

# *A Temporary Fix? Implications of the Move Away From Comprehensive Health Benefits*

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*Issue Brief*

- This *Issue Brief* explores one of the potential consequences of the return to double-digit health cost inflation: a movement away from comprehensive health care coverage and the degradation of the health insurance risk pools necessary to maintain such coverage. There is growing concern in the health policy community about attempts to “control” health care costs through the temporary fix of demand-side mechanisms (i.e., enrollee cost-sharing) and abandonment of supply-side, or provider-side, mechanisms (i.e., traditional managed care tools). In particular, there is concern about the impact of these changes on the 125 million Americans with chronic illnesses for whom comprehensive health insurance is essential.
- Insurers and health plan purchasers tend to use three primary means of reducing or moderating premiums: 1) implementing enrollee cost-sharing; 2) excluding or limiting coverage for certain types of procedures, conditions, and providers; and 3) using selective provider networks and managed care approaches pioneered by health maintenance organizations (HMOs). The *Issue Brief* examines the first two approaches; the third does not seem to be where most health plans are heading.
- Actuaries generally concur that significant premium savings cannot be achieved through minor cost-sharing increases. To have a large impact on premiums, a health plan must introduce or increase deductibles and coinsurance. To explore the variation in cost-sharing arrangements available in California’s small-group market, the authors searched an on-line insurance quote Web site to determine what plans would be offered to a fictitious small employer. There was a striking amount of variation among the plans and premiums offered.
- A pressing question related to proliferation of less comprehensive coverage is how such plans will impact enrollees’ use of services and, ultimately, their health status. The RAND Health Insurance Experiment provides insight into these questions, revealing that significant cost-sharing does substantially reduce both appropriate and inappropriate utilization of all types of health services.
- It is likely that trends toward higher cost-sharing and/or reduced benefits will continue. While it is unclear what impact these trends will have on health status, they are likely to have important effects on insurance market dynamics, such as: a shift from supply-side to demand-side means of cost-containment; the disappearance of comprehensive coverage; and a return to the “single plan replacement” model of employer-carrier contracting, with its attendant impacts on competition among plans and providers.

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## Introduction

Throughout its evolution, American health insurance has been viewed at different times and by different parties as either a service benefit or a financial benefit.<sup>1</sup> After World War II, large employers, particularly those with union contracts, tended to offer more service-oriented plans (often BlueCross BlueShield plans), with carriers paying providers directly for necessary care. For other employers, health insurance was primarily a financial tool, designed to reimburse individuals for unforeseen medical expenses. In the 1970s, health benefit plans became increasingly generous due to efforts by employers to differentiate their programs based on the range of covered benefits and modest levels of employee cost-sharing. Since the rise of managed care, initially championed by employers in the 1980s to stem rising costs, health insurance has again come to be viewed more as a service benefit, rather than a financial one.

Instead of reimbursing patients for care “after the fact,” managed care exerted influence over care “before the fact,” by stressing prevention, early intervention, and care coordination. As a result, many consumers now think of their health insurance policy as a promise to provide all necessary care with “first-dollar” (no deductible) coverage, not merely a promise to reimburse them for large, unexpected expenses. However, with health care costs and premiums again on the rise, many employers and individuals are finding that comprehensive first-dollar coverage is becoming unaffordable.

The average premium increase for all types of health plans was 11.0 percent between 2000 and 2001, compared with 4.8 percent between 1998 and 1999.<sup>2</sup> Small businesses, those with three to 199 workers, were harder hit, with premium increases of 12.5 percent between 2000 and 2001. Much of the recent increase in private health insurance premiums is due to increased

spending on inpatient and outpatient hospital care (47 percent of the overall spending increase in 2000) and on pharmaceuticals (27 percent of the overall increase in 2000).<sup>3</sup> The underwriting cycle has also played a part in recent premium increases.<sup>4</sup>

Many industry observers believe there is a growing demand in the market for more affordable, less comprehensive benefit plans that share features with the traditional indemnity (or financial benefit) plans that were commonplace 30 years ago. For example:

- BlueCross of California offers individual and small-group plans that provide coverage only for preventive and catastrophic care, while the consumer pays for all other care out of pocket.
- Providence Health Plan, Oregon’s second-largest health maintenance organization (HMO), offers plans that feature copays for primary care but require coinsurance of 20 percent to 30 percent on specialist visits. In addition, there is no primary care gatekeeper for specialist care. Employers can choose to offer these plans with deductibles ranging from \$250 to \$1,000.<sup>5</sup>

In addition to implementing significant cost-sharing, insurers may respond to market demand for lower premiums by excluding coverage of new drugs and technologies that are deemed lifestyle-enhancing, rather than life-saving (although many new drugs and technologies fall between these extremes).<sup>6</sup> Due to their cost-increasing effects, advances in biotechnology complicate the debate over which health care services are critical enough that their costs should be shared by society (through the mechanism of insurance) rather than borne only by the users of care.

It is not clear whether purchaser demand for less costly/less comprehensive coverage will become significant in the group markets,<sup>7</sup> although anecdotal evidence from health plans and brokers suggests that it will. Like the emerging concept of defined contribution health care,<sup>8</sup> less-comprehensive coverage may be a cost-

*Some health policy experts advocate the proliferation of less-comprehensive coverage as the only hope of ensuring access to health care for all Americans, or, at the very least, preventing further increases in the uninsured population.*

control strategy that employers would like to, but have been unable to, adopt in a tight labor market. However, unemployment has been steadily rising during the current economic recession.<sup>9</sup> The softening economy and rising premiums may force employers to modify their health benefits programs by shifting more costs onto employees.

This could be done in several ways, such as through defined contribution health plans, by adopting higher cost-sharing plans, or by structuring benefit plans that exclude new, high-cost technologies when possible.

Proliferation of e-commerce technologies that enable “consumer-directed health care” may accelerate these trends. An expert panel convened by the Center for Studying Health System Change discussed the likelihood of employers switching to defined contribution arrangements and the insurance supply-side changes that would be needed to accommodate such a shift.<sup>10</sup> The panel featured speakers from three Internet firms that allow individuals to design their own health plans by choosing providers and different levels of cost-sharing. Over time, such plans may create competition for more traditional, comprehensive care plans.

Some health policy experts advocate the proliferation of less-comprehensive coverage as the only hope of ensuring access to health care for all Americans, or, at the very least, preventing further increases in the uninsured population. In 2000, among the 38.5 million nonelderly uninsured in the United States, 63.1 percent were in families in which the head of the household was employed full-time for the full year.<sup>11</sup> In addition, in 2001, 65 percent of small firms (three to 199 workers) and 99 percent of larger firms (200+ workers) offered some type of health benefits.<sup>12</sup> Taken together, these data suggest that many of the working uninsured are without insurance because they can’t afford it or don’t want or value it, not because it is not offered to them. A study by the Center for Studying Health System Change found that among uninsured workers who were offered

an employment-based plan, two-thirds said they did not enroll in the plan because it was too expensive (not because they didn’t need it, etc.).<sup>13</sup> Among low-income uninsured workers who were offered employment-based coverage, three-fourths cited cost as their primary reason for declining coverage. These

findings raise the question of whether more people would purchase insurance if less comprehensive, more affordable coverage were available.

While it is not certain that more people would buy insurance if it were less expensive, some research suggests this would be the case. Based on an analysis of national data sources, including the U.S. Census Bureau’s Current Population Survey March Supplements and the National Health Accounts, Kronick and Gilmore of the University of California determined that the decline in health insurance from 1979 to 1995 can be accounted for almost entirely by the fact that per capita health care spending (including insurance premiums) rose much more rapidly than personal income during the same period.<sup>14</sup> Kronick and Gilmore estimated that reductions in spending growth would create measurable increases in health insurance coverage for low-income workers in the future.

In 2001, several states debated the issue of affordability by introducing legislation to exempt small-group insurers from state health benefit mandates in certain circumstances. The Colorado and Georgia legislatures developed bills that would have allowed small employers and insurers to mutually agree to exclude mandated benefits from coverage. Neither bill was passed. A bill introduced in the Oregon legislature would have redefined the small-group guarantee-issue plan to eliminate coverage for most previously mandated benefits. The goal of this legislation was to reduce the cost of coverage. The bill was defeated, largely because it failed to address mental health parity issues. It is likely that a similar measure will be introduced in the next

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legislative session.<sup>15</sup>

While policymakers proposing such legislation were primarily focused on premium cost reduction, the question raised by the legislation is this: Do Americans prefer to provide *some* people access to comprehensive insurance while others have none, or would we rather *everyone* have access to less comprehensive coverage? What level of coverage is truly optimal? The most comprehensive coverage isn't necessarily optimal because it induces demand for some care that may not be effective. Given both rising health care costs and a boom in medical technology, can Americans determine a level of coverage that is "appropriate" or adequate, even if it is not optimal?

