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Cost Sharing: The Good, The Bad, And The Ugly

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Cost sharing in a fee-for-service health care system is almost universally recommended by health economists. The reason: When patients pay some part of the costs of their care, they are likely to be more conservative, prudent shoppers in the medical marketplace.

Under the recently enacted health reform, for example, the out-of-pocket exposure can be as high as $6,645 for individuals and $13,290 for families in 2014. (Estimate of the Medicare Actuary.)

Yet there are three major problems with the current practice of cost sharing:

- Even under the best design, copayments and deductibles are a very inefficient way of sharing costs between patients and their insurers.
- In the most common arrangements, cost sharing affects incentives weakly and often not at all.
- All too often, cost-sharing arrangements are a facade — masking an underlying effort to shift costs from the healthy to the sick.

To make matters worse, all three problems are likely to escalate under the new law—especially in the health insurance exchanges.

The best way to think about cost sharing is to understand that there are two types of insurance: self-insurance—say, through a general bank account or a Health Savings Account (HSA)—and third-party insurance. The economic problem is to find the ideal division between the two. What bills (or what proportion of bills) should be paid by the patient directly and what should be paid by the third-party insurer?

Ideal Health Insurance. In my original paper on this subject, I argued that there are three types of medical care for which people should self-insure: when patients can exercise discretion; when patients should exercise discretion; and when the amount of money involved is not large.

A broken leg, a ruptured appendix, cardiac arrest, the onset of a stroke—all of these are cases where patients cannot exercise discretion; and, even if they could, they probably shouldn't. In these instances, care decisions (including decisions about the resources needed for that care) need to be made by professionals.

On the other hand, almost all primary care—including general checkups and most diagnostic tests—fit the three criteria almost perfectly. Since experts disagree, for example, about when (and how frequently) people should get general checkups, mammograms, pap smears, PSA tests, etc., and since people differ a lot in their attitudes toward risk in general and medical care in particular, these are precisely the areas where individual decision making and individual purchase makes sense.

Ideal health insurance, then, would carve out entire areas of care, where it is appropriate and desirable for patients to make their own decisions and where it is understood and accepted that not all patients will make the same decisions. Patients would self-insure for these expenses through an HSA. Within this sphere of medicine, patients would bear the full costs and reap the full benefits of the decisions they make. (Think of this as the "live and let live" sector of medical practice.)

Where individual discretion is neither possible nor desirable, however, third-party insurance should be involved in the decisions and pay for their full cost. (Think of this as the "we're all in this together" sector of medical practice.) Here, of necessity, insurers will legitimately intervene in the practice of medicine from time to time, because when a patient draws money from an insurance pool, every other member of the pool has a legitimate interest in how the money is spent.

A third category of care combines features of the first two. These involve procedures that need to be done but for which patients can legitimately exercise discretion over where, how, and when they are done. For expensive procedures of this type, a third party might make a lump sum available (calculated to cover almost all of the cost of an efficient doctor and an efficient care facility), leaving the patient free to make other choices and pay the marginal cost of those decisions from an HSA. (Think of this as the "casualty model" of insurance.)

The Roll of Deductibles and Copayments. Nothing in the preceding discussion required us at any point to bring up the topic of deductibles and copayments. In fact, the way these are ordinarily used is completely inconsistent with ideal health insurance, which assigns 100 percent of the cost of each decision to the decision maker. Certainly an across-the-board deductible, covering all procedures—both inpatient and outpatient—is completely inconsistent with ideal insurance. Ditto for across-the-board copayments (a percent of the provider fee), covering all procedures.

The Opposite of Ideal Health Insurance. Imagine an insurance plan that turns ideal insurance upside down. This is a plan in which the decision maker never pays the cost of his or her decisions. In particular, imagine a plan in which (1) whenever the patient is making decisions, the third-party payer pays, but (2) whenever decisions are being made by someone other than the patient, the patient often pays. Sound like something out of a Marx Brothers movie? Believe it or not, this describes the most common form of insurance sold in the market today.

Under a typical plan, for example, most primary care, most diagnostic tests, and most inexpensive drugs are available to the patient at no charge, or for a nominal fee. This means that where patients have the most discretion about care, they pay almost none of the cost directly. But these same plans often have high deductibles and hefty copayments above the deductible. This means a person could be hit by a truck and end up owing a hospital $5,000 or more in out-of-pocket payments, even though the patient exercised no discretion whatsoever over the care.

Perverse Reasons for Faulty Insurance Design. In my analysis of managed competition, I argued that when health plans are forced to community-rate their product and accept all comers, they will try to attract the healthy and avoid the sick; and, after enrollment, they will be tempted to overprovide care to the healthy and underprovide it to the sick. The reason why that observation is important is that (loosely speaking) you can think of the entire employer market as managed competition writ large.

The employer, for example, cannot refuse coverage or charge a higher premium based on health status. Employers can, however, manipulate the design of their health insurance in order to attract the healthy and repel the sick. Of course, this is terrible from the point of view of efficient cost control. But as everyone in the trade knows, there is no plan design known to humanity that can control costs better than hiring only healthy employees.

How Health Reform May Make Things Worse. For all the criticism one can level at current health insurance designs, there is one overwhelming virtue of the current system: The government is not telling you that you have to be in a poorly designed plan. However, that is about to change.

What I have described as the "opposite of ideal health insurance" is about to be forced on the entire private sector. Eventually, every plan will be required to provide first-dollar coverage for preventive care, and the only avenue left to keep premiums down will be to collect large deductibles and copayments from people who are sick enough to require hospital care.

To make matters worse, most other traditional methods of cost control (such as choosing a more limited package of benefits) are being taken off the table. So the pressure on employers to have plans that are unattractive to sick people will intensify. And, as I have explained elsewhere, the perverse incentives will be even more intense in the exchange.