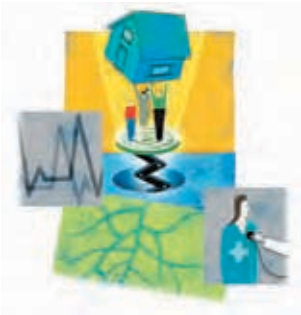
The Promise of Progressive Cost Consciousness in Health-care Reform



AS HEALTH-CARE SPENDING RISES, more families are uninsured, in peril of losing their insurance, or have insurance policies that leave them exposed to unlimited out-of-pocket expenses. Although families ultimately pay for all their health-care costs, there has been a dramatic shift in the financing of health care over the past several decades away from out-of-pocket spending and toward insurance coverage. In 1965, the average person received $995 worth of medical care (in inflation-adjusted dollars). Almost half of these expenses—$483—were paid out of pocket with the remainder largely covered by private insurance. By 2006, health-care spending per capita had risen to $6,640, while out-of-pocket spending increased to $837—or 13 percent of total health-care spending. While more comprehensive health insurance benefits is largely a positive development, the increased insulation of consumers from direct out-of-pocket health-care costs has also contributed to higher overall spending on health care, which, in turn, increases both the number of uninsured and the risks faced by those who have insurance.

In a new discussion paper released by The Hamilton Project, Jason Furman advances a proposal for progressive cost sharing in health insurance. Furman rejects health savings accounts (HSAs) approaches because they involve costly tax breaks for the affluent while increasing risks for low- and moderate-income families. Furman suggests an alternative approach that bases cost sharing on income and potentially includes evidence-based exceptions for highly valuable treatments and preventive care. Furman estimates that progressive cost sharing could reduce health insurance premiums by 22 to 34 percent without compromising health outcomes. This approach provides robust protection against major risks, providing every family with an affordable ceiling on out-of-pocket spending. In addition, out-of-pocket expenses would fall for more than 23 percent of families, primarily low- and moderate-income families and families with large out-of-pocket expenses.

THE CHALLENGE

In the past several decades, health care has been transformed by increased utilization and expensive new technologies, most notably advances in prescription drugs and medical imaging. While health spending as a whole has been very valuable, much of the expensive care delivered today is inappropriate or even harmful, while in other areas—like prevention and drugs to manage chronic conditions—high-value, evidence-based treatments are underutilized.

Individuals bear the full cost of health spending—through out-of-pocket spending, insurance premiums, forgone wages, and higher taxes. As a result, the typical family of four now spends nearly one-fifth of its income on health care. The form of this financing has been transformed in recent decades. Figure 1 shows the clear and continuous trend of individuals paying a smaller and smaller fraction of health-care costs out of pocket from 1960 to 2006. Out-of-pocket health-care spending has also fallen relative to total income and total consumption.

Although cost-sharing rates have declined across the board, including for those in the lowest income quintile, cost sharing still falls hardest on low-income families. These families spend a higher percentage of their income on out-of-pocket expenses than do high-income families.

