CALIFORNIA HEALTHCARE FOUNDATION

# Insurance Markets

## Individuals Find Wide Price Spreads and Differing Benefits When Shopping for Insurance

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TRENDS & ANALYSIS

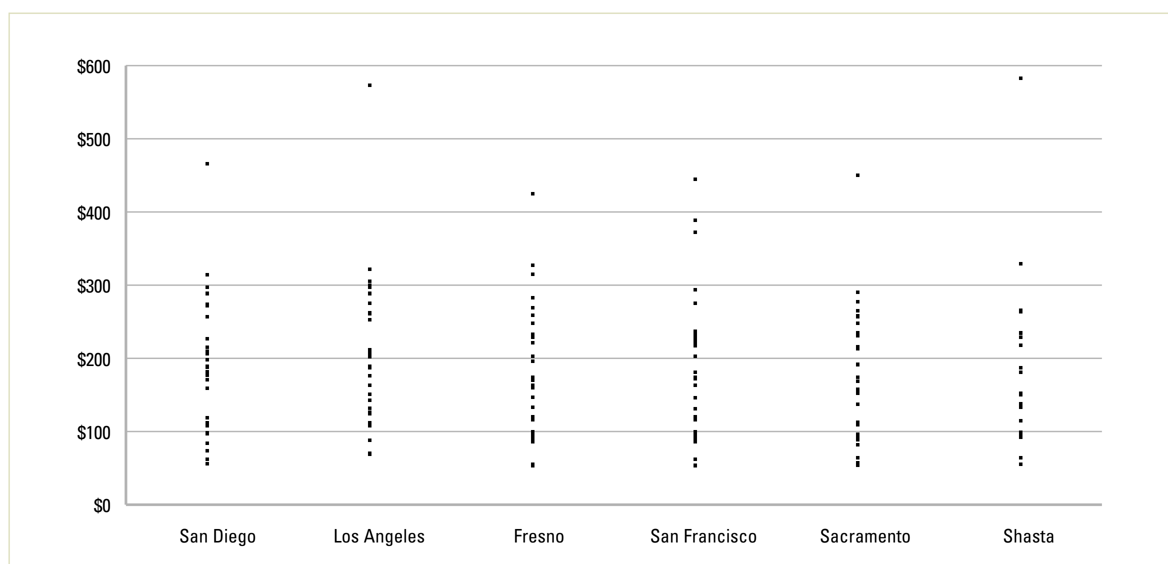
### Introduction

Approximately 5 percent of non-elderly Californians—1.5 million people—have health insurance coverage through the individual (non-group) market. The California HealthCare Foundation recently inventoried individual health insurance products offered by the five major insurers serving this market (Blue Cross of California, Blue Shield of California, Health Net, Kaiser Permanente, and PacifiCare). Depending on the geographic area, up to 31 different benefit packages are available from these insurers, with prices varying seven- to eleven-fold.[1] Price differences reflect in part the very broad range of available benefit packages, but prices vary considerably even when benefits are comparable. There is no simple formula for choosing the best option, but close examination of the market offers insights that can inform consumer decision-making.

### Products and Prices Vary Widely

Figure 1 illustrates the wide array of products and prices available to individuals in several California counties. In the spring of 2002, prices ranged from $69 to $573 per month for a healthy 44-year-old in Los Angeles. Benefit levels ranged from "bare bones" to comprehensive coverage. At the low end of the benefit continuum, coverage might exclude prescription drug and maternity coverage entirely,

**Figure 1. Prices for Individual Health Insurance Offerings for a Healthy 44-Year-Old, Spring 2002**



cover hospital costs after a $1,000 deductible, and cover other services (such as office visits) only after $3,500 is spent out-of-pocket. At the high end of the spectrum, coverage might involve no cost-sharing for hospitalization, a $500 copayment for maternity, and minimal copayments for office visits ($10) and prescription drug coverage ($10 generic/$25 brand name).

Individual purchasers' health and financial circumstances, as well as their values and priorities, vary widely. Health plans make different products available at different price points in order to respond to heterogeneous consumer preferences. A wide range of options increases the likelihood that most consumers will find something that fits their budgets and preferences, but it may also be confusing and hinder well-informed choices.

