HOW SHOULD PUBLICLY SPONSORED HEALTH INSURANCE BE STRUCTURED?

Policymakers considering how to structure a program of publicly sponsored health insurance for low-income Americans face a set of fundamental issues about its design. This section addresses seven core elements that play a large part in determining the scope, shape, impact, and sustainability of a publicly financed health coverage program. In the following pages, we outline the issues and present the evidence relevant to these defining policy dimensions:

- **Eligibility**
- **Participation**
- **Use of Premiums**
- **Scope of Benefits**
- **Use of Cost-Sharing**
- **Access to Care**
- **Financing**

Use of Cost-Sharing

The issue

Cost-sharing, usually in the form of copayments and deductibles, is sometimes advanced as a means to increase personal responsibility for health care and discourage unnecessary utilization. However, cost-sharing creates different financial burdens for individuals at different income levels. The burden of cost-sharing tends to be heavier for low-income people because their finances are limited and their health care needs are often significant – a result with important implications for low-income people's access to care.

Historically, federal Medicaid law has limited beneficiary cost-sharing to nominal levels. While the Deficit Reduction Act of 2005 greatly increased state authority to impose cost-sharing in Medicaid, cost-sharing remains prohibited or limited for certain groups and certain services. The State Children's Health Insurance Program (SCHIP) also builds in protections, limiting copayment amounts for children in families with income below 150% of the poverty level, and limiting total out-of-pocket spending (i.e., premiums, deductibles, and copayments) to 5% of family income.

The evidence

Research examining the experience of Medicaid beneficiaries and the low-income population has found adverse effects of cost-sharing. In particular, evidence shows that cost-sharing causes low-income people to delay or reduce their use of care, leading to poor health outcomes. Research has not substantiated concerns that low or no cost-sharing might lead to over-utilization.

Even low levels of out-of-pocket spending can impose heavy financial burdens on low-income people, and out-of-pocket health costs consume a disproportionately large amount of their income. The financial burden of cost-sharing is heavier on people with more extensive needs for care, and heaviest on those with both greater health needs and low income.

When individuals and families cannot pay their out-of-pocket costs, the resulting medical debt is a barrier to obtaining health care. Research shows that people with medical bill problems are much more likely than those without medical bill problems to report unmet medical needs and delays in care. Many, even among those with private insurance, experience significant problems paying their medical bills, and evidence indicates that privately insured adults with medical debt limit their care in many of the same ways and as often as adults with no health insurance.

Cost-sharing also affects the providers who serve the low-income population. Providers are responsible for collecting cost-sharing amounts. In addition, their net reimbursement is reduced if they provide care to patients who do not pay their cost-sharing.

While cost-sharing is being used increasingly in the private insurance market to promote cost-consciousness and handle rising costs, the evidence shows that for low-income people, cost-sharing can affect access to care and health outcomes adversely. Even at low levels, cost-sharing can place a disproportionately heavy burden on the tight budgets of low-income individuals and families, especially those with the most health needs. In light of current gaps in access for low-income Americans and efforts to promote effective management of chronic disease, cost-sharing, if used, should be applied judiciously and on an income-related basis. To advance health goals, specific populations and/or services could be exempted from cost-sharing.

Key Evidence

Medical bill problems impede access to health care.

- A 2003 national survey found that 1 in 6 privately insured adults – 17.6 million adults – were continuously insured but reported substantial problems paying their medical bills. The survey results indicate that after adjusting for social, economic, and health factors, the privately insured with medical debt limit their care in many of the same ways and as often as those who have no health insurance. A quarter or more of respondents in both groups reported that they skipped a test or treatment, did not fill a prescription cost, and/or postponed care due to cost.[1]

- People in families with problems paying medical bills are five times more likely to report an unmet medical need in the past year and four times more likely to report delaying care in the past year due to cost concerns, compared with people in families with no medical bill problems. Also, 30% of individuals in families with bill problems report that they did not get prescription drugs because of cost, compared with 7% of those in families without bill problems.[2]

- An analysis of out-of-pocket expenses and unmet need related to obtaining prescription drugs found that families who spent more than 5% of their income on out-of-pocket costs for prescription drugs were more than twice as likely to report an unmet need for prescription drugs as families who spent 5% or less of their income on such costs (15.4% versus 6.3%).[3]

