Survey Results Show That Adults Are Willing To Pay Higher Insurance Premiums
For Generous Coverage Of Specialty Drugs

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John A. Romley, Yuri Sanchez, John R. Penrod and Dana P. Goldman
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ABSTRACT Generous coverage of specialty drugs for cancer and other diseases may be valuable not only for sick patients currently using these drugs, but also for healthy people who recognize the potential need for them in the future. This study estimated how healthy people value insurance coverage of specialty drugs, defined as high-cost drugs that treat cancer and other serious health conditions like multiple sclerosis, by quantifying willingness to pay via a survey. US adults were estimated to be willing to pay an extra $12.94 on average in insurance premiums per month for generous specialty-drug coverage—in effect, $2.58 for every dollar in out-of-pocket costs that they would expect to pay with a less generous insurance plan. Given the value that people assign to generous coverage of specialty drugs, having high cost sharing on these drugs seemingly runs contrary to what people value in their health insurance.

Health insurance coverage for high-cost therapy raises interesting and important questions. Sick patients might be unwilling or unable to pay for costly treatments out of their own pockets without some contribution from their health plans. If patients faced with the full cost of care declined to undergo treatment, one might conclude that the treatments are not “worth it.”

However, insurance lowers out-of-pocket costs not only for those who currently receive treatments, but also for people who may need treatment in the future. These healthy people may dislike the financial risk associated with future illness, and therefore they may be willing to pay enough in insurance premiums to finance the average cost of coverage among beneficiaries. Because these individuals apparently value the protection enough to pay for it, the costs of the covered treatments may also be justified. Healthy people might even be willing to pay more than its actual cost for coverage, which would suggest that the value they place on it exceeds what it costs to provide.

Thus, the value that healthy people receive from generous coverage could be substantial, yet payers might not fully appreciate it when they decide which treatments are worth covering. This study investigated the value that generous insurance coverage would generate for the healthy in the context of “specialty” drugs. These are typically innovative but high-cost agents used to treat cancer and other serious health conditions, including anemia, growth hormone deficiency, rheumatoid arthritis, and multiple sclerosis.

Many of these drugs and treatments are placed in specialty categories in tiered drug lists or formularies used by insurance and pharmacy benefit plans. Among the forty-three drugs that were placed on these specialty formulary tiers for at least 90 percent of Medicare Part D plans in 2008, fifteen were used to treat cancer.¹

Specialty drugs can provide highly sophisticated and effective treatments for conditions for which few other options are available. For example, the use of imatinib (Gleevec) has in-
In 2008, specialty drug expenditures, including patient cost sharing and plan reimbursement, averaged $11,746 per person (measured in 2010 dollars) among users covered by a group of large commercial plans, with specialty drugs again defined based on Part D formulary status. Insurance plans typically charge a coinsurance rate of 25–33 percent for specialty drug use, often resulting in sizable out-of-pocket costs.

Indeed, cancer patients have demonstrated a substantial willingness to spend out of pocket for specialty drugs. Users of the drugs would undoubtedly prefer lower cost sharing for these expensive therapies. Yet people who do not currently use the drugs may also value health insurance plans that cover them generously. These currently healthy people may need specialty drugs in the future, and generous coverage mitigates their associated financial risk.

There is no direct evidence on how much healthy people value generous specialty drug coverage. We therefore attempted to quantify willingness to pay for generous coverage of specialty drugs among healthy US adults.

**Background**

Economic reasoning offers useful insights into the value of health insurance coverage. On the one hand, the benefit of insurance is that it provides protection against the risk of medical costs due to future illness. On the other hand, it can encourage the use of treatments that have limited clinical benefit, precisely because beneficiaries do not have to pay the full cost of medical care.

A well-designed insurance plan balances the benefits of reduced financial risk against the costs of excessive utilization. Lower cost sharing for patients enhances the value of an insurance policy when the spending “at risk” is relatively large, or when patients’ use of services or drugs is not particularly responsive to cost-sharing incentives.

