Insurance Markets

Small Businesses and Individuals Face Greater Cost-sharing and Increasing Complexity

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California HealthCare Foundation

Introduction

In recent months, there have been marked shifts in the types of benefits offered in California's small group and individual health insurance markets. Early results from a California HealthCare Foundation study tracking changes in benefits and prices show that health plans are developing a wide array of new benefit offerings. Many of these new benefit packages contain extensive consumer cost-sharing not previously included in managed care products. These complex new cost-sharing requirements make it increasingly difficult for purchasers to evaluate their health insurance options and to understand the tradeoffs between lower monthly premiums and higher cost-sharing at the time of service.

HMO and PPO Benefits for Small Businesses

Small businesses (up to 50 employees), like other health insurance purchasers, face many choices when selecting health insurance coverage. At the most basic level, purchasers choose between two broad classes of products: HMOs, which typically provide comprehensive coverage with limited cost-sharing but a restricted network of providers; and PPOs, which typically require greater cost-sharing but offer more choice of providers. Two benefit packages, which illlustrate prototypical benefits available to small businesses as of summer 2001, are shown in Table 1. The packages represent a traditional HMO as well as a "mid-level" (neither extremely comprehensive nor very minimal) PPO benefit package. Actual benefit packages have additional features and may limit coverage or require additional cost-sharing for outpatient surgery, infertility, and other specialty services.

Table 1: Examples of Benefit Packages Offered to California Small (2-50 employees) Businesses as of Summer 2001

Product	Annual Deductible (single)	Office Visit Cost-sharing	Hospital Cost-sharing	Pharmacy Cost-sharing	Annual Maximum Out-Of-Pocket (Single/Family)
HMO	$ 0	$10-$15 copay in-network; out-of-network not covered	generally $0	two or three tier plan with copayments from $10 to $35	$1,500/$3,000
PPO	$250	$10-$20 copay in-network; 30-50% coinsurance out-of-network	10-20% coinsurance after deductible	two or three tier plan with copayments from $10 to $35	$2,000/$4,000

Additional Cost-sharing for Small Businesses

Annual spending on health care was more than $4,600 per person nationally in 2000, up from about $1,100 in 1980, and is expected to continue to rise.[1] Spending increases are due in part to rising prescription drug and hospital costs and the introduction of new technologies that add to the complexity of medical services.

Rising health care costs cause the price of insurance to increase. Rising insurance costs, in turn, can be passed on to consumers either through increased monthly premiums or through additional cost-sharing at the time that care is delivered (the "point of service"). Cost-sharing at the point of service provides potentially desirable incentives for cost-conscious care. A challenge for health plans is to set cost-sharing at levels that discourage unnecessary care, yet do not set up barriers to needed care.

In 2001, the average premium increase for California small businesses was 11.5 percent.[2] To be responsive to price-sensitive small businesses and avoid still higher premium increases, health plans are developing and marketing products with increased cost-sharing at the time of service. Tables 2 and 3 provide examples of cost-sharing features that have been introduced in some small group HMO and PPO products since the summer of 2001. The approaches shown are not limited to one low-cost option offered by one health plan but have been incorporated in some of the benefit options offered by at least two large California health plans.

As premiums increase and benefit designs change, purchasers have a greater need to understand the tradeoffs between monthly premiums and cost-sharing at the time of service. Most small businesses, however, do not have the resources to carefully evaluate health insurance options. Many new cost-sharing arrangements have the potential to leave purchasers confused and enrollees facing unexpectedly high medical bills. For example, enrollees accustomed to comprehensive HMO benefits may be surprised by the introduction of PPO-style cost-sharing in HMO benefit packages, such as two-tier pricing for in-network hospitals and the use of copays or deductibles for hospital care. An individual with HMO coverage who had been hospitalized at no charge in the summer of 2001 and who had, due to changes in employment, subsequently enrolled in a new HMO product, might pay $1,500 (three days at $500 per day) for a similar in-network hospitalization in the summer of 2002.

Table 2: HMO Cost-sharing Approaches Introduced Between Summer 2001 and Spring 2002

HMO Cost-sharing Approach	Example
Separating hospitals into tiers with different levels of cost sharing	$0 copay for 1st tier hospitals; $100 per day copay for 2nd tier hospitals
Annual deductible for hospital-based services and ambulatory surgery centers	$240-$1,500 per member
In-network hospital copay	$50-$500 per day (with 3-7 day maximum)
Deductible for brand name prescription drugs	$150-$250 per member

Table 3: PPO Cost-sharing Approaches Introduced Between Summer 2001 and Spring 2002

