical professionals will provide the necessary information?

We’ll address that question in detail later in this course. For now, though, a very brief answer: **No – leaving all medical education to physicians has been conclusively proven ineffective.** See Mr Rosof’s comments above, along with Dr. Fisher’s.

Relying on doctors to educate patients has generated a waste factor in American healthcare of up to about 30% of all spending. Brokers – responsible to employers for both assembling benefit programs and helping control costs – cannot leave all medical education to physicians and the internet.

Of course, since brokers are not licensed medical professionals, they can only provide a specific type of consumer education. We’ll articulate that below. But the message so far – from Mr. Rosof, Dr. Fisher and Dr. Prasad: leaving medical education exclusively to physicians has been proven to raise costs, raise risks and generate sub-optimal outcomes. The broker has, at minimum, an ethical responsibility to disclose this fact to clients.

**Second, some specifics.** Various highly respected medical organizations publish lists of ‘Things Providers and Patients Should Question’ on ChoosingWisely.com. (All brokers should be aware of ChoosingWisely, our opinion.) Among things to question, per this initiative:

**Stress tests on asymptomatic patients.** The American College of Cardiology states bluntly on ChoosingWisely ‘

- Don’t perform stress cardiac imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.
- Don’t perform annual stress cardiac as part of routine follow-up in asymptomatic patients.
- This practice may lead to unnecessary invasive procedures without any proven impact on patients’ outcomes.

Stress tests on insured patients costs about $200 - $400 per test – often an unnecessary expense that can lead to unnecessary procedures (according to the College of Cardiology)

Our ethical question: who tells this to your clients?

**Allergy tests**. The American Academy of Allergy, Asthma and Immunology, consisting of 6500 members in 60 countries, developed this statement for ChoosingWisely

- Don’t perform indiscriminant battery of immunoglobulin tests in evaluation of allergy…Appropriate diagnosis is based on the patient’s clinical history
- Random allergy testing usually doesn’t help, can lead to unnecessary lifestyle changes…give up foods, such as wheat, soy, eggs, or milk, end up with nutritional problems

Who advises patients to ask their physicians about these risks?

**Back MRIs.** The American Academy of Family Physicians, representing 105,000 physicians, bluntly states on ChoosingWisely

- Don’t do imaging for low back pain within the first six weeks unless red flags are present
- …Imaging of the lower spine before six weeks does not improve outcomes but does increase costs
- Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected.

But the American Academy of Family Physicians isn’t alone in questioning the utility of back MRIs when someone feels back pain. Here’s the North American Spine Society, 7500 members from orthopedic surgery, neurosurgery, radiology and physical therapy, also on ChoosingWisely

- Don’t have advanced imaging (e.g., MRI) of the spine within the first six weeks for non-specific acute low back pain in the absence of red flags.
- In the absence of red flags, advanced imaging within the first six weeks has not been found to improve outcomes, but does increase costs.

- Red flags include, but are not limited to: trauma history, unintentional weight loss, immunosuppression, history of cancer, intravenous drug use, steroid use, osteoporosis, age > 50, focal neurologic deficit and progression of symptoms.
- Again, who tells this to your clients?

The American College of Physicians representing 126,000 physicians agrees with this official statement on ChoosingWisely

- Don't obtain imaging studies in patients with non-specific low back pain.
- In patients with back pain that cannot be attributed to a specific disease or spinal abnormality following a history and physical examination (e.g., non-specific low back pain), imaging with plain radiography, computed tomography (CT) scan, or magnetic resonance imaging (MRI) does not improve patient outcomes.

And the American Society of Anesthesiologists – Pain Medicine, comprised of 50,000 members who advocate for patients who need anesthesia or pain medicine, goes even further