In cases where use is not responsive to cost sharing, asking for a high level of cost sharing from patients does not discourage the sick from using “low-value” health care with high cost but limited clinical benefit. Instead, it increases the cost burden on those who are sick. High cost sharing also imposes greater financial risk on people who are healthy but may need care in the future.

Specialty drugs might seem to be good candidates for low cost sharing, given their high costs and therapeutic benefits. Moreover, there is good evidence that generous specialty drug coverage does not encourage excessive use, at least among cancer patients. A recent study found that a 25 percent reduction in out-of-pocket costs led to only a 5 percent increase in the probability of initiating therapy with specialty cancer drugs.

Thus, healthy people may receive high value from insurance plans that offer low cost sharing—that is, generous coverage—in the event of a future illness requiring specialty drugs.

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**Study Data And Methods**

**Survey Instrument** We developed a survey instrument that isolated the willingness to pay for generous specialty drug coverage. Survey methods known as “contingent valuation” allow for quantification of the value of a good or service when direct evidence from the marketplace is unavailable or hard to come by.

The survey instrument defined specialty drugs for participants and described their therapeutic potential using the examples of treatment of chronic myelogenous leukemia and multiple sclerosis. Survey participants were then asked to consider the situation of a person who does not currently use specialty drugs but may need them in the future.

Participants were presented with two hypothetical insurance plans that differed only in how generously they covered specialty drugs. There was no cost sharing in the generous plan. In the high-cost specialty drug plan, monthly out-of-pocket spending was set to the ninety-fifth percentile level ($167 per month for the average user, measured in 2010 dollars) within a group of large commercial plans in 2008.

Survey participants were told that 3 out of 100 people use specialty drugs in any given year. Hence, as an approximation, expected future out-of-pocket costs were $5.01 lower each month in the plan with generous specialty drug coverage ($167 times 3 percent), compared to the plan with high specialty drug costs.

To encourage participants to reveal the true value of specialty coverage to them, they were told that they could not switch insurance plans in the future. To test their ability to understand the decision problem, they were also asked which plan they would prefer if monthly premiums were the same. The survey was pilot tested as described in the online Survey Appendix, which also shows the final drug coverage scenario presented to survey participants.

The survey then asked participants how much extra in monthly insurance premiums they would be willing and able to pay for their pre-
deferred health insurance plan, compared to the alternative plan. We used the “payment card” format, in which a participant is presented with a set of possible values and asked to identify the maximum value he or she would willingly pay.12 Payment cards help minimize nonresponse, given that some survey participants object to open-ended questions about willingness to pay.12 They also help avoid starting-point bias and other known cognitive biases.15,16

OTHER INFORMATION In addition, the survey collected information on self-rated health and other personal characteristics, including age; sex; race or ethnicity (white, African American, Asian or Pacific Islander, Hispanic, or other); current insurance (uninsured, Medicare, Medicaid, private insurance, other, or don’t know/no answer); education (high school diploma or less, some college, bachelor’s degree, or postgraduate education); and family income. The survey design was approved by an Institutional Review Board.

The survey was fielded in November 2011 to a random sample of 352 US adults in the RAND Corporation’s American Life Panel.17 The panel, which has been used extensively in academic research,18–25 consists of approximately 5,000 members. Panelists were recruited in a variety of ways, as described in the Survey Appendix.14 The panelists are regularly interviewed over the Internet.

An Internet survey may avoid the tendency of respondents to answer questions the way they think the questioner might want—a problem known as social desirability bias.26 And although participating in repeated surveys may affect responses, the evidence for such an effect is not strong.27,28 Most members of the American Life Panel have their own Internet access; those who do not are provided with a laptop or Internet-enabled TV and an Internet subscription.