PPO Cost-sharing Approach	Example
Separating hospitals into tiers with different levels of cost-sharing	10% coinsurance for 1st tier hospitals; 20% coinsurance and $500 admission charge for 2nd tier hospitals
Setting a maximum per diem payment for out-of-network inpatient care, with patient responsible for all additional charges	Plan pays $400–$650 maximum per day; patient pays 100% of remaining costs (and these are not subject to annual out-of-pocket maximum)
Increased coinsurance for in-network hospital services	25% coinsurance
Coinsurance rather than copayments for professional services such as x-ray and laboratory	25% coinsurance
Hospital copay and coinsurance for maternity services	$1,000 copay plus 25% coinsurance
Maximum number of physician visits per year at the standard copay or coinsurance level	2 visits per adult per year covered at $20 copay; patient pays for additional visits until reaching out-of-pocket maximum
Deductibles and copays for brand drugs	$500 deductible, then $25 copay

While it has always been difficult for purchasers and enrollees to evaluate the tradeoffs between lower monthly premiums and higher out-of-pocket costs, new benefit features have added another layer of complexity to the task. Benefits involving cost-sharing based on provider fees can be particularly difficult to understand. Complicated terminology and inadequate information are both sources of confusion. For example, purchasers may be asked to compare two options for care at in-network facilities: one with coinsurance at 25 percent of a "negotiated fee" and another with coinsurance at 25 percent of an "allowable" or "usual and customary" amount. (The negotiated fee is based on a contracted amount, whereas an "allowable" or "usual" amount is based on regional average fees for these services. Providers agree to accept negotiated fees as payment in full, but may bill consumers for the portion of their fee that exceeds the plan's "allowable" or "usual" amount.) Neither full charges ("sticker prices"), negotiated fees, nor allowable amounts for particular services and levels of care are specified in benefit descriptions and can be difficult to ascertain prior to obtaining care. Even if fee information were available, complicated rules regarding deductibles and annual maximums make predicting a patient's total share of costs exceedingly difficult for all but the most sophisticated consumers.

New benefit features allow purchasers to obtain health coverage at more reasonable monthly premiums. Healthy enrollees who rarely need care may fare relatively well under these new arrangements. For regular users of health care services and higher-risk enrollees, however, new cost-sharing approaches can result in additional charges and uncertainty about just how much they will pay for a given course of care.

Cost-sharing for Individuals and Families

Conventional wisdom holds that the individual market, in which individual enrollees bear the full cost of coverage, is even more price-sensitive than the small group market. In an effort to keep premiums as low as possible, health plans have historically incorporated greater cost-sharing requirements in products for individuals than for small businesses. For example, pharmacy deductibles of $250 to $500 have been available for some time among individual PPO products but are only beginning to be seen among small group PPO products.

As with the small group market, a number of new cost-sharing features have been introduced in the individual market since summer 2001. These include:

- Among less comprehensive HMO products, introducing an in-network maternity copayment of as much as $1,000, plus meeting a standard deductible across all services.
- Among some PPO products, limiting the annual number of physician office visits (for example, 2-12 visits) that are covered at a stipulated copay or coinsurance level before incurring a significant deductible.
- Among some PPO products, increasing coinsurance for well-baby care (ages 0 to 2-6 years) to as much as 30 to 50 percent.
- Among some PPO products, raising annual out-of-pocket maximums for in-network providers to $2,500 to $4,000 for a single person or $5,000 to $8,000 for a family, while excluding certain services (such as maternity copays or deductibles) from the maximum.

Looking to the Future

Because these cost-sharing approaches are being offered to small businesses and individuals for the first time, it is difficult to know how purchasers will respond. In an era of double-digit premium increases, however, pressure on purchasers to seriously consider less comprehensive coverage options is inevitable. Increased cost-sharing at the point of service can help limit premium increases, allowing more Californians to maintain health insurance coverage. But the added complexity associated with these new benefit approaches has important, and potentially negative, consequences for purchasers.

Although policymakers, regulators, and other stakeholders may not be able to control premium increases, they may have a role in helping enrollees to navigate the increasing complexity of health insurance benefits. One step toward improving the purchasing process would be to require standardized benefit terminology across products and plans. Health plans could also be required to provide standardized examples of reimbursement levels and out-of-pocket costs for a set of pre-defined medical conditions.

Methodology

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

Endotes

1. Levitt, Katharine, et al., "Inflation Spurs Health Spending in 2000," *Health Affairs* 21: 172-181, January/February 2002; Diede, Mick L. and Richard Liliedahl, "Getting on the Right Track," *Managed Care* February 2002.

2 Kaiser Family Foundation/HRET, "California Employer Health Benefits 2001," February 2002 (www.kff.org/content/2002/3205/).

Future ***Trends and Analysis in Insurance Markets*** pieces 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 more information on the work of Health Insurance Markets and the Uninsured, contact us at **insurance@chcf.org**.