The Evidence on Cost Sharing

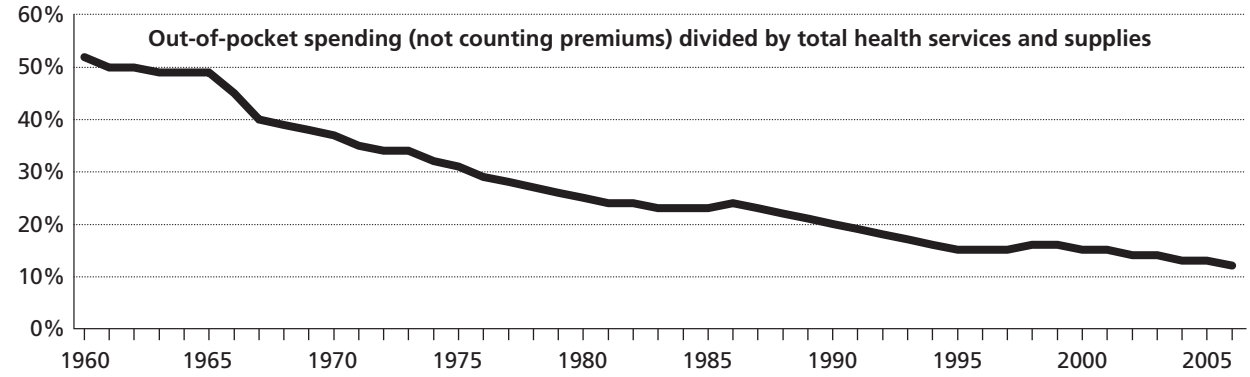
According to Furman, progressive cost sharing can have significant impacts on health-care spending with little adverse effect on health outcomes. The most important evidence comes from a particularly ambitious social science experiment, the RAND Health Insurance Experiment, which was conducted from 1974 through 1982 and used randomized trials to develop definite evidence about health insurance. Although RAND still provides the most conclusive evidence, the major changes in the twenty-five years that have elapsed since the experiment suggest its findings must be read with consideration and supplemented with other studies.

The key finding of the RAND study is that income-related cost sharing can reduce health-care spending without harming health outcomes. The experiment placed people into various insurance plans with different coinsurance rates (i.e. the fraction of health costs paid by the consumer) and an out-of-pocket maximum that was based on income but capped at $1,000 (in nominal dollars, equivalent to $5,000 today if adjusted for per capita income growth, or to $9,000 if adjusted for per capita health-care spending growth). The study's results have clear implications for cost sharing's ability to lower spending. Going from free care (a zero percent coinsurance rate) to a 25 percent coinsurance rate results in a 19 percent reduction in spending. Adding more cost sharing reduces spending even more—an additional 18 percent when going from 25 percent coinsurance to 95 percent. In total, the study shows that going from free care to a high-deductible plan reduces spending by 31 percent. Spending fell by more for high-income families (35 percent) than for low-income families (26 percent) because low-income families faced a lower threshold for reaching their maximum out-of-pocket spending after which insurance fully covered their care. The RAND study found no evidence that these up-front savings were offset by increased hospitalizations or other costs down the road.

While the RAND experiment is still the best work in this field, the finding that higher out-of-pocket costs reduce health-care spending has been corroborated by a number of subsequent studies. New research also

FIGURE 1

Aggregate Cost-sharing Rate, 1960–2006



Source: Author's calculations based on the Centers for Medicare and Medicaid Services' (CMS') National Health Expenditure (NHE) data. Numbers for 2006 are based on CMS projections.

indicates that the systemwide effects of cost sharing could be substantially larger than the direct effects on individual participants. Massachusetts Institute of Technology economist Amy Finkelstein used the natural experiment provided by the enactment of Medicare (in 1965) to infer the effect of insurance that reduces out-of-pocket expenses. She found that the systemwide effects of increased insurance on health-care spending were six times larger than the RAND estimates. This effect occurred because the introduction of Medicare made it viable for hospitals to undertake the fixed costs associated with entering new markets or buying expensive new equipment. In addition, insurance has the ability to change broader cultural norms and specific practice styles about which treatments are appropriate in which circumstances. Over longer periods of time, cost sharing can also increase the incentive to develop cost-saving technologies.

There are several popular arguments that question whether cost sharing could significantly affect health-care spending. Some argue that the potential impact of cost sharing is limited because health-care bills are driven by the exorbitant health-care spending of a minority of consumers who are no longer subject to cost sharing. For example, in 2004, 20 percent of nonelderly households were responsible for 70 percent of nonelderly health-care expenditures. These high expenditures are well above the range to which cost sharing could conceivably apply, reducing its ability to affect spending. While this illustrates an important limitation of cost sharing, Furman argues that this simple assertion has one main shortcoming. A typical high-deductible health plan will include cost sharing up to about $7,000 of health-care expenditures for individuals and $14,000 for families, thresholds that included 41 percent of all expenditures for nonelderly households in 2004. As a result, RAND and other evidence suggest that modest levels of income-related cost sharing can meaningfully reduce health spending and increase the affordability of insurance.

