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Sharing the Cost

A Changing Landscape

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Informing Policy. Advancing Health.

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About this series:

Nearly one-fifth of the U.S. gross domestic product (GDP) is comprised of health care spending.[1] But the return on investment in terms of overall health and health outcomes doesn't measure up.

This is the first in a series by the Colorado Health Institute that analyzes efforts to improve the quality and efficiency of the health care system with a focus on market-based solutions.

We will study whether these approaches lead to more engaged and informed consumers who take greater responsibility for their health and health care. We will search out innovation and promising programs. We will look at whether successful efforts in the private sector can be transferred to the public sector. And finally, we will assess whether these initiatives have the potential to lower the growth of health care costs in the United States while improving the overall health of its citizens.

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Introduction

Any discussion of rising health care spending is sure to touch on the concept of consumer cost-sharing. The idea behind it is simple: The more that people pay for something, the more that market forces kick in and the more they think critically about their purchasing decisions and demand greater value for their money.

In terms of health insurance, the theory is that consumers who are responsible for a portion of their medical bills will make better choices about their care and will work harder to stay healthy in the first place. The goal: A new level of consumer involvement, fueled by market incentives and aided by increased cost transparency, which helps to further bend the health care cost curve.

In fact, cost-sharing may already be contributing to the slowdown in the growth of health care costs – growth that dropped to its lowest level in five decades between 2009 and 2012.[2,3]

As the nation continues to work on creating a more efficient health care system, with lower costs and better quality, cost-sharing is increasingly viewed as an important tool. Insurance companies are adding plans with higher deductibles, higher co-pays, and higher co-insurance. More employers are opting to offer these types of plans. And more consumers are choosing them, many enticed by the lower premiums.

Colorado is proving to be a leader in this area, with one of the highest percentages of private insurance enrollment in high-deductible plans.

The question, then, becomes whether cost-sharing is effective at controlling costs and whether health outcomes are impacted, either positively or negatively. The answer, according to research, is that cost-sharing is a useful tool for slowing cost growth among healthy populations, but it is not as effective among unhealthy populations.

According to studies, increasing the level of cost-sharing:

- Leads to less use of medical care, especially when increased cost-sharing is first implemented.
- Results in some people cutting back on all medical services, including care that may be covered by their insurance or care that is needed to maintain their health.
- Motivates some people to select less-costly options, such as generic drugs.
- Contributes to worse health for low-income people who are already sick.
- Fails to curb the highest users of medical care. This group, responsible for the majority of health care costs, continues to use the most services, even with cost-sharing.

This paper provides a broad understanding of the theory and goals of cost-sharing, examines the evidence of its ability to curb costs, and looks at whether cost-sharing impacts the use of health care and, ultimately, health outcomes.

Cost-Sharing: A Changing Landscape

Cost-sharing shifts some of the expense for medical care from the insurer to the consumer. Three common forms of cost-sharing are:

- **Co-payments:** The consumer pays a fixed dollar amount for services such as office visits or prescriptions.
- **Deductible:** The consumer pays a specified sum each year, often $1,000 or more, before insurance coverage kicks in.
- **Co-insurance:** The consumer pays a percentage of all costs even after meeting the deductible.

While insurance premiums generally are not considered to be an element of cost-sharing, the premium amount and the level of cost-sharing are related. Low-premium insurance plans often require consumers to pay more out-of-pocket for their care. Conversely, consumers who pay higher premiums often have lower out-of-pocket costs.

What is Moral Hazard?

The phenomenon in which people change their behavior when they aren't responsible for the full consequences of their actions. For example, if insurance covers all health care costs, people are likely to use more services because they don't have to pay for them.

In Colorado, for example, employers, on average, were facing a 10.9 percent jump in premiums for 2014. The premium increase was whittled down to 6.4 percent, however, in part by increasing the amount of cost-sharing for covered workers.[4]

Colorado's high-deductible plan enrollment reached 304,651 in January 2013, accounting for 8.4 percent of all private health insurance enrollment and placing Colorado in the top 12 states (see Map 1).