For this survey, panelists were paid a nominal sum ($3) to participate. Research suggests that a financial incentive improves response rates and, ultimately, representativeness and data quality.29–32

The American Life Panel reports sampling weights based on population characteristics in the Current Population Survey, a monthly survey of US households conducted by the Census Bureau for the Bureau of Labor Statistics. In particular, the panel weights exactly match the distribution of age, race or ethnicity, household income, and education, as each interact with sex. These weights were used to produce nationally representative estimates.33

ANALYSIS In analyzing survey responses, we used interval regressions because participants reported their willingness to pay on the payment cards within ranges, rather than as exact amounts. The analysis accounted for family income, age, self-rated health, current insurance, race or ethnicity, and education. Mean willingness-to-pay estimates were virtually identical when we varied the model covariates. Details regarding the analysis methods (and results) are presented in the online Technical Appendix.14

Study Results
CHARACTERISTICS OF THE SAMPLE The analysis sample included 270 US adults, for a response rate of 77 percent. Another six people provided incomplete responses. The personal characteristics of the survey participants are described in Exhibit 1, weighted for comparison to nationally representative sources.

The average age of the participants was 46.5 years, and 52 percent were female (Exhibit 1). In comparison, the 2011 Current Population Survey reported that 51 percent of US adults were female, with an average age of 46.1 years. The racial and ethnic composition of the participants and US adults was also similar. Both groups were 14 percent Hispanic. The par-

EXHIBIT 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean/percent</th>
<th>Standard deviation</th>
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<tr>
<td>Female (%)</td>
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<tr>
<td>Male (%)</td>
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<td>Age (years)</td>
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<td>–</td>
</tr>
<tr>
<td>Other, not Hispanic</td>
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<tr>
<td>Private insurance</td>
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<tr>
<td>Other</td>
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<td>–</td>
</tr>
<tr>
<td>Don’t know/no answer</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td><strong>HEALTH STATUS (%)</strong></td>
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<tr>
<td>Poor health</td>
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**NOTES** Authors’ calculations based on survey responses. Statistics are weighted according to sample weights. Insurance coverage sums to more than 100 percent because of multiple sources of coverage. *Not applicable.
Participants were 69 percent white and 11 percent African American, while US adults were 68 percent white and 12 percent African American. In the study survey, family income averaged $75,442 (Exhibit 1), compared to a mean of $74,359 in 2011 dollars in the 2010 Current Population Survey. Just over four-fifths of the respondents rated themselves in very good or good health. In comparison, two-thirds of Americans rated their health similarly in the Medical Expenditure Panel Survey in 2009.34 And that survey reported insurance coverage that was similar to that of our survey respondents, with 60 percent having private insurance (compared to 61 percent in our study), 19 percent participating in Medicare (compared to 20 percent), and 8 percent having Medicaid (compared to 7 percent). The national representativeness of the survey sample with respect to sex, age, race or ethnicity, income, and insurance is demonstrated in the Technical Appendix.14

**Willingness to Pay** Turning to generous coverage of specialty drugs, Exhibit 2 shows respondents’ willingness to pay, based on the payment cards. Seventy-eight percent of respondents (211 out of 270) would prefer the health insurance plan with generous coverage of specialty drugs, if it had the same premium as the alternative plan with high specialty drug costs. Willingness to pay varied from $0–$5 per month (14 respondents) to more than $60 (5 respondents). Twenty-two percent of respondents (59 out of 270) would not prefer the plan with generous specialty drug coverage; their willingness to pay for the plan was less than zero.

Based on the statistical analysis, we estimated that respondents were willing to pay an extra $12.94, on average, in insurance premiums per month for generous specialty drug coverage. This average amounts to $2.58 in willingness to pay per dollar of higher expected specialty drug costs with the less generous insurance plan. Based on the midpoints of the willingness-to-pay ranges provided on the payment cards, average willingness to pay within those ranges was higher still, at $18.02 per month (data not shown).

Willingness to pay did not vary significantly with age. Nor did it vary with race or ethnicity, current insurance, or education, after adjustment for comparisons among multiple categories.35 There was some evidence that people with better self-reported health expressed a lower willingness to pay.

