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Consumer Cost Sharing: The Ranges of Alternatives

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Overview

- Cost sharing: goals and characteristics
- Benefit design alternatives
  - Copayments and coinsurance
  - High-deductible health plans
  - Reference pricing and network designs
- Market and policy trends

Goals of Consumer Cost Sharing

- **Economics**: reduce use of low-value services, including inappropriate services and overpriced products & providers
- **Pooling**: reduce pressure on insurance premium and thereby encourage coverage
- **Simplicity**: easy to understand and administer
- **Fairness**: excessive cost sharing burdens the ill and exposes all patients to risk

Instruments for Cost Sharing

- **Copayment**s: fixed dollar payments for each physician visit (e.g., $20) or hospital admission (e.g., $250)
- **Coinsurance**: percentage payment for each service (e.g., 20%), up to an annual maximum (e.g., $5000)
- **Deductible**: patient pays first $X in claims cost per year (e.g., $500) or high deductible (e.g., $5000) with taxed favored savings
- **Reference pricing**: Insurer pays first $X and then consumer pays remainder of provider charge (reverse deductible)

Copayments

- **Economics**: modest copays have only modest effect on use, except for drugs
  - Copay does not vary according to unit price for drugs, MD visits, hospitals etc.
- **Pooling**: does not have major effect on premium and hence on coverage
- **Fairness**: copays protect the ill, as their exposure to risk is limited
- **Simplicity**: easy to understand and collect
- **Copay-based plans are expensive, losing market share to plans based on coinsurance (and deductibles)**

Coinsurance

- **Economics**: have significant effect on reducing use, but OOP max limits effect on high-cost services, admissions, drugs
  - Coinsurance does vary according to unit price
- **Pooling:** can have large effect on premium if % and annual OOP max are high
- **Fairness**: coinsurance exposes the ill to much more risk than copays, up to OOP max
- **Simplicity**: difficult understand and collect
- **Coinsurance is replacing copayments, is being incorporated into deductible-based PPO and CDHP products**

Deductibles

- **Economics**: have major effect on use and also shifts responsibility to patient
  - But once patient has exceeded the deductible, cost sharing does not affect use of high-cost drugs, MD visits, hospitals etc.
- **Pooling:** Has major effect on premium, if deductible is high enough
- **Fairness**: deductibles expose patient to risk, but most deductibles have been modest
- **Simplicity**: easy to understand but not easy to administer or collect

