Cost Sharing in Medical Insurance Plans

by Cathy A. Baker

Originally Posted: March 31, 2004

Changes in health plan features and required employee plan contributions provide insights into changes in health care cost sharing between employers and employees. BLS data on benefits show that employees increasingly were required to make contributions for their coverage, that these contribution amounts have risen, and that medical plan deductibles have increased over the years.

In response to the rising costs of providing health care benefits, employers have looked for ways to share costs with workers and their families who receive the benefits. One way of sharing costs, in all types of plans, is to require employees to contribute towards the cost of their coverage. In addition, the following major medical plan provisions[1] are traditional types of benefit cost sharing used in non-health maintenance organization plans[2]:

- Annual deductible
- Annual out-of-pocket expense maximum
- Lifetime maximum
- Coinsurance

This article discusses developments in employee contribution requirements over the past decade, and in deductibles, annual out-of-pocket expense maximums, and lifetime maximums.[3]

Employee Contributions

Data from BLS surveys of employee benefits[4] show that the percent of medical plan participants required to make contributions (for all types of plans) has risen over time. Among private sector employees (full and part time combined) who were covered by medical care plans in March 2003, 78 percent of those with single coverage and 90 percent of those with family coverage were required to make employee contributions. These figures are up from the 54 percent required to pay towards single coverage and the 74 percent required to pay for family coverage in 1992-93.

Similarly, most employees of State and local government who participated in medical insurance plans were required to make contributions to their plans. In 1998, the last time data were collected for government workers, 51 percent of full-time workers[5] who participated in medical plans were required to make premium payments for single coverage, and 75 percent were required to contribute for family coverage. In 1992, the comparable numbers were 43 percent for single coverage, and 72 percent for family coverage.

The dollar amount that employees are required to contribute also has increased over time. Since 1992-93, by far the most common form of contribution has been a flat amount, which BLS has published as a monthly figure.[6] Among full-time workers in private industry in 1992-93, medical plan participants who had to make flat contributions were required to pay an average of $34 per month for single coverage, and $131 for family coverage. By March 2003, these monthly averages had risen by about 75 percent, to $60 for single coverage and $228 for family coverage. During this same period, medical care prices rose about 50 percent, according to the Consumer Price Index for All Urban Consumers.

For State and local government, full-time employees paid an average of $29 per month for single coverage medical plans in 1992, and $139 per month for family plans. By 1998, those figures had risen to $32 for single coverage, and $152 for family coverage.[7]

Other Cost Sharing Provisions

Most non-health maintenance organization plans require participants to pay an annual deductible amount before any covered medical expenses are paid for by the plan.[8] Such plans often require separate individual and family deductibles.[9] In 2000, 72

percent of full-time private industry employees in non-health maintenance organization plans were subject to an individual deductible.[10] The average annual amount for individual deductibles steadily increased over the years. In 2000, for example, private industry data show that the average individual deductible was $334, up from $219 in 1992-93. (See table 1.) Similarly, in State and local governments, 72 percent of full-time workers in non-health maintenance organization plans were required to meet individual deductible requirements, which increased to $226 in 1998, up from $186 in 1994, and $173 in 1992. (See table 2.) These increases far outweigh the increase in medical care prices as measured by the Consumer Price Index over the same periods.

In addition to annual deductibles, non-health maintenance organization plans often have an out-of-pocket expense maximum, typically in conjunction with a coinsurance provision. The coinsurance provision requires the insured to pay a percent of covered charges (often 20 percent) up to the out-of-pocket expense maximum. This is the maximum amount that any individual has to pay per year for all covered medical expenses; once the out-of-pocket expense maximum is met in any given year, the plan pays all of the remaining expenses in that year. As tables 1 and 2 show, both individual and family out-of-pocket expense maximums increased over the decade in both private industry and State and local government.[11] Plans frequently limit covered expenses by imposing a lifetime ceiling on benefits and often do not fully cover expenses related to mental health care or substance abuse.

Another non-health maintenance organization plan provision is a lifetime plan maximum--the maximum amount that a plan will pay for all covered medical expenses for an individual during his or her lifetime. While changes in deductibles and out-of-pocket expense maximum provisions have required employees to share greater costs over time, the lifetime maximum benefits amounts have risen over the decade. Tables 1 and 2 show that average maximum lifetime amounts have increased for both the public sector and for full-time employees in private industry over the study period.[12]

BLS plans to release detailed tabulations later this year showing the features of private industry health insurance plans in 2002 and 2003. These tabulations will be available on the Internet at http://www.bls.gov/ebs/home.htm.

Cathy A. Baker
Economist, Division of Compensation Data Analysis and Planning, Bureau of Labor Statistics.
Telephone: (202) 691-6260; E-mail: Baker.Cathy@bls.gov

Notes

1 Plan provisions are the benefits and limits in the insurance plan.

2 Non-health maintenance organization plans are fee-for-service, preferred provider organizations, and most point of service plans.

3 Other types of cost sharing features, such as overall coinsurance provisions and the application of co-payments, also have evolved over the past decade, but they are not covered in this article.

4 The BLS Employee Benefits Survey (EBS) provides data on the incidence and characteristics of employer-provided benefits, including health care contributions and medical care plan provisions. In the early and middle 1990s, BLS conducted biennial surveys for small private establishments (1 to 99 employees) and for State and local governments in even years, and for medium and large private establishments (100 or more employees) in odd years. The last EBS was conducted in 1998. Subsequently, the EBS was replaced with the new BLS National Compensation Survey (NCS). For more information on the change from the EBS to the NCS, see Technical Note in *Employee Benefits in Private Industry, 2003*, USDL 03-489 (U.S. Department of Labor), September 17, 2003, pp. 11-13; or visit the NCS section of the BLS website at http://www.bls.gov/ncs/ebs/.