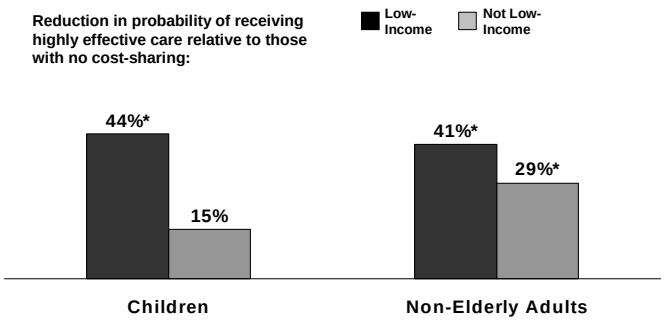
- The Congressional Budget Office estimated that provisions of the Deficit Reduction Act of 2005 that permit states broader use of premiums and cost-sharing in Medicaid and authorize higher cost-sharing would result in reduced Medicaid spending of $1.9 billion over five years and $9.9 billion over ten years. CBO attributed about 70% of the savings to increased cost-sharing, and estimated that about 80% of the savings from higher cost-sharing would come from decreased use of services.[4]

Cost-sharing can reduce the use of appropriate care and contribute to worse health outcomes in the low-income population.

- The RAND Health Insurance Experiment (HIE) investigated the impact of cost-sharing on utilization and health outcomes. It found that both children and adults in cost-sharing plans had reduced use of highly effective care compared with those in plans with no cost-sharing (Fig. 33), and the effect of cost-sharing was stronger in the low-income groups. Among people who were poor and sick, those in plans with cost-sharing had reduced use of all types of

Figure 33

Impact of Cost-Sharing on Likelihood of Receiving Highly Effective Medical Care, by Income



*Difference significant at p<.05.
Note: "Low-income" defined as lowest third of income distribution, roughly equivalent to <200% of federal poverty level.
SOURCE: Lohr et al, "*Effect of Cost-Sharing on Use of Medically Effective and Less Effective* Care," Medical Care, 24(9), September 1986.

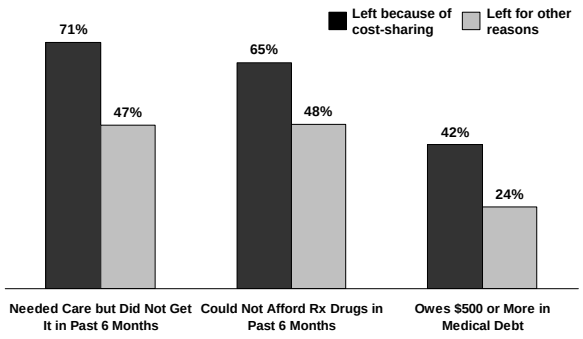
health services studied compared with those in the free-care plan. The reduced utilization adversely affected health outcomes in this population. In particular, the poor with hypertension had their blood pressure lowered more on the free-care plan than on the cost-sharing plans, and the impact on predicted mortality rates – a drop of about 10% – was substantial for the free-care group. More broadly, serious symptoms were less prevalent on the free plan than on the cost-sharing plans, especially for those who began the Experiment poor and with serious symptoms. There also appeared to be a beneficial effect on anemia for poor children in the free-care plan.[5 6 7 8 9 10]

- Researchers have found that the use of prescription drugs is sensitive to price in general, but also specifically in low-income groups. A study of the impact of a new cost-sharing requirement on prescription drugs in Quebec found that the use of essential, as well as less essential, drugs declined substantially among welfare recipients and the low-income elderly in response to the cost-sharing. The rate of serious adverse events (hospitalization, long-term care admission, or death) and emergency department visits associated with reduced use of essential drugs also rose.[11 12 13 14]

- Studies examining the impact of copayments have found that they reduce access to and use of prescription drugs and other ambulatory care among Medicaid beneficiaries and other poor populations. A survey of adults conducted after the Oregon Medicaid program increased premiums and introduced copayments showed that 44% of those who left the rolls disenrolled for cost sharing-related reasons. Those who left for cost sharing-related reasons were significantly more likely than those who left for other reasons not to have received needed care in the past six months, to have skipped buying prescription drugs because of cost, and to owe $500 or more in medical debt (Fig. 34).[15 16 17 18 19 20]

Figure 34

Unmet Need and Financial Impacts among Adults, by Reason for Leaving Oregon Health Plan, 2003



Notes: "Cost-sharing" includes premiums and copays. "Other reasons" include: program-appropriate loss of eligibility; returned paperwork too late; left because desired benefit was cut. Differences significant at p<.001.
SOURCE: Wright et al, "*The Impact of Increased Cost Sharing on Medicaid Enrollees*," Health Affairs, July/August 2005.