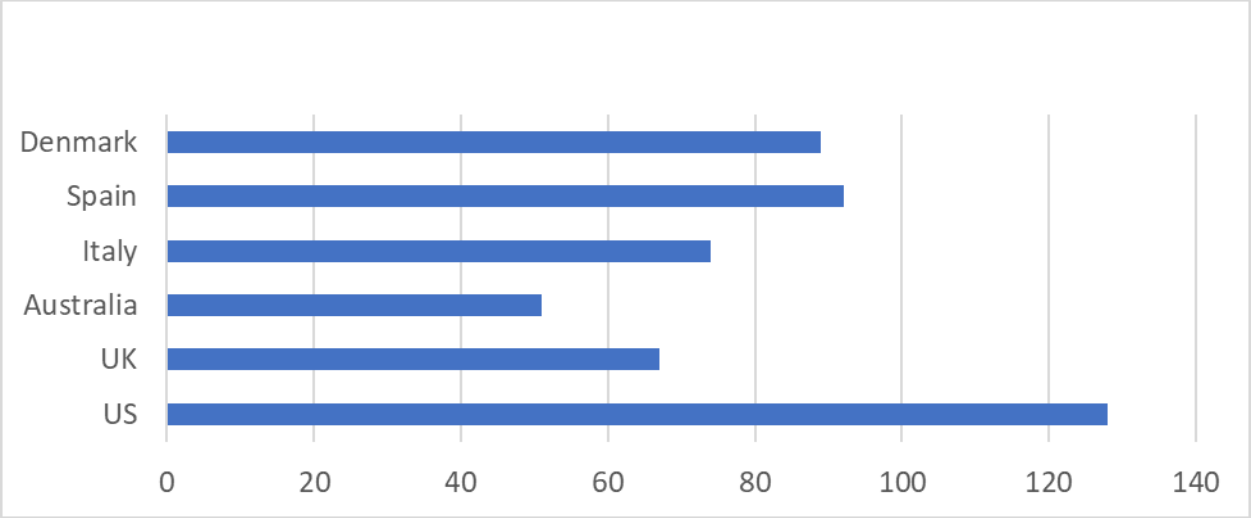
- Avoid imaging studies (MRI, CT or X-rays) for acute low back pain without specific indications.
- Imaging for low back pain in the first six weeks after pain begins should be avoided in the absence of specific clinical indications (e.g., history of cancer with potential metastases, known aortic aneurysm, progressive neurologic deficit, etc.).
- Most low back pain does not need imaging and *doing so may reveal incidental findings that divert attention and increase the risk of having unhelpful surgery.*

Why do we make such a big point about back imaging and list so many medical societies that recommend against having such a test when you first feel the pain? Because our national rate of MRIs has increased from about 56 per thousand people in 2000 to 128 per 1000 people in 2019. [7] Clearly the medical community has not educated patients about the risks of unnecessary MRIs.

Here's the excess-MRI issue on a broader scale, comparing the number of MRIs per 1000 Americans to the number per 1000 British, French or Canadians.

[7] OECD data https://data.oecd.org/healthcare/magnetic-resonance-imaging-mri-exams.htm

**MRI Exams per Thousand Population, 2019 OECD data**




Some MRIs are clearly useful. Based on the evidence from other countries that are demographically and socio-economically like us, having about 80 scans per thousand of population seems about right. That's about what other advanced countries – with slightly better infant mortality and longevity data – have. We currently do far more than that. But Danish, Spanish, Italian, Australian and British life expectancies slightly exceed ours and their infant mortality rates slightly trump ours. Their relative lack of MRIs has not, apparently, harmed their national statistics.

Here's a very rough estimate of the economic costs of those additional or unnecessary MRIs: $30 billion annually.

> The calculation: MRIs cost about $2000 each, according to New Choice Health, a website that compares medical care prices. [8]
>
> That's $2000 for each of the 50 unnecessary MRIs per thousand of us…and there are about 310 million of us!

Remember the key point here: the medical community is unable to cut the rate of apparently unnecessary MRIs on its own. The excess harms our employer clients who pay for the unnecessary utilization as well as employees who may actually be harmed

[8] http://www.newchoicehealth.com/MRI-Cost

by the excessive scans. Our customers pay – either individually through their deductible or self funded companies by spending their own money unnecessarily.

**Should brokers 'let the buyer beware?'**

Ethical brokers, from our point of view, should tell their clients about their risks of receiving excessive, unnecessary and potentially harmful medical care.

Ethical brokers should make resources like ChoosingWisely available to their clients.

Ethical brokers should inform their clients that the medical community has questions about the utility of certain medical practices.

And ethical brokers should help their clients learn the key questions to ask their physicians to avoid medical harms.

We'll discuss the origins of these ethical standards next.

## A comparison of two ethical standards

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.

## Some Judeo – Christian Business Ethical Positions on Disclosure

Let's start with the first commercial transaction in the Torah or Old Testament, in which Abraham laid down the 'full disclosure' commercial principle.[9]

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.