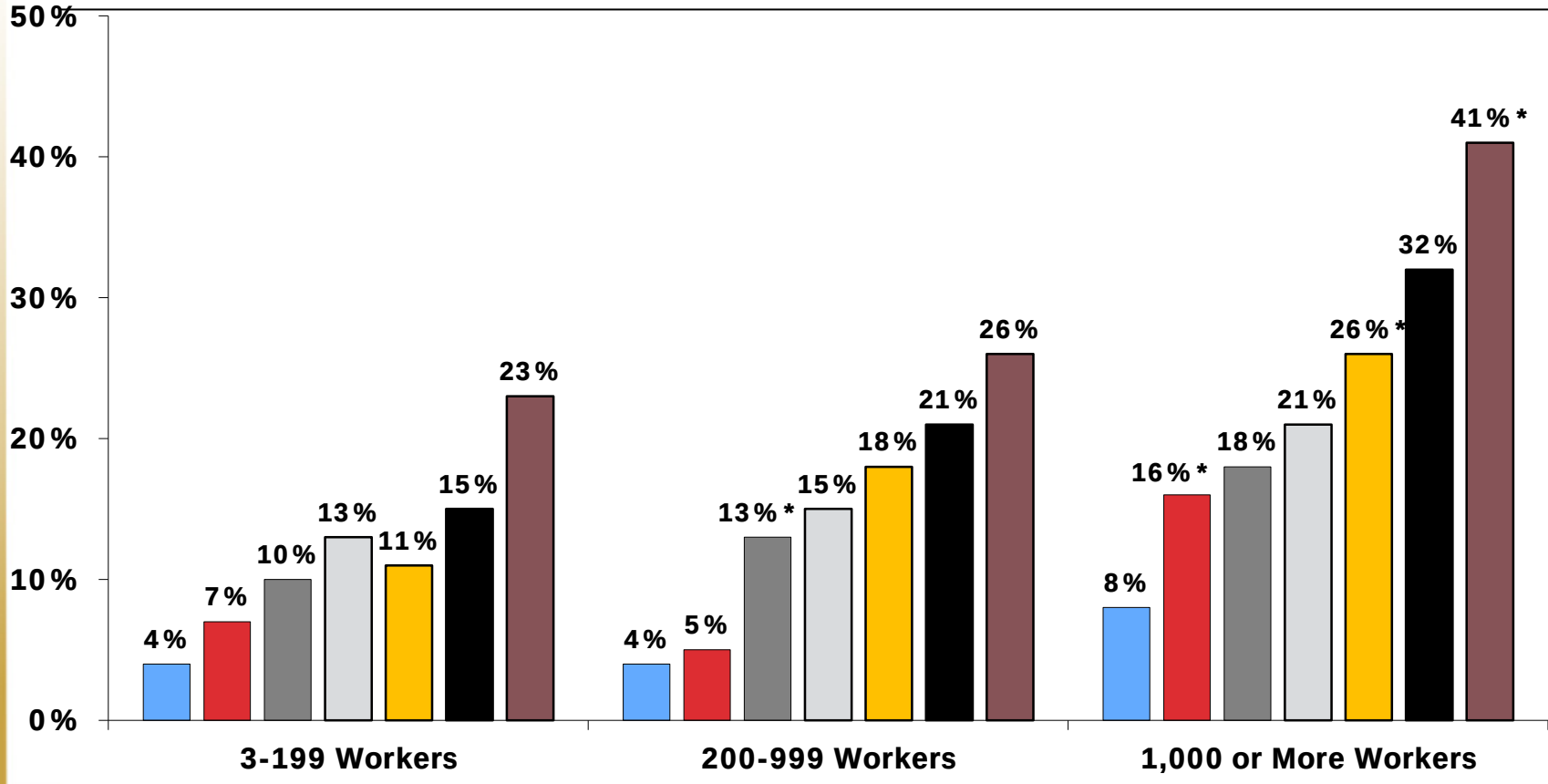
High-Deductible Health Plans (HDHP)

- Impact of deductible on use (and shifting responsibility for payment to patient) has encouraged employers and insurers to offer higher deductibles of $2500 - $15000, at much lower premiums
- “Consumer driven health plans” (CDHP)
- Enrollees can invest in tax-favored savings plans for non-insured uses
- Some HDHP are offering first dollar coverage for effective drugs and preventive services
- “Value-based insurance design”

Reference Pricing

- **Economics**: has major effect on patient choice of provider or product
  - Is especially well suited for services with wide variance in price but low variance in quality
- **Pooling:** Could have major effect on premium, if used more widely
- **Fairness**: if enrollees can have adequate choice of provider and product under the reference price limit, they can avoid costs
- **Simplicity**: can be difficult to explain to consumers, as a novel principle. Providers may have difficulty collecting

Percentage of Firms that Offer Insurance Benefits Which Offer High Deductible Health Plan



