Written testimony from Vt. Workers' Center on Cost Sharing 4/8/14
--James Haslam

Dear House Committee on Healthcare,

There was one other thing we wanted to share with you today. We understand that the committee is considering the use of cost-sharing as a policy tool to reduce utilization and contain costs to the system as a whole. We appreciate your consideration of these policy goals, yet we would like to draw your attention to the demonstrated failure of cost-sharing to achieve these goals.

Research over the last four decades has consistently concluded that the imposition of cost sharing reduces both necessary and unnecessary care and correlates with increased risk of poor health outcomes. Moreover, it has a very limited effect on system-wide health spending, as it mainly shifts costs from an insurance or government payer to low-income patients - the most regressive form of financing. In so far as it encourages delaying needed care, cost-sharing can effectively increase system costs through the greater use of emergency and inpatient care.

One of our new members is a retired health insurance company executive from Bennington County who can share a strong perspective around this with the committee on this and he may be able to testify this Thursday.

Research evidence for adverse health effects of out-of-pocket costs ("cost-sharing")

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 disproportionally 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]
- 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]

- 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]
- 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.[6]
- 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.[7]
- 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. [8]
- 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.[9]

Out-of-pocket costs also harm the financial health 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.[10]
- 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.[11]

In summary, contrary to wide-spread assumptions, "cost-sharing" is not about "skin in the game;" instead, it puts lives on the line, as aptly put by Families USA.[12]

Rather than increasing health risks in the hunt for elusive cost savings, 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 effectively steer patients toward more efficient use of health care, and, more importantly, incentivize physicians to provide care more efficiently. Evidence shows that the problem of inefficient care is primarily caused by the behavior of providers, not patients – it is less the use of care than the provision of care that must be corrected. Fee-for-service payments, incentives to medicalize basic health procedures, incentives to overuse expensive equipment, etc., are only a few of the key drivers of inefficient care provision. Payment reform can address some of these drivers, as can other provider rules, such as compulsory generic prescribing. Changing the interaction between health professionals and patients toward a focus on protecting health rather than a market-type interaction between "consumer" and "service provider" will also result in efficiency gains.

Such measures include enhancing the role of primary care doctors and enabling them to serve as gatekeepers to secondary and tertiary care, and enrolling patients in disease management programs.

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[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 3003 (http://www.kff.org/medicaid/upload/Health-Insurance-Premiums-and-Cost-Sharing-Findings-from-the-Research-on-Low-Income-Populations-Policy-Brief.pdf).

[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/NEJMsa0904533).

[5] M 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] 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/).

[7] Michael Chernew, 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).

[8] Tamblyn 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.

[9] 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).

[10] Cited in Hudman, supra note 2.

11 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.

[12] Op cit, supra note 2