

VIEWPOINT

HEALTH AND THE 2024 US ELECTION

Why Cost Sharing on Its Own Will Not Fix Health Care Costs

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Viewpoint

As the US emerges from the COVID-19 pandemic, health care utilization, which decreased substantially in early 2020, has largely returned to its prepandemic levels, and the question of how best to address high private-sector health insurance costs is again attracting attention. According to the Kaiser Family Foundation,¹ the average premium for family coverage through an employer has increased by 20% over the last 5 years, and as of 2022, totaled nearly \$22 500 overall (with employers paying \$16 400 and workers \$6100, on average). In this context, one policy proposal that keeps resurfacing is putting more individuals in the US in plans with high cost sharing, with high-deductible health plans (HDHPs) linked to pretax health savings accounts often the preferred version. The well-worn argument is that more “skin in the game” will lead patients to avoid unnecessary care, improve shopping for lower-priced services, and reduce health care inflation. However, a large body of research evidence indicates that such an approach is far from a panacea, will generally not produce all of its promised benefits, and in the process will harm many patients at high risk for adverse outcomes.

Evidence that patient choices can drive price competition is extremely limited. Increasing patient’s skin in the game through high deductibles has not increased price shopping, as patients in HDHPs rarely, and no more frequently than those in traditional health plans, compare out-of-pocket costs across health care physicians or facilities (4% vs 3%).² Only a very small minority of patients use price transparency tools to learn the prices they would pay for health care—for instance, roughly 4% of patients in 1 study.³ Empirical studies show that patients in HDHPs do not choose lower-priced physicians or facilities for their care.⁴ Reference-based pricing benefit design, where patients pay substantially lower cost sharing if they choose lower-cost settings (eg, surgical settings instead of hospital outpatient departments) have been successful in steering patients to those settings; this shift in the location of care decreases overall spending, but for the most part has not led health care organizations to lower their prices.⁵

Rather, empirical studies have shown that cost sharing saves money by reducing utilization, in many cases with negative effects on quality of care.⁴ A review of 28 studies of HDHPs and health care use finds that patients in HDHPs reduce both appropriate (eg, preventive care and medications for chronic conditions) and inappropriate care (low-severity emergency department visits).⁶ As noted in the landmark RAND Health Insurance Experiment, while cost sharing may save money without major health impacts on patients who are healthier and have higher incomes, for patients with chronic health problems and lower incomes, cost sharing deters care that in turn worsens health. Another con-

sideration is that HDHPs may be paired with health savings accounts that allow people to pay for health care using pretax dollars funded by themselves or their employers; while one aim of this subsidy is to reduce out-of-pocket costs to increase use of needed care, because this subsidy is largest for higher-income patients (since they have higher tax rates), these plans exacerbate income-based inequities in health care.

So, what can be done? Though there are numerous flaws in the US health care system, too much health insurance is not one of them. A range of quasi-experimental and randomized trial data shows that expanded health insurance coverage provides substantial benefits to patients, including better disease management, improved health-related well-being, and reduced mortality.⁷ And studies indicate that millions of individuals in the US have health coverage but are underinsured, meaning they are at high risk for financial distress in case of illness, another harmful outcome.⁸ Less coverage—or less generous coverage—is not the answer.

Meanwhile, the fundamental driver of the US’s extraordinarily expensive system is that prices are too high, and as seen above, cost sharing is generally an ineffective tool for improving price competition. Policies that reduce prices for health care services are needed. Site neutral payment policies, which would not permit hospital outpatient departments to assess extra facility fees for services that can be safely provided in other outpatient settings such as physician offices, are one example. Direct price negotiations, such as those introduced for prescription drugs under the Inflation Reduction Act of 2022, provide another potential avenue if they can be extended to private coverage.

On the topic of cost sharing, there is some evidence that so-called smarter cost sharing, as opposed to a blunt tool, which HDHPs typically are, could provide some benefit without excess risk to patients. First, smart cost sharing with simple, clear incentives works better for patients. One study found that highly simplified information on hospital costs in a tiered hospital network system can produce substantial savings (8%-17%), and may create pressure to hold down prices across hospital systems.⁹

In addition, smarter cost sharing includes benefit designs that reduce or eliminate cost sharing for high-value care, which may be better than deductibles that are applied broadly to all health care utilization. For instance, the Affordable Care Act required most private insurance plans to cover recommended preventive care free of cost sharing; similar policies to promote zero cost sharing for care for chronic conditions such as diabetes and hypertension are also being explored by some insurers and could be incentivized by policy makers. Meanwhile, one proposal in the aftermath of the pandemic,

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exempting telehealth from deductibles and cost sharing, does not appear to fit the bill for smarter cost sharing, as the value of the care rather than the modality through which it is delivered ought to be the primary determinant for cost sharing approaches.

Finally, protecting lower-income individuals and those with chronic conditions from high deductibles is critical to avoiding adverse health effects from this cost sharing. This rationale should be extended to Medicaid, limiting efforts to increase cost sharing in this

population, where some state efforts to increase consumerism or use health savings accounts have mostly led to enrollee confusion and coverage losses.¹⁰

Controlling costs in health care is largely a question of prices. Cost sharing to cut quantity indiscriminately is a recipe for harm. Smarter cost sharing can play a role in meaningful efforts to reduce health care cost growth, but should only be used as part of a broader policy effort that views do no harm as the guiding principle.

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