5 Data for State and local government employees are for full-time workers only; data for private sector workers are for combined full- and part-time workers.

6 Other types of contributions, such as contributions that include payment for other types of insurance or payments that vary by the worker's age, salary, length of service, or selections in a cafeteria benefits plan, are not included in the monthly averages calculated by BLS.

7 For an earlier look at employee contribution trends, see Ann Foster, "Employee Contributions for Medical Care Coverage," *Compensation and Working Conditions*, Summer 1996, pp. 51-53.

8 An annual deductible is a minimum dollar amount (say, $250) that must be paid by the health plan participant before the insurance company starts paying for medical services. Health maintenance organization plans generally do not contain the major medical provisions discussed in this article.

9 Medical plans often express family annual deductible amounts as multiples of individual deductible amounts. For example, the individual deductible requirement might be $200, while the family deductible is twice that, or $400. Family deductible amounts are most commonly 2 or 3 times greater than individual deductible amounts.

10 Data for 2003 on deductibles in private industry will be published later in 2004.

11 Data on 2003 maximums for out-of-pocket expenses will be published later in 2004.

12 Standard errors have not been calculated for EBS estimates. Consequently, none of the statistical inferences made in this report could be verified by a statistical test.

Table 1. Cost sharing provisions in non-health maintenance organization medical insurance plans, full-time participants, private industry, selected years, 1992-93 to 2003

Average Provision(1)	1992-93	1994-95	1995-96	1996-97	2000
Individual					
Annual deductible(2)	$219	$255	$279	$288	$334
Annual out-of-pocket maximum(4)	1,197	1,285	1,446	1,553	1,469
Lifetime maximum(5)	972,000	927,000	880,000	1,225,000	1,658,000
Family					
Annual deductible(2)	(6)	(6)	(6)	(6)	799
Annual out-of-pocket maximum(4)	(7)	2,669	3,027	3,146	3,165

Footnotes:
(1) The average is presented for all covered workers; averages exclude workers without the plan provision.
(2) The deductible is the amount of covered expenses that an individual or family must pay before any charges are paid by the medical plan. Deductibles that apply separately to a specific category of expenses, such as a deductible for each hospital admission, were excluded from this tabulation.
(4) The out-of-pocket expense maximum is the amount an individual or family must pay before the plans will pay 100 percent of additional charges. Deductibles were excluded from computation of the out-of-pocket dollar limit. Usually, out-of-pocket limits were specified on an annual basis. Charges for certain services, such as mental health care, may not be counted toward the out-of-pocket maximum.
(5) The maximum is the total amount of expenses that the plan will pay. The maximum described is for each insured person. Where the maximum differed for employees and dependents, the employee maximum was tabulated.
(6) Data were not published for these years. Most commonly, family deductibles were equal to 2 or 3 times the individual deductible.
(7) Data were not published for this year.

Table 2. Cost sharing provisions in non-health maintenance organization medical insurance plans, full-time participants, State and local governments, 1992, 1994, and 1998

Average Provision(1)	1992	1994	1998
Individual			
Annual deductible(2)	$173	$186	$226

Footnotes:
(1) The average is presented for all covered workers; averages exclude workers without the plan provision.
(2) The deductible is the amount of covered expenses that an individual or family must pay before any charges are paid by the medical plan. Deductibles that apply separately to a specific category of expenses, such as a deductible for each hospital admission, were excluded from this tabulation.
(3) The out-of-pocket expense maximum is the amount an individual or family must pay before the plans will pay 100 percent of additional charges. Deductibles were excluded from computation of the out-of-pocket dollar limit. Usually, out-of-pocket limits were specified on an annual basis. Charges for certain services, such as mental health care, may not be counted toward the out-of-pocket maximum.
(4) The maximum is the total amount of expenses that the plan will pay. The maximum described is for each insured person. Where the maximum differed for employees and dependents, the employee maximum was tabulated.
(5) Data were not published in 1992. Most commonly, family deductibles were equal to 2 or 3 times the individual deductible.

Average Provision(1)	1992	1994	1998
Annual out-of-pocket expense maximum(3)	908	941	1,027
Lifetime maximum(4)	986,000	988,000	1,326,000
Family			
Annual deductible(2)	(5)	441	$518
Annual out-of-pocket maximum(3)	1,856	1,947	2,407

Footnotes:
(1) The average is presented for all covered workers; averages exclude workers without the plan provision.
(2) The deductible is the amount of covered expenses that an individual or family must pay before any charges are paid by the medical plan. Deductibles that apply separately to a specific category of expenses, such as a deductible for each hospital admission, were excluded from this tabulation.
(3) The out-of-pocket expense maximum is the amount an individual or family must pay before the plans will pay 100 percent of additional charges. Deductibles were excluded from computation of the out-of-pocket dollar limit. Usually, out-of-pocket limits were specified on an annual basis. Charges for certain services, such as mental health care, may not be counted toward the out-of-pocket maximum.
(4) The maximum is the total amount of expenses that the plan will pay. The maximum described is for each insured person. Where the maximum differed for employees and dependents, the employee maximum was tabulated.
(5) Data were not published in 1992. Most commonly, family deductibles were equal to 2 or 3 times the individual deductible.