Another criticism of greater cost sharing is that it reduces health-care spending at the expense of people's health. Furman argues that the evidence does not support this claim. According to the RAND study, the 40 percent increase in health service use in the free-care plan had negligible effects on average adult health, and some indicators, for example, days of work lost to disability, actually improved under the plans with cost sharing. An important exception, however, was low-income people in initially poor health. The 6 percent of people who fell into this group were less likely to diagnose and treat their hypertension, as well as less likely to have vision problems corrected and have dental cavities filled. Other studies have also corroborated the negative effect of cost sharing on low-income populations. Again, this finding should inform how cost-sharing plans should be structured to protect those least able to bear these new costs.

Key Highlights

The Context

- Total health-care spending has increased dramatically in the past several decades while average out-of-pocket payments have barely risen.
- The increased comprehensiveness of health insurance benefits is largely a positive development, but the downside is that health insurance is less affordable and sometimes less effective.
- Health savings accounts (HSAs) have proven to be expensive for the federal budget and unnecessarily risky for families' finances and health outcomes.

A New Approach

- The RAND experiment found that income-related cost sharing could reduce total spending by 31 percent without worsening health outcomes for the majority of families. Other evidence suggests the effects could be even larger.
- A new approach would limit cost sharing to 7.5 percent of a family's income (and even less for low- and moderate-income families) and potentially include evidence-based exceptions for highly valuable treatments.
- The approach can make health insurance more affordable, reducing premiums by 22 to 34 percent and total health spending by 13 to 30 percent.
- All families would have an affordable cap on their out-of-pocket health expenses, protecting them from major risks.
- Cost sharing should be implemented as part of a broader health-care reform that improves and ensures insurance coverage for all.

The flip side of lower health-care spending from increased cost sharing is that potentially greater financial risk for small expenses is shifted to the individual. Whether this risk outweighs the potential benefits, Furman argues, depends on the income of the person subjected to cost sharing. Furman concurs with other critics of policies such as HSAs who argue that heavy, across-the-board cost sharing can impose large and unaffordable out-of-pocket costs on low- and moderate-income families. After all, a risk of spending $5,000 is far most costly to a family making $10,000 than for a family making $100,000. This hypothetical is not so different from the risks embedded in a high-deductible insurance plan: even if the poor and the rich face identical health risks and have identical insurance plans, the prospect of paying the out-of-pocket maximum weighs much more heavily on poor families than on rich ones.

A NEW APPROACH

Relating Cost Sharing to Income

Furman argues that cost sharing should be an integral component of overall health-care reform, but that, done correctly, the degree of cost sharing should be a function of income. When cost sharing is related to income, health-care spending is reduced to a larger degree, health outcomes are better, and risk is mitigated. Furman offers a template for a progressive cost-sharing plan:

> Under this plan, most households would pay 50 percent of their health-care costs up to 7.5 percent of their income. Households with incomes under 150 percent of the poverty line (about $30,000 for a family of four) would pay no coinsurance, and families with incomes between 150 and 200 percent of the poverty line would pay full coinsurance only up to 5 percent of their income. The maximum out-of-pocket cap would be set at $15,000 (for a family earning $200,000 or more).

To evaluate his proposed template, Furman uses health-care expenditure data from 2004 to simulate the effect of this plan as compared to conventional health insur-

TABLE 1

Simulated Health-care Spending under Alternative Policies

	Out of- pocket	Covered expenses (actuarially fair premium)	Total	Percent reduction in total premiums	Percent reduction in total spending
Assuming health-care spending responds moderately to price (elasticity = 0.22)					
Conventional plan	1,155	6,685	7,840		
HSA-type high deductible plan	2,707	4,063	6,770	-34%	-14%
50% coinsurance up to 7.5% of income	1,916	4,833	6,748	-24%	-14%
Progressive cost-sharing plan	1,842	4,986	6,828	-22%	-13%
Assuming health-care spending responds strongly to price (elasticity = 0.6)					
Conventional plan	1,155	6,685	7,840		
HSA-type high deductible plan	1,978	3,317	5,295	-44%	-32%
50% coinsurance up to 7.5% of income	1,398	3,899	5,296	-36%	-32%
Progressive cost-sharing plan	1,403	4,094	5,498	-34%	-30%

