

Healthcare Is a Human Right Campaign



Research brief:

Evidence for adverse health effects of out-of-pocket costs (“cost-sharing”)

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There is a large body of research evidence that shows that all forms of out-of-pocket costs, or “cost-sharing,”¹ harm people’s health. Out-of-pocket costs, even at very low levels, discourage people from seeking necessary care and filling their medication prescriptions, thus causing them to become sicker. The burden falls disproportionately on people in poor health.

- A large-scale experiment on cost-sharing showed that low-income adults in cost-sharing plans were only 59 percent as likely to seek timely and effective health care for acute conditions as those who were not subject to cost-sharing. This is just one of many findings emerging from the RAND Health Insurance Experiment conducted in the 1970s and supported by the federal government, which yielded a large body of data used by many studies on cost-sharing.² It is generally accepted that cost-sharing indiscriminately reduces use of both necessary and unnecessary care, and that it particularly affects the use of recommended care for chronic conditions.
- Low-income populations in insurance plans without cost-sharing had significantly better health outcomes (for three main health conditions, including a 10 percent reduction in the risk of dying for high risk groups) compared to similar populations with cost-sharing. Similarly, low-income patients in poor health, who were subject to cost-sharing, had a higher prevalence of serious health symptoms, compared to those without cost-sharing. These are findings from several studies based on the RAND Health Insurance Experiment and reported by the Kaiser Foundation in 2003.³
- Increased cost-sharing for ambulatory care in Medicare reduced the use of outpatient care, increased inpatient care and may have had adverse health effects, reported the NEJM in 2010, summarizing the results of a Brown University study.⁴

¹ “Cost-sharing” is a deliberately biased term since patients already pay for the healthcare system through premiums or taxes. Instead of “sharing” costs, out-of-pocket charges place an additional burden, a user fee, on those people who need to see a healthcare professional.

² See discussion and citations in: Families USA, *Cost-Sharing in Medicaid: It’s Not about “Skin in the Game”—It’s about Lives on the Line*, September 2005 (<http://www.familiesusa.org/assets/pdfs/Cost-sharing-in-Medicaid-Sept-2005.pdf>); Julie Hudman and Molly O’Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, The Kaiser Commission on Medicaid and the Uninsured, March 2003 (<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/health-insurance-premiums-and-cost-sharing-findings-from-the-research-on-low-income-populations-policy-brief.pdf>); Leighton Ku and Victoria Wachino, “The Effect of Increased Cost-Sharing in Medicaid,” July 2005 (<http://www.cbpp.org/cms/?fa=view&id=321>); Amitabh Chandra, David Cutler, Sirui Song, “Who Ordered That? The Economics of Treatment Choices in Medical Care,” in: Mark Pauly et al. (eds.), *Handbook of Health Economics*, Volume 2, 2011, 397-432.

³ Hudman, op. cit.; Emmett Keeler, Rober Brook, George Goldberg, et al., “How Free Care Reduced Hypertension in the Health Insurance Experiment,” *Journal of the American Medical Association*, 1985;254(14):1926-1931 (<http://jama.ama-assn.org/content/254/14/1926>).

⁴ Amal N. Trivedi, Husein Moloo, and Vincent Mor, “Increased Ambulatory Care Copayments and Hospitalizations among the Elderly,” *New England Journal of Medicine* 2010;362:320-8. (<http://www.nejm.org/doi/full/10.1056/NEJMs0904533>).

- Increasing risk for out-of-pocket costs is associated with higher subsequent mortality among elderly Americans, according study results reported in the Archives of Family Medicine, March 2000.⁵
- Medication adherence is particularly adversely affected by cost-sharing. A recent literature review of 160 articles on the subject found that “increasing patient cost sharing was associated with declines in medication adherence, which in turn was associated with poorer health outcomes.”⁶
- Out-of-pocket costs for elderly patients led to noncompliance with recommended drug use and increased pain and severity of conditions, as reported in the American Journal of Public Health, July 2002.⁷
- Higher co-pays for prescription drugs that treat chronic diseases may cause patients to skip their treatment, reports the Journal of General Internal Medicine in 2008 about a Harvard Medical School study.⁸
- The introduction of cost-sharing led to a decreased use of essential drugs and caused emergency room visits to increase by 78% and serious adverse health events to increase by 88%, reported the Journal of the American Medical Association in 2001 about research conducted in Quebec, Canada.⁹
- The main effect of co-pays for prescription drugs is to make it less likely that patients, especially those in fair or poor health, fill their doctors’ prescriptions, reported Health Affairs in 1999 about a study elderly and disabled Medicaid patients in 38 states using Medicaid Current Beneficiary Survey data.¹⁰ This was also found by a study of cancer patients in Georgia, who reduced their usage of needed prescription drugs in response to Medicaid’s imposition of increased co-pays.¹¹
- Poor benefit design, particularly high cost-sharing, has been found to impede access to treatment and continuity of care for substance abuse, which is consistent with the development of chronic health problems.¹²
- A 2014 Commonwealth Fund study revealed that “two of five adults who had deductibles that