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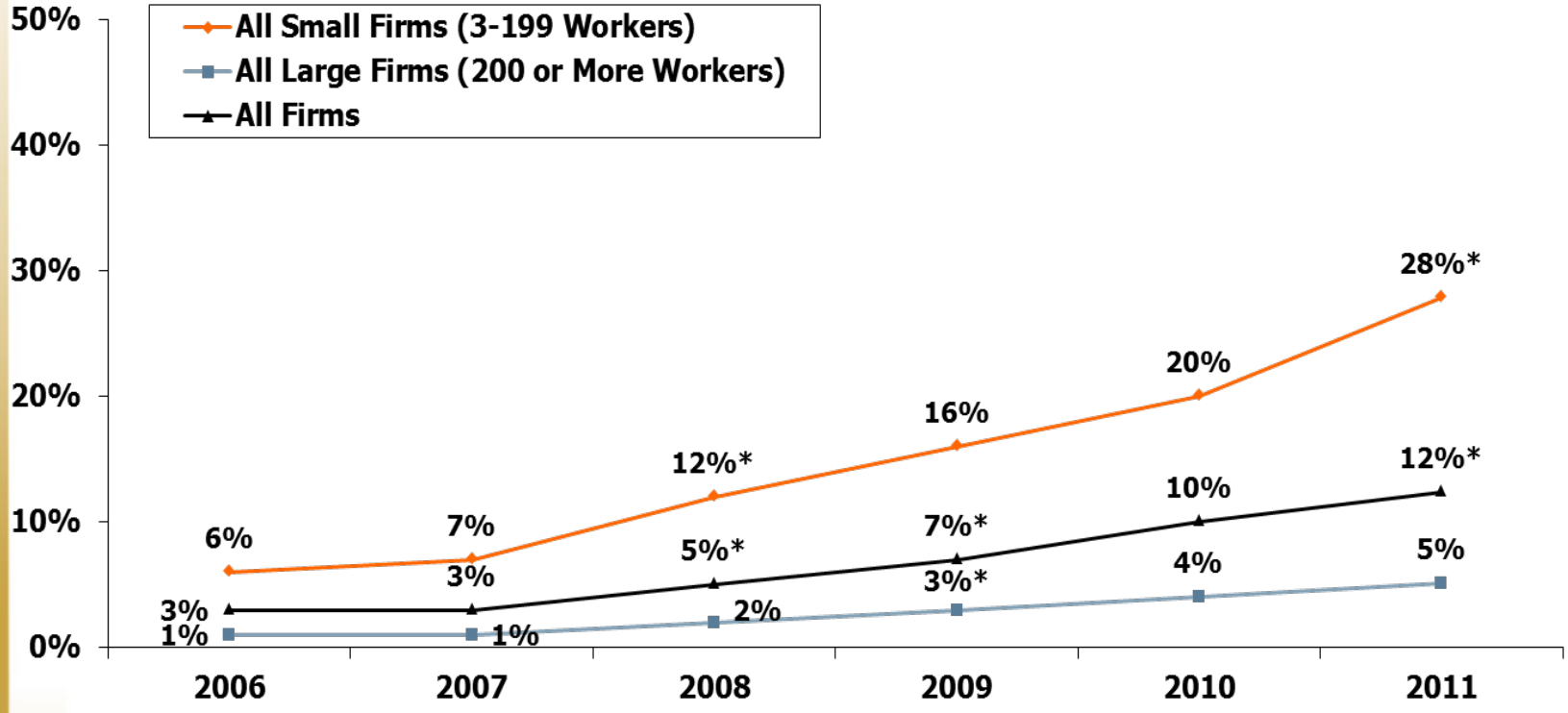
Percentage of Covered Workers Enrolled in a Plan with an Annual Deductible of $2,000 or More for Single Coverage,



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Market Trends: Network Design

- Deductible-based PPOs are seeking to adopt network designs from HMO (narrow network, capitation, prior auth)
- HMOs are developing very narrow networks to reduce premium while retaining copays
- Centers of Excellence are being developed for high cost acute services with high variance in performance (ortho, cardiac)

Policy Trends: California

- State has numerous mandated benefits, with pressure to limit cost sharing on them
- Health insurance exchange is pondering “qualified health plans” and “bronze” benefits
- DMHC imposes stringent rules on network access and limits on deductibles, leading more plans to shift to CDI

Policy Trends: United States

- Federal government will be imposing more benefit mandates and limits on cost sharing as part of Obamacare
- Preventive services must be free
- IOM and “essential health benefits”

Culture

- Though cost sharing has been increasing, it still has not changed the cultural perception that health care is free rather than a valuable and scarce resource
- This culture created the backlash against managed care in the 1990s, against CDHP in the 2000s, against Obamacare today
- The public's ideal insurance plan covers all providers and all services, imposes no cost sharing requirements, and is paid for by someone else
- Health care is a human right, no?

Conclusion

- Cost sharing is here to stay
- Structure of cost sharing matters a lot
  - Economics, pooling, fairness, simplicity
- Trend favors deductibles, coinsurance
- Challenge is to combine HMO network design with PPO benefit design
  - Let's call this "ACO"
- New ideas: reference pricing, coordinating network designs with benefit designs
- Regulation will limit innovation in benefits
- Culture trumps economics every day