Summary[1]

New medical technologies hold both the promise of significant health benefits and the prospect of additional health care spending. Private health insurance companies—through which most health care is paid for—shoulder a considerable responsibility in deciding which new technologies will be covered by insurance, and when in the cycle of development the time arrives to approve coverage. In general, insurance coverage is denied for technologies that are considered unproved or experimental. Despite the obvious importance of these decisions, relatively little systematic information is available about the procedures that insurers go through and the criteria they use to weigh the evidence.

This background paper presents some empirical information on how insurers consider payment for new medical devices. It describes the survey results of medical directors affiliated with private health insurers about their coverage decisions using, as examples, three applications of lasers: laser angioplasty for opening narrowed or blocked coronary arteries; laser discectomy for treating herniated intervertebral discs; and photodynamic therapy (using a light–sensitive dye) for bladder cancer.

Though there is no set procedure that all insurers follow to evaluate new technologies for coverage under their policies, it appears that most companies—whether indemnity insurers or health maintenance organizations (HMOs)—go about the process similarly. The company medical directors are nearly always involved in coverage decisions and, in most companies, are assisted by a committee.

The factors weighed in coverage decisions appear to be relatively consistent across companies. Among the most important are medical acceptability, efficacy, safety, cost–effectiveness, and regulatory considerations (in the case of lasers, Food and Drug Administration (FDA) approval of the device). One of the differences found between decisionmaking of indemnity insurers and HMOs was that HMOs appear to give more weight to cost–effectiveness—they were less likely to cover a new technology if it had a higher cost for the same effectiveness.

The largest barrier to decisionmaking, for all types of insurers, is the paucity of reliable information on the effectiveness, safety, and cost–effectiveness of new technologies at the time coverage decisions have to be made. Insurer medical directors view the medical profession, health care institutions, manufacturers, and the federal government as having the greatest responsibility for assuring that technologies yield reasonable benefits at reasonable costs.

[1] This background paper is based on "Technology Coverage Decisions: The Process and Considerations Used by Health Plans,," unpublished contractor report prepared by C.A. Steiner, N.R. Powe, and G.F. Anderson for the Office of Technology Assessment, U.S. Congress, Washington, DC, January 1995.