LEAGUE OF WOMEN VOTERS® OF NEW YORK

Update on Healthcare and the Financing of Healthcare (2019-2021) Materials

Instructions & Updated Positions

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Healthcare Position Update Committee

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Appendix C

Pro/Con on Cost Sharing

NOTE: The update committee has included this as background because, although we did not include cost sharing as a disfavored cost-control method in the proposed new positions because of a conflict with the LWVUS position, it is relevant to current healthcare reform discussions in general.

Cost sharing is the share of healthcare claims (medical services or medications) covered by insurance that is paid by patients through deductibles, co-pays, and co-insurance. It does not include health insurance premiums (even when an individual "contributes" to the cost of the premium). The rationale for cost sharing is reduction of "moral hazard": when people use their own money, they will only use healthcare or medication they really need, and will obtain it from the most economical source.

Arguments which FAVOR cost sharing as a healthcare cost-control method:

1. **Cost-sharing increases personal responsibility** for selecting healthcare services by encouraging price-shopping and "consumer-directed" choices based on relative value to the patient.[143]
2. **Cost-sharing saves money by reducing demand** for less effective healthcare services, i.e., the "moral hazard" of people over-using what they get for "free." Paying for healthcare gives them "skin in the game."
3. **The Rand Health Insurance Experiment (HIE) — often cited as the "gold standard" study** on healthcare costs, demand, and outcomes — concluded that "modest cost-sharing reduces use of [healthcare] services with negligible effect on health for the average person."[144]
4. **The Rand HIE, conducted from 1974-81, found limited adverse health outcomes only among the poorest and sickest** patients, e.g., those suffering from specific chronic diseases such as hypertension, lipid disorder, diabetes, and schizophrenia.
5. **Cost-sharing reduces the tax burden for public health insurance plans**.

Arguments which DISFAVOR cost sharing as a healthcare cost-control method:

1. **Cost-sharing impedes universal access by creating financial barriers that ration healthcare services** by income, even for those with private insurance.[145] LWVNY has lobbied successfully to prevent Medicaid from charging co-pays on the grounds that cost-sharing discourages Medicaid clients from seeking essential healthcare services, resulting in serious health consequences and more expensive forms of medical care.[146]
2. **Cost-sharing doesn't control costs.** It reduces demand for the least expensive services (primary and preventive care) and also care associated with managing chronic diseases, thus decreasing health, increasing adverse health events and cost. Because excess healthcare capacity drives U.S. utilization, [147]

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[143] https://www.rand.org/capabilities/solutions/determining-the-effects-of-cost-sharing-in-health-care.html (begun in 1971).

[144] https://www.rand.org/health-care/projects/HIE-40.html The RAND HIE was a ground-breaking study that ran between 1974 and 1981, funded by HEW at a cost of $294M. To quantify price sensitivity and elasticity of cost-sharing — and the "moral hazard" — in health insurance, they "provided health insurance to more than 5,800 individuals from about 2,000 households in six different locations across the United States," enough to create randomized samples, to determine how families trade off healthcare cost against healthcare use. Each selected household received a plan that provided something between free coverage and almost no coverage up to $4,000 (in 2011 dollars)

[145] "50% of all privately insured respondents reported skipping or delaying at least one type of care because of cost,"."72% of these respondents skipped or delayed multiple types of care." *From Coverage to Care* https://www.nyhcampaign.org/report

[146] Impact on Issues, updated 2018, p. 87.

[147] "There is now ample evidence in the health policy literature to show that excess capacity in the health care system results in over-utilization, defined as an increase in utilization without a reasonably commensurate improvement in health care outcomes." https://pnhp.org/news/health-care-marketplace-creates-wasteful-excess-capacity/

reducing demand does not affect costs.[148] Further, cost-sharing increases administrative complexity (BIR costs).[149]

3. **The Rand HIE study was methodologically flawed**, invalidating its key finding that reducing needed healthcare has no adverse health consequences. Specifically, HIE was not representative of the US population (it included only people in the workforce and their dependents, not the elderly or those too sick or disabled to work) and HIE failed to account for those who exited HIE early (e.g., for health or affordability issues).
4. **Cost-sharing discourages good management of chronic diseases**, increasing medical costs, while reducing public health and labor productivity**.** Medical breakthroughs in managing many chronic diseases (hypertension, diabetes, asthma, schizophrenia, etc.) can now effectively slow disease progression and reduce expensive adverse health events but only when patients rigorously adhere to protocols.[150]
5. **Cost-sharing saves money for private insurers** but can significantly increase the cost to taxpayers, while reducing overall public health outcomes.[151]

Supplementary Reading on Cost-Sharing in Healthcare

The RAND HIE

Arguments in favor of cost-sharing continue to reference a ground-breaking study by RAND that ran 1974 to 1982, funded by HEW at a cost of $294M. To quantify price sensitivity and elasticity of cost-sharing — and the "moral hazard"[152] — in health insurance, RAND "provided health insurance to more than 5,800 individuals from about 2,000 households in six different locations across the United States,"[153] enough to create randomized samples, to determine how families trade off healthcare cost against healthcare use. Each selected household received a plan that provided something between free coverage and almost no coverage up to $4000 (in 2011 dollars).