The story of Abraham purchasing a burial plot for his wife Sarah – who died while on an out-of-town business trip with her husband - 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 to the local people what he needs in vague terms – a burial plot for his wife. He does not stipulate where or exactly what kind of burial plot and indeed, doesn't know the local burial plot details or issues;
> **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 to 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;

[9] 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*

**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.

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.

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

'Let the buyer beware' assumes that all parties to a commercial transaction have the same information regarding price, quality, use, location, comparative markets, 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 or an insurance broker. The seller deals in this market, for this product, far more frequently than does the typical buyer so understands it better.

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 while the buyer only purchases health insurance one time per year.

### 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.

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 or fishermen 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.

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 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.

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 because buyers would have a very high degree of confidence in the seller's representations.

**Translating These Ideas to Product Sales and Business**

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 my local mechanic – i.e. my car expert.

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.

An ethical expert shares his/her expertise with clients. An unethical expert does not. Note some issues with this lack of disclosure:

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 things 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.  I want him to do me a favor, not let me beware!

**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!

## Unequal Knowledge about Health Insurance

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)

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.

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?

We suggest adopting the ‘do your fellow a favor’ ethical position, based on the Judeo-Christian roots described above. This has served as the moral and ethical foundation of western civilization for thousands of years.

## Business Ethics = Business Efficiency

Ethical Practices = Good Customer Service

Traditional ethics equates business ethics with business efficiency. The 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.

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. The principles 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: 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.

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

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 Massachusetts hospitals using 2020 data. [10] I've grouped these regionally – Brockton and Weymouth, Salem and Beverly, Clinton and Framingham. See how the chance of C-section delivery changes by hospital even within these fairly narrowly defined geographic regions and among demographically similar towns:

[10] Data published by the Leapfroggroup, downloaded April 2021 https://ratings.leapfroggroup.org/

| Hospital Name | Rate of Caesarian Births |
|---|---|
| Health Alliance – Clinton | 15.2% |
| MetroWest – Framingham | 26.1% |
| Brockton Hospital, Brockton | 14.0% |
| South Shore, Weymouth | 28.7% |
| North Shore, Salem | 16.2% |
| Beverly Hospital, Beverly | 28.4% |

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 Holy Family more frequently than Heywood.

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. [11]

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

The New Hampshire insurance department looked into similar C-section rate disparities among New Hampshire hospitals and concluded, in the official report

> There are no obvious reasons that explain why c-sections are higher at one NH hospital vs. another … [and] … there does not appear to be a relationship between c-section rates and health status. [12]

Or, stated more bluntly in a 2013 Harvard School of Public Health study

> the same woman would have a different chance of undergoing a c-section based on the hospital she chooses [13]

---

[11] Boston Globe, 6/7/10

[12] A Commercial Insurance Study of Vaginal and Cesearean Section Rates at New Hampshire Hospitals, State of New Hampshire Insurance Department, April 1, 2011

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?

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 analyses above, play a relatively minor role in all this.

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. They verbalize – though not in so many words – a desire to 'do their fellow a favor'.

[13] Pregnant women's likelihood of cesarean delivery in Massachusetts linked to choice of hospitals, Harvard School of Public Health News, March 19, 2013

**Review Questions**

Correct answers on next page

1. What does ‘unequal knowledge between sellers and buyers’ mean?
    a. Sales people generally know far more about their product than do consumers, because sales people have specialized education or training in that product, which consumers generally do not have
    b. Consumers are generally smarter and more worldly than sales people because they shop for many different kinds of products while the sales person specializes in only one or a few products
    c. Consumers have access to much more information (on the internet, for example) than they used to, so today they generally have equal – not unequal – product knowledge today
    d. Consumers can comparison shop widely, so generally know more about a specific product than does the sales person

2. What does the ethical concept of ‘full disclosure’ mean?
    a. That the seller has an ethical obligation to disclose everything he/she knows about the product *or the implications of the product*, to the buyer
    b. That the seller should disclose any and all financial relationships that he/she has with the product supplier *and/or with the buyer*
    c. That the consumer should disclose any and all financial relationships that he/she has with the product supplier
    d. That both the seller and the buyer should sign a ‘full disclosure’ document that covers both from potential fraud *and non-disclosure* accusations

3. What does ‘let the buyer beware’ mean?
    a. That the buyer should beware that the seller is probably lying when he/she represents something
    b. That the buyer should beware that the seller is probably taping the transaction to protect him/her self in the event of a fraud accusation
    c. That the buyer should beware that the product probably contains hidden defects that the seller is not under any legal or ethical obligation to disclose
    d. That they buyer must do his/her own product research because the seller feels him/her self under no ethical obligation to disclose product details