- A review of study findings from states that have recently increased or imposed new cost-sharing requirements in their Medicaid, SCHIP, or other public coverage programs found that cost-sharing led to unmet medical need and financial stress among some beneficiaries, even when amounts were nominal or modest.[21]

- A study of the impact of Medicaid copayments shows that elderly and disabled Medicaid beneficiaries living in states with copayment requirements have significantly lower rates of drug use than their counterparts in states without copayments. The primary effect of copayments – to reduce the likelihood that Medicaid beneficiaries fill any prescriptions during the year – burdens those in poor health disproportionately.[22]

- A growing body of studies provide additional evidence that cost-sharing reduces low-income people's use of appropriate care and adversely affects their health outcomes.[23 24 25 26]

- Nearly all of the 22 studies included in a 2004 review of the research literature found that, among seniors, cost-sharing reduces either the appropriate use of services or health status, or both. In one of the studies that did not find this result, generous provisions were in place to protect vulnerable populations from incurring undue financial risk as a result of cost-sharing.[27]

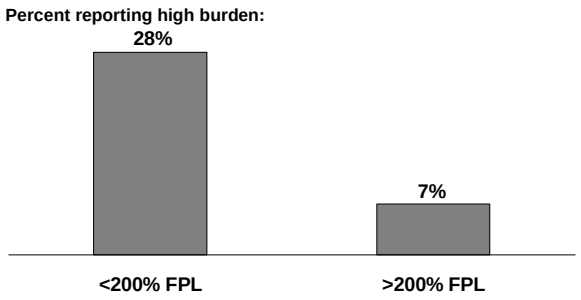
- A review of study findings from states that have recently increased or imposed new cost-sharing requirements in their Medicaid, SCHIP, or other public coverage programs found that cost-sharing led to unmet medical need and financial stress among some beneficiaries, even when amounts were nominal or modest.[28]

Cost-sharing and out-of-pocket costs for care that is not covered place a disproportionately heavy financial load on low-income people.

- Low-income people are more likely than others to face out-of-pocket health care costs that exceed 5% of their family income. Findings from a 2003 household survey indicate that about 1 in 5 low-income families have problems paying their medical bills. Among those at or above 400% of the poverty level, fewer than 1 in 10 families report this difficulty. About half of all families with medical bill problems are low-income. Other research provides evidence that, among the insured, 28% of low-income families incur out-of pocket costs (exclusive of premiums and dental care) exceeding 5% of family income, compared with 7% of families with higher income (Fig. 35).[29] [30]

Figure 35

High Out-of-Pocket Burden Among Insured Families by Income, 2002



Notes: Includes only non-elderly families. "High out-of-pocket burden" defined as out-of-pocket spending (excluding premiums and dental care) exceeding 5% of family income. "FPL" means federal poverty level.
SOURCE: Shen and McFeeters, "*Out-of-Pocket Health Spending Between Low- and Higher-Income Populations: Who is at Risk of Having High Expenses and High Burdens?*" Medical Care, March 2006.

- Analysis shows that the share of family income spent on medical expenses rises as income falls. In 2001, poor families with children spent $75.25 out-of-pocket (excluding premiums) per $1,000 of income, compared to $15.55 per $1,000 of income paid by families with income above 400% of the federal poverty level. The regressive nature of cost-sharing is also apparent in the distribution of high out-of-pocket burden. Research indicates more than one-quarter of families below poverty have total out-of-pocket spending (including premiums) that exceeds 10% of their family income –compared with 6.3% of families with income over 400% of the poverty level who have out-of-pocket spending at this level.[31] [32]

- An analysis of out-of-pocket spending by the insured population shows that the median share of income devoted to health care costs (not including premiums) is 4% for poor non-elderly families insured throughout the year, compared with 1% for non-elderly insured families at or above twice the poverty level. The extremely large difference between the two groups in their average out-of-pocket burden – 18% versus 2% – reveals that some poor families bear a much larger out-of-pocket burden.[33]

- Low-income individuals and families facing out-of-pocket expenses have very little remaining income to meet other needs. One study found that, among working-age adults with chronic conditions whose families had problems paying medical bills in the past year, 68% had problems paying for other necessities, such as food and shelter, 64% were contacted by a collection agency, 55% put off major purchases, and 50% had to borrow money. Nine in 10 families experienced at least one of these impacts and almost one-quarter experienced all four.[34] [35]

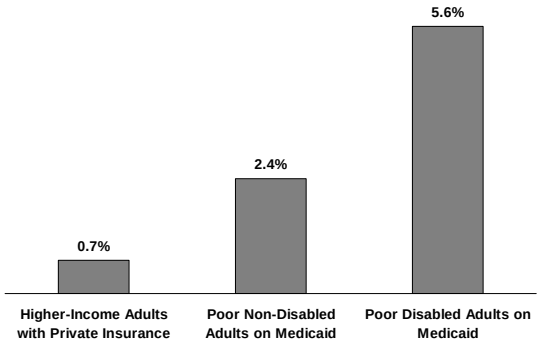
- A study of children with special health care needs found that, in 2000, the children under 200% of the poverty level were 11 times more likely to have out-of-pocket costs exceeding 5% of family income than the children at or above 400% of the poverty level.[36]

