

Can Targeted Copayments Hit the Mark?

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Why Cost-sharing? What We Know.

- Not to hold down premiums since risk protection benefits are important. Better coverage for care with larger financial risk.
- In economic theory, ideal copayments are also higher for services whose insurance-caused additional use is large and has low value (not zero) relative to its net cost: Moral hazard. In optimum, higher cost sharing for more user-price responsive care.
- If patients are properly informed by their physicians and others about medical benefits, such optimal copayments will also reflect marginal medical effectiveness; they embody value based cost sharing.

Clearing the Underbrush

- Existing coverage tends to have lower copayments for types of services associated with high financial risk and low response to coverage: cost sharing for inpatient care is only 1% but is 50% for dental care.
- A well known point: if additional use of a preventive type service causes a future reduction in use and costs for an insured treatment, the preventive service should have a low (even zero or negative) copayment. But this is probably rare.
- If there is a partial cost offset, the preventive service should have some coverage but usually less than that for the treatment.

Defining the Hard Case

- Think of a service with positive net cost that yields health benefits but for which patients have not been appropriately informed.
- Ignorant patients might either underestimate or overestimate benefits.
- One might consider using targeted cost sharing as a substitute for better information. Lower cost sharing tricks underappreciative patients into using services with high marginal net (of cost) benefits, and higher cost sharing discourages excess enthusiasm.

Relationship to Cost Effectiveness Analysis

- Assume that we have really good data on both medical effectiveness and costs so that we can compute cost effectiveness of each service. Ignore administrative costs imposed on insurer, doctor, and patient.
- Model I: the British NHS: Characterize services by CE ratio relative to a benchmark ceiling.
- Free care for cost effective services, no coverage for services with ratio higher than benchmark. No role for partial coverage. Why offer incentives for noncompliance if docs are always right?

Model 2: Finer distinctions

- How tell if patients are misinformed? See whether the CE ratio at the margin in actual community settings (not trials) is (much) above or below the benchmark.
- Then adjust to get closer to the benchmark.
- Optimal coinsurance will depend on both extent and direction of misestimation *and* on user price responsiveness (moral hazard). Lowest copayment for an underused service with low price responsiveness. Less need to lower copayment for highly responsive underused services.

From Theory to Reality

- At least at first, start with the extreme cases of patient overestimation or underestimation. Insurer administrative costs and complexity are high already.
- Don't talk about "effective" services but rather cost effective services. Evidence based medicine is necessary, not sufficient. Some harm to health is ok.
- Suppose a service has a good CE ratio when used within guidelines but there is much use outside of guidelines (e.g., statins). Then what? You cannot cite NEJM; you need a new measure of marginal cost effectiveness in community practice.
- Blissful ignorance: Leave underusers ignorant?

Will Consumers Like Costly Insurance with Value-based Cost Sharing?

- If they have faith in medical evidence even when it overrides what they think is best for them, yes.
- But not if they trust their own decisions more than they trust medical ones.
- There will always be some patients who undervalue; sometimes this is systematic but sometimes the average patient is correct in the midst of underuse and overuse. Then what?

Are there messages here for public policy?

- Mostly not. The value of value-based insurance is an ideal candidate for choice in competitive private markets (undistorted by tax subsidies or special tax treatment of high deductible plans). No need for politicians to design insurance.
- But imperfect portability of coverage biases against services with large cost offsets in the future.
- What about Medicare? The political process may not be suitable for evaluation of evidence. Best tried out by a Medicare Advantage plan.