

POLICY 10

Cost-Benefit Analysis in Health Care

Cost-Benefit Analysis in health care is the analysis of health care resource expenditures relative to possible medical benefit. This analysis may be helpful and necessary in setting priorities when choices must be made in the face of limited resources. This analysis is used in determining the degree of access to, or benefits of, health care to be provided.

Clarity of the medical decision-making process demands that cost-benefit analysis be separated and differentiated from risk-benefit analysis as well as from determinations of efficient and cost-effective medical care during medical decision-making.

Risk-Benefit Analysis weighs the potential for undesirable outcomes and side effects against the potential for positive outcomes of a treatment and is an integral part of the process of determining medical necessity in the delivery of quality medical care.

Efficient Medical Care is correlated to the timeliness of delivered medically necessary services and supplies that are delivered at the least cost and are consistent with the applicable standard of care.

Cost-Effective Medical Care is the selection of the least expensive medically necessary treatment from two or more that are equally efficacious in achieving a the desired health care outcome.

References:

American Medical Association Council on Long Range Planning and Development in Cooperation with the Council on Constitution and Bylaws, and the Council on Ethical and Judicial Affairs. *Policy Compendium of the American Medical Association*. Chicago: American Medical Association, 1999: E-2.03, E-2.095.

Adopted by the Board of Trustees, 11/13/97

Amendments adopted by the Board of Trustees, 2/21/04

POLICY 11

Limiting Health Care Benefits

The decision to limit reimbursements for, or certification of, medically necessary services and supplies by benefit determinations may be made on a contractual basis between a self-insured employer, insurance company, health service plan or managed care system and their employees, insureds, or subscribers. Benefit restrictions may also be made by governmental agencies and the beneficiaries they serve. Benefit determinations must not be confused with determinations of medical necessity. Limiting certification or reimbursements for health care through benefit restrictions of a health plan may result in the denial of, and access to, medically necessary care. Services and supplies may be medically necessary, but may not necessarily be benefits covered by the applicable private or governmental health care plan.

Access to medical care should not be limited by a self-insured employer, insurance company, health service plan or a managed care system through the use of a medical decision-making process which operates to deny contractually covered, medically necessary standard of care treatment.

Any exclusions or limits of services or supplies must be documented clearly and unambiguously in a written health care plan. This allows the subscriber the right to make an informed decision either to seek out additional coverage or to pay for medically necessary treatment not contractually covered.

All contractually covered benefits must be certified and paid for fairly and promptly.

References:

Health Insurance Association of American. Code of Ethics. Washington, DC: Health Insurance of American, September 1995.

Nazay v. Miller, 949 F2d 1323 (3rd Cir 1991).

National Network Accreditation Standards. Washington, DC: The American Accreditation Health Care Commission, formerly the Utilization Review Accreditation Commission, April 1996.

Health Carrier Grievance Procedure Model Act. National Association of Insurance Commissioners, Washington, DC: 1996. www.naic.org.

Adopted by the Executive Committee, 12/5/92

Amendments adopted by the Board of Trustees, 11/13/97, 2/21/04