Still described as a "gold standard," the RAND study, often called HIE —Health Insurance Experiment — concluded, broadly[154]

- Each 2% increase in cost-sharing resulted in 10% reduction in spending (less utilization)
- Households reduced spending equally for clinically important and unimportant services

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[148] https://www.rwjf.org/en/library/research/2011/12/cost-sharing--effects-on-spending-and-outcomes.html

[149] "Complexity [drives BIR costs]… determining patient insurance and cost sharing; collecting copayments …; receiving and depositing payments; … collecting from patients…," *Healthcare Imperative*, p141, Natl Acad, 2010, https://www.nap.edu/read/12750/chapter/7#143 .

[150] Per the CDC: "90% of the nation's $3.5T in annual health care expenditures are for people with chronic and mental health conditions … Preventing chronic diseases, or managing symptoms when prevention is not possible, can reduce these costs." https://www.cdc.gov/chronicdisease/about/costs/index.htm.

[151] "As Perkowski's and my analysis of 28 countries over a 10-year period concludes, one-third of all advanced countries (e.g., Canada) have no cost-sharing, and their costs cannot be distinguished from those that do have cost-sharing. The real reason for cost-sharing (in the US, at least) is to reduce the cost to the insurer and force the patient/consumer to pay part of the cost. (Note that, for the most expensive part of health care, hospitalization, cost-sharing is small and has almost no impact on usage.)" Rodberg by email, Perkowski & Rodberg, "Cost Sharing, Health Care Expenditures, and Utilization: An International Comparison,"2015, https://journals.sagepub.com/doi/abs/10.1177/0020731415615312?journalCode=joha

[152] "Moral hazard," a phrase dating to the 1600's, developed negative connotations in the 19th-C suggesting fraud or immorality by the insured. In the 1960s, a variant definition arose among economists (Arrow, Pauly) to "describe inefficiencies that can occur when risks are displaced," when "a person takes more risks because someone else bears the cost of those risks," e.g., when a patient with health insurance uses more healthcare than a patient without health insurance. Summarized from Wikipedia "Moral Hazard" and Michel Grignon, et al, "Moral Hazard in Health Insurance," *Oeconomia* 8-3, p. 367-405 (2018). https://journals.openedition.org/oeconomia/3470.

[153] "The RAND Health Insurance Experiment, Three Decades Later," Aviva Aron-Dine, et al. Published in final edited form as: *J Econ Perspect*. 2013 ; 27(1): 197–222. doi:10.1257/jep.27.1.197. https://siepr.stanford.edu/research/publications/rand-health-insurance-experiment-three-decades-later

[154] The Health Insurance Experiment: A Classic Rand Study (RAND 2006), Robert Brook, et al, https://www.rand.org/pubs/research_briefs/RB9174.html

- No reduction in health outcome accompanied reduction in spending (except for a few specific conditions in the lowest-income households)

When policy makers today discuss "moral hazard" and "skin in the game," they are referencing RAND conclusions: namely, when patients do not pay for care, they over-use it; when they must pay for it, they use less; and using less does not harm their health.

Because RAND collected so very much data across so large a population, policy makers continue to mine the HIE data. Additional conclusions include:

- Requiring people to take on cost did not influence behaviors associated with poor health (e.g., smoking, obesity)
- Cost-sharing does not significantly address drivers of cost growth since it had little effect on treatment costs, once treatment was sought
- While there appeared to be no difference in quality between the insurance categories, quality of care was rated at 62% (a 2003 national follow-up rated it at 55%)

Rebuttals to RAND

Even in the 1980's, rebuttals to RAND's findings appear, particularly around the notion that patients can make effective healthcare decisions based on cost without harming their health

Flawed statistical conclusions:

- The population sampled didn't represent the US population:
  - excluded the elderly and seriously sick
  - included only those healthy enough to be employed
- Cohorts analyzed did not include those who dropped out to return to their original medical plan after
  - being assigned to HIE high-cost plan
  - developing serious health issues

Skewed data means "the RAND finding … is spurious."[155]

This 1985 cartoon illustrated a NEJM article[156]

Medical advances — in 2019, patient compliance costs more but has greater health value

