

Congressional Health Care Reform Education Project
October 10, 2008
Benefits in Health Insurance

House Summary

Gary Claxton of the Kaiser Family Foundation's Health Care Marketplace Project provided an overview of the function of health insurance: why we have it, what services should be covered, and the policy issues inherent in making benefit decisions. In support of why we have health insurance, Claxton pointed out that a beneficiary in the top one percent of health care spending incurs \$30,000 in annual expenses from all sources, except premiums. The risk is spread throughout the pool of insured individuals, which includes those requiring no care (the bottom 50 percent). Without insurance, an individual in the top tier would have to pay \$60-70,000 out of pocket for their care – a sum unaffordable for most. He also noted that everyone is at risk for a high cost health event over time and that the function of insurance is to share exposure to such potentially unaffordable costs.

As to what services should be covered, Claxton noted some recent changes in emphasis to include disease management, and prevention and wellness programs. He added that in the design of benefits one may want to consider ways to encourage desirable health behaviors in addition to weighing the coverage of costly events over providing a broader range of benefits.

Claxton stressed that cost sharing can be used to discourage or encourage benefit usage. He also noted that co-pays can influence policy selection. For example, a high co-pay for chemotherapy would steer cancer patients, or those at risk, away from that insurer. In a cautionary note, Claxton raised the issue of moral hazard, pointing out that "if someone else is paying, you're more likely to use the benefit. Cost sharing prevents some of that."

Some policy questions he suggested keeping in mind are: 1) how do you weigh protection limits against limits by scope of benefits? 2) What does it mean to choose the types of benefits that you need if 50 percent of potential beneficiaries don't need any? 3) What is the role of cost sharing for services over which the patient has no control, e.g. radiation therapy?

John Bertko of RAND, and former chief actuary for Humana, provided an actuarial perspective (i.e., through the focus and lens of numbers) of calculating the costs and premiums of health insurance.

In a discussion of average allocation of each premium dollar, Bertko noted that actual allocation varies dramatically from the average by type of coverage. For example, though the average is 10 cents for administration and 5 cents for profits, large group coverage enjoys lower administrative costs and high profits.

In looking at benefit plan design, Bertko noted that cost-sharing is a “blunt instrument.” In questions of affordability, there is a trade-off between cost-sharing and premium cost. He also noted that there is flexibility in design to encourage desirable behaviors and outcomes. Cost-sharing, including copays and deductibles need not be the same for all benefits. Designs can be devised to have lower or no cost-sharing for primary care office visits, screening, and preventive services. As an example, Bertko mentioned a large retailer that offers four office visits before the deductible kicks in.

In consideration of which design to use as a starting point, Bertko listed FEHBP’s BCBS Standard Plan as an example of high level of benefits; and Medicare A and B without supplemental coverage as an example of low level of benefits.

Bertko reviewed other tools used in benefit design: actuarial equivalence and limits on rate variation, including adjusted community rating, rate bands, underwriting in the individual market and high risk pools. He noted that there are very few people in high risk pools, possibly a total of 200,000 across the country.

In a discussion of premiums, Bertko noted that premiums vary dramatically by geographic region, age and level of benefits.

Michael Chernew of Harvard University provided an overview of value based insurance design (VBID). He began by stating that the problem of high and ever rising health care costs is a given. He went on to say that there are two types of solutions: supply side and demand side reforms. On the supply side he listed improving the delivery system and being “smarter” in health care delivery by improving value. Value, according to Chernew, means reaping beneficial effects and reducing harmful effects of health care services. He emphasized that saving money is not the main objective in VBID, as the best way to save money is to provide no care – not a desired solution.

Chernew cautioned that standard demand theory may not apply in health care. Consumers do not necessarily respond as one might predict in standard economic demand theory. For example, using copays to reduce demand yields the same reductions in appropriate use of health services, such as preventive services and necessary pharmaceuticals, as for inappropriate use. In VBID you can tier copays and reduce the amount for high value services, e.g., chronic disease management.

Chernew emphasized the need for health information technology and comparative effectiveness research to “get the system we want.”

Cathy Schoen of the Commonwealth Fund stressed that the core goals of health insurance - access, affordability, and risk pooling – must be kept in sight when discussing benefit design. Schoen pointed to a recent surge in underinsurance as a reason for needing a national minimum benefit floor. She noted a 60 percent increase in underinsurance in 2007 over the previous period and stated that the underinsured “are starting to behave like the uninsured” with regard to access and medical debt issues.

Echoing the notion stated earlier by John Bertko that cost-sharing is a blunt instrument, Schoen noted that in Canada an increase in cost-sharing yielded a reduction in prescription drug use; and that low income persons reacted even more strongly than other groups, at risk to their own health.

Schoen outlined the principles for designing a national minimum benefit. She cautioned against using disease or service-specific limits that can lead to unintended consequences. For example, Schoen cited a case of someone who had exceeded a limit on drug expenses to prevent liver failure but whose policy would cover a liver transplant if/when needed. She said, "Some limits don't make medical sense" and that these should be avoided.

Q&A Session

In response to questions regarding disease management, Chernew explained that there are contradictions in the current system. On the one hand you want people to comply with their recommended regimens, e.g., take their blood pressure medicine. On the other hand, you want to charge more for copays to control demand. Cost-sharing decisions in health care are not equivalent to getting value in other sectors or to making "good" decisions, he continued.

In response to a question about the criteria used to select and/or keep providers in a PPO plan, Bertko replied that some plans measure efficiency and quality of providers. He added that quality is difficult to determine. He also noted that plans that limit provider networks are not popular. Employers tend to "want everyone in the network." There are also regional variations. In some areas, beneficiaries are more willing to constrain themselves to a more limited network. For example, in Sacramento, 50 percent are in network plans.

Responding to a question about value to the insurer in a market where there is churning of beneficiaries, Bertko explained that large employers ask for value benefits in their policies. For small employers, insurance companies charge more for the same benefits or may not even offer them in that market.

In a discussion about prevention, Chernew and other panelists noted that there is not good evidence that prevention saves money. However, the threshold for benefit decisions should not be whether it saves money, Chernew emphasized. It was also noted that putting prevention in an insurance package does not guarantee its delivery.

Background materials provided for this session plus any additional materials referenced during the discussion will be posted at:
<http://www.allhealth.org/chcrep/oct10benefitshealthinsurance.asp>. Announcements about future sessions and the URL for materials will be made to participants by email. Please note alteration in schedule pattern for the remainder of the series. The series will continue on Fridays and Tuesdays through October. There will be no event on November 7.

