The Failure of Patient Cost-Sharing

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Christopher T. Robertson, Exposed: Why Our Health Insurance Is Incomplete and What Can Be Done About It (2019).

There are many reasons to reject deductibles, co-payments, and other ways in which insured patients are expected to pay out-of-pocket when they receive health care. In particular, as former FDA Commissioner Scott Gottlieb has observed, “sick people aren’t supposed to be subsidizing the healthy.” But as Gottlieb recognized, that’s exactly what out-of-pocket payments entail. Unlike insurance premiums which spread the cost of health care across both healthy and sick, deductibles and co-payments are paid primarily by those who are sick.

In *Exposed*, Christopher Robertson discusses this flaw and the many other deficiencies in patient cost-sharing. As he documents, cost-sharing rests on misguided (though prominent) economic thinking, ignores key concerns of moral theory, and persists despite solid empirical evidence of its ineffectiveness. Designed to eliminate wasteful spending, cost-sharing often leads the sick to forego valuable health care. For example, one study found that doubling the co-payments for prescription drugs decreased medication use and increased emergency department visits and hospital stays for patients with diabetes or asthma. Similarly, when patients have high-deductible health plans, those with lower incomes reduce their emergency department visits not only for low-value care but also for high-value care.

Moreover, cost-sharing diverts attention from the real causes of high health care spending in the United States. As Robertson observes, whether one prefers Medicare-for-All, Obamacare 2.0, or greater reliance on market competition, patient cost-sharing can play at best only a marginal role in cost containment. Indeed, as he points out, it is easy to find low health care cost countries that do not employ patient cost-sharing as a cost containment strategy.

Health care costs are higher in the United States than in any other country not because American patients pay more visits to their doctors or have more hospitalizations. Actually, doctor visits and hospital stays are less frequent. As Robertson notes, the real health care cost drivers lie in (a) the monopoly power that health care providers possess and that allows them to charge high prices for their services, (b) inadequate information about the efficacy of many medical treatments, and (c) the financial interests of hospitals and physicians that encourage high-cost care rather than high-quality care.

There are many strengths to this book. Robertson delves into economic theory, moral theory, and the empirical evidence. He reviews a wide range of research on decision-making in general and in the context of health care in particular. He also provides an illuminating history of cost-sharing and the role that mainstream economics played in exaggerating concerns that when people carry health insurance, they will too quickly seek care. Rather, as indicated above, health insurance primarily makes it possible for people to afford care they need.

And even to the extent that insurance encourages overutilization, cost-sharing can’t solve that problem. As Robertson discusses, health care decisions are complex, require medical expertise, and are difficult to make prudently when experiencing the stress of illness. It is not surprising that efforts to make patients more careful shoppers for health care have come up short. In one study, patients could reduce their exposure to costs by comparing MRI prices online and choosing a lower cost provider. Less than one percent of the patients used the online information. The patients chose MRI providers based on their physicians’ recommendations.

While Robertson would prefer that cost-sharing be eliminated, he also suggests how cost-sharing can be improved as long as it is used. For example, insurers could expand existing practices that vary the amount of cost-sharing with the

value of care. The Affordable Care Act already ensures that people can receive effective preventive care such as flu shots without any out-of-pocket payments. For other treatments, insurers could require minimal cost-sharing for highly-effective care and significant cost-sharing for care whose effectiveness is uncertain. Or reward patients for choosing lower-cost care that is equally or more effective compared to higher-cost care. Patients could be paid for choosing the lower-cost care or charged for choosing the higher-cost care. For example, greater use could be make of "reference pricing," in which insurers reimburse at the level of the lower-cost providers, with the patient paying the difference when choosing a higher-cost provider.

Robertson also would vary cost-sharing based on a person's income. Rather than imposing a $5,000 deductible on all policies, an insurer could peg the deductible at a percentage of the person's income (e.g., 6 percent). Similarly, insurers could reduce co-payments for lower-income families and raise them for higher-income families. Tying out-of-pocket costs to income would respond to the problem of cost-sharing discouraging lower-income patients from seeking valuable care. It also would generally be simple to implement since most Americans receive their insurance from their employers.

Exposed provides a rigorous, comprehensive, and authoritative analysis of cost-sharing in health care. It really is an essential read for scholars, policymakers, and others interested in strategies for containing health care spending.

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