

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

**Senate Summary**

**Paul Ginsburg** of the Center for Studying Health System Change reviewed key benefit structure or design elements needed for considering coverage expansions. Benefit structure applies to states in discussions of Medicaid and SCHIP and to the structuring of markets for non-group private insurance. Ginsburg said there is a need to make these markets more efficient and useful than they have been historically. He noted that to keep premiums affordable, patient incentives need to be structured to encourage judicious use of care. Consumers need to have real choices. Ginsburg explained that plans might increase consumer comfort in making decisions by avoiding unnecessary complexity.

A critical design element is the degree of financial protection, e.g., size of deductible and limit on out-of-pocket spending. Ginsburg noted that lower-income people need more financial protection. He also mentioned that some large employers schedule benefits based on earnings. A major difficulty in benefit design is getting the right proportion of financial protection and cost sharing. Greater cost sharing can keep premiums lower and lead to lower use of services but consumers do not always “cut” low-value care.

In a final note about risk pooling, Ginsburg said that insurance is good at pooling unpredictable risk but not so good with predictable risk. Here government needs to step in, he said.

**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. He also said that high value is not the same as cost saving.

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. She noted that in Europe there is no evidence of this, i.e. going without care for covered services, or going into medical debt.

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 a question regarding annual deductibles, Bertko explained that deductibles “make you think about whether you need the service. It’s a good filtering device, up to a point.” It contributes to lowering premiums, which could increase take-up rate, Ginsburg added.

Comparing high risk pools, risk adjustment and reinsurance, panelists said:

- 1) high risk pools require an extra step of complexity and they are expensive
- 2) risk adjustment is administratively difficult, requires much claims data, and is invisible to patients
- 3) reinsurance is a blunt instrument only catching “the worst of the worst,” and collects high cost claims, mostly those that are unpredictable through risk adjustment. An example of where it works better than risk adjustment is in high cost neonatal care.

In response to a question about getting control of spending in the high cost group, panelists provided some cautionary notes:

- 1) requires a change in incentives in the delivery system; management and provider incentives will be important
- 2) have to worry about distributional consequences – i.e., if you pull this population out of the general insurance pool
- 3) there is tension and a challenge determining who pays for greater efficiency in disease management
- 4) requires predictive modeling and we can only predict one of three who will be in that group

During a discussion about cost savings from prevention services, panelists strongly agreed that there was little evidence to support this. For example, large employers who have tried prevention programs have not seen a noticeable effect in 10-15 years.

In response to a question about the savings to insurers from life-time limits, Bertko stated that the difference between \$1 million and \$5 million is about 1 cent per member per month.

In response to a question about including prescription drug coverage in a minimum benefit plan, Chernew said that if you are interested in improving health, then you should include prescription drugs. The question then is how generous must it be. Bertko added that in a “bronze level” plan using the Massachusetts typology, it would be a big part of the cost. On a historical note, it was mentioned that before the 1970s drug benefits were uncommon and there were none in 1965 when Medicare was enacted.

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.