## Prices for Similar Coverage Also Vary

No two benefit packages offered by health plans to individual California consumers are exactly equivalent.[2] For comparison purposes, however, we defined two benefit levels: a comprehensive HMO benefit and a $1,500-deductible PPO benefit.[3] Within each level, products share many features but some differences in benefit details and cost-sharing arrangements remain.

Table 1 illustrates how much prices can vary even when benefit levels are similar. A healthy 44-year-old buyer in Sacramento, for example, would encounter a 59 percent price spread for comprehensive HMOs and a 12 percent spread on $1,500-deductible PPOs. Substantial price spread among products with similar benefits was observed in all age categories in each of the six study counties.

## No Easy Answers

Confronted with this degree of price variation, consumers might seek easy decision rules that could help them choose. Unfortunately, because products are complex and prices vary for reasons unrelated to benefit level, decision-making is not well supported by generic advice or simple rules of thumb.

**Table 1. Premium Spreads among Similar Benefit Levels Available to a Healthy 44-Year-Old, Spring 2002**

| COUNTY | COMPREHENSIVE HMO | | | $1,500-DEDUCTIBLE PPO | | |
|---|---|---|---|---|---|---|
| | Low Premium | High Premium | Spread | Low Premium | High Premium | Spread |
| San Diego | $189 | $314 | 66% | $159 | $159 | 0% |
| Los Angeles | 189 | 305 | 61% | 187 | 202 | 8% |
| Fresno | 174 | 269 | 55% | 133 | 163 | 23% |
| San Francisco | 174 | 372 | 114% | 131 | 163 | 24% |
| Sacramento | 174 | 277 | 59% | 137 | 153 | 12% |
| Shasta | not available | | — | 137 | 187 | 36% |
| AVERAGE | | | 71% | | | 17% |

Note: Monthly premiums for a single individual are shown. Spread is calculated as (high – low)/low. Average spread is calculated as a simple average of the percent spread across the six areas. For definitions of the benefit levels, see Endnote 3.

To illustrate more concretely the challenges facing consumers, Table 2 compares some of the coverage options available to a 44-year-old in Sacramento. This table includes several options within a fairly narrow price range ($137 to $174 monthly premium). It includes two $1,500-deductible PPOs (Blue Shield of California and Blue Cross of California), one comprehensive HMO (Kaiser Permanente "Personal Advantage"), and one HMO product with more limited benefits (Health Net "HMO 40"). This comparison is illustrative only. Consumers of any age and geographic location would face a similar array of product options. However, product prices differ—both in absolute amount and relative to one another—for other locations and ages.

When comparing the two PPO products, consumers must make a number of trade-offs. For example, which office visit coverage is more comprehensive: a flat $40 copayment or paying coinsurance of 25 percent? (A per-visit charge of $160 makes the two coverage levels equal, but it can be difficult to obtain provider fee schedules in advance from plans and providers, so consumers do not always know what they'll be charged.) In some regards, the Blue Shield product provides better coverage: for example, the copayment for generic prescriptions is lower and the lifetime coverage limit is higher. But in other respects, the Blue Cross product is more comprehensive. For example, hospital coinsurance after the deductible and prescription copayments for brand and non-formulary drugs are lower with Blue Cross than Blue Shield.