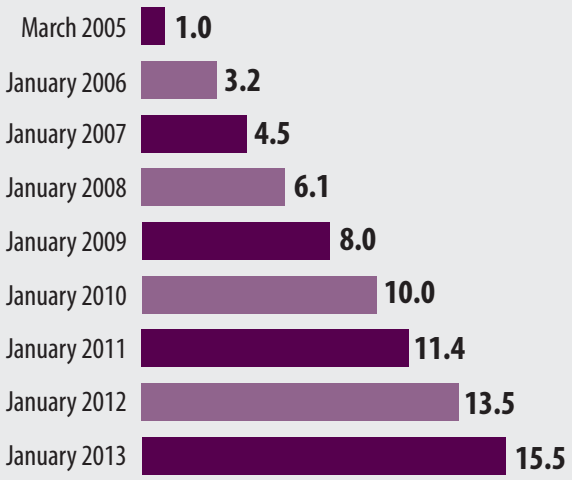
The Growth of High-Deductible Plans

Nearly half (47 percent) of Colorado employers report that they offer plans with deductibles of $1,000 or more. The percentage of Colorado employers offering high-deductible health plans that qualify for health savings accounts (HSA) – the two are usually linked – has increased dramatically in the past decade, from three percent in 2003 to 38 percent in 2013.[5]

At the same time, about 22 percent of Colorado employers who don't offer these plans said they were thinking of adding them.[6]

Nationally, more people are opting for high-deductible plans, with enrollment reaching nearly 15.5 million in January 2013, up from 11.4 million in 2011, an annual growth rate of about 15 percent, according to America's Health Insurance Plans, Center for Policy and Research (see Graphic 1).[7]

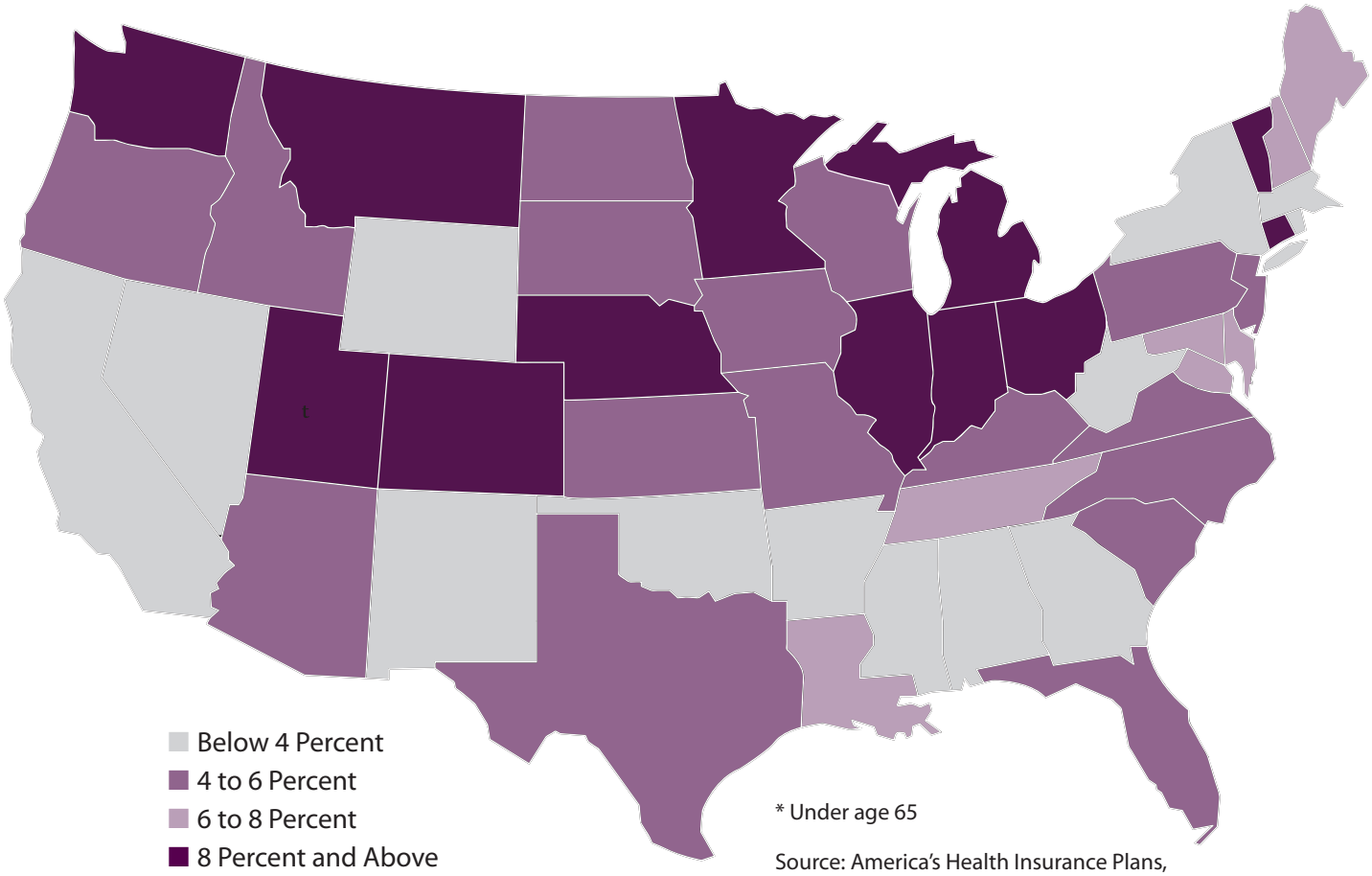
Graphic 1: Growth of High-Deductible Health Plan Enrollment, Millions, March 2005 to January 2013*