One view is that the appropriate level of coverage is whatever the market demands. An alternate view is that notions of appropriateness should vary depending on what one sees as the primary objective(s) of health coverage (e.g., maintaining and improving health, sharing the cost of core services, financial protection of enrollees, etc.). In the face of changing consumer demands and steeply rising health care costs, health plans, providers, employers, and others may need to re-examine standards for determining the appropriateness of benefit design.

This report provides an overview of available research and issues that might be considered in light of current market trends toward higher consumer cost-sharing and less comprehensive coverage. It draws heavily from the insights gleaned from an expert roundtable discussion, "Connecting Public Policy to Health Benefit Design," sponsored in 2001 by *Health Affairs* and the Kaiser Permanente Institute for Health Policy.<sup>16</sup> The meeting was partially supported by the Robert Wood Johnson Foundation.

This report begins with a review of the evidence regarding a trend toward increased cost-sharing and/or reduced benefits. This is followed by a description of how insurers use these mechanisms to contain costs and an analysis of the most common plan types currently available in Northern California's small-group market.

The following section presents information on the effects of cost-sharing and exclusions on utilization of services. The next section provides an analysis of the policy implications of the current trends. The report concludes by outlining potential policy interventions to address some of the concerns raised by current trends, focusing on delivery system reforms and the proper scope of coverage in light of technological and scientific advances.

## *Is There a Trend Away From Comprehensive Coverage?*

Is there, in fact, a trend toward greater employee cost-sharing or reduced benefits? The evidence is mixed. Studies and surveys reporting on 2000 data do not tend to pick up such a trend yet. However, more recent opinion surveys suggest a shift may be under way.

In a review of various employer and household surveys conducted for the Kaiser Permanente Institute for Health Policy, Paul Fronstin found a modest increase in employee cost-sharing at the point of service, but none in regard to premium. Among his findings:<sup>17</sup>

- **As of 2000, employers had not started to shift premium cost increases onto employees by decreasing the employer share of premium.** One data source indicates that the employee share of premium has remained unchanged between 1993 and 2000, while a second source indicates that it has actually decreased slightly (as a percentage of the premium).
- **Deductible levels do appear to be increasing, although some of the increase may be due to inflation.** For example, the use of a \$500 or higher

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deductible in a preferred provider organization (PPO) increased from 5 percent of surveyed employers in 1994 to 22 percent in 2000.

- **Coinsurance rates for inpatient care have been increasing between 1994 and 2000**, meaning employees have been asked to pay a greater share of the cost of inpatient services.<sup>18</sup>
- **Use of incentives for employees to use less costly pharmaceuticals has been increasing.** Between 1998 and 2000, for every type of health plan, the percentage of employers allowing lower co-payments for generic drugs increased, as did the percentage allowing lower co-payments for use of mail-order service.

In another paper commissioned by the Kaiser Permanente Institute for Health Policy, Paul Ginsburg reported on evidence of cost-sharing and benefit trends based on site visits to 12 communities that are part of the Community Tracking Study of the Center for Studying Health System Change.<sup>19</sup> Ginsburg found a number of striking changes that may have implications for cost and therefore cost-sharing in the future, such as: increased use of direct-access plans (where no referral is required for a specialist visit); reduced premium differentials between PPOs and HMOs; reduced use of pre-authorization; and decreased network stability.<sup>20</sup> He did not yet see major changes in health benefit design but predicts that, given the observed general weakening of managed care, cost-sharing will increase. He particularly notes that a likely development will be “tiered” cost-sharing structures for major benefits, with different levels of copays for different providers, based on a number of criteria.

While the 2000 and early 2001 survey data do not show a clear trend, other data sources provide more persuasive evidence. Opinion surveys asking employers and human resource managers to project into 2002 suggest there will soon be a shift in the balance of financial responsibility for health care services. For example:

- A recent survey by Watson Wyatt Worldwide found that employers expect health care premiums to increase by 13.6 percent from 2001 to 2002. As a result, 71 percent of employers are likely or somewhat likely to reduce benefits or increase copays in the next 12 months (the survey was based on responses from 200 companies covering 1.4 million employees).<sup>21</sup>
- In a Harris Interactive survey of 304 corporate human resource officers, 70 percent of respondents said they will increase the amount of employee cost-sharing in the next two years.<sup>22</sup>
- Employer benefits consulting firm Hewitt Associates estimates that employers will see average premium increases of 13 percent to 16 percent in 2002, up from an average increase of 10.2 percent in 2001. The largest increases (18 percent) will be associated with premiums for HMOs. Hewitt’s analysis predicts that many employers will pass along at least 25 percent to 30 percent of that rate increase to employees. Other anticipated employer reactions include cost-sharing increases and prescription drug plan design changes.<sup>23</sup>

It should be noted that employers do not always do what they predict they will do. Other pressures may prevent employers that would like to increase cost-sharing from actually doing so. However, with this caveat, and based on the above evidence, it is fair to say that a trend away from comprehensive, low cost-sharing coverage is beginning and is likely to accelerate in the near future.

## *Means of Reducing Premium*

Insurers and purchasers tend to use three primary means of reducing or moderating premiums:

- 1) Implementing enrollee cost-sharing.

*To have a larger impact on premiums, deductibles and coinsurance would need to be introduced and/or out-of-pocket spending maximums would need to be eliminated.*

- 2) Excluding or limiting coverage for certain types of procedures, conditions, and providers.
- 3) Using selective provider networks and managed care approaches pioneered by HMOs.

This section examines the first two of these approaches; the third does not seem to be the direction in which many health plans, with the exception of certain HMOs, are heading.<sup>24</sup>

## Enrollee Cost-Sharing

Actuaries generally concur that major premium reductions cannot be achieved through minor cost-sharing increases. Kaiser Permanente's own pricing practices reflect this fact: If a \$10 office visit copay is doubled to \$20, all other aspects of the plan being equal, the premium is reduced only 8 percent.<sup>25</sup> A recent employer survey shows that the average monthly premium for HMO coverage in the United States in 2001 was \$200 for single coverage and \$545 for family coverage.<sup>26</sup> For a low-income employee, 8 percent premium savings on such a base are small—\$16 per month for single coverage, and \$44 per month for family coverage—perhaps too small to induce such an employee to take up coverage when it is offered.

To have a larger impact on premiums, deductibles and coinsurance would need to be introduced and/or out-of-pocket spending maximums would need to be eliminated. For example, according to research commissioned by the Kaiser Permanente Institute for Health Policy:<sup>27</sup>

- Premium savings of 22 percent to 44 percent could be achieved by moving from an HMO-like cost-sharing structure (with \$15 office visits and no deductible) to various plan designs with coinsurance ranging from 20 percent to 30 percent and deductibles ranging from \$250 to \$1,000.
- Elimination of maximum out-of-pocket spending

limits can have the effect of reducing premiums by anywhere from 5 percent to 32 percent, depending on the level of coinsurance and deductible (the effect is smallest for plans with lower levels of coinsurance and deductibles).

Cost-sharing schemes are essentially risk-sharing arrangements that can be arrayed along a continuum. At the higher-premium end of the continuum there is comprehensive coverage, under which the enrollee bears almost no financial risk for his own utilization, while the insurer bears full risk. At the lower-premium end of the continuum, the enrollee bears a significant portion of the risk, while the insurer bears comparatively little. Employers and employees choose coverage along this continuum based on their willingness to tolerate risk, their own knowledge about how much care they will likely use, their ability and willingness to pay, and, for employers, their values regarding what level of coverage "should" be provided.

With increasing premiums and increased consumer desire for choice in many sectors of the economy, industry observers and employers are calling for more variation in health plan offerings to accommodate different values, financial circumstances, and preferences for risk. Comprehensive HMO coverage is still fairly popular. In 2001, 23 percent of covered workers in the United States were enrolled in an HMO.<sup>28</sup> However, while HMO growth has declined in the last few years (from 31 percent of covered workers in 1996), PPO enrollment is increasing. In 1996, 28 percent of covered workers were enrolled in a PPO, compared with 48 percent in 2001.

While some stakeholders are considering moving away from managed care, others believe that the comprehensive HMO model is not only the most efficient but that it provides the most appropriate and "fair" level of coverage by removing most financial barriers to necessary care. While this may be true, it is also true that comprehensive coverage is expensive; even when employ-

*With these hybrid plan designs, insurance carriers are responding to a need in the small-group market for plans that are less expensive but that provide more protection and less uncertainty for primary and preventive care than do catastrophic plans.*

ers offer it, many employees are unable to afford their share of the premium. In addition, some believe that the comprehensive HMO model may be less efficient than is desirable precisely because it removes many financial barriers to care, thereby making consumers indifferent to the costs of care they demand (this is of special concern in the current age of direct-to-consumer drug advertising). As a result, there is a growing interest in less-comprehensive products with higher cost-sharing and lower premiums.

To explore the variation in cost-sharing arrangements available in California's small-group market today, the authors searched the Web site [www.ehealthinsurance.com](http://www.ehealthinsurance.com) (an online service to compare and buy health insurance) to determine what plans would be available to a fictitious San Francisco small employer that had four workers of varying ages and a total of four dependents (two children and two spouses).