⁵M P Doescher, P Franks, J S Banthin, C M Clancy, “Supplemental insurance and mortality in elderly Americans. Findings from a national cohort,” *Archives of Family Medicine* (2000) Volume 9:3, 251-257 (<http://www.mendeley.com/research/supplemental-insurance-mortality-elderly-americans-findings-national-cohort/>).

⁶ Michael T. Eaddy et al., "How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review," in: *Pharmacy & Therapeutics* 37: 1, 2012, 45-55 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278192/pdf/ptj3701045.pdf>)

⁷ Jae Kennedy and Christopher Erb, “Prescription Noncompliance due to Cost Among Adults With Disabilities in the United States,” *American Journal of Public Health*, 92, July 2002, pp. 1120-24 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447201/>).

⁸ Michael Chernenow, Teresa B. Gibson, Kristina Yu-Isenberg, et al., “Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care,” *Journal of General Internal Medicine*, August 2008; 23(8): 1131–1136 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517964/?tool=pubmed>).

⁹ Tamblin R, Laprise R, Hanley JA, et al., “Adverse events associated with prescription drug cost-sharing among poor and elderly persons,” *Journal of the American Medical Association*, Jan 24-31, 2001;285(4):421-9.

¹⁰ Stuart B, Zacker C., “Who Bears the Burden of Medicaid Drug Co-payment Policies?” *Health Affairs*, March/April 1999, (<http://content.healthaffairs.org/content/18/2/201.long>).

¹¹ Sujha Subramanian, “Impact of Medicaid copayments on patients with cancer: Lessons for Medicaid expansion under health reform,” *Medical Care*, 2011: 49 (9), 842-847.

¹² “There is little logic to benefit designs that make it highly difficult to enter early into treatment or to monitor the progress of people with chronic chemical dependency, while covering high-tech medical and surgical services without limits for those same patients whose illnesses can be traced to drug or alcohol dependence.” Jon R. Gabel et al., "Substance Abuse Benefits: Still Limited After All These Years," *Health Affairs*, July 2007, Vol. 26 No. 4, 474-482 (<http://healthaff.hiwire.org/content/26/4/w474.full>).

were high relative to their income said they had delayed or avoided needed care because of the deductible. Nearly one-quarter of people with high deductibles cited them as the reason they had not gotten a preventive care test, even though by law these tests are excluded from deductibles.”¹³

Out-of-pocket costs also harm the financial well-being of individuals, families and the state. Not only do out-of-pocket costs reduce the financial protection provided by health insurance, and thereby produce healthcare bills that cut into families’ budgets for rent and food. They also increase the risk of high medical bills leading to bankruptcy. Moreover, cost-sharing can actually increase overall healthcare costs by leading to greater use of more costly emergency and inpatient hospital care.

- The introduction of a \$1 co-pay in California’s Medicaid program in 1972 led to an 8% reduction in physician visits and a 17% increase in hospital days, according to a 1978 study based on the RAND Health Insurance Experiment data.¹⁴
- Even modest cost sharing can add to families’ financial hardship, forcing difficult choices between necessary health care and other basic necessities, reported Health Affairs in 2009, summarizing a government study about potential cost sharing in Medicaid and CHIP.¹⁵
- The argument for cost-sharing as saving costs in the system through preventing overutilization is also theoretically flawed. As the vast majority of health care costs are incurred by a very small subset of the population with serious chronic health conditions, and as the majority of costs incur once a patient is in the system, not at the point of access, cost-sharing cannot significantly change the overall costs of care.¹⁶

In summary, contrary to widespread assumptions, “cost-sharing” is not about “skin in the game;” instead, it puts lives on the line, as aptly put by Families USA.¹⁷