* Covered lives

Source: America's Health Insurance Plans, Center for Policy and Research, January 2013 Census

Map 1. High-Deductible Plan Enrollment as a Percentage of Total Commercial Plan Enrollment, by State, January 2013



* Under age 65

Source: America's Health Insurance Plans, Center for Policy and Research, January 2013 Census

Insurance and Cost-Sharing: A Quick History

American health insurance began as hospital insurance during the Great Depression. Baylor Hospital in Dallas led the way by offering each local teacher 20 days of hospital care each year if at least three-quarters of them agreed to pay 50 cents a month. This insurance model, called Blue Cross, rapidly spread across the country, along with pre-paid medical plans based on the same concept.[8]

The stunning increases in health care costs have had significant impacts on insurers and consumers. Today, insurance companies pay for the vast majority of health care. In 1960, consumers covered 55 percent of personal health care costs with their own money; in 2011 it was 13 percent. But during that same time, the real annual out-of-pocket cost for consumers has almost doubled, from less than $500 per person in the early 1960s to more than $900 in 2008, mostly because of the climb in costs.[9]

Now, the industry is looking to swing the pendulum back and have consumers pick up a bigger percentage of the cost.

Terms to Know:

Private Insurance Market: Health insurance offered by private companies, including policies sold in the individual market and employer-sponsored insurance.

Public Insurance Market: Health insurance funded by state and federal governments, including Medicaid, Medicare, Child Health Plan Plus (CHP+) and TRICARE, the Department of Defense health care program.

Employer-Sponsored Insurance: Health insurance coverage provided by an employer. Usually the employer and the employee each pay part of the premium. In the self-insurance model, employers cover the cost of the claims with the assistance of a third-party administrator. Alternatively, employers can purchase fully insured products from a health insurance plan.

Small Group Market: The health insurance market for companies with 50 or fewer employees that offer insurance to their employees. This market is regulated by the state and federal governments.

Individual Market: The health insurance market in which people purchase insurance on their own. This market is regulated by the state and federal governments.

HSA-Qualified High-Deductible Plans: A health savings account (HSA) is a tax-exempt savings account that can be used to pay for current or future qualified medical expenses. To have an HSA, an individual must be covered by an HSA-qualified high-deductible health plan. For 2014, these plans must have deductibles of at least $1,250 for an individual and $2,500 for a family.[10]

Essential Health Benefits: A standard set of benefits that must be provided by small group and individual insurance plans beginning in 2014, as required by the Affordable Care Act (ACA).

Grandfathered Plans: A group health plan that was created, or an individual health insurance policy that was purchased, on or before March 23, 2010, when the Affordable Care Act was signed into law. Grandfathered plans are exempt from many ACA requirements. Plans or policies may lose their grandfathered status if they make significant changes that reduce benefits or increase costs to consumers.

The Evidence: What Cost-Sharing Studies Tell Us

Cost-sharing is effective in reducing health care costs, but to what extent and for how long? How does cost-sharing change behaviors? How does it impact health?

Recent changes in the health insurance market offer new opportunities to explore these questions. But much of the evidence comes from the RAND Health Insurance Experiment, which was carried out between 1971 and 1982.

The RAND Health Insurance Experiment

This study, widely considered to be the gold standard of cost-sharing research, looked at three questions:

- How does cost-sharing affect the use of health services compared with care with no cost-sharing?
- How does cost-sharing affect the appropriateness and quality of care received?
- What are the consequences for health?

