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The Implications of Cost Sharing

In the past few years, as the cost of health care has steadily increased, one response from employers and the insurance community has been to offer purchasers a menu of health care plans with expanded "cost sharing" options. This paper explains several cost sharing terms to give a basis for understanding the techniques. It also looks at cost sharing arrangements and asks whether they contain costs and / or restrict access to care.

First, we define a few terms. *Co-pays*, typical in managed care settings, are fixed-dollar amounts often ranging from a few dollars to $25 or more paid by the consumer each time a health care service is utilized.

Deductibles, more often found in PPOs (Preferred Provider Organizations), are fixed dollar amounts, typically ranging from $250 - $1000, that an employee or member must pay in total before insurance begins to pay for services.

Co-insurance, also typical of PPOs, generally takes effect after the employee has paid a deductible, and refers to the percentage of the physician's fee (or drug cost) that is the employee's responsibility. The percentage varies, but 20-30 percent of the total fee is not unusual.

Out-of-pocket maximums typically cap the catastrophic costs paid by the employee. If expenses reach the out-of-pocket maximum, insurance covers 100% of remaining expenses.

Another cost sharing technique, *tiered systems*, is gaining in popularity, particularly tiered pharmacy benefits. See the January 2002 *FYI* for more on tiered pharmacy benefits: http://www.phc4.org/reports/FYI/fyi5.htm. (Multi-tier hospital networks are still in their infancy.)

Two key features of *defined contribution plans*, sometimes used interchangeably with the term *flexible benefit plans*, are: 1) an employer contribution is placed in a personal health account and the employee uses the money to purchase health care services *with tax advantaged dollars* (making the employee's dollar stretch further); and 2) the provision of a major medical policy, also purchased with a portion of the employer's contribution to cover the cost of catastrophic illnesses. Under this arrangement, employees pay for any health care expenses they incur that exceed the balance in their account, up to a maximum amount. The employer's insurance plan covers the cost of a serious or catastrophic illness.

One subset of defined contribution insurance products is the Personal Health Account, or *Personal Savings Account (PSA)*, and this arrangement is stimulating interest among some larger employers. For example, the American Postal Workers Union (APWU) has announced that in 2003 its members will, for the first time, have a PSA option. The APWU says it will lower costs (saving taxpayers money), while offering better benefit options to union members.

In the mid-1980s, health care cost increases produced a move to managed care plans such as Health Maintenance Organizations (HMOs), Point of Service plans (POSs), or PPOs. From the start, these approaches were designed to rein in health care spending. Generally, HMOs and POS plans featured little or no cost to the consumer using a network of covered services through a primary care physician as a "gatekeeper." PPOs were seen as a compromise between fee-for-service indemnity plans and HMOs, and typically allowed broader access to physician services, with slightly higher, but still minimal costs to consumers.

Initially, many felt the HMO, POS and PPO approach had the desired impact, restraining premium increases. However, some consumers felt they were being denied referrals to trusted physicians for care. In response, HMOs loosened restrictions on referrals and gradually expanded their

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networks, thus dissipating some cost savings, and PPOs grew in popularity.

Some studies indicate that in the 1990s few employers made consequential changes in benefit design. For example, a survey of large and small business health care purchasers, conducted from June 2000 to March 2001 by researchers from the Center for Studying Health System Change (HSC) in Washington DC, found that only a small number of employers had increased cost sharing with their employees among the twelve geographic markets they randomly surveyed. Any reports of co-pay increases were modest. Purchasers and their consultants said that in order to attract and retain good workers they were reluctant to diminish benefits or add employee costs to benefit programs.

But more recent survey results indicate this trend is changing as corporate profits have tightened and health plans have fewer premium-cutting strategies. A recent Watson Wyatt Worldwide study indicates that a majority of large employers now plan either to reduce benefits or increase employee cost sharing. For example, plan designers and employers are now increasing co-pay amounts, and routine office visits that once cost $5 now have $15 or $25 co-pays. Drug co-pays are increasing by similar amounts.

Some observers have reservations about cost sharing measures, which are generally applied without regard to health status or income level. One concern is that cost sharing may limit access to care, because some consumers cannot afford the shared cost. One study, published in the *Journal of the American Medical Association*, examined prescription drug cost sharing in poor and elderly populations, and found that use of essential drugs were significantly decreased with increased co-pays. Other studies indicate cost sharing decreased use of preventive services in HMOs and PPOs. One emergency department introduced small co-pays and the result was a utilization decrease of 15% - although the decrease was mostly for non-emergency conditions.

One major insurer in the Commonwealth has estimated that there may be as many as 6 million persons in the U.S. who choose not to be insured because they cannot afford the cost of co-insurance.

Yet another study indicates that increases in the traditional range of co-pays, even when substantial, do not exert a strong influence on the premium, as they constitute a small portion of spending on hospitalization and pharmacy services. Some research studies indicate that deductibles and co-insurance are more effective than co-pays in offsetting premium increases.

As corporate profits have diminished, employers are looking closely at cost sharing mechanisms. Many studies suggest that co-pays shift costs to employees, somewhat limiting care, while deductibles and co-insurance result in more restrictions on access to care. Those who promote *defined contribution plans* believe that employees will be more prudent (or cautious) about spending if they realize they are spending "their own" money, instead of "the company's" money. To some extent, the view is, as one insurance industry CEO says, "People will pay more attention." While this might be true with any type of cost sharing arrangements, some observers note that patients also might seek *less* care, leading to higher long-term costs.

Other possible advantages to PSAs: administrative costs are lower, employees can roll leftover balances into the next year's account to build a cushion for future medical bills, and PSAs typically offer no-cost coverage for preventive care (just as HMOs do), meaning employees should not be tempted to forego important preventive procedures.

Still, few purchasers are using PSAs at this time. Consumers do not have access to actual charges for some procedures, and thus cannot comparison-shop. Employees have other concerns: high deductibles, chronic conditions may limit employee use or make PSAs a gamble, unexpected illness or injury may cause huge personal costs, and existing technology is not sufficiently advanced to provide consumers with health care information to make informed decisions. Will PSAs increase demand for questionable services? Will younger healthier employees pick PSAs while older / sicker persons pick traditional plans and force employers to higher premiums?

As costs increase, like in the 1980s, purchasers look for containment ideas and ways to increase consumer responsibility. Cost sharing typically does not address *quality of care*, but PHC4 (created during the 1980s' cost escalation) *does* focus on quality outcomes, as well as charges! Purchasers might want to address quality outcomes in their planning, as well as charges, using PHC4 data (www.phc4.org). Using quality outcome measures is viewed as the optimal way to reduce costs.

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