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The Upshot

THE NEW HEALTH CARE

With Sickest Patients, Cost Sharing Comes at a Price

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The growth in health care spending is slowing down, and one reason might be that cost sharing is rising.

The proportion of insured workers with at least a \$1,000 deductible was 41 percent in 2014, quadruple that in 2006. Hidden in the numbers is the fact that increasing cost sharing for patients with chronic illnesses can backfire, causing their health care spending to go up, not down.

When patients face higher cost sharing for prescription drugs, they tend to cut back on them. That's a finding from a recent study from the National Bureau of Economic Research by Peter Huckfeldt and colleagues, who examined employer-based health plan enrollees who use drugs to treat high cholesterol, hypertension and diabetes. They even found that patients cut their drug use when drugs were exempt from the deductible. Perhaps they did so because they did not understand the drugs had no deductible. They may also have cut back on visiting the doctor to get a prescription because the visits were subject to the deductible.

These kinds of cuts in care can be especially problematic for patients with more severe illnesses. A number of studies document the adverse effects of cost sharing on sicker patients. When applied indiscriminately, cost sharing can hurt the sicker patients by prompting them to delay or avoid the preventive care they need. A 2012 study showed that higher cost sharing reduces spending on physician visits and

drugs, but can increase hospital spending. When Medicare beneficiaries face higher cost sharing, hospitalizations go up, not down, especially for those with chronic illnesses.

A 2010 study by the Harvard economist Amitabh Chandra and colleagues found that when cost sharing for physician visits and prescription drugs goes up, so does overall Medicare spending. They examined Medicare beneficiaries enrolled in supplemental health plans offered to public-sector retirees in California. Some of those plans raised co-payments for physician visits and prescription drugs in 2010. In response to this higher cost sharing, hospital spending grew substantially for the sickest patients. For every dollar saved on doctor and drug spending, Medicare's hospital spending increased by more than \$6.

After surveying evidence like that, in 2012 the Congressional Budget Office changed how it assesses the budget implications of Medicare policy proposals. If proposed Medicare legislation would decrease prescription drug use (e.g., by increasing cost sharing), it increases its estimate of overall Medicare spending to account for higher hospitalization costs the program would have to finance.

If higher cost sharing harms sicker patients and doesn't even save money, insurers and public programs then might want to reconsider how they impose it. After all, insurers get the data on the diagnosis of chronic conditions from doctor and hospital billing. Cost sharing could be reduced specifically for drugs and visits meant to address chronic conditions.

This isn't a new idea. It is known as **value-based insurance design**, first described by Dr. Mark Fendrick, a professor of internal medicine at the University of Michigan, over a decade ago.

If reduced cost sharing is targeted at the preventive and maintenance care and the medications that patients with chronic illnesses need, value-based insurance could save money. (In practice, it often doesn't because it isn't so finely targeted; reducing cost sharing for healthier patients does not save money.) The way cost sharing is being applied today is too blunt. Charging sicker patients the same as healthy ones for the drugs and preventive care they need ultimately costs more.

It's not intuitive, but the studies show it's true: Spending more on prevention — but only for the sickest patients — can save money down the road.

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