Source: Author's calculations.
Note: Detail may not add to total because of rounding. Total premiums assume a load factor equal to 15 percent of the covered expenses in the conventional plan.

ance and to two other approaches that encourage more cost sharing:

- A high-deductible HSA-qualified plan with a $2,000 deductible for individuals ($4,000 for families), 20 percent coinsurance, and a $3,000 out-of-pocket maximum for individuals ($6,000 for families)

- A simpler income-related cost-sharing plan where households pay 50 percent of their medical costs up to 7.5 percent of income, with no special protection for low-income families and no overall cap.

The results of this analysis are shown in the Table 1. Based on his analysis, Furman draws the following lessons:

- **Cost sharing can have a significant impact on total health-care spending, potentially reducing it by 13 to 32 percent.** Even though the majority of health-care spending is driven by a few very sick people with very high spending, enough spending takes place in the range affected by cost sharing to have a substantial effect.

- **Premiums fall by even more than total health expenditures, reducing an entry barrier to purchasing health insurance.** More cost sharing has two effects on premiums. First, it reduces total health spending and thus required premiums. Second, it increases out-of-pocket spending and thus, as a matter of accounting, reduces the premiums needed to cover the remaining expenses. As a result, under the progressive cost-sharing plan premiums would fall by 22 to 34 percent.

- **Income-sensitive cost sharing can be more effective than one-size-fits-all cost sharing in reducing health-care expenditures, while minimizing the added financial risks.** For example, both the HSA plan and the featured progressive cost-sharing plan result in similar reductions in spending: 14 percent and 13 percent, respectively, assuming a moderate responsiveness of spending to changes in price. Under the HSA plan, however, the average out-of-pocket payment is $2,707, compared with $1,842 under the plan with variable cost sharing.

The progressive cost-sharing plan would provide substantial protections for low- and moderate-income families, generally more than most insurance plans today. These protections come at virtually no aggregate cost—the percentage reduction in total health-spending in the progressive cost-sharing plan is only 1 to 2 percentage points smaller than in the income-related cost-sharing plan.

- **It is better to undertake systemwide reform, which has potential savings for families that are more than twice as large as if reform were undertaken at the individual level.**

Furman also analyzes the potential downside of the substantial premium savings: the potential for increased exposure to financial risks. He shows that HSAs do indeed increase exposure to risk, with the largest increases for the lowest-income families. In contrast, the progressive cost-sharing proposal would reduce the risks facing low- and moderate-income families. The typical middle-income family would face modestly more financial risks, but these risks would be limited to smaller expenditures and would be more than outweighed by the 22 to 34 percent reduction in premiums. Moreover, the proposal would represent a reduction in major financial risks for many of the 22 percent of workers who currently have insurance plans with no maximum out-of-pocket limits.

Designing Smart, Evidence-based Cost Sharing

Although substantial reductions in many types of health-care spending are possible without compromising health, Furman points out that this is not always the case. The RAND experiment identifies various areas in which greater cost sharing harms health outcomes, particularly for people with low incomes or chronic conditions. According to Harvard health economist Joseph Newhouse and the RAND Insurance Experiment Group, all of these areas have three shared characteristics: the conditions are common, standard diagnostic tests are relatively inexpensive, and the treatment is well known and efficacious.

Some argue the rules for current high-deductible plans under HSAs address these concerns by covering preventive care even before the deductible is reached. But these exceptions may be inadequate because they fail to address disease management for the chronically ill, including those with diabetes, high cholesterol, or a history of heart disease. There is also substantial evidence that high-risk individuals and the chronically ill underutilize care, and there is some evidence that cost sharing could make that problem worse. As a result, Furman argues that it would be necessary to carve out exceptions for certain services based on the best evidence about which are most effective. The devil, of course, is in the details, and our current state of knowledge is not strong enough to effectively design a system of exceptions. According to Furman, further research into what health measures should be cost free for consumers is critical: another round of a RAND-like experiment could repay its cost several hundredfold.