In January 2002, the following insurers and managed care plans made products available for small employers through the site: HealthNet, BlueShield of California, Kaiser Permanente, PacifiCare, and BlueCross of California. Of these insurers, Kaiser and PacifiCare were the only two that did not offer a variety of cost-sharing options. (Kaiser offered only traditional HMOs, some with point-of-service (POS) options, with cost-sharing ranging from \$5 office visit copays to \$30, and no deductibles. PacifiCare offered traditional HMOs as well, but also offered one PPO with coinsurance and a deductible.) The other three carriers offered a number of plans that fell all along the continuum, from the insurer bearing most of the risk (comprehensive coverage) to the enrollee bearing most of the risk (noncomprehensive or "catastrophic" coverage).

For example, on the least comprehensive side, BlueCross of California offered a \$1,000 deductible plan with no coverage for office visits and 20 percent coinsurance on in-network providers and 50 percent (of

approved fees) on out-of-network providers. For the fictitious group, the total cost of this plan would be approximately \$554 per month.<sup>29</sup> Toward the other end of the continuum, Blue Cross offered an HMO with \$10 office visit copays, no charges for outpatient surgery or hospital stays, and no deductible. This plan would cost the group

approximately \$1,899 per month.

Between these extreme plan designs, there was a surprising variety of offerings. Figure 1 lists a sample of the 35 plans available to the group on this Web site. The plans are listed (roughly) from least comprehensive to most comprehensive. Several of these plans blur the line between what is traditionally considered an HMO versus a PPO. For example:

- **The HealthNet Saver PPO** is one of the least comprehensive plans, but it does include some features that distinguish it from a simple, high-deductible catastrophic plan. Although there is a deductible (\$500) and coinsurance (20 percent/50 percent), there is a \$20 copay for office visits, limited to two per year per adult and four per year per child.
- **The BlueCross \$40 PPO**, also one of the less comprehensive plans, has several PPO features, including a \$250 deductible and high coinsurance—40 percent in-network and 50 percent out-of-network. However, the plan also includes \$40 office visits (limited to 12 per year), an HMO-like feature.
- **The BlueCross Saver HMO** is also a hybrid. It includes the PPO-like feature of a large deductible—\$1,500—but office visits have only a \$10 copay and are unlimited, and there is no cost-sharing on hospitalization after the deductible is met.

With these hybrid plan designs, insurance carriers are responding to a need in the small-group market for plans that are less expensive but that provide

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more protection and less uncertainty for primary and preventive care than do catastrophic plans. By including low and predictable office visit copays and high deductibles, these plans pay for preventive care and catastrophic care, leaving the enrollee to pay out-of-pocket for most of the care in between these extremes.

## Exclusion of Coverage for Certain Conditions, Procedures, and/or Providers

In theory, a second major tool health plans could use to reduce premiums is the exclusion of coverage for certain conditions, procedures, and/or providers. For example, a small group might wish to save money by buying a plan with no mental health coverage.

Research commissioned by the Kaiser Permanente Institute for Health Policy indicates that employers could achieve up to a 13.9 percent premium savings by scaling back coverage of certain benefits, including mental health and substance abuse care, preventive care, prescription drugs, durable medical equipment, hearing and vision care, and care exceeding \$100,000 in health plan costs per year.<sup>30</sup> Savings of up to 21.5 percent could be achieved by eliminating coverage for these services. (Compare this to savings of 5 percent to 44 percent available from modifying cost-sharing in various ways—see page 7.) However, insurers are constrained in their ability to exclude certain types of coverage due to state benefit mandates. For the moment, this discussion puts aside the question of whether such exclusion of coverage is desirable and/or ethical and focuses on its feasibility as a cost-containment mechanism.

States have the authority to regulate health insurance and managed care companies, and virtually all states impose benefit mandates. Health mandates differ by state and are the result of a political process. For the most part, mandates are created through pressure applied by special interest groups or by the public's

response to anecdotes and news stories (e.g., all states now mandate a minimum 48-hour maternity stay as a result of public outrage over “drive-through deliveries”).

Mandates are normally created on a case-by-case basis, rather than through a process of prioritization, carefully balancing the merits of certain types of coverage relative to other types.<sup>31</sup> As a result, mandates do not necessarily require coverage of the benefits determined, through cost-effectiveness analysis, to be of the most value *relative to other benefits*. Instead, they cover benefits deemed to be of value in a comparative vacuum. As each mandate may increase the health insurance premium, it seems incumbent upon state legislatures to perform a rational analysis to determine what truly must be covered by a society with limited financial resources.<sup>32</sup> This issue becomes more pressing as medical science expands the scope of conditions that can be treated and cured.

Due to benefit mandates and the resulting lack of flexibility in benefit design, many large employers choose to self-insure. Under the federal Employee Retirement Income Security Act (ERISA) of 1974, private-sector employee health plans are subject to state regulation only when they are fully insured (in this case, it is the insurer that is regulated, not the employer). However, small employers are generally unable to self-insure and so must contract with state-regulated insurers.

Rather than (or, in addition to) seeking exceptions from state benefit mandates, insurers can also moderate premiums by providing less or no coverage for new technologies, experimental procedures, and “lifestyle” interventions, such as Viagra.<sup>33</sup> Some new technologies, such as organ transplants and bone marrow transplants for some medical conditions, can be life-saving. Others, such as photorefractive keratectomy for corrected vision, are lifestyle enhancing. Most new technologies fall between these extremes and are designed to prevent, diagnose, or treat medical conditions that may not be life-threatening but do detract from quality of life. The debate about whether and how such

**SAMPLE OF SMALL-GROUP HEALTH PLANS AVAILABLE IN SAN FRANCISCO, CA (1/21/02)**

Figure 1

Name of Plan	Deductible	Coinsurance (in/ out-of-network) <sup>a</sup>	Office Visit	Inpatient Care	Rx Coverage	Out-of-Pocket Maximum	Estimated Monthly Premium for Group <sup>b</sup>
Blue Cross Basic PPO <sup>c</sup>	\$1,000 per member (two-member maximum).	20%/50%	Not covered.	Subject to deductible and coinsurance.	In-network: \$10 generic; \$25 brand. Out-of-network: 50% of fee schedule plus 100% of excess charges.	Deductible, plus \$2,000 per member (two-member maximum).	\$554
HealthNet PPO Saver PPO	\$500 per member.	20%/50%	In-network: \$20. Out-of-network: 50% (limited to two visits per adult, four per child).	Subject to deductible and coinsurance; no out-of-network coverage.	Subject to coinsurance; \$500 annual maximum.	\$2,500 per member.	\$820
BlueCross \$40 Copay PPO	\$250 per member (two-member maximum; does not apply to office visits).	40%/50%	In-network: First 12 visits per year—\$40; 50% of negotiated fee for visits after that. Out-of-network: 50% of negotiated fee plus 100% of excess charges.	Subject to deductible and coinsurance.	\$150 deductible for brand; \$15 generic; \$25 brand.	In-network: \$4,500 per member (two-member maximum). Out-of-network: once BlueCross payments reach \$10,000, member pays nothing for remainder of year.	\$1,262
BlueShield 80/50 Plan PPO	\$1,000 per member, \$2,000 per family.	20%/50%	In-network: \$45. Out-of-network: 50%.	Subject to deductible and coinsurance.	In-network: \$10 generic; \$25 formulary brand; \$35 nonformulary brand. Out-of-network: same as in-network, plus 25% of allowed amount. Annual \$250 deductible for all brands.	In-network: \$4,000 per member; \$8,000 per family. Out-of-network: \$10,000 per member; \$20,000 per family.	\$1,494
BlueCross Saver HMO	\$1,500 per member (does not apply to office visits).	None.	\$10 copay (not subject to deductible).	Subject to deductible.	\$150 deductible for brand; \$10 generic; \$20 brand.	\$2,250 per member; \$4,500 per family.	\$1,497
PacificCare Premier 20 HMO	None.	20% (no out-of- network benefits available).	\$20.	Subject to coinsurance.	\$10 generic; \$25 formulary brand; \$35 nonformulary brand.	\$3,000 per member; \$5,000 per family.	\$1,538

(continued)

Figure 1. (continued)

Name of Plan	Deductible	Coinsurance (in/ out-of-network) <sup>a</sup>	Office Visit	Inpatient Care	Rx Coverage	Out-of-Pocket Maximum	Estimated Monthly Premium for Group <sup>b</sup>
Blue Cross 100% HMO	None.	None (no out-of-network benefits available).	\$10.	No charge.	\$150 deductible; \$10 generic; \$20 brand.	\$1,750 per member; \$3,500 per family.	\$1,899
BlueCross Premier No Deductible \$20 Copay PPO	None.	20%/40%	In-network: \$20 for first 12 visits; 40% after that. Out-of-network: 40% of reasonable and customary plus 100% of excess charges.	Subject to coinsurance and deductible.	\$10 generic; \$20 brand.	\$2,500 per member (two-member maximum).	\$1,912
BlueShield 90/70 Plan PPO	In network: None. Out-of-network: \$500 per member; \$1,000 per family.	10%/30%	In-network: \$10. Out-of-network: 30%.	Subject to coinsurance and deductible.	In-network: \$15 generic; \$15 formulary brand; \$30 nonformulary brand. Out-of-network: same as in-network, plus 25% of allowed amount.	In-network: \$2,000 per member, \$4,000 per family. Out-of-network: \$5,000 per member; \$10,000 per family.	\$2,578
Kaiser Permanente Plan 20-N HMO	None.	None (no out-of-network benefits available).	\$20	No charge.	\$10 generic formulary; \$25 brand formulary.	\$1,500 per member; \$3,000 per family.	\$1,316
Kaiser Permanente Plan 5-N HMO	None.	None (no out-of-network benefits available).	\$5	No charge.	\$5 generic formulary; \$15 brand formulary.	\$1,500 per member; \$3,000 per family.	\$1,689

Source: [www.ehealthinsurance.com](http://www.ehealthinsurance.com)

<sup>a</sup>Out-of-network coinsurance is generally expressed as a percentage of approved fees, not as a percentage of billed charges.