- Chronic disease management/prevention was in its infancy, with few treatments available in 1970s[157]
  - In 2019, 60% of Americans live with at least one chronic disease; 40% with at least 2; [158]
  - **"90% of the nation's $3.5T in annual health care expenditures are for people with chronic and mental health conditions."** [159]
  - "Education interventions may improve compliance with important services, but may not reduce the price sensitivity of patients… patients responded to lower copayment rates."[160]
  - US seniors of all incomes have two-to-four times as much cost-related non-adherence to drug protocols as seniors in 11 peer countries.[161]

[155] "Cracks in the moral hazard foundation" (2007): http://www.pnhp.org/news/2007/september/cracks_in_the_moral_.php
[156] "Cost Sharing in Health Insurance, a reexamination," M. Edith Rasell, NEJM 4/27/1985 accessed through https://pnhp.org/system/assets/uploads/2009/12/Cost-Sharing-Reexamination.pdf
[157] *"What Does the RAND Health Insurance Experiment Tell Us About the Impact of Patient Cost Sharing on Health Outcomes?"* https://www.ajmc.com/journals/issue/2008/2008-07-vol14-n7/jul08-3414p412-414
[158] CDC National Center for Chronic Disease Prevention and Health Promotion https://www.cdc.gov/chronicdisease/index.htm
[159] *Ibid*. https://www.cdc.gov/chronicdisease/about/costs/index.htm
[160] "What does the RAND HIE tell us about the impact of patient cost sharing on health outcomes?" Chernew, Newhouse, 2008 AJMC, accessed through https://www.ajmc.com/journals/issue/2008/2008-07-vol14-n7/jul08-3414p412-414
[161] See graphic: "Cost-related non-adherence to prescribed medicines among older adults" from BMJ study at http://dx.doi.org/10.1136/bmjopen-2016-014287, also available at https://pnhp.org/pharma/

- "We find that physician visits and prescription drug usage have elasticities that are similar to those of the RAND Health Insurance Experiment (HIE). Unlike the HIE, however, we find substantial "offset" effects in terms of increased hospital utilization. **The savings from increased cost sharing accrue mostly to the supplemental insurer, while the costs of increased hospitalization accrue mostly to Medicare**" (**estimated at six-fold increase)** for unhealthiest Medicare patients, but doubling the HC cost for others. [162]

Healthcare is not a "market"

> "Economists call the approach price discrimination, which means the identical service is sold to different buyers at different prices... Because the word rationing is anathema in the US debate on health policy, the strategy has been marketed instead under the felicitous label of consumer-directed health care," Uwe Reinhardt.[163]

The purchase of medical services and medications is not a true marketplace. Patients are seldom in a position to shop for best value: urgent care rarely allows discretion in treatment or timing of treatment; prices of services vary widely (by provider, insurer, policy); patients rarely have sufficient information to decide on the best course of treatment before seeking care; providers cannot guarantee outcomes or predict total costs:

- Cost-sharing does not control or drive down costs
- Savvier "shopping" by consumers (for necessary care) will not control costs[164]
- The for-profit insurer "business" model depends on denying care, not providing it

Fifty-plus years ago, Nobel laureate economist Kenneth Arrow published *Uncertainty and the Welfare Economics of Health Care*[165], arguing that free-market models cannot be applied to healthcare.[166] His arguments are frequently cited today to rebut arguments that free-market deregulation will "improve" HC or HC pricing.

Reduced utilization by delaying care doesn't reduce intensity of care (the number and type of services) — and the US has low utilization rates, relative to peer countries:

- The average # of contacts with physicians was less than half the rate of Germany and Japan in 1990 — both with better health outcomes in 2018:[167]
  - Americans visit physicians 4.5/year and live to expected 78.7 years
  - Japanese visit physicians 13/year and live to expected 84.2 years
  - Germans visit physicians 10/year and live to expected 81.3 years
- "Even under the extreme (and incorrect) assumption that those without health insurance use no health services at all, the utilization rate … [would be] lower than all the other countries examined, except the UK."[168] [UK now averages 6 visits/year as of 2017][169]

Financial Issue: **Medical care which is subject to price sensitivity from cost-sharing has *de minimus* effect on overall costs**:[170]

- "Shopping around" to find better prices isn't possible for patients in narrow networks or needing urgent/ER care

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[162] "Indeed, the hospital spending effect is enormous for those who are unhealthiest by this measure, with hospital spending increasing by almost $2 for every $1 saved on other spending—and Medicare's hospital spending increasing by more than $6 for every $1 saved on physician spending!"… "Our results suggest that the donut hole in coverage, by increasing coinsurance rates to 100 percent for some of the most chronically ill Medicare beneficiaries, could *increase* Medicare's costs." Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly" Am Econ Rev, 3/1/2010, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2982192/

