Cost Shifting and Cost Sharing

Cost shifting, charging some customers more in order to subsidize other customers who won't or can't pay as much, isn't unique to healthcare—though the amounts and consequences are more dramatic. Hospitals, clinics and practitioners have to balance their budgets. When a car crash patient who has no assets walks away from a $10,000 bill or Medicaid cuts reimbursement, charges to other insured patients are boosted in order to make it all even out.

One reason Oregon hospitals backed the expansion of coverage that came with the Oregon Health Plan is that it sliced their charity care and bad debt loads. According to the state Office for Oregon Health Policy & Research web site, the Oregon Association of Hospitals and Health Systems reported, "in 1994, charity care at state hospitals declined by 18.7% relative to the previous year and bad debts, by 10.6%. In the Portland metropolitan area, these reductions were even greater, 23.8% and 15.7%, respectively. Charity care admissions continued to decline in 1995; for the first seven months of the year they were down 32.5% relative to the same period of the previous year, and bad debts were down 8.5% (20.1% in rural areas)." So while taxpayers may have subsidized more care directly, they were relieved of some of the burden of inflated hospital bills and insurance premiums.

Healthcare is particularly prone to cost shifting since there is often a tenuous and shifting relationship between the actual production cost of an item or service and the price charged. For instance, most medicines cost pennies a pill to manufacture; the price is mostly a calculation of how much of the maker's research, development and marketing expenses the buyers of that pill will bear. Things get especially tricky when different buyers pay vastly different amounts for the same items, with Medicare and Medicaid usually paying the least, followed by members of large insurance plans and uninsured patients (those with the least ability to pay) typically being charged the highest prices.

Cost Sharing

"Cost sharing" is increasingly bandied about as a strategy for coping with rising healthcare spending. The concept includes:

- **Premiums:** the fixed rate paid for insurance coverage. At larger companies, typically, part of the premium is paid directly by the employer and part is deducted from employee paychecks; but it all comes out of the same budget for employee compensation, which includes all wages and benefits. As employers get hit with premium hikes, many are increasing the percentage deducted from paychecks.
- **Deductibles:** the out-of-pocket amount an insured patient pays in full before insurance kicks in. "Full coverage" plans have low deductibles and higher premiums, because insurance ends up paying for minor illnesses and routine care. "Catastrophic coverage" plans have high deductibles but relatively low premiums, since the patient assumes the risk for run-of-the-mill healthcare and deductible limits are exceeded only in rare instances.
- **Co-insurance:** the percentage of fees that the patient is responsible for even after the deductible is met. For instance, a patient may pay 20% of all charges up to $3000 a year, after which the insurance plan pays 100%.
- **Co-pays:** a flat fee for a service or product. For example, $20 per office visit or $10 per prescription.

Cost sharing is intended to reduce the risk and responsibility of the insurance plan, employer or government healthcare purchaser. Many supporters of cost sharing hope that it will help patients become more efficient purchasers of healthcare. However, cost sharing schemes usually affect only the out-of-pocket expenses of generally healthy people, who consume relatively little healthcare. People with chronic illness or major trauma quickly satisfy their deductibles and other limits, leaving almost the full bill for the insurer.

According to an analysis in the March/April 2001 issue of Health Affairs, 10% of patients in managed care plans consume 70% of the services (which means that changing the healthcare spending habits of 90% of us would affect less than 30% of the nation's healthcare spending.) The report calculated that the average patient in the top 1% uses more than $56,000 worth of medical care each year, while the average patient in the bottom 50% uses just $122 worth of medical care.

Also, cost sharing obviously affects poor people more than rich people. A $20 co-pay is unlikely to keep a well-off parent from running to the doctor every time Junior sniffles, but it may prompt a fast-food outlet cashier to delay seeing a doctor about a chronic cough until it develops into a serious (and much more expensive) case of pneumonia.

Perhaps greater cost sharing will make people more aware of the high costs of healthcare; but raising up-front costs for medical care could also turn out to be a "penny-wise, pound-foolish" boondoggle for the nation's healthcare budget—and the people's health.

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