<sup>b</sup>Estimated premiums are the total monthly premiums for all four employees and four dependents.

<sup>c</sup>Preferred provider organization.

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technologies should be covered by insurance is heightened by increasing cost pressure and employer concern.

## *Effects of Cost-Sharing and Exclusion of Benefits on Utilization and Health Status*

One of the most pressing questions related to the proliferation of less comprehensive coverage is how such plans will affect enrollees' use of services and, ultimately, their health status. For example, would elimination of coverage for preventive care result in enrollees forgoing such care? What would be the impact on enrollee utilization of a benefit plan that fully covered preventive and catastrophic care but imposed significant coinsurance on mid-level care recommended as a result of preventive screenings?

There has been a significant amount of research on the effect of cost-sharing on utilization but somewhat less on its effect on health status. Most of this research has focused on fairly minor cost-sharing differences among plans. For example, in 1989, in an unpublished synthesis of several natural experiments within their own membership, Kaiser Permanente and Group Health Cooperative of Puget Sound researchers found about a 10 percent reduction in utilization when office visit copays were increased from \$0–\$2 to \$5. The Permanente Medical Group conducted research on the effect of implementing emergency room copays, finding a 14.5 percent reduction in emergency room use among patients whose copay was raised to from \$0 to \$25 or \$35.<sup>34</sup> There was no corresponding increase in use of other services, such as urgent or outpatient care.

There has been little published research compar-

ing utilization under plans with very different cost-sharing structures, such as a flat-dollar copay HMO versus a \$500 or \$1,000 deductible PPO. This section summarizes findings from the relevant research. Studies reviewed include the RAND Health Insurance Experiment, Oregon Health Plan research on the effects of the prioritized list on utilization, and a review of research on utilization and health status of the uninsured.

### The RAND Health Insurance Experiment

The RAND Health Insurance Experiment was conducted from 1974 through 1982 in six geographic regions of the United States. Utilization rates were studied for people randomly assigned to different coinsurance plans. One group was assigned to a free-care plan in which there was no cost-sharing. Others were assigned to plans in which they paid 25 percent or 50 percent of all health care costs up to an income-related maximum of 5 percent to 15 percent of family income, or \$1,000, whichever came first. (Note that in the early 1970s, \$1,000 was a much more significant maximum than it would be today.) Some families were assigned to what was considered a “catastrophic” plan, in which enrollees paid 95 percent of all health care costs, up to an income-related maximum or \$1,000.

For purposes of this report, the relevant utilization comparisons are between plans similar to traditional, comprehensive HMO coverage (with low, flat-dollar copays) and plans similar to PPOs (with no or little coverage before a deductible is paid). In the RAND experiment, the plans that come closest to these structures are the free-care plan and the 95 percent coinsurance plan.

The main questions this work seeks to answer are:

1. Does significant cost-sharing on most routine, preventive, and chronic care (such as is found under a modern-day PPO with a high deductible) greatly impact utilization of these important services? Is there a differential impact on low-income populations?

2. Does such cost-sharing differentially impact unnecessary/ineffective care versus necessary/effective care?
3. What, if any, impact does significant cost-sharing have on health status?

In general, the RAND experiment, whose findings are described in a number of publications, reveals that ***significant cost-sharing does substantially impact utilization of all types of services, and that the impact on a range of care, from preventive to trauma-related, is fairly consistent. The utilization impact on the poor is greater than the impact on the nonpoor. Findings related to health status are inconsistent.***

Specific findings include:

- **Use of coinsurance significantly reduces all types of utilization. The differential impact on the poor, particularly poor children, is greater than the impact on the nonpoor.**<sup>35</sup>
  - On average, adults enrolled in all cost-sharing plans made about two-thirds as many outpatient visits and were hospitalized two-thirds as many times as those receiving free care.<sup>36</sup>
  - Free care caused expenditures to increase nearly 50 percent (across all types of care) over the 95 percent cost-sharing plan. All evidence indicates that this difference was due to utilization, not price of services. (Price per person among hospitalized individuals did not differ among plans with different coinsurance.)<sup>37</sup>
  - Compared with individuals on the free care plan, those with cost-sharing had about 34 percent fewer episodes of acute care, 25 percent fewer episodes of foreseeable chronic care, and 23 percent fewer episodes of well care.<sup>38</sup> Raising cost sharing also lowered the demand for ambulatory mental health care (cut by 50 percent) and emergency room care, especially for less urgent problems.<sup>39</sup>
  - Across all drug categories studied and among all adults, cost-sharing reduced the probability of

having any use of pharmacy by as much as 50 percent. Primarily, this was due to decreased likelihood of seeking any kind of care.<sup>40</sup>

- Cost-sharing had no measurable effect on care seeking for any diagnosis among nonpoor children, but it deterred use for one-quarter of diagnostic groups for poor children. The effect of cost-sharing on adults was somewhere between the values for poor and nonpoor children.<sup>41</sup>
- **Cost-sharing is a blunt instrument: It does not selectively reduce inappropriate/ ineffective utilization versus appropriate/effective utilization.**
  - Cost-sharing did not selectively reduce inappropriate hospital utilization.<sup>42</sup>
  - On average, there was no differential impact on care-seeking for diagnoses for which medical care was deemed to be very effective (e.g., major trauma) versus not effective (e.g., common cold).<sup>43</sup> However, both poor and nonpoor children saw a differential impact (larger) on care seeking for the “rarely effective” category, in contrast to the “highly effective/acute conditions” category. The differential was greater for nonpoor children.
  - Cost-sharing had equivalent effects in curtailing use of highly effective care (e.g., care for strep throat, pneumonia, and fractures) and only rarely effective care (e.g., care for viral influenza, fever, or sprains and strains).<sup>44</sup>
  - **There is no clear pattern of impact of cost-sharing on health status.**
    - For persons with poor vision and for low-income persons with high blood pressure, free care bought some, but not significant, improvement. For the average participant and for subgroups differing by income and initial health status, there were no significant effects on health as measured by eight variables during the three-year course of the study.<sup>45</sup> (It is unknown whether there were longer-term health impacts.)
    - Enrollment in a more generous plan, resulting in

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- an average of one to two more encounters per year for several years, had no impact on smoking, weight, or cholesterol levels.<sup>46</sup>
- Free care had no effect on five general self-assessed measures of health status.<sup>47</sup>
  - Despite observed impacts on utilization, few adverse health effects of cost-sharing were detected.<sup>48</sup>

While these results are useful, they are dated and do not accurately predict what would happen today if significant cost-sharing or deductibles were imposed by managed care plans. All the plans in this portion of the RAND experiment were traditional fee-for-service plans.<sup>49</sup> Under this type of plan, financial incentives are the only means of managing utilization. In contrast, under both HMOs and some PPOs, there are other mechanisms to manage care. For example, if Kaiser Permanente were to implement a \$250 deductible, it is not known whether this cost-sharing requirement would deter preventive care as it did in the RAND experiment, or whether Kaiser's other efforts—such as patient education about the importance of preventive care—would mitigate this effect.

## Oregon Health Plan Research on the Effects of the Prioritized List on Utilization

Analysis of the Oregon Health Plan (the state's Medicaid program) provides some insight into the effects of benefit exclusions on utilization and health status. While the Oregon Health Plan does not impose large cost-sharing burdens *per se*, it does altogether exclude certain types of treatments, *de facto* imposing 100 percent enrollee cost-sharing on them. For these treatments, it is as if the Oregon Health Plan has a large deductible. As a result, the experience of the Oregon Health Plan may shed some light on the impacts of major benefit exclusions and large deductibles.