4. What does ‘let the buyer beware’ assume?
    a. That the buyer understands that the seller is probably lying when he/she represents something
    b. That all parties to the transaction have equal abilities to understand the product information available
    c. That buyers have a certain minimum level of intelligence
    d. That sellers have less than a certain minimum level of intelligence

5. Is ‘let the buyer beware’ an ethical or unethical standard?
    a. This is an ethical standard
    b. This is not an ethical standard. In fact, it is unethical
    c. It is only an ethical standard for service type products like health insurance
    d. It is generally an ethical standard but is inappropriate for service type products like health insurance

6. What does ‘do your fellow a favor’ mean?
    a. That buyers should help sellers whenever possible
    b. That sellers should try to put themselves in the buyer’s position, and should educate buyers as they would like to be educated themselves if they were the buyer
    c. That sellers should embrace ‘the selfishness of Sodom’ thus creating a more competitive market
    d. That buyers should embrace ‘the selfishness of Sodom’ thus putting more demands on the seller

7. Is ‘do your fellow a favor’ an ethical standard?
    a. No
    b. Yes
    c. Only when the buyer figures that the ‘favor’ is worth less than the product in question
    d. Only when the buyer figures that the ‘favor’ is worth more than the product in question

**Review**
**Correct answers in bold**

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## Some Ethical Advice Issues
## The problem of treatment variation

Geographic treatment variation means that the *same* patient, with the *same* medical condition, might receive *different* care in *different* geographical regions.

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 as the same person living in Miami.[14]

Or a woman diagnosed with early stage breast cancer is about 40% more likely to have a mastectomy in Connecticut than in Massachusetts. [15]

How can this be?

### 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.

   This suggests that treatment intensity above the minimum may be unnecessary and wasteful, potentially causing more harm than patient benefit.

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.

Note how the broker shares long-term financial interests with the employer-client. The client may switch carriers and change provider networks 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.

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.

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[14] https://data.dartmouthatlas.org/surgical-discharges/#by-year

[15] https://data.dartmouthatlas.org/surgical-discharges/#by-year

## Why Variations Exist

Perhaps the key source of geographic 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 described this situation for many years (the site has recently been updated without this useful explanation):

> 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.
>
> 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.

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.[16]

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.

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

Why might regions with more hospital beds and physicians per capita of the population provide more medical care?

## 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.[17]

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.

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

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

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%.

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

> 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, using 2006 data: [18] I quote this study for 2 main reasons. First, it's thorough and targeted, useful for our purposes. Second, when Warren Buffet read it, he contacted the author and ultimately hired him to work on Buffet's healthcare reform initiative, Haven.

> 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:

[18] Atul Gawande, Cost Connundrum, New Yorker, September 2009.