- In a 2003 survey, 1 in every 5 low-income families reported they had trouble paying medical bills, compared with fewer than 1 in 10 families with income of at least 400% of the poverty level.[37]

- In 2002, poor working-age, non-disabled adults in Medicaid spent an average of $210 for out-of-pocket health costs (including deductibles, copayments, coinsurance, and expenses for non-covered care) – much less than the $548 spent by privately insured adults with income at or above 200% of the poverty level. However, because the Medicaid adults' average income was about one-ninth that of the comparison adults ($8,846 versus $80,325), their out-of-pocket costs consumed a substantially larger share of their income: 2.4% versus 0.7%. Poor disabled adults in Medicaid spent an average of 5.6% of their income on out-of-pocket medical costs (Fig. 36).[38] [39]

Figure 36

Percent of Family Income Spent on Out-of-Pocket Health Care Costs, 2002



Notes: "Higher-income" defined as >200% of HHS poverty level, which was $30,040 for a family of three in 2002. "Poor" defined as <100% of HHS poverty level, which was $15,020 for a family of three in 2002.
SOURCE: Ku and Broaddus, *Out of Pocket Medical Expenses for Medicaid Beneficiaries Are Substantial and Growing*, Center on Budget and Policy Priorities, May 2005.

Out-of-pocket costs place a heavier financial burden on individuals with extensive needs for health care, and the burden is heaviest of all for those with both greater health needs and low income.

- Compared with others, people living with chronic conditions are more likely to spend a greater share of their income on out-of-pocket medical costs. While 12% of all non-elderly adults in 2003 had family out-of-pocket costs exceeding 5% of family income, 19% of those with chronic conditions faced this level of out-of-pocket costs. Chronically ill adults with low-income were hardest-hit: 38% of such adults had out-of-pocket health costs exceeding 5% of family income, compared with 8% of chronically ill adults with income above 400% of the poverty level.[40]

- Some 14% of all U.S. families report problems paying their medical bills, but among families with a member in fair or poor health, one-quarter report medical bill problems. Compared with their counterparts without medical debt, privately insured non-elderly adults with medical debt are twice as likely to report their health status as only fair or poor (21% versus 9%).[41 42]

- An analysis based on 2000-2002 data from the Medical Expenditure Panel Survey found that among high-cost (i.e., in top 20th percentile of health spending) low-income non-elderly adults, even those with public coverage carry significant out-of-pocket burdens, averaging more than 12% of family income. Also, nearly one-quarter of low-income families with at least one family member in fair or poor health reported going without needed care for financial reasons, twice the proportion associated with families in which no one is in fair or poor health.[43]

- Between 2000 and 2003, the proportion of low-income, privately insured, chronically ill people with out-of-pocket costs exceeding 5% of family income rose from 28% to 42%. This 50% increase likely reflects the impact of increased cost-sharing for insured people, as well as health care cost inflation that outpaced increases in income.[44]

- In 2000, average out-of-pocket expenses for special-needs children were twice those for other children. Out-of-pocket expenses were also highly skewed, with more than half of all out-of-pocket spending for special-needs children attributable to the children with expenses in the top decile.[45]

Research findings on Medicaid beneficiaries and the low-income population have not substantiated concerns that no or low cost-sharing contributes to overuse of health care.

- Medicaid beneficiaries use about the same amount of services as the low-income privately insured population, once health status differences between the two populations are controlled.[46 47]

- Low-income people are about twice as likely to report an unmet need as higher-income people. Among those with access problems, cost is the most frequently cited barrier to getting needed care.[48]

- Studies probing the causes of higher use of emergency departments by Medicaid beneficiaries compared with the privately insured population have concluded that frequent emergency department use is associated with chronic illness and high use of health care in general, and that systemic inadequacies in health care access (e.g., lack of equipment for asthma care, limited office hours, waiting time to be seen by a physician) are key contributing factors.[49 50 51 52 53 54]

Cost-sharing may expose providers to financial losses.

- Citing Medicaid's prohibition against refusing care based on a beneficiary's nonpayment of cost-sharing, some providers have characterized unpaid cost-sharing as an indirect reduction in Medicaid reimbursement. Concerns about the impact of cost-sharing on providers as well as on access to care have emerged in state policy deliberations. Some have expressed concern that cost-sharing will eventually lead to legislated reductions in provider payment, increased levels of state audits, and administrative complexity.[55 56]

- A study of the impact of Medicaid drug copayments found that Medicaid recipients in the states that impose copays reported paying nothing for one-third of their prescriptions fills (compared with three-quarters in the states with no copays). In virtually every case, Medicaid was listed as the sole payment source. This means that pharmacies in copay states failed to collect anything from patients for one of every three Medicaid prescriptions dispensed.[57]

Endnotes

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