The RAND experiment included 2,750 families, 7,700 family members and six sites. RAND randomly assigned each participant to one of five health insurance plans designed specifically for the experiment. The plans used co-insurance to designate cost-sharing levels, ranging from no consumer cost-sharing to 95 percent co-insurance, which meant the consumer was responsible for 95 percent of the cost .

RAND processed the claims, so it was able to gather data on the use of health care, its cost and its quality. Participants answered surveys at the beginning and end of the study and underwent physical exams. The study found that participants:

- Used fewer services as cost-sharing levels increased, leading to cost savings. Those in the 25 percent co-insurance plan spent 20 percent less than those with no cost-sharing, while participants in the 95 percent co-insurance plan spent about 30 percent less than those with no cost-sharing.[11]
- Went to the doctor less often if they were in cost-sharing plans. However, when they did seek treatment, they tended to use a comparable amount of care – at a comparable cost – as those with little or no cost-sharing.[12]
- Sought less treatment of all kinds – effective and appropriate care as well as ineffective and inappropriate care – as cost-sharing increased.[13]

Finally, participants in the bottom six percent of both health status and income, essentially the sickest and the poorest, showed worse health outcomes in four common conditions – hypertension, vision, dental care, and prevalence of serious symptoms – when they were enrolled in plans with cost-sharing compared with similar patients who were in the plan with no cost-sharing.[14]

Increased cost-sharing did not have a negative impact on the health of other participants.[15]

Recent Research on Effects of High-Deductible Health Plans

The rapid spread of high-deductible health insurance plans has created new opportunities to look at how increased cost-sharing affects cost and use of care. Newer research shows that:

- Total spending appears to decrease between 20 percent and 25 percent in the first year after switching to a high-deductible health plan. Savings appear to continue, but at a slower rate, in following years.[16, 17]
- About two-thirds of first-year savings are due to people seeking less care. The rest is due to patients selecting less expensive services, such as generic drugs or fewer specialist visits.[18]

- Healthier people are more likely to reduce spending than people in worse health.[19, 20]

Based on cost savings observed in the first year after people switched to a high-deductible health plan, researchers estimate that annual health costs would fall by about $57 billion, or 4 percent of health care spending for the nonelderly, if half of Americans with employer-sponsored insurance were enrolled in this kind of plan.[21] But research looking spending after the first year of switching to a high-deductible plan suggests that this level of savings would not be sustained.[22]

Meanwhile, some research shows that people enrolled in high-deductible plans use fewer preventive services, even though they are provided at no cost. Other studies have found little or no decrease in use of preventive services by those enrolled in high-deductible plans.[23, 24]

Other findings suggest that employer-sponsored high-deductible plans may put a financial squeeze on lower-income employees, while other research shows that lower-income or chronically ill employees do not reduce their spending or use of high-value care more than other enrollees in these plans.[25, 26]

The design of the high-deductible plan and the characteristics of people enrolled could help explain the variable findings. For example, people who choose high-deductible plans tend to be in better health, younger, have higher incomes and be better educated.[27] But if a high-deductible plan is the only option, a wider range of employees are likely to participate, including those who may pass up needed care because of the cost.

Finally, there is concern that higher levels of cost-sharing could leave some people underinsured, meaning that they can't afford their out-of-pocket medical expenses, particularly in the event of an unexpected health issue. The percentage of underinsured Coloradans grew to 13.9 percent in 2013 from 12.8 percent in 2011.[28]

The Evidence: Bottom Line

Health care spending in the United States is dramatically skewed, with five percent of the population responsible for nearly half of expenditures.[29]

But this high-use population is the least likely to cut back on treatment, even with high-deductible plans, which could limit the impact of cost-sharing on total health care spending. This is likely because they reach their deductible quickly, and then have no financial incentive to avoid more expensive services. For this group, reference pricing may be a more effective tool to reduce spending.

Another Idea: Reference Pricing

Another model that counts on consumer involvement to help save costs - reference pricing – is gaining some traction.

An insurance company sets a "reference" price it believes is reasonable for a specific medical procedure – a knee replacement, for example. If a consumer chooses to have a procedure for which the provider's charge is more than that reference amount, the consumer must pay the difference.