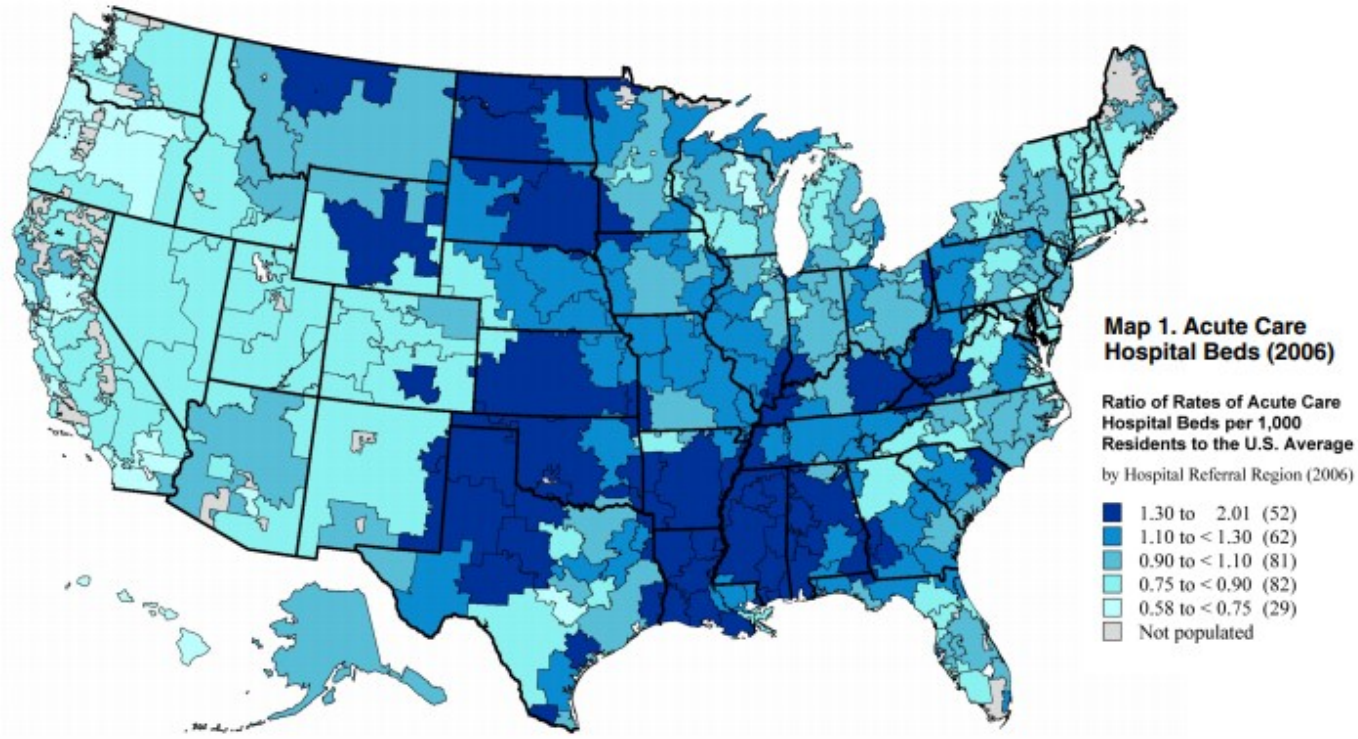
| | McAllen | El Paso |
|---|---|---|
| Average household income | $40K | $36K |
| Poverty rate | 27% | 27% |
| % Hispanic | 80% | 77% |

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.

**Would Your Clients Like to Know This?**

The number of acute care beds and specialists varies significantly by region, even if the population demographics do not.

Here, for example, is a map showing the number of acute care beds per 1000 of population. The darker colors indicate more beds.[19]




[19] Dartmouth Atlas Capacity_Report_2009.pdf

Regions with more medical resources available tend to have higher utilization and spending according to Roemer's Law. The Dartmouth researchers found that this played out in practice: the greater the hospital bed supply, the more hospitalizations in a region…but not better patient outcomes.

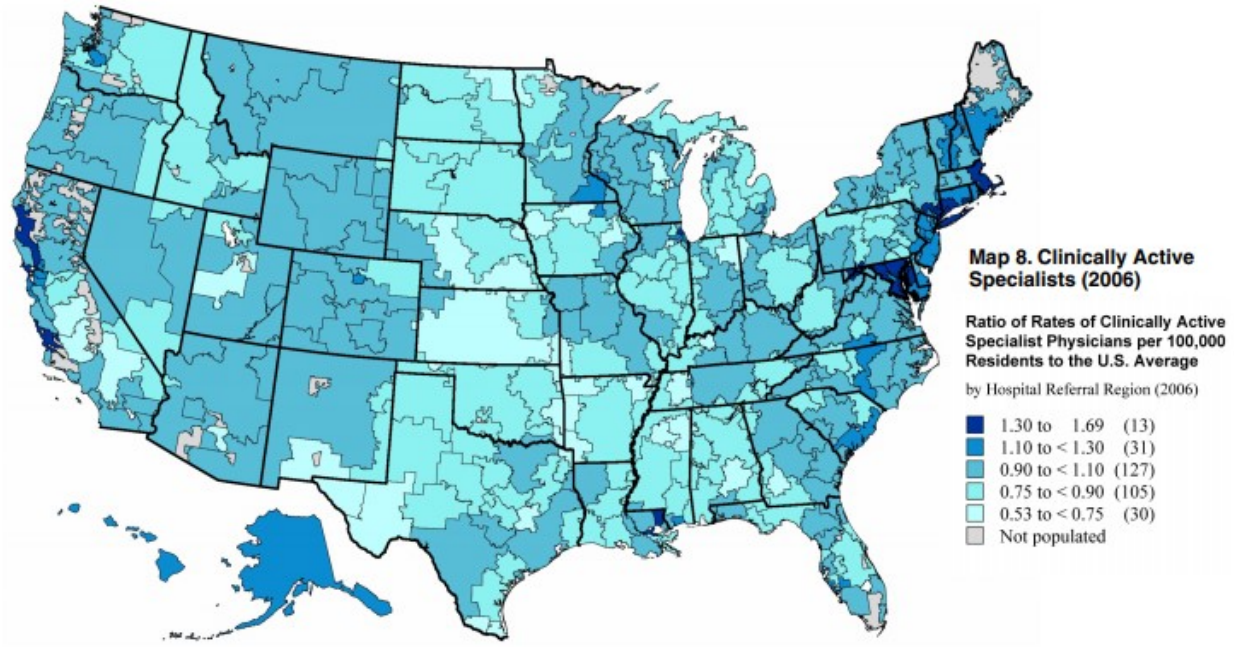
Here's Fisher again, from his same studies:

> 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.

Thus the amount of medical care received by people in the higher spending regions does not impact positively on patients.

Somewhat depressingly, the physician workforce grows more quickly than does the US population with about 60% of the new physicians being specialists.

Here's a map showing specialist distribution in the US, 2006, the most recent available on the Dartmouth Atlas.




See how there are more specialists per 100,000 people in Washington DC, New York, New England and the west coast. This was the same situation as 10 years before.

Why?

Two researchers from Dartmouth, Katherine Baicker and Amitabh Chandra suggest 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. [20]

In other words, specialists like to settle in affluent communities near the teaching hospitals where they trained, not in regions with higher disease rates – i.e. 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 and where they like to live.

For patients in regions with high concentrations of specialists, 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. [21]

'Excess mortality' is a death rate higher than the underlying demographics would predict.

Why does access to more specialists lead to this 'excess mortality'? We'll turn to the final researchers in this section, 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:

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

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

> 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. [22]

Here's our summary:

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

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

## Case Study

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;

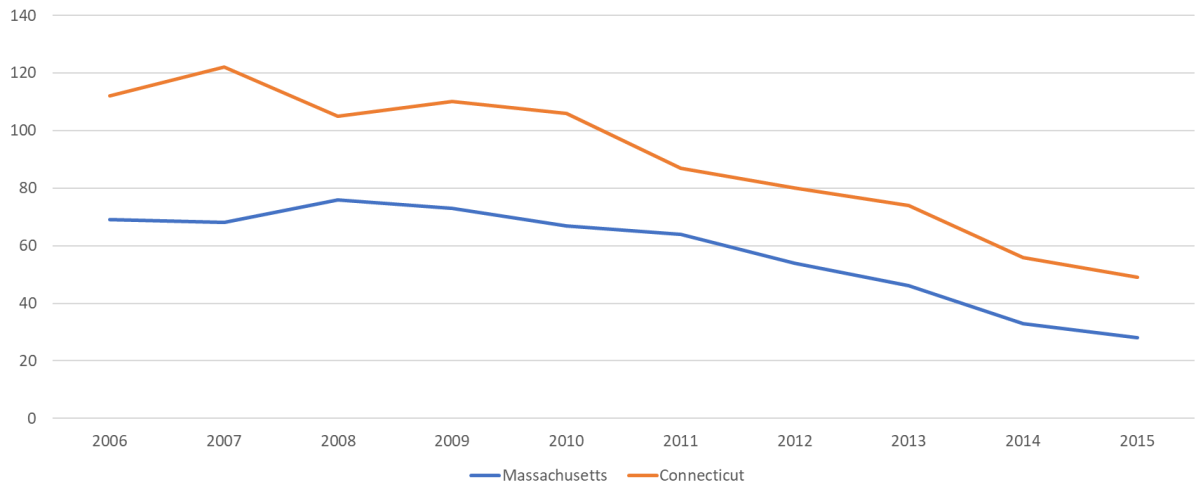
Second, we've discussed one of those systemic risks: regional treatment variation or the chance that people will receive excessive and unnecessary care in certain regions, and have higher medical risks as a result.

In this Chapter, we will look at some types of medical care 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

We'll consider first the chance that a woman with early stage breast cancer will have a mastectomy or other treatment. This chart shows the variation between Massachusetts and Connecticut per 100,000 female Medicare beneficiaries.(Connecticut is the top line, Massachusetts the bottom.)




Why would this be the case? Are Connecticut women less healthy / more prone to breast cancer than Massachusetts women?