[163] https://pnhp.org/news/important-uwe-reinhardt-on-health-care-price-transparency-and-economic-theory/

[164] Robert J Wood Foundation Report on Cost-Sharing and PNHP comment, 2010, https://pnhp.org/2011/03/31/important-rwjf-report-on-cost-sharing/

[165] Accessible at https://web.stanford.edu/~jay/health_class/Readings/Lecture01/arrow.pdf

[166] This provides a 2016 interview with Arrow https://pnhp.org/news/kenneth-arrow-says-single-payer-is-better-than-any-other-system/

[167] https://international.commonwealthfund.org/stats/annual_physician_visits/

[168] *Ibid*. M. Edith Rasell, NEJM 4/27/1985

[169] *https://www.bma.org.uk › media › files › pdfs › general-practice*

[170] Robert J Wood Foundation Report on Cost-Sharing and PNHP comment, 2010, https://pnhp.org/2011/03/31/important-rwjf-report-on-cost-sharing/

- Most people are healthy, so increasing cost-sharing enough to reduce their spend by 10% would save 0.3% — 50% of our population uses 3% of healthcare dollars
- The sickest among us are focused on accessing healthcare they need and have already met deductibles
  - The sickest 20% spend 80% of healthcare dollars
  - Cost-sharing is not intended to reduce needed care for significant diseases or injury
- The remaining 30% use about 16% of healthcare dollares
  - Some of this is urgent/ER care, where price-shopping is irrelevant
  - Reducing their spending by 10% might save 1.6% of total healthcare spending

These savings total under 2% — "relatively paltry savings from creating price sensitivity… [which is offset by] the higher costs of deferred medical management"[171]

Cost-sharing has been demonstrated to result in adverse outcomes[172] that constitute a significant portion of our national healthcare costs.[173]

- For **low-income individuals and families**: low Medicaid reimbursement rates ration care:
  - Unwilling providers "balance" patient rolls based on patient income
  - Financially strapped local and state govts increase cost-sharing to balance state budgets on those with least political importance, reducing costs by reducing access
- For **those with chronic diseases**, cost-sharing at point-of-service results in the opposite of its intent: instead of reducing "over-use" or "moral hazard," inadequate disease management means **cost-sharing results in higher costs** of emergency rooms, hospitalization, even life-threatening conditions:[174]
  - Doubling co-payments reduced anti-diabetes Rx use "by 23%," "anti-hypertension by 10%"
  - When an employer raised cost-sharing by $10-$20 per Rx, 21% of patients stopped their high-cholesterol medication
  - Higher cost-sharing for Rx "led to worse physiologic outcomes… more visits to the emergency room, and even greater mortality."
  - "high cost sharing resulted in worse compliance … more hospital admissions and other poor health outcomes."
  - "Reducing copayment rates seems to have the opposite effect."
  - "higher cost sharing will reduce use of preventive or screening tests…[e.g.,] reduced use of mammography after increases in copayment rates."

For-profit insurer self-interest: cost-sharing allows "cherry picking" and "lemon dropping"
High-deductible plans attract relatively healthier consumers; disproportionate numbers of healthier enrollees cause the plans to

- "look as if they spend less than plans that cover a more normal mix of customers"
- be as much as "26% cheaper to cover, an advantage that has nothing to do with how the plan creates incentives for lower healthcare use."[175]

Most OEDC countries either provide first-dollar coverage for primary care and out-patient specialists (who accept government payments) or waive cost-sharing based on income. [176]

- No cost-sharing: Australia, Canada, Denmark, Germany, Greece, Italy, Spain, United Kingdom …
- Co-pays under $10: Belgium, France, Iceland, Portugal (60% of country pays nothing), Sweden[177]

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[171] *Ibid*. RJW Report
[172] *Ibid.* Frakt
[173] *Ibid*. "Cost-related non-adherence to prescribed medicines among older adults." Also see https://www.cdc.gov/chronicdisease/about/costs/index.htm
[174] Listed research studies cited in "What does the RAND HIE tell us about the impact of patient cost sharing on health outcomes?" Chernew and Newhouse, 2008 AJMC, accessed through https://www.ajmc.com/journals/issue/2008/2008-07-vol14-n7/jul08-3414p412-414 Googling generates dozens more studies in peer-reviewed publications.
[175] "Health Care Cost-Sharing Works — Up to a point," Frakt, 5/26/2014, NYT https://www.nytimes.com/2014/05/27/upshot/health-care-cost-sharing-works-up-to-a-point.html
[176] Ibid., Perkowski, appendix compares 28 OEDC countries on their cost-sharing for medical, hospital, and pharmaceuticals.
[177] OEDC Health System Characteristics, http://www.oecd.org/health/health-systems/characteristics.htm