In 1993, the state of Oregon obtained a waiver from the federal government to expand its Medicaid program to include individuals with incomes up to 100 percent of the federal poverty level (FPL). Previously, the income eligibility threshold was under 54 percent of the FPL. As did many states, Oregon proposed to finance this expansion by mandating that most Medicaid recipients join managed care plans. Oregon took cost containment one step further by creating a prioritized list of health services that would be covered under the new Medicaid program—the “Oregon Health Plan.” The prioritized list consists of paired conditions and treatments that are ranked hierarchically from most- to least-medically necessary.<sup>50</sup> Based on budget constraints, the state determined a line below which condition/treatment pairs would not be covered. The line was initially set at 578 out of a total of 744 condition/treatment pairs.

One of the results of this work was that certain services that had been covered under the state's previous Medicaid program, which provided all “medically necessary” care, were no longer covered. Examples include treatment for colds, hernia repairs, and allergy testing. Other services, such as dental care and adult preventive care, were newly covered under the prioritized list.

The Oregon Health Plan is an example of cost savings achieved through the exclusion of coverage for specific procedures and conditions. Savings from the prioritized list and from mandated managed care allowed the Oregon Health Plan to expand coverage to 100,000 previously uninsured individuals. However, the question remains: How did elimination of specific coverages impact utilization of those services, and what was the impact on health status?

There has been only preliminary work on this subject. Mitchell and Bentley surveyed a representative sample of adult, nondisabled Oregon Health Plan members, asking whether they had ever been denied a service under the plan, what that service was, and how they would rate the effect of that denial on their health

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status.<sup>51</sup> They found the following:

- About one-third of respondents (31.3 percent) reported they had needed a service that the plan would not cover. Based on further questioning, Mitchell and Bentley determined that only 38 percent of those denials were because the service was “below the line” on the prioritized list (the majority of denials were due to inappropriate use of managed care, such as visiting a specialist without a referral). They estimated that 12 percent of all Oregon Health Plan members were denied a service because it was below the line.
- The most frequently denied below-the-line services were hernia repair, chiropractic treatment, dental splints, and newborn circumcision.
- About half of those denied a service because it was below the line received the service anyway, mostly paying out-of-pocket.
- Of those unsuccessful in receiving a denied service, 60 percent reported that their health had worsened as a result, but there was no causal evidence to tie health status to denial of a specific service.

More work is needed to determine the impact of the Oregon Health Plan prioritized list on utilization and health status. Oregon’s experience suggests it may be possible to eliminate or pare down benefits and save money while having few adverse effects on health. While Oregon used only the criterion of “effectiveness in improving health,” the cost savings of such a strategy would be maximized if services that are denied are those that are both expensive (or frequently used) and of marginal medical value.

## Utilization and Health Status of the Uninsured

A third body of evidence, one that compares the insured to the uninsured, can be considered when examining the impact of cost-sharing on utilization and health status.

Utilization patterns of the uninsured may provide some insight into utilization patterns (and therefore health status) of the underinsured, or those who are effectively uninsured, for most routine and acute care due to a large deductible. This analysis does not suggest that the *uninsured* can be used as a proxy for the *underinsured* because there are clearly a number of other confounding factors, such as income, education, etc. However, for purposes of discussion, it may be useful to understand the experience of the uninsured.

In a recent article, Ayanian et al. summarized the literature on differences in utilization and health status between the insured and uninsured.<sup>52</sup> They report:

“Prior studies have documented that lacking health insurance is associated with important clinical consequences. Uninsured adults generally encounter greater barriers to preventive services and treatment of chronic illness than to acute care. They are more likely than insured adults to report poor health status, delay seeking medical care, and forgo necessary care for potentially serious symptoms. Uninsured adults receive fewer screening services for cancer and cardiovascular risk factors, present with later-stage diagnoses of cancer, and experience more avoidable hospitalizations.”<sup>53</sup>

Using the 1997 and 1998 Behavioral Risk Factor Surveillance System (BRFSS) data, they also examined the unmet health needs of the insured versus the uninsured. They found that long-term and short-term uninsured adults were more likely than insured adults to report that they could not see a physician when needed due to cost (26.8 percent, 21.7 percent, and 8.2 percent, respectively).<sup>54</sup> This was particularly true of adults in poor health (as defined by the presence of various self-reported but physician-diagnosed risk factors, such as current smoking, obesity, hypertension, diabetes, etc.). Long-term uninsured adults were also significantly more

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likely than insured adults to have lacked clinically indicated preventive services (based on national guidelines or evidence-based studies). This was particularly true for services related to cancer screening and cardiovascular risk reduction.

Again, this body of research provides some insight into likely utilization and health status patterns of the underinsured (or those with major cost-sharing), but does not directly answer the relevant questions.

## *Policy Implications*

Based on various sources of evidence described in this report, it is likely that trends toward higher cost-sharing and/or reduced benefits will continue, driven by escalating health care costs. While it is unclear what impact these trends ultimately will have on health status, it is likely that they will have important effects on insurance market dynamics.

These market changes seem to signify a shift from supply-side (or provider-side) mechanisms to manage health care costs toward demand-side (or patient-side) mechanisms.<sup>55</sup> In 1973, the federal HMO Act was created to encourage providers to organize in new ways to manage the comprehensive care of populations, employing a variety of tools to ensure that the care provided was necessary, cost-effective, and of high quality. During the 1980s and into the early 1990s, HMOs did in fact succeed in keeping health care costs down. However, the current managed care backlash (which was caused, in part, by employers forcing employees into managed care rather than offering it as a choice<sup>56</sup>) and continuing interest in choice have caused enrollment in HMOs collectively to decline. Even these plans are under pressure in today's environment of ever-increasing costs, increasing unemployment, direct-to-consumer drug advertising, the widespread use

of the Internet to obtain health information, and an explosion of expensive and promising, but untested, medical technology. This does not mean, however, that America will or should abandon supply-side means of controlling costs. Physician decisions have a significant effect on utilization. Weakening incentives that support physicians' cost-effective health care decisions may have unanticipated side effects.

For the past decade, organizations representing health care purchasers, such as the Washington Business Group on Health, the Pacific Business Group on Health, and the Buyers Health Care Action Group, have advocated for supply-side reforms to increase quality and provide greater value. More recently, the Leapfrog Group has designated three quality "leaps" that providers contracting with its member-employers must take. Moreover, in its recent report, *Crossing the Quality Chasm*,<sup>57</sup> the National Institute of Medicine (IOM) calls for organized delivery systems using evidence-based principles and technology to more rationally allocate health care resources. Should it gather momentum, the shift toward higher cost-sharing and patient-directed rationing of care may move the country away from key delivery system changes necessary for "crossing the quality chasm," as the IOM termed the issue. While some purchasers favor the introduction of cost-sharing as a way to make consumers more cost-conscious, it is not a substitute for supply-side reforms.

With the shift to demand-side incentives, coupled with the consumer backlash against managed care, the nation is moving from insurance markets in which health benefits have been structured substantially by public policy (e.g., the federal HMO Act and many state laws, including benefit mandates) to those that are less subject to those rules (e.g., non-federally qualified health plans, increased cost-sharing regulated minimally or not at all by state law, ERISA plans, etc.). Yet, there has not been a significant public policy debate about whether this trend is desirable.

This shift to a less-regulated market has been taking place while policymakers have focused their

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attention elsewhere—on reforms designed to promote patient rights and address some of the more egregious problems with managed care. The irony is that the very regulations (or threat of regulations) that are designed to “correct” what’s wrong with managed care (e.g., direct access to specialists, external review of plan decisions, etc.) have contributed to managed care’s difficulty in controlling costs. For many consumers, the relative cost advantage of HMOs over PPO alternatives no longer clearly outweighs the disadvantages related to limited choice of provider, more controlled access to specialists, etc. As a result, there has been a “flight” from managed care products to products that are less regulated. In essence, the confluence of increased costs, increased public and regulatory scrutiny of managed care, and increased consumer desire for choice has chased many employers and patients out of the managed care frying pan and into the cost-sharing fire.

While all states have laws that mandate coverage of certain benefits, those laws tend to provide only minimal regulation of cost-sharing for those benefits. In other words, such laws focus on the *type* of benefits to be provided but do not address the equally important question of *how much* of the benefits must be provided. If these laws were intended to ensure access to necessary services, the question must be asked: At what point does significant enrollee cost-sharing become a barrier to access, while at the same time recognizing that modest cost-sharing may be necessary to curb excessive demand? As discussed previously, the RAND Health Insurance Experiment provides some insight into this question, but the answer is not completely clear, given today’s increasing health care costs and the proliferation of medical technology.

In this time of rapid change in the insurance markets, it is important for policymakers to better understand the impacts of increased cost-sharing on

access. This is necessary so that policymakers can know whether they are, in fact, regulating what they think they are regulating. In addition, there needs to be an honest examination of the most *appropriate* role of government in structuring competition in the new health insurance markets.

To help inform such an examination, the following are “best guesses” about what will take place if the current trend toward more cost-sharing continues. This trend is likely to have two possible outcomes: 1) the disappearance of comprehensive, low-cost-sharing coverage due to adverse selection; and/or, 2) a return to the “single-plan replacement” model of employer purchasing, with its attendant impacts on consumer choice of health plan and provider competition.