Willingness to pay also appeared to decrease as family income rose, particularly after it reached $75,000. In the top third of the income distribution, willingness to pay was only $1.45, although this estimate was not statistically different from zero or from the expected cost savings of $5.01. (We present more details on this seemingly counterintuitive finding below.) In the lower two thirds, willingness to pay was estimated at $17.64 (Exhibit 3). This estimate was statistically precise and significantly exceeded $5.01, the expected savings from the generous insurance plan in future out-of-pocket costs on specialty drugs. The results from alternative specifications of income are reported in the Technical Appendix.14

**EXHIBIT 2**

Respondents’ Maximum Willingness To Pay Per Month For A Health Insurance Plan With Generous Specialty Drug Coverage, 2011

![Graph showing respondents’ maximum willingness to pay per month for a health insurance plan with generous specialty drug coverage, 2011.](http://content.healthaffairs.org/)

Source: Authors’ analysis of survey responses.

**Discussion**

We surveyed US adults about their willingness to pay higher premiums for a health insurance plan that had generous coverage of specialty drugs (no out-of-pocket costs) versus a plan in which monthly out-of-pocket spending would be at the ninety-fifth percentile ($167 per month for the average user) within a group of large commercial plans in 2008.3 We asked participants to respond as if they did not currently use these drugs but might need them in the future.

Approximately one out of five respondents preferred the insurance plan with high out-of-pocket specialty drug costs, if its premiums were the same as the plan with generous coverage. With equal premiums, however, no one should have preferred the plan with high out-of-pocket costs on specialty drugs, which was stipulated not to differ from the generous plan in any other way.
This behavior in a minority of our respondents is consistent with recent evidence showing that Medicare beneficiaries have difficulty choosing the prescription drug plan with the lowest overall cost, or premiums plus out-of-pocket cost. In our survey, a seventy-five-year-old was nearly 50 percent more likely than a forty-five-year-old to prefer the “wrong” plan—that is, the one with higher out-of-pocket costs—even after we accounted for educational attainment.

Higher-income people also seemed more likely to prefer the plan with high out-of-pocket costs, even if the premiums were the same as for the plan with generous coverage. Perhaps these respondents viewed costs for specialty drugs as a signal that a plan was superior in other important dimensions.37

**Strong Preference for Generous Drug Coverage** Despite this behavior, the vast majority of survey respondents valued the health insurance plan with generous coverage of specialty drugs. Specifically, the analysis indicated that US adults who do not currently use specialty drugs would be willing to pay an average of $12.94 per month now in return for generous coverage should they need specialty drugs in the future, although the cost of covering the drugs is about $5 per month.

Another way to view this result is that healthy adults are willing to pay $2.58 in insurance premiums per dollar of higher expected specialty drug costs with a less generous plan. This evidence is consistent with the idea that health insurance is valuable because it reduces the financial risk associated with future illness.

Willingness to pay for generous coverage of these treatments varied only slightly according to respondents’ age, race or ethnicity, insurance status, or education. Altogether, these findings suggest that survey participants were largely unaffected by their personal circumstances when asked to respond as if they did not currently use specialty drugs but might need them in the future.

These findings might help alleviate concerns about the representativeness of the survey sample, in case respondents were less healthy than the US population as a whole and could easily anticipate needing specialty drugs in the future. In fact, the participants were less likely than the broader population to be in relatively poor health, and the sample was quite similar to the US population in terms of sex, age, race or ethnicity, income, and insurance status. However, there was some evidence that people in poorer health had a higher willingness to pay.

**Effects of Income Level** The additional finding that willingness to pay seemed to be higher in the bottom two-thirds of the income distribution suggests that lower-income respondents were more concerned than high-income ones about the financial risk associated with future specialty drug use. In other settings, health insurance appeared to be quite valuable to lower-income people. Adults recently covered by Medicaid in Oregon were 25 percent less likely to have an unpaid medical bill sent to a collection agency, compared to low-income adults who also applied for coverage but were not selected in a lottery for limited Medicaid slots.38

Mark McClellan and Jonathan Skinner found that health insurance in the form of Medicare has provided elderly Americans in the bottom third of the income distribution with $1.88 in well-being for each dollar in medical spending. In our context, US adults in the bottom third of the income distribution were willing to pay $3.52 in insurance premiums per dollar of higher expected specialty drug costs (17.64/5.01 = 3.52).

