



Insurers Again at Odds With Hospitals and Physicians

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Sara Lazar, PhD, assistant professor of psychology at Harvard Medical School, whose research has shown MBSR to be associated with structural changes in the brain, believes that the perceived need for a sham intervention may be overblown.

"No one does sham surgeries," said Lazar, adding that often, research on "meditation is held to a higher standard than [other] medical practices."

Lazar also pointed out that an active control group can mask an intervention's therapeutic effects. What's more, another type of masking effect due to the "frustration response," whereby patients not receiving the intervention become disappointed and pursue independent mindfulness practices, can underestimate an intervention's effect size (Gotnick RA et al. *PLoS One*. 2015;0[4]:e0124344).

On the other hand, waitlist and passive-control groups may also yield misleading results, as they don't account for attentional effects of mindfulness interventions that arise from patient interactions with health care professionals. Lazar believes that ideally, studies need 3 groups: treatment as usual, an active control, and the intervention.

According to some experts, future research should focus on noninferiority trials assessing the efficacy of mindfulness interventions relative to established therapies. Such research should also account for treatment administrator certification as well as the consistency of participants' practice (Rutledge T et al. *JAMA Intern Med*. 2014;174[7]:1193).

Mindfulness in Practice

Steven M. Tovian, PhD, clinical and health psychologist and associate professor of psychiatry and behavioral sciences at Northwestern University's Feinberg School of Medicine, emphasized the importance of managing patient expectations.

"This is not a cure," he said. "It's a control mechanism." Tovian uses MBSR techniques in conjunction with biofeedback to help neutralize patients' stress and anxiety, help control pain, and reduce levels of arousal that can exacerbate coexisting medical conditions. For example, he has used mindfulness with biofeedback to help a patient with tinnitus and associated sleep problems to fall asleep faster.

Tovian admits that some patients find mindfulness interventions too plodding. "We live in a world of computers and fast relief," he said. "We can take a Xanax and get an effect within 20 minutes."

"People have to like it and make it their lifestyle," Lavretsky added. "Those who adhere do really well."

For patients to have access to formalized mindfulness programs, clinicians must have access to training. And that training isn't cheap. At the University of California, San Diego (UCSD), Center for Mindfulness, the cost of MBCT and MBSR training is \$8440 and \$9500, respectively, for a program that includes 10 to 12 days of instruction and mentorship sessions (<http://mbpti.org/mbct-teacher-qualification-and-certification/>). Among other prerequisites, participants must have an advanced degree in a mental

health field, previous meditation training, and a committed daily meditation practice (<http://bit.ly/1M68nTs>).

According to Steven D. Hickman, PsyD, director of the Center for Mindfulness and associate clinical professor in the Department of Psychiatry at UCSD, while MBSR need not be administered by health care professionals, it is often administered by therapists and even by some physicians. Hickman says that MBSR is usually (although not always) an out-of-pocket expense for patients because it's not considered treatment, but a way to help patients hone their coping skills. As a form of psychotherapy, MBCT is usually offered by therapists, social workers, or psychiatrists and can be billed to insurance as group therapy.

These costs related to MBSR and MBCT could translate to a lack of access for patients who might otherwise benefit from such interventions. But resistance at the professional level, at least, may be waning.

Twenty years ago, said Tovian, "I think there was push-back about mind/body duality issues, but not anymore." Tovian also noted that medical training, particularly as it relates to primary care, is now more accepting of approaches that address psychosocial factors associated with disease.

Whether physicians choose to recommend mindfulness practices to their patients may ultimately depend not just on accessibility, but on their willingness to incorporate mindfulness approaches into their clinical toolbox that are supported by the evidence base. ■

The JAMA Forum

Insurers Again at Odds With Hospitals and Physicians

David M. Cutler, PhD

The longest running battle in medical care is heating up again. I refer, of course, to the struggle between insurers and physicians, hospitals, and pharmaceutical companies. Recently, Aetna and Humana announced their intention to merge, as did Anthem and Cigna. If these mergers go through, the "big 5" health insurers will be down to the "big 3."

Physicians and hospitals were not happy with the news. "Given the troubling trends in

the health insurance market, the AMA believes federal and state regulators must take a hard look at proposed health insurer mergers," said Steven J. Stack, MD, the group's president, in a statement (<http://bit.ly/1JFDPMi>). Melinda Reid Hatton, senior vice president and general counsel at the American Hospital Association (AHA), said that these transactions "merit the closest scrutiny" (<http://bit.ly/1JAFM7N>).

For their part, the insurers argue that consolidation on their end is needed, among

other reasons, to combat the growing size of medical groups and health care facilities.