## The Disappearance of Comprehensive Coverage

A major concern related to the proliferation of higher cost-sharing plans is that they will create adverse selection against lower-cost-sharing, comprehensive coverage. This effect is somewhat mitigated in the small-group market by the fact that employers normally make coverage decisions for a whole group and do not have good information about group members’ expected health care needs (this is perhaps less true of the smallest of the small groups—those with fewer than 25 employees). However, when individuals choose their own health plan, as in a small-group purchasing pool or under a defined-contribution model, risk selection can be a more serious concern.

Most carriers protect their comprehensive plan designs from adverse selection by limiting the circumstances in which they can be offered in an individual-choice model. Carriers often refuse to offer an HMO or other comprehensive plan side-by-side with another plan (insured by a different carrier) with a

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significantly lower or different level of benefits. While this strategy does prevent risk selection against comprehensive plans, it runs counter to employers' desire to offer more choice of benefit design and thus make fewer health care decisions for their employees. Increased consumer empowerment, anti-managed care sentiment, and the threat of employer liability in adverse health plan decisions may cause employers to re-think their role in choosing a health plan for their employees.

Employers that wish to limit their involvement in health care decisions may well consider an employee-choice model. Carriers hoping to compete for such individuals will need to offer a variety of plan designs to meet individuals' varying needs and budgets. Without the employer playing the intermediary role of choosing the level of coverage, comprehensive plans may find they are no longer able to control the circumstances in which they may be offered.

In this new competitive environment, a carrier that traditionally offers comprehensive coverage would have several choices: 1) advocate for implementation of rules that would protect comprehensive plans against adverse selection in individual-choice circumstances (e.g., employees switching during open enrollment from a catastrophic to a comprehensive plan would be required to undergo a pre-existing condition waiting period); and/or, 2) drop its comprehensive plan designs and develop its own lower levels of coverage to avoid risk selection.

Even now, at the beginning of this trend, organizations that traditionally provide comprehensive HMO coverage, such as Kaiser Permanente, are feeling competitive pressure to increase member cost-sharing. In the 2002 California small-group market, in addition to its traditional \$5 and \$15 copay plans, Kaiser Permanente began offering a plan with its largest office visit copay ever—\$30.<sup>58</sup> This plan also has a \$500 inpatient hospital copay, the first to be offered by Kaiser under its small-group plans.

With competitors implementing larger and larger deductibles and raising cost-sharing on selected

services, comprehensive plans will be at risk of becoming the plans of choice only for those groups and individuals expecting to use significant amounts of care. Such a dynamic would accelerate cost differences between comprehensive and high cost-sharing plans, resulting in additional adverse selection. Comprehensive plans' only option in this case may be to follow the market, resulting in only (or mostly) high cost-sharing plans being available.

Why should policymakers be concerned if comprehensive coverage disappears due to market dynamics? One answer is that it is important for America as a society to maintain the choice of comprehensive (or low cost-sharing) coverage for those who want it and, particularly, for those whose health status requires it. If today's plans stop offering comprehensive coverage, or if, because of further segmentation of risk pools, they are able to offer it only at a prohibitive price, those who actually need significant care—those with chronic conditions—will become, for all intents and purposes, uninsured for large portions of their care. People with chronic conditions account for a significant and growing portion of the population in the United States, particularly as the post-World War II baby boom generation approaches retirement age. Researchers estimate that there are 125 million Americans—nearly half the population—with at least one chronic condition (defined broadly), and that the number will increase to 171 million by 2030.<sup>59</sup> Data from Kaiser Permanente in California indicate that 25 percent of all adult members are included in one or more of the plan's chronic disease registries.<sup>60</sup> These members account for three-quarters of the plan's inpatient hospital days when maternity is excluded from the calculation. They also account for almost half of all outpatient visits (including emergency room, urgent care, primary care, and specialist visits) and 60 percent of all outpatient pharmacy costs.

Clearly, this large segment of the population requires a great deal of care on an ongoing basis—care for which they may be unable to pay if they have health plans with major enrollee cost-sharing. Depending on

*There may be a reversal of the trend of the last decade in which employers and other purchasers have asked plans to compete on the basis of cost and quality.*

income level, such individuals may postpone or forgo needed care. Others may join the ranks of the uninsured and rely on public resources.

People with known, chronic conditions are not the only individuals who can benefit from the protection of more comprehensive coverage. The onset of a chronic condition is nearly impossible to predict at an individual level. Equally random is the possibility of serious illness requiring extensive care (infectious disease, trauma, unpredictable strokes in younger people, etc.). As a result, segmented risk pools raise the stakes for individuals who may have “chosen wrong” during open enrollment, opting for a noncomprehensive plan with substantial cost-sharing.

Policymakers’ interest in these developments should be clear. Some policymakers will recognize that as sicker citizens are forced out of the private insurance markets because they cannot buy the coverage they need, not only will the political and budgetary pressures on state and federal coffers become greater, but the argument for maintaining a private insurance market will be weakened. Other policymakers will be concerned about the added pressure on state and federal programs because it may result in the poor not receiving the care they need or in other social service spending priorities being neglected.

## The Return to “Single Plan Replacement”

As described above, carriers can protect their comprehensive plan designs from adverse selection by limiting the circumstances in which they can be offered in an individual-choice setting. Given the current cost trends, however, a carrier refusing to offer its comprehensive plan in such a setting may find few takers for its product, as employers will be unwilling to offer *only* a comprehensive plan. As a result, the carrier may develop a set of its own higher-cost-sharing products to offer alongside its comprehensive plans, managing risk selection internally.<sup>61</sup>

Major carriers are already developing this type of employee-choice product for small employers (e.g., BlueCross of California’s

“FlexScape” plans). With these products, carriers hope to satisfy employers’ need for a range of coverage options and price points, avoid adverse selection, and maintain an exclusive contract with each employer. This model of health plan/employer exclusive contracting is known as “single plan replacement” because the employer contracts with a single plan (carrier) at a time, replacing it when necessary with another single plan.

Why should policymakers care about an increase in single plan replacement? First, to the extent that consumers now have or wish to have choices, such a trend would deprive them of choice among carriers and among delivery systems, where those systems are functionally tied to a carrier. Second, such a trend would also have important implications for competition among health plans: All health plans will have to be all things to all people. It is likely that smaller, more specialized or “niche” plans will be unable to compete in this environment. Finally, carriers offering single plan replacement will need broad provider networks to remain attractive to employers. With health plans essentially contracting with “any willing provider” in a community, their ability to negotiate over price and to work with providers on quality initiatives will erode. With this erosion, there may be a reversal of the trend of the last decade in which employers and other purchasers have asked plans to compete on the basis of cost and quality through the development of accountable, selective networks. Single plan replacement tends to block very selective networks from competing because they are unable to offer the broad choice of provider that is necessary if only one plan is available to employees. One’s ideological perspective will determine whether one views these changes in plan/provider relationships in a positive or negative light. The point here is that the single plan replacement model has widespread implications for competition in both the health plan and provider markets. Policymakers need to

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understand how such market inter-relatedness will either contribute to or ameliorate the problem of increasing health care costs.

## Potential Policy Interventions

The challenge for policymakers is to balance the competing and legitimate goals of: 1) maintaining choice for people of all income levels, while also, 2) “protecting” more comprehensive coverage for those who need health care services. Clearly, some coverage, even if it is “thin,” is better than no coverage *for an individual*; but taking a population-based view, too many individuals with “thin” coverage add up to inadequate coverage for most, due to adverse selection and the resulting degradation of risk pools.

For health insurance coverage to be affordable, both the healthy and the sick must purchase it. The insurance concept does not work if only people who know they will use services purchase the product. Public policy interventions that allow coverage to be affordable but also keep both the healthy and the sick in the market include, among others:

- Setting reasonable, evidence-based standards that specify both a set of benefits and a level of cost-sharing below which carriers (and, potentially, self-insured plan sponsors) cannot go. A balance must be struck between under- and over-regulation: Too rich benefits (i.e., too many benefit mandates) and too little cost-sharing can result in people dropping coverage because it is unaffordable. Increased cost-sharing does moderate premium increases, potentially keeping some individuals insured who would otherwise become uninsured. However, an absence of regulation or limits on cost-sharing may also result in high rates of *underinsurance* (or “illusory” insurance),

particularly for low-income people with chronic conditions.

- Creating risk-spreading mechanisms among carriers so that more comprehensive plans do not experience premium “death spirals.” Such mechanisms may include high-cost condition pools, reinsurance, risk adjustment, etc. There are many models of these mechanisms in the public and private sectors, and researchers continue to seek ways to refine and improve them.
- Developing market rules that protect comprehensive plans against adverse selection in certain circumstances. For example, employees switching during open enrollment from catastrophic to comprehensive coverage would be required to undergo a pre-existing condition waiting period. (In the small-group market, such a rule would require both federal and state legislative changes.)
- Educating consumers about the importance of health insurance so that they value it as much as or more than other goods and services they might purchase with the same dollars.
- Promoting competition among provider groups as a means of improving quality and moderating cost. A number of proposals to do this have been considered in the past.