In contrast, we were unable to reject the possibility that currently healthy adults in the top third of the income distribution were willing to pay anything for health insurance that reduced the financial risk associated with future use of specialty drugs. Outside of the health care context, there is some complementary evidence that high-income people are willing to accept greater risk—with respect to future job earnings—than lower-income people.40

Another possible explanation for a negative relationship between income and willingness to pay is that lower-income respondents judged they would be unable to afford specialty drugs if they were enrolled in the plan with high out-of-pocket costs (paying $167 per month, on average). If so, their willingness to pay for the gen-

**EXHIBIT 3** Respondents’ Maximum Willingness To Pay Per Month For Health Insurance Plan With Generous Specialty Drug Coverage, By Income Tertiles, 2011

![Graph showing willingness to pay by income tertiles](http://content.healthaffairs.org/)

**Source** Authors’ analysis of survey responses.
erous plan would reflect not only the value of decreased financial risk but also the value of access to specialty drugs, and thus the value of the therapeutic benefits from their use.

**Role of Cost Sharing** Although this interpretation of the study findings cannot be ruled out definitively, some evidence indicates that cost sharing can have a modest (albeit negative) effect on the use of, and thus access to, specialty oncology drugs.\(^6\) Altogether, the combined evidence from prior research on cost sharing and utilization and our survey suggests that willingness to pay for generous coverage seems to be driven by the value of reduced financial risk, should there be a need for specialty drugs in the future.

**Conclusion** This study has implications for the financing of specialty drug use. In general, generous insurance coverage can encourage excessive use of medical care. However, sick people appear to view specialty drugs as essential.\(^6\)

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**Financing specialty drugs through high cost sharing could undermine the value of health insurance.**

Thus, financing specialty drugs through high cost sharing could undermine the value of health insurance, not only to current users of specialty drugs but also to potential users who benefit from the financial protection provided by generous coverage in the event of a future need.

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**NOTES**

1. Drugs in the commercial plans were deemed to be “specialty drugs” if they were placed on a specialty formulary tier by at least 90 percent of Medicare Part D plans surveyed in 2008. See Hargrave E, Hoadley J, Merrell K. Drugs on specialty tiers in Part D. Washington (DC): Medicare Payment Advisory Commission; 2009.


4. These commercial plan data have been used in prior research. See, for example, Solomon MD, Goldman DP, Joyce GF, Escarce JJ. Cost sharing and the initiation of drug therapy for the chronically ill. Arch Intern Med. 2009;169(8):740–8.


11. Most immediately, insurance lowers the out-of-pocket cost of medical care for current illness. The focus in this study is on the value of insurance to people who are currently healthy.


14. To access the Appendix, click on the Appendix link in the box to the right of the article online.


21. Delavande A, Manski CF. Candidate preferences and expectations of election outcomes. PNAS. 2012;


In this month’s *Health Affairs*, John Romley and coauthors report on their study of how much healthy people value generous insurance coverage of expensive specialty drugs, including many that treat cancer and other serious health conditions like multiple sclerosis.

In a type of survey that attempts to quantify values of goods not easily traded in a marketplace, conducted on the Internet, the authors found that the average respondent was willing to pay an extra $12.94 a month in insurance premiums for generous specialty drug coverage. Because that amounted to $2.58 for every dollar in out-of-pocket costs that people would pay with a less generous insurance plan, they concluded that people assign high value to generous coverage of these specialty drugs.

“Insurance doesn’t simply provide sick individuals with access to treatments,” says Romley, a research assistant professor in the Price School of Public Policy, University of Southern California. “It can also provide value to those who are healthy, by helping to limit the financial risks associated with future illness.”

In addition to his post at USC, Romley serves as an adjunct economist at the RAND Corporation. He holds a doctorate in economics from Stanford University.

Yuri Sanchez is an economist at Precision Health Economics. “Insurance doesn’t simply provide sick individuals with access to treatments,” says Sanchez, an economist at Precision Health Economics, where he specializes in the fields of human capital, health economics, and applied microeconomics.

Before joining the firm, Sanchez was an economics lecturer at the University of Chicago. He received a master’s degree in economics for development from Oxford University and both a master’s degree and a doctorate in economics from the University of Chicago.

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