Shifting the focus from patients to providers

Rather than increasing health risks in the hunt for elusive savings through cost-sharing, policymakers should turn to alternative policy levers in order to enhance efficiency in the use and provision of care. There are numerous value-for-money based interventions that can incentivize providers to manage utilization and deliver care more effectively and efficiently. Evidence shows that the problem of

¹³Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel, “Too High a Price: Out-of-Pocket Health Care Costs in the United States: Findings from the Commonwealth Fund Health Care Affordability Tracking Survey,” September–October 2014, 8 (http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/nov/1784_collins_too_high_a_price_out_of_pocket_tb_v2.pdf); see also this overview: Martin Sipkoff, “Higher Copayments and Deductibles Delay Medical Care, A Common Problem for Americans,” *Managed Care*, January 2010 (http://www.managedcaremag.com/archives/1001/1001_downstream.html).

¹⁴ Cited in Hudman, supra note 2.

¹⁵ See National Health Law Program, *Cost Sharing Studies and the Impact on Medicaid Beneficiaries*, August 2011, (http://www.healthlaw.org/images/stories/medicaiddefense/2011_08_02_NheLP%20Cost%20Sharing%20Summary.pdf), citing: Thomas M. Selden, Genevieve M. Kenney, Matthew S. Pantell, et al., “Cost Sharing In Medicaid And CHIP: How Does It Affect Out-Of-Pocket Spending?” *Health Affairs* July/August 2009 28:4w607-w619. For a more recent summary of research findings on access to needed care by low-income individuals, see David Machledt and Jane Perkins, “Medicaid Premiums and Cost Sharing,” National Health Law Program, March 2014 (<http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing#.Vil8sllbSh>)

¹⁶ Jill Bernstein, Deborah Chollet, and Stephanie Peterson, “Financial Incentives for Health Care Providers and Consumers,” *Mathematica*: May 2010 (http://www.mathematica-mpr.com/~media/publications/PDFs/Health/reformhealthcare_IB5.pdf).

¹⁷ Op cit, supra note 2

inefficient, costly care is primarily caused by the behavior of providers, not patients – it is providers and not patients who control the utilization of care: “when people seek physician care or go to hospitals for care, the intensity of services provided reflects norms of care and decisions made by the providers rather than patients.”¹⁸ Those norms and decisions are largely driven by financial incentives that can be changed through policy interventions. This means policy levers should focus on the delivery side of the care relationship, including the various supply industries. “The literature points to the importance of supply-side incentives over demand-side factors in driving treatment choice.”¹⁹ After all, people “have little visibility into pricing, let alone control of it. They have little choice of hospitals or the services they are billed for, even if they somehow know the prices before they get billed for the services. [...] They have no choice of the drugs that they have to buy or the lab tests or CT scans that they have to get, and they would not know what to do if they did have a choice.”²⁰

Fee-for-service payments, financial and legal incentives to medicalize basic health procedures, financial incentives to overuse expensive equipment, drug prescription protocols, etc., are key drivers of inefficient, expensive care provision that may lead to placing business imperatives above medical efficacy. The supply industries, such as labs, medical device makers, and purveyors of CT scans, MRI, and other medical equipment, also play a significant role in cost increases, benefiting from a lack of regulations and concerted payment reform.

Payment reform can address a number of these drivers, such as “overdoctoring” - which can adversely affect patients’ health - by moving to outcome-based incentives. Changing the relationship between health professionals and patients to emphasize health protection rather than a market-type exchange between “consumer” and “supplier” will also result in efficiency gains. Enhancing the primary care infrastructure and ensuring every person has continuity of care could also foster primary care practitioners’ role as gatekeepers to secondary and tertiary care. Finally, a universal health care system that moves away from an insurance business model could establish an independent expert body, accountable to the public, to provide evidence-based guidance on which treatments, tests and drugs - available at different costs and effectiveness levels - represent the best quality of care and the best value for money.

¹⁸ Katherine Swartz, “Cost-sharing: Effects on Spending and Outcomes,” Robert Wood Johnson Foundation, December 2010, 9 (http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1).

¹⁹ Chandra, op cit, supra note 2, 425.

²⁰ Steven Brill, “Bitter Pill: Why Medical Bills are Killing Us,” Time Magazine, April 2013.