While all of the above interventions have some merit, none addresses the underlying inflationary nature of the U.S. health insurance market. Costs are high partly because insurance is expected to cover every new “miracle” technology or drug as soon as it is available, regardless of whether it is lifesaving or only lifestyle enhancing, and regardless of whether there are less-costly but equally effective alternatives. Policy interventions that address this issue of the proper scope of insurance include:

- Defining “medical necessity” as used by health plans in coverage decisions to include cost-effectiveness analysis of treatment alternatives and/or review of the highest standard of scientific evidence available.

*Several years of increased cost-sharing may lead to a second consumer backlash, with Americans once again becoming willing to accept limits on their choices to promote affordability and comprehensiveness of care.*

- Exploring the creation of an evidence-based review process for all proposed benefit mandates. Such a review would ensure that legislatures prove the value of a new benefit before mandating its coverage, as opposed to reacting purely to political pressures for new mandates. Several states have already created such processes.

Increased cost-sharing is a temporary fix that primarily addresses the symptoms of one type of market failure—runaway costs—without fully addressing the cause. In addition, increased cost-sharing fails to address what is perhaps a more serious type of market failure—the exclusion of millions of Americans who need access to health care services. The cause of such failure, broadly put, is the fundamental notion that, given the current allocation of resources to health care, the nation can either provide *some* people access to nearly every conceivable health benefit/service while others have none, or it can provide *everyone* access to an adequate (but not necessarily optimal), range of benefits/services. To date, the United States has gone down the former road, resulting in a long-term increase in the numbers of uninsured.

A useful addition to the debate would be a critical examination of how purchasers (both individuals and employers) and health plans make decisions about what should be covered by insurance. Under the managed care revolution of the 1980s and 1990s, purchasers willingly delegated the task of resource allocation—deciding who gets what health care, how much, and when—to health plans, in return for the promise of lower premiums. Today's managed care backlash demonstrates that the public is not as willing to let health plans play that role. The alternative—increased cost-sharing—puts patients and their families in charge of such resource allocation decisions: they can have all the care they want, whenever they want it, as long as they can pay for

it. But this strategy will also grow old, as families realize that they do not have as many choices as they thought they had (i.e., if they can't afford it, they really do not have a choice about buying it).

Previous experience has shown that it is not possible to reform the health care system by focusing *only* on one part of the equation—the demand-side *or* the supply-side. Too great a focus on supply-side reform resulted in the managed care backlash. But as shown, too great a focus on demand-side reforms can lead to significant problems in the insurance markets. This is particularly the case when increased cost-sharing is accompanied by the expansion of build-your-own networks and the contraction of managed care tools. This would suggest that a balance between supply-side and demand-side approaches is needed. Many experts argue that under the influence of informed and organized purchasers, managed care did result in some new and better ways of practicing medicine and caring for populations, and that the health care industry should not “throw the baby out with the bathwater” by getting rid of care management advances as a way of “compensating” consumers for increased cost-sharing.

Several years of increased cost-sharing may lead to a second consumer backlash, with Americans once again becoming willing to accept limits on their choices to promote affordability and comprehensiveness of care. The question remains: how will such limits be set, if not by “care managers” (i.e., health plans) and not by consumers (through the mechanisms of cost-sharing)? In the near future, perhaps the public will be more willing to openly discuss issues of cost-effectiveness and the need to make health coverage decisions collectively. Many consumer advocates, physicians, and others have called for community-wide discussions, including all stakeholders, to address the question of what should rightly be covered by insurance. One model for such community discussion is the Oregon Health Plan. More

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work is needed to determine what model would work best on a broader scale. Regardless of how it is implemented, such rational cost-effectiveness analysis is perhaps the last bastion of hope for a health care system unwilling to forego comprehensiveness, affordability/accessibility for all, or choice.

## Conclusion

In the face of rapidly increasing health care costs and a softening economy, it is a given that purchasers will look for ways to redesign their health insurance coverage to make it more affordable. Increased cost-sharing is one means of achieving that goal. This report makes the case that this option may have serious negative consequences for consumers who truly need more comprehensive coverage—those with chronic conditions. This report also makes the case that in addition to consumer cost-sharing (which, when used properly, can help curb inflation due to excessive demand), health care stakeholders need to consider the tools of delivery system reform, or supply-side incentives. Ultimately, stakeholders in the American health care system will have to take a closer look at the appropriate scope of health insurance coverage, as science and technology further expand consumer expectations.

At first glance, a call for both comprehensive (low-cost-sharing) coverage and for a re-examination of public expectations about coverage of new technologies may seem contradictory. But in this case, “comprehensive” is defined as coverage that provides only *necessary* and *cost-effective* services with an appropriate level of cost-sharing to promote consumer responsibility, but not so much as to create an undue barrier to access. If health plans can work more effectively with provider groups to reform delivery systems, and with consumers/communities to openly discuss difficult resource allocation

decisions, such “comprehensive” coverage may not be out of reach. Without these two factors—delivery system reform and a focus on the proper scope of coverage—increased cost-sharing may be the only tool left in the cost-control tool-box. But the reality is that increased cost-sharing can be a blunt and (for some) even dangerous instrument when used on its own.

This report outlines many of the issues raised by a move toward greater consumer cost-sharing, coupled with the weakening of managed care cost-control tools. Given these market dynamics, policymakers must determine whether these trends are likely to lead to the desired outcome of access to needed and appropriate care for all. There is still an opportunity for policymakers and other stakeholders in the health care system to shape this trend, but first there must be a broader understanding that current trends are likely to have a profound and lasting impact on the U.S. health insurance markets.

## Appendix A

### Roundtable Goals and Participants

“Connecting Public Policy to Health Benefit Design.”  
Sponsored by *Health Affairs* and the Kaiser Permanente Institute for Health Policy With Support from The Robert Wood Johnson Foundation.

September 10 and 11, 2001  
San Francisco, CA

### Roundtable Goals

- To discuss the current trend toward more affordable but less comprehensive low-option health benefit plans; to understand where this trend will lead and the implications for access to health care.

- To identify public policy changes that would influence the trend toward low-option plans and/or exacerbate problems of risk segmentation.
- To identify public policy interventions that would enable the most responsible means of meeting the market demand.

## Participants

Inclusion in the participants list does not necessarily indicate that an individual has reviewed or is in agreement with any portion of this report. All views expressed in this report are solely those of the authors.

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## Endnotes

<sup>1</sup> A “service benefit” is one that provides its beneficiary with a service (in this case health care services), rather than providing the beneficiary with money to purchase (or reimburse for) a service.

<sup>2</sup> J. Gabel and L. Levitt et al., “Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats,” *Health Affairs*, Vol. 20, no. 5 (September/October 2001): 180–186.

<sup>3</sup> B. Strunk, P. Ginsburg, and J. Gabel, “Tracking Health Care Costs: Hospital care surpasses drugs as the key cost driver,” *Health Affairs*, Web Exclusive, September 26, 2001, pp. W39–W50.

<sup>4</sup> Ibid.

<sup>5</sup> *American Healthline*, April 19, 2001.

<sup>6</sup> Regulatory structures may make exclusion of specific drugs and technologies difficult in some states.

<sup>7</sup> See Paul Fronstin, *Is There a Trend Towards More Affordable, Less Comprehensive Health Benefits?* prepared for the *Health Affairs/Kaiser Permanente Institute for Health Policy Roundtable – Connecting Public Policy to Health Benefit Design*, September 10–11, 2001, San Francisco, CA (unpublished, call (510) 271-2366 for information).

<sup>8</sup> See Paul Fronstin, “Defined Contribution Health Benefits,” *EBRI Issue Brief* no. 231 (Employee Benefit Research Institute, March 2001).

<sup>9</sup> The U.S. Bureau of Labor Statistics reports that unemployment reached a low of 3.9 percent of the civilian population in October 2000, and rose to 5.6 percent in January 2002 (see: <http://data.bls.gov/cgi-bin/survey/most?bls>).

<sup>10</sup> *Defining Defined Contributions: New Directions for Employer-Sponsored Health Insurance*, Conference Transcript, October, 2000, Center for Studying Health System Change (see [www.hschange.com](http://www.hschange.com)).

<sup>11</sup> Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey,” *EBRI Issue Brief* no. 240 (Employee Benefit Research Institute, December 2001).

<sup>12</sup> J. Gabel and L. Levitt et al., “Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats,” *Health Affairs*, Vol. 20, no. 5 (September/October 2001): 180–186.

<sup>13</sup> P. Cunningham, E. Schaefer, and C. Hogan, “Who Declines Employer-Sponsored Health Insurance and is Uninsured?” *Issue Brief – Findings from HSC*, No. 22 (Center for Studying Health System Change, October 1999).