**Table 2. Comparing Selected Insurance Products for a Healthy 44-Year-Old in Sacramento, Spring 2002**

| | BLUE SHIELD OF CALIFORNIA<br>$1,500 Deductible PPO | BLUE CROSS OF CALIFORNIA<br>PPO Share $1,500 | HEALTH NET<br>HMO 40 | KAISER PERMANENTE<br>Personal Advantage HMO |
|---|---|---|---|---|
| **Monthly Premium** | $137 | $153 | $158 | $174 |
| **Hospital Cost Sharing*** | $1,500 deductible +30% | $1,500 deductible +25% | $2,000 per admission | None |
| **Office Visit Copayment** (deductible waived) | $40 in network | 25% in network | $40 | $15 |
| **Prescription Drug Deductible** (brand name drugs only) | $250 | $250 | $100 | $0 |
| **Prescription Drug Copayment** | | | | |
| Generic | $7 | $10 | $15 | $10 |
| Brand | $25 +10% | $25 | $25 | $25 |
| Non-formulary | $45 +10% | $25 after preauthorization | $35 | † |
| **Out-of-Pocket Maximum** | $4,500 | $4,000 | $2,500 | $1,500 |
| **Lifetime Limit** | $6 million | $5 million | Unlimited | Unlimited |
| **Physician Network** | Self-refer to any provider, with incentives to choose from within a network | | Closed panel‡ | Closed panel‡ |

* Cost sharing for other services, such as outpatient surgery, may also count toward meeting the deductible. In some benefit packages, maternity services are subject to a separate deductible.

† Members receiving non-formulary prescriptions that are deemed not medically necessary are charged the Kaiser Permanente retail price.

‡ A "closed panel" means that covered individuals must receive care from a selected list of physicians in order to receive any health insurance benefits. The panel for Health Net's HMO product includes community-based physicians, most of whom contract with other health plans as well as Health Net. The Permanente physician panel, on the other hand, has an exclusive relationship with Kaiser Foundation Health Plan.

The monthly premiums for the Blue Cross PPO and Health Net's HMO 40 product differ by only $5. In addition to weighing network differences, consumers comparing these two options must evaluate:

- Which level of inpatient cost-sharing is preferable: a $1,500 deductible plus 25 percent of the negotiated hospital fee under the Blue Cross PPO or a flat $2,000 deductible under the Health Net HMO?
- Which combination of prescription drug coverage is preferable: a higher deductible ($250) and lower copayments on generic ($10) and non-formulary ($25 with pre-authorization) drugs under the PPO or a lower deductible ($100) and higher copayments on generic ($15) and non-formulary ($35) drugs under the HMO?
- What is the added value of an annual out-of-pocket maximum of $2,500 in the HMO product as compared to $4,000 for the PPO?

The Kaiser Permanente HMO product includes no deductibles and has lower office visit cost-sharing than the other three options. But, among the four options shown in Table 2, Kaiser's premium is highest and its network most restricted.

Uncertainty about use of services and charges can make it very difficult for consumers to assess the relative value of different coverage levels within each benefit dimension. The fact that different products are likely to be viewed as stronger along some dimensions, but weaker along others, further clouds the decision.

## Other Sources of Price Variation

Some differences in monthly premium are associated with actual benefit differences such as those illustrated above. But premiums also vary due to underlying factors that affect an insurer's costs but not the value of a consumer's coverage. Such factors include health plan efficiency, the terms of insurers' contracts with providers, and the health status of enrollees.

Health plans' prices may also vary depending on strategic pricing decisions. For example, a plan may set prices lower in an area in which it is aggressively seeking market share than in an area where it is already well-established and faces few strong competitors.

## Helping Consumers Choose

In California, as in most states, individual purchasers are not guaranteed access to coverage, but instead must pass medical review in order to qualify.[4] Because health status can worsen over time, initial health plan and product choices can have long-term implications for consumers who need coverage for a lengthy period through the individual market. When assessing the relative value of different options, consumers should:

***Look for differences in the benefits that are likely to impact them.*** Although it might be desirable for consumers to read and understand all the fine print differences in benefits available to them, few have the time and inclination to do so. But it is important to make at least a few broad comparisons (for example, hospital, office visit, and pharmacy cost-sharing). Depending on individual circumstances, it can also be worth the time to dig deeper into the details of maternity coverage, behavioral health, or other specialty services that can be subject to high cost-sharing or exclusions.

***Consider the breadth of the provider network.*** In California, consumers face a fundamental decision regarding whether to obtain coverage through Kaiser

Foundation Health Plan, and thus be limited to its physician network and hospitals, or to opt for an alternative plan with a broader network. There is considerable network overlap among plans other than Kaiser, but consumers should nevertheless confirm that their preferred physicians and hospitals are in the health plan's network. The fact that a particular provider is part of a network today does not guarantee that the provider will continue to participate in the future. In the event that a particular physician or hospital leaves the network, the consumer should consider whether the plan offers acceptable alternatives.