It turns out that we have the answer to that question. The American Cancer Society tracks breast cancer incidence in both states. Here's their summary from 2011 – 2015:

| | Breast Cancer Incidence Rate / 100K women |
|---|---|
| Connecticut | 142 |
| Massachusetts | 138 |

Not *exactly* the same but pretty close. Clearly not different enough to explain the mastectomy treatment variation.

Equally important: did the Connecticut women enjoy better breast cancer outcomes?

Again, the American Cancer Society provides the answer: No

| | Breast Cancer Mortality Rate / 100K women |
|---|---|
| Connecticut | 18 |
| Massachusetts | 18 |

Exactly the same breast cancer mortality rates in the two states, despite the far higher mastectomy rate and related spending in Connecticut. The additional medical care provided to the Connecticut women in this example did not benefit them.

Jack Wennberg, the founder of Dartmouth Institute for Health Policy and Clinical Practice, 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.* [23]

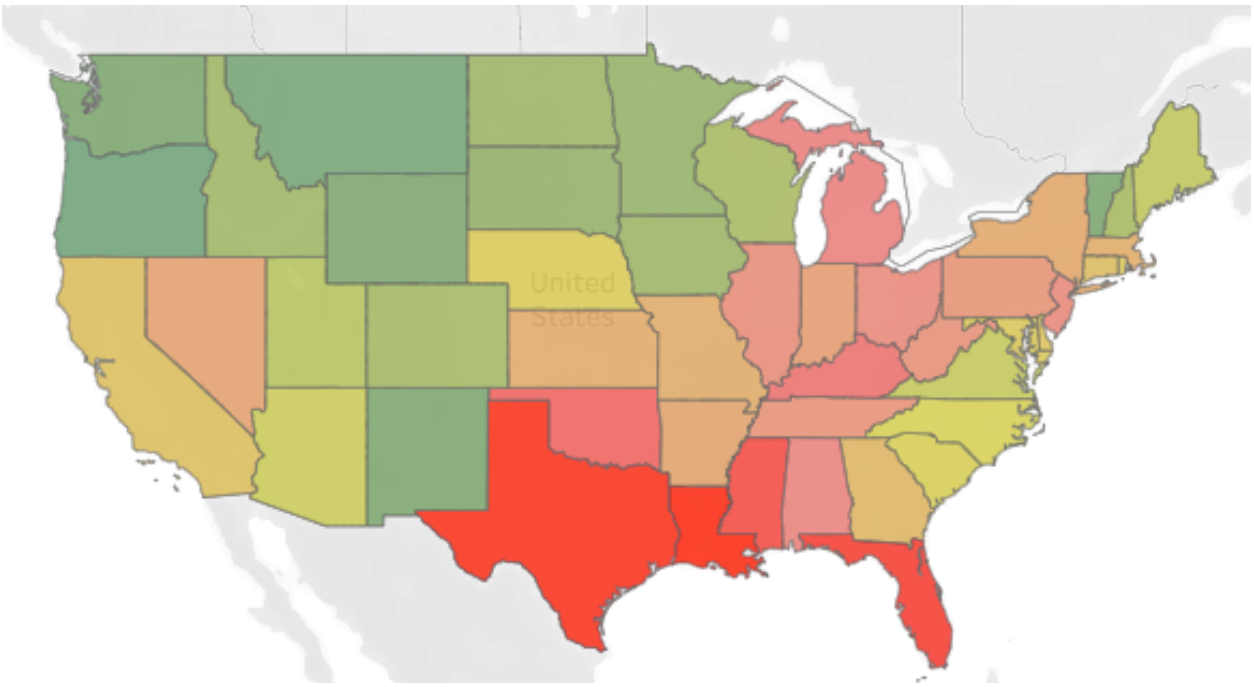
The reason: physicians in a region develop 'medical cultures' that get transmitted to new doctors entering the area. Young docs learn from more senior partners in their practice. Career advancement may mean accepting the senior's approach. After all, what senior partner wants a junior partner who very 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 by region. We already saw how it varied by hospital – the C-section discussion above. We could extend this analysis to other treatments - leg amputation, coronary artery stent insertion, Rx prescribing and much more.

[23] Brownlee, op cit, page 41

Does this same analysis hold at the national level? Let's look at average medical care spending per capita by state and life expectancy. This map shows Medicare spending per person by state in 2016.

Texas ($11,700), Louisiana ($11,800) and Florida ($11,400) were the 3 highest spending states, averaging about $11,600 per person.