Of course, this battle is just the latest in a long series of skirmishes, dating back decades. Utilization review was invented in the 1950s (<http://bit.ly/1UfMnWM>). Certificate of Need regulations came to prominence in the 1960s and 1970s (<http://bit.ly/1Jmpuvv>). And who can forget the managed care era of the 1990s?

In the managed care era, excess capacity in the hospital industry allowed insurers to

play off one hospital vs another and bargain for lower prices. (Insurers used the same tactic for lowering prices of pharmaceuticals by pitting close competitors against each other.) Hospitals responded to the price pressure by merging with possible competitors.

Insurers' next move was to create tiered networks: high-priced physicians, hospitals, and pharmaceuticals would still be covered, but on less generous terms. This led to still more mergers of physician groups and hospitals. Some clinicians opted out of the system entirely, going out-of-network and making consumers pay all of the cost for seeing them.

And now it's insurers who have the merger bug. The Aetna-Humana and Anthem-Cigna proposed mergers mirror those in the pharmacy benefits management industry.

Both sides—insurers and those who care for patients—claim to be looking out for the best interest of patients. But neither has truth fully on their side. When physicians (<http://bit.ly/1MRiUBO>) and hospitals (<http://bit.ly/1WVgwyP>) face less competition, medical prices rise. When insurers have fewer competitors, premiums charged to the companies offering employee health plans increase (<http://bit.ly/1PW3zQr>). Neither side's interests are perfectly aligned with those of patients.

Of course, the health care system will never work perfectly. But continued fighting and higher costs is not a recipe for a well-functioning one.

It is possible that one side or the other will "win." Clinicians and hospitals won the battle over managed care, and it took insurers a decade to recover. Indeed, insurers were out of the cost savings game for so long that government started to bypass them completely. The accountable care organization program in Medicare was in many ways a response to the view that the major insurers had not developed appropriate tools for cost management.

But physicians do not always win. In the 1990s, insurers significantly changed how people receive behavioral health services. Inpatient and outpatient psychotherapy were made difficult to obtain, and medications were encouraged instead. Sensing that outpatient care was too expensive, insurers kept the fees they paid to mental health professionals very low. Mental health care clinicians have never fully recovered.

That said, it seems unlikely that either insurers or clinicians and hospitals are poised for a major victory. What happens then?

More Government

One possibility is that state and federal governments will get even more involved in health care than they are already. Not surprisingly, the AMA and AHA have both petitioned antitrust authorities to closely examine the proposed health insurance mergers. The national trade association representing the health insurance industry, America's Health Insurance Plans, did the same in recent hospital mergers.

But federal intervention need not end there. In response to concerns that insurer profits are too high, the federal government recently mandated limits on the ability of insurers to charge premiums in excess of what they pay out in claims. For their part, some states are enacting limits on what hospitals and doctors can charge patients in emergency settings, even when they are out of a patient's health plan's network. In the pharmaceutical industry, high prices for new drugs such as the hepatitis C medication Sovaldi have led to renewed calls for price limits on new drug launches. And states like Maryland (<http://bit.ly/1bDoqGb>), Massachusetts (<http://bit.ly/1JoToSi>), and Oregon (<http://bit.ly/1f1RYXX>) are pioneering policies to restrain the overall growth of medical spending.

Governments are not always well informed, and their execution leaves much to be desired. But in a choice between no government involvement with very high prices and imperfect government involvement with lower prices, people will look to government for answers.

Technology to the Rescue?

A second possibility is that technological changes may undercut the position of both physicians and insurers. Might an Internet-based resource do a better job at diagnosis than a physician? Can a smart phone replace the hospital imaging facility? Is Internet-based disease management better than insurer-run disease management? Famed cardiologist Eric Topol, MD, of the Scripps Research Institute in La Jolla, California, believes the answer is yes. In *The Patient Will See You Now* (<http://bit.ly/1xxMrKg>), Topol argues that a new wave of technology will disrupt an enormous part of medical care today.

Silicon Valley agrees. Health care venture capital is moving from its historic focus on pharmaceuticals and devices to a much greater emphasis on medical services (<http://onforb.es/1Q7TYq7>). A lot of money is riding on the idea that disruptive innovation in medical care is just around the corner.

If this view is right—even half right—the effects would be bigger than any set of insurance mergers one could imagine. Formal medical care use would decline, excess capacity in physician and hospital services would drive down spending, and the rationale for many insurance company programs would disappear. The landscape of insurers, physicians, and hospitals would change tremendously.

Who Will Lead?

At the end of the day, the real fight is not over the Affordable Care Act, the latest information technology standards, or the burden of quality reporting. What we are witnessing is nothing less than a battle for control of medical care itself, driven by spiraling costs and the belief that we are not getting our money's worth in a sector representing close to 20% of the economy. Will it be a system overseen by physicians, by insurers, or by organizations that dispense with them both? ■

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