***Assess affordability and financial risk.*** An insured individual's total cost is composed of two parts: a fixed monthly premium and out-of-pocket costs that vary depending on use of services. Before trading lower premiums for less coverage, it's important to think about how out-of-pocket costs could be affected. Most consumers understand the basics of deductibles, copayments, and coinsurance, but they may be less familiar with the concepts of lifetime limits and out-of-pocket maximums. Lifetime limits cap at a specified level the total benefits that a health plan will pay, and can expose consumers to very high costs in the event of catastrophic illness. An out-of-pocket maximum, on the other hand, caps the annual costs that a consumer can incur. If the consumer reaches the out-of-pocket maximum, the health plan waives out-of-pocket charges for the remainder of the year (unless the consumer reaches the lifetime limit). The most comprehensive coverage would involve a *high* lifetime limit and a *low* out-of-pocket maximum, but those features require higher premiums. In recent years many health plans, seeking to keep monthly premiums as low as possible, have increased out-of-pocket maximums and capped lifetime limits. Consumers should consider how all of a product's cost-sharing features affect their overall financial risk.

In the individual market, a wide range of benefit levels and prices assures consumer choice, at least for the healthy. But exercising that choice can be time-consuming and difficult. Although not all of the challenges associated with evaluating individual options can be readily addressed, the process might be improved through regulatory changes. Specifically, policymakers could require plans to offer some standardized benefit packages. The availability of one or more standardized benefit packages (even if offered alongside existing options) from all health plans participating in the individual market would facilitate direct apples-to-apples comparisons of plans.

## Methodology

From June 2001 through June 2002, the California HealthCare Foundation conducted a project to track premiums, products, and benefits offered by health plans with a substantial presence in California's commercial small group and individual markets. The study produced quarterly analysis of the benefits and prices offered by health plans in six California counties: San Diego, Los Angeles, Fresno, San Francisco, Sacramento, and Shasta (Redding). Research for this project was conducted by Joan B. Trauner, Ph.D. in conjunction with Acordia of California and Katherine B. Wilson.

## ENDNOTES

1. Premiums for new coverage were compared for individuals in the same age group and geographic area and reflect standard rates (that is, rates for individuals in excellent health). The minimum premium variation observed was 7.3 fold in the 20–24 age group in Sacramento. The maximum variation was 11.6 fold in the 50–54 age group in Shasta (Redding). Actual premiums vary even more substantially when compared across health status, age, and geographic categories.
2. For more information on the complexity of benefits in California's small group and individual markets, see *Small Businesses and Individuals Face Greater Cost-Sharing and Increasing Complexity,* California HealthCare Foundation, April 2002 (www.chcf.org).
3. The comprehensive HMO benefit level was defined as providing: inpatient (non-maternity) care at no charge, office visits with a copayment of $15 or less, prescription drug coverage, and maternity care subject to a deductible of $1,500 or less. Three or four (of up to 31 total) products per county in five counties fit this definition. No comprehensive HMO options were offered in Shasta County. The $1,500-deductible PPO benefit level was defined as providing: inpatient hospital care subject to the $1,500 deductible, office visits with a per visit charge (deductible waived), prescription drug coverage, and maternity subject to a $1,000 maternity deductible. Two (of up to 31) plans per county fit this definition.
4. The rules that apply to California's individual health insurance market will be explored in an upcoming *Trends & Analysis.*

Future *Trends and Analysis in Insurance Markets* will identify trends in California's insurance markets, analyze regulatory and policy issues, and provide industry updates. Analyses will be posted as they become available at the California HealthCare Foundation's Web site at **www.chcf.org**.

The California Healthcare Foundation's program area on Health Insurance Markets and the Uninsured seeks to improve the functioning of California's health insurance markets, particularly the small group and individual markets, and to expand coverage to the uninsured. For information on the work of Health Insurance Markets and the Uninsured, contact us at **insurance@chcf.org**.