The other shortcoming of more cost sharing is its effect on the chronically ill who could hit their out-of-pocket limits year after year. Furman writes that well-designed cost sharing could help by providing more first-dollar coverage for well-understood, highly beneficial preventive treatments. Other measures should also be considered, such as using the income tax system to provide tax credits for people that reach their out-of-pocket limit year after year. He also notes that any cost sharing should be implemented as part of a broader health-care reform that would include measures to improve the availability and effectiveness of insurance for the chronically ill.

Furman suggests implementing income-related cost sharing as part of far-reaching, fundamental health-care reform. For instance, a single-payer insurance system could easily have income-related cost sharing. Alternatively, a system of risk-adjusted vouchers, such as that proposed by Victor Fuchs and Ezekiel Emanuel, could include income-related cost sharing in the benefit requirements for private insurance companies under the proposal. The potential benefits of greater cost sharing may be larger if the change is made systemwide.

Short of systemwide reform, the federal government could lead the charge by incorporating income-related cost sharing as part of its own programs, such as Medicare or the Federal Employee Health Benefits Program. The government could also encourage private insurance companies to offer income-related coinsurance, possibly limiting the current tax exclusion to employers as an incentive to adopt the plan. Alternatively, the government could implement this directly with a tax credit for out-of-pocket medical expenses in excess of a certain fraction of income, although this route raises serious issues about complexity and the timing of payments.

CONCLUSION

Health-care spending has been rising rapidly in recent years, and any proposal to address our health-care challenges must not only expand coverage, but also maintain affordability for households. Furman's proposal for income-related cost sharing in health insurance represents an evidence-based approach for reducing health-care costs and insurance premiums without endangering health outcomes or imposing unbearable costs on those who cannot afford them. Progressive cost sharing does not eliminate tough choices in health care, but it has the merit of giving individuals greater control over these tough choices. Furman argues that such cost sharing should be included among the elements of comprehensive health insurance reform as a complement to other policies to increase affordability, promote effectiveness, and expand coverage.

Additional Hamilton Project Proposals

Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing
The new Medicare Part D provides many important benefits to the elderly in need of prescription drugs. The program suffers from a variety of problems, however, including complexity, inefficiency, and discontinuity in coverage (the "donut hole"). This paper proposes reforms that, by better utilizing the forces of competition, would improve health outcomes, reduce the financial risks faced by the elderly, and provide options for closing the "donut hole".

- **A Wellness Trust to Prioritize Disease Prevention**
  America's health infrastructure is ill-suited to deliver services that would reduce the largely preventable or manageable chronic diseases that now account for most of the health-care system's deaths and costs. This paper proposes the establishment of a Wellness Trust that would prioritize, fund, and deliver preventive services, thereby contributing to a healthier and more productive nation.

The Hamilton Project seeks to advance America's promise of opportunity, prosperity, and growth. The Project's economic strategy reflects a judgment that long-term prosperity is best achieved by making economic growth broad-based, by enhancing individual economic security, and by embracing a role for effective government in making needed public investments. Our strategy—strikingly different from the theories driving economic policy in recent years—calls for fiscal discipline and for increased public investment in key growth-enhancing areas. The Project will put forward

innovative policy ideas from leading economic thinkers throughout the United States—ideas based on experience and evidence, not ideology and doctrine—to introduce new, sometimes controversial, policy options into the national debate with the goal of improving our country's economic policy.

The Project is named after Alexander Hamilton, the nation's first treasury secretary, who laid the foundation for the modern American economy. Consistent with the guiding principles of the Project, Hamilton stood for sound fiscal policy, believed that broad-based opportunity for advancement would drive American economic growth, and recognized that "prudent aids and encouragements on the part of government" are necessary to enhance and guide market forces.

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