Innovation in Benefit Design

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Three Problems

- High prices
- Over use
- Under use
Growth in cost sharing

Cumulative Increases in Health Insurance Premiums, General Annual Deductibles, Inflation, and Workers’ Earnings, 2011-2016

NOTE: Average general annual deductible is among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
Insurance Balances Risk with Incentives
Why the cost sharing?

To lower premiums ✗

To tax the sick? ✗

To improve incentives ✓
  – Reduce ‘excess use’
  – Encourage price shopping
Benefit Design Options

- Higher copays, co-insurance or deductibles
  - HDHPs w/ HSAs or HRAs
- Reference pricing
- Tiered networks
- Value Based Insurance Design (VBID)
  - Align copays with value
Benefit Design Results

- Patients clearly respond to cost sharing
  - Shift sites of care
    - Reference Pricing:
      - Potentially meaningful shift in volume
      - Smaller $ effects
    - Tiered network: 5% of total PMPM
  - Reduce use
    - HDHPs: 5%-14%
    - VBID: Only save $ if raise cost sharing on low value care
Consumers Do Not Make Wise Decisions

- Reductions in appropriate use same as for inappropriate use (Sui et al. 1986)
  - Copays reduce use of preventive services
  - Copays reduce use of ‘valuable’ pharmaceuticals
Will Benefit Design Changes Work

Can clearly solve the public spending problem
  – Simply shift spending to patients

Will reduce utilization
  – HIE participants in the large-cost sharing plan (95% coinsurance) plan used 25-30% fewer services than those in the free-care plan

Benefit Design Concerns

- Quality of care
- How much risk do we transfer?
- How does this affect disparities?
Keep It Simple
Everything is Relative

- We want
- We have
- We can build
END END