In their article published in the April/May issue of the journal (AHDB. 2009;2:70-77), Haren and McConnell report the results of a recent survey (conducted in 2008) of large employers, employee benefit consultants, and managed care executives. The survey was focused on recent and expected increases in patient cost-sharing, and the article provides the aggregated responses of those surveyed.

The survey results are fascinating, showing that most employers and health plans have increased both premiums and consumer copayments (of many types) in the past 12 months. A substantial minority of employers and health plans has also reduced copayments, strategically, on particular services, based on specific clinical considerations or chronic conditions. Of note, both groups, but especially the employers, report their high levels of satisfaction with the overall results of higher copayments. One would think that this was a story of complex organizations positively adapting to changes in their environment as healthcare delivery becomes more costly. Indeed, the survey results show the importance of health and drug benefit design.

Oddly, in their commentary on the results, the authors seem to take the trends revealed in their survey as bad news rather than good news. In part, this is the result of confounding cost-shifting (ie, raising premiums) with cost-sharing (ie, raising copayments). Cost-shifting only affects the consumer’s choice of whether to purchase insurance or which policy to purchase. It does not affect incentives to use more or less healthcare services. Cost-sharing, however, strongly affects incentives to use more or less healthcare. Indeed, this effect, called “moral hazard,” is probably the best established empirical regularity in the entire field of health economics.

The concept of moral hazard originated in the insurance industry, where insurance that led to higher losses was generally viewed as a moral issue. (Dramatic examples, such as insurance-induced arson, fit this view fairly well.) That moral hazard in healthcare, which was simply a demand response to lower out-of-pocket prices, was first clearly explained by Mark V. Pauly in 1968, and has since become a staple of health economics textbooks.

The existence of moral hazard, of course, implies that more cost-sharing (higher copayments) will reduce the demand for healthcare services. As Pauly clearly showed, this is simply a result of movement up an ordinary demand curve. This concept lies at the heart of theoretical and empirical studies on demand for healthcare, which is probably the most carefully and completely studied demand topic in the entire field of economics, not merely in health economics. A recent survey done for the US Department of Defense lists 70 references on this topic, mostly empirical demand studies.

The most famous research on healthcare demand sets the gold standard. This study, the RAND Health Insurance Experiment, which spanned the late 1970s through the early 1980s, randomly assigned consumers to different health plans, neatly (if expensively) side-stepping the statistical problem caused by the possibility of adverse selection (where sicker consumers choose more complete health insurance).

The RAND study is one of the largest social science experiments ever conducted. It showed large and long-lasting cost-savings from higher consumer copayments (and also from health maintenance organization utilization controls). Much of the savings, regardless of exactly how the copayments were designed and defined, occurred in hospitalization costs. For example, coinsur-
ance imposed only on outpatient services reduced inpatient hospitalization expenses, as well as outpatient expenses. The effects on health status were nonexistent for most measures, small for correctable vision and periodontal health among the lowest-income consumers. Similar and consistent results are found in other studies, observational and natural experiments, in many countries, but no similar massive social experiments have been done.

This moral hazard, or demand effect, is well-known to insurers and actuaries. In a letter to Anthem Blue Cross/Blue Shield of Maine, a Milliman actuary predicted the effect of various levels of copayments on utilization, ranging from 0.997 for the lowest cost-sharing to 0.730 for the highest cost-sharing—a 27% decrease from the least to the most cost-sharing. Even before the RAND study, actuaries and insurers took account of the cost-controlling effects of consumer copayments.

There are only a few ways in which health insurers can control or influence costs: price bargaining with providers, utilization controls, and consumer copayments. It is well-established that employers and insurers believe that raising copayments reduces costs. The US healthcare system has well-known problems, such as the tax subsidy to employee health insurance and the high percentage of the uninsured. But, one advantage of that system is that the degree of utilization control, aggressive price bargaining, and benefit design are determined by the competitive interaction of many well-informed buyers and competing insurers. Thus, the system is subject to experimentation, innovation, evolution, and consumer choice.

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References