In one test by the California Public Employees Retirement System (CalPERS), reference pricing saw the cost of hip and knee replacements decline by 19 percent. CalPERS permitted hospitals that allowed charges of no more than $30,000 for the procedures to join its plan. Those that didn't agree to limit the charge to $30,000 were excluded.[30]

Some potential problems may arise in implementation, however, including consumers who don't know how much the reference price is – or how much the hospital is charging. Critics also point to the arbitrary nature of choosing a reference price. Other experts, however, say that reference pricing is a policy worth exploring.

The Affordable Care Act and Cost-Sharing

The Affordable Care Act (ACA) addresses cost-sharing in a number of ways. The law requires:

- Preventive services, such as immunizations and screening tests, to be offered without charge.
- Insurers in the individual and small group markets to offer plans with actuarial values of at least 60 percent. (Actuarial value is the percentage of total average costs for covered benefits that a plan will pay. For example, if a plan has an actuarial value of 60 percent, on average, the consumer would be responsible for 40 percent of the costs of all covered benefits.) This average value makes it easier to compare cost-sharing between health insurance plans.
- A limit on annual out-of-pocket costs to $6,350 for individuals and $12,700 for families. The cap includes co-payments and deductibles, but it does not include premiums. Grandfathered plans are the only exception.
- Lower out-of-pocket limits for people with incomes at or below 400 percent of the federal poverty level (FPL), and cost-sharing subsidies for families with incomes at or below 250 FPL to protect them from high out-of-pocket costs.
- No lifetime limits on essential health benefits, the standard set of services that many insurance plans are required to cover under the ACA. In addition, most plans can no longer set a yearly dollar limit on essential health benefits. Grandfathered plans are the only exception.

Cost-Sharing in Public Insurance Programs

While public health insurance programs already use modest forms of cost-sharing, there's interest in whether additional cost-sharing could encourage more personal responsibility on behalf of enrollees and help to save taxpayer dollars.

Research on cost-sharing in public insurance programs, including Medicaid, the federal-state public insurance program for those with low incomes, has found:

- Enrollees with low incomes and significant health care needs may encounter barriers in getting necessary services, which can lead to worse health.[31]
- Providers often don't collect Medicaid co-payments because of difficult administrative requirements.[32]
- In many states, Medicaid cost-sharing is not enforceable, so providers can't refuse to treat Medicaid patients for failing to cover the co-pay. Changing that policy could help care providers collect co-payments.[33, 34]

When it comes to emergency department use, the findings are mixed on whether increased cost-sharing cuts down on non-urgent visits.[35] This may be because it most likely takes a while for Medicaid enrollees to find out co-pays have increased for an emergency department visit and then change their behavior.[36] This highlights the need for effective communication.

Federal regulations allow states to impose limited cost-sharing for most benefits in Medicaid, depending on an enrollee's income

level and the cost of the medical service.[37] Colorado lawmakers in 2012 had a spirited discussion but decided against raising Medicaid co-pays,[38] which generally range from $1 to $3 and cannot be charged for certain groups, including children and pregnant women.[39]

States may institute cost-sharing in the Child Health Plan Plus (CHP+) public insurance program for children and pregnant women. In Colorado, co-pays range from $1 to $50 depending on the service provided and family income. Out-of-pocket spending for members of a household enrolled in CHP+ is capped at five percent of family income.[40]

Conversations are ongoing at the federal level about how to reduce the cost of Medicare, the federal insurance program for seniors over the age of 65 and people with disabilities. Some policy suggestions focus on changes to cost-sharing, including increasing deductibles and using cost-sharing for home health services, the first 20 days of a skilled nursing facility stay and clinical lab services.[41]

Conclusion

Increasing the level of consumer cost-sharing is gaining popularity as one weapon in the battle against higher costs.

The evidence to date shows that cost-sharing can slow cost growth among healthy people, but that it is not as effective for unhealthy people. Heavy consumers of health care – those responsible for most medical spending – are unlikely to cut back on treatment, even with high-deductible plans. This may limit the impact of cost-sharing on total health care spending.

As the use of cost-sharing increases, education will be important to ensure that consumers don't pass up necessary care – especially preventive care that is covered by insurance. Helping consumers know when cost-sharing is required, and how much, will also help them make cost-effective choices about about when and where to access care.

Because there is limited research on the long-term effects of increased cost-sharing on the health of different demographic groups, it will be important to monitor the long-term consequences of cost-sharing on health.

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