Meanwhile, Montana ($8,200), Oregon ($8,000) and New Mexico ($8,500) were the 3 lowest spending states, averaging about $8,200 per capita.

The 3 highest spending states spent about $3,400 (41%) more per capita than the 3 lowest spending states.

Did the higher spending states enjoy better outcomes?

According to the Kaiser Family Foundation, life expectancies at birth were virtually identical in these states with the lower spending ones actually enjoying better outcomes.

- Florida 80.1
- Louisiana 76
- Texas 78.8

} 78.3 on average

- Montana 78.6
- Oregon 79.6

} 78.8 on average

- New Mexico 78.4

More spending, just as Dr. Fisher predicted, generated no better patient outcomes as measured by life expectancy. More spending just generated more care.

## 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.

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.

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.

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.

**Review Questions**

Correct answers next page

1. Which factor, below, strongly influences physician decisions according to John Wennberg of Dartmouth Medical School?

a. The reputation of the nearest medical school

b. The capacity or supply of the local medical market, including the per capita number of specialists, hospital beds or ICU beds

c. The educational background of other physicians in the region

d. The quality of the local hospitals

2. Complete this sentence: According to Dartmouth's Wennberg, treatment protocols vary more based on _____ than on _____.

a. local epidemiological differences *than on* local medical differences

b. medical supply differences and the regional medical culture *than on* patient medical differences

c. patient medical differences *than on* insurance reimbursement differences

d. insurance reimbursement differences *than on* medical supply differences

3. According to John Wennberg, what predicts your risk of surgery?

a. Your genetic background

b. The rate of surgery in your geographic area 10 years ago

c. Your job or occupation

d. The type of health insurance you have

4. What is Roemer's Law?

a. Brokers who 'let the buyer beware' generate smaller commissions than brokers who 'do their fellow a favor'

b. Brokers who 'do their fellow a favor' generate smaller commissions than brokers who 'let the buyer beware'

c. The more medical services available in a community, the lower the mortality rate in that community

d. A hospital bed built is a hospital bed occupied

5. Our legal system requires 3 different functions to interact: a prosecuting attorney, a defense attorney and a judge. The judge decides 'truth' after hearing from both prosecution and defense. (OK, sometimes juries decide also). In our legal system no one party has all the power. But our medical system determines 'truth' very differently. What, in our medical system, is 'truth'? Who determines truth? How do they determine it?

a. Insurance carriers determine 'truth' i.e. the correct diagnosis, after reviewing medical diagnoses from specialists

b. Hospital administrators determine 'truth' i.e. what the patient needs, after hearing from various physicians who have examined the patient

c. The physician chosen by the patient determines ‘truth’, i.e. the correct medical diagnosis and appropriate treatment, after examining the patient
d. Medicare administrators determine ‘truth’ i.e. the correct treatment plan after receiving appropriate paperwork from physicians and hospitals

6. Our legal system requires 3 different functions to interact: a prosecuting attorney, a defense attorney and a judge. The judge decides ‘truth’ after hearing from both prosecution and defense attorneys who are paid to disagree. (OK, sometimes juries decide also). The prosecuting and defense attorneys are paid to disagree with each other over questions of fact, and the interpretation of facts. Who, in our healthcare system, is paid to disagree with the diagnosing physician?

a. The hospital administrators
b. Insurance carriers
c. No one
d. Medicare administrators

7. About what percent of our medical care generates ‘no discernible benefit’ according to researchers at Dartmouth Medical School?

a. 1%
b. 1.5%
c. 30%
d. 97.5%

8. What does treatment variation mean?

a. That there are many different ways to perform the same medical treatment
b. That some patients respond to the same medical treatment very differently
c. That the same patient might receive different treatments for the same medical problem in different parts of the country
d. That different medical treatments cost very different amounts of money

**Review Questions**

Correct answers in bold

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**Case study: A Discussion with a Benefits Administrator**

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. He's a fine broker who is perfectly capable of running rates and showing alternative policies.*
>
> *I won't show you any plans that he doesn't. And I offer all the same services as he does.*

*But in addition to offering everything that he offers, under my 'do your fellow a favor' standard, I'll also educate your employees about how to use our healthcare system.*

*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 2 to 1. The infant mortality rates and maternal mortality rates, though, are about the same among all in-state hospitals.* [24]

*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 Caesarian 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.*

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

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

‘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.*[25]
>
> *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:

> *Again 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.*

‘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

[25] 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