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<sup>14</sup> R. Kronick and T. Gilmore, "Explaining the Decline in Health Insurance Coverage, 1979-1995," *Health Affairs*, Vol. 18, no. 2 (March/April 1999): 30–47.

<sup>15</sup> Personal communication with Barney Speight, Kaiser Permanente Northwest, Government Relations, 4/11/01.

<sup>16</sup> Sept. 10 and 11, 2001, San Francisco, CA; see Appendix A for roundtable goals and list of participants.

<sup>17</sup> All data are from: Paul Fronstin, "Is There a Trend Towards More Affordable, Less Comprehensive Health Benefits?" prepared for the *Health Affairs/Kaiser Permanente Institute for Health Policy Roundtable – Connecting Public Policy to Health Benefit Design*, September 10-11, 2001, San Francisco, CA (unpublished). Reviewed data included: the Current Population Survey; William M. Mercer surveys of employer-sponsored health plans; Hewitt Associates employer surveys; and Kaiser Family Foundation/HRET employer surveys.

<sup>18</sup> In various contexts, the term "coinsurance" has been used to refer either to the portion paid by the insurer or the portion paid by the patient. In this report, "coinsurance" always refers to the portion paid by the patient.

<sup>19</sup> See [www.hschange.com](http://www.hschange.com).

<sup>20</sup> P. Ginsburg, *Changing Approaches to Managed Care: Two Stages*, prepared for the *Health Affairs/Kaiser Permanente Institute for Health Policy Roundtable – Connecting Public Policy to Health Benefit Design*, September 10–11, 2001, San Francisco, CA (unpublished).

<sup>21</sup> Watson Wyatt Worldwide, *Health Care Costs 2002 - A Watson Wyatt Worldwide Survey*, October 2001, ([www.watsonwyatt.com/research/reports.asp](http://www.watsonwyatt.com/research/reports.asp)).

<sup>22</sup> "As Corporate Concerns About Health Care Costs Continue to Rise, Many Employers Plan to Shift More Costs to Their Employees," *Health Care News*, Vol. 1, Issue 29 (October 9, 2001), Harris Interactive.

<sup>23</sup> "Double-Digit Health Care Cost Increase Expected to Continue in 2002," Hewitt Associates (press release),

Oct. 29, 2001, <http://was.hewitt.com/hewitt/resource/newsroom/pressrel/2001/10-29-01.htm>.

<sup>24</sup> The issue of selective provider networks is discussed in more detail later in this report.

<sup>25</sup> Pricing information from Kaiser Permanente Colorado Region, for a large employer group.

<sup>26</sup> J. Gabel and L. Levitt et al., "Job-Based Health Insurance in 2000: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs*, Vol. 20, no. 5 (September/October 2001): 180–186.

<sup>27</sup> J.S. Lee and L.Tollen, "The Impact of Reducing Benefits and Increasing Cost Sharing on Health Insurance Premiums." March 2001 (unpublished: call (510) 271-2366 for more information).

<sup>28</sup> See footnote 26.

<sup>29</sup> Estimated premiums represent the high end of the range provided by the Web site. Because California's small-group law permits some rating based on health status, it is not possible to show more precise premiums for the fictitious group without providing detailed health information about the covered individuals. Note that premiums shown are the *total* monthly premiums for *all four employees and four dependents*.

<sup>30</sup> J.S. Lee and L.Tollen, "The Impact of Reducing Benefits and Increasing Cost Sharing on Health Insurance Premiums." March 2001 (unpublished: call (510) 271-2366 for more information).

<sup>31</sup> A notable exception to this statement is the coverage required under the Oregon Health Plan (Medicaid). That state underwent an extensive, rational, public process of ranking types of care according to their "value" to the patient and society and developing a "prioritized list" of covered services. This type of explicit value comparison is virtually unheard of elsewhere in the United States. The Oregon Health Plan experience is discussed elsewhere in this report.

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<sup>32</sup> While many state legislatures do require a financial and social impact analysis of any proposed benefit mandate, these analyses generally do not compare proposed mandates with one another. There is no explicit consideration of the merits of one mandate in relation to another.

<sup>33</sup> Insurers' ability to do this depends on the state regulatory environment.

<sup>34</sup> J. Selby, B. Fireman, and B. Swain, "Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization," *New England Journal of Medicine*, Vol. 334, no. 10 (March 7, 1996): 635–641.

<sup>35</sup> J.P. Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine*, Vol. 305, no. 25 (Dec. 17, 1981): 1501–1507.

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*

<sup>38</sup> E.B. Keeler and J.E. Rolph, "How cost sharing reduced medical spending of participants in the Health Insurance Experiment," *JAMA*, Vol. 249 (April 22–29, 1983): 2220–2227.

<sup>39</sup> *Ibid.*

<sup>40</sup> K.N. Lohr et al., "Use of Selected Drugs and Procedures," *Medical Care*, Vol. 24, no 9, Supplement (September 1986): S39–S51.

<sup>41</sup> K.N. Lohr et al., "Effect of Cost-Sharing on the Probability of Episodes of Care for Specific Diseases," *Medical Care*, Vol. 24, no. 9, Supplement (September 1986): S18–S30.

<sup>42</sup> A.L. Siu et al., "Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans," *New England Journal of Medicine*, Vol. 315, no. 20 (March 4, 1988): 1259–1266.

<sup>43</sup> K.N. Lohr et al., "Effect of Cost-Sharing on Use of

Medically Effective and Less Effective Care," *Medical Care*, Vol. 24, no. 9, Supplement (September 1986) S31–S38.

<sup>44</sup> *Ibid.*

<sup>45</sup> R.H. Brook et al., "Does Free Care Improve Adults' Health?" *New England Journal of Medicine*, Vol. 309, no. 23 (Dec. 8, 1983): 1426–1434.

<sup>46</sup> *Ibid.*

<sup>47</sup> *Ibid.*

<sup>48</sup> *Ibid.*

<sup>49</sup> A different portion of the experiment did in fact look at differences in care delivery between an HMO (Group Health Cooperative of Puget Sound) and FFS providers, although this latter portion did not examine differences in cost-sharing in the HMO *per se*.

<sup>50</sup> J.B. Mitchell and F. Bentley, "Impact of Oregon's Prioritized List on Medicaid Beneficiaries," *Medical Care Research and Review*, Vol. 25, no. 2 (June 2000): 216–234.

<sup>51</sup> *Ibid.*

<sup>52</sup> J.Z. Ayanian, J.S. Weissman, E.C. Schneider, J.A. Ginsburg, and A.M. Zaslavsky, "Unmet Health Needs of Uninsured Adults in the United States," *JAMA*, Vol. 284, no. 16 (Oct. 25, 2000): 2061–2069.

<sup>53</sup> *Ibid.*, pp. 2061. See article for a full list of literature reviewed.

<sup>54</sup> "Short-term uninsured" was defined as having been without insurance for less than one year and being uninsured at the time of the survey. "Long-term uninsured" was defined as having been without insurance for more than one year, and being uninsured at the time of the survey.

<sup>55</sup> J. Robinson, "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design," *Health Affairs* Web exclusive, March 20, 2000: W139–W154.

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<sup>56</sup> Regarding the relationship of choice of plan to satisfaction with managed care, see: K. Davis et al., “Choice Matters: Enrollees’ Views of Their Health Plans,” *Health Affairs* (Summer 1995): 99–112; and A. Enthoven, H. Schauffler, and S. McMenamin, “Consumer Choice and the Managed Care Backlash,” *American Journal of Law and Medicine*, Vol. 27, no. 1 (2001): 1–15.

<sup>57</sup> Institute of Medicine, Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academy Press, 2001).

<sup>58</sup> Other cost-sharing increases were implemented for all of Kaiser Permanente’s California small-group plans for 2002: emergency room copays were raised from \$35 to \$50; ambulance services went from no copay to \$50; durable medical equipment went from no cost-sharing to 20 percent enrollee coinsurance; and pharmacy cost-sharing went from one tier to a three-tiered structure.

<sup>59</sup> Data from Partnership for Solutions: Better Lives for People with Chronic Conditions, a project of Johns Hopkins University and the Robert Wood Johnson Foundation, [www.partnershipforsolutions.org/statistics/prevalence.htm](http://www.partnershipforsolutions.org/statistics/prevalence.htm). In this case, chronic conditions are defined broadly to include any condition that lasts a year or longer, limits what one can do, and may require ongoing care.

<sup>60</sup> These conditions include asthma, coronary artery disease, congestive heart failure, diabetes, hypertension, and chronic pain. Unpublished data provided by The Permanente Medical Group, Chronic Conditions Management, January 2002.

<sup>61</sup> Carriers “manage risk selection internally” by cross-subsidizing the premiums of plans that attract high-risk, high-cost enrollees (comprehensive plans) with premiums of plans that attract low-risk, low-cost enrollees (low-option plans). As a result, the premiums of the high- and low-option plans do not entirely reflect their expected costs, and the high-option plans remain affordable.

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