Research Shows the Negative Impact of Out-of-Pocket Costs on Low-Income People

Premiums

Research clearly shows that low-income people's decision to enroll in health care programs or take up insurance is very sensitive to premium costs—because they have very little disposable income to spend on health care after paying for housing, utilities, food, and other necessities. State records from the California SCHIP program (Healthy Families Program) showed that nonpayment of premiums was the reason one-third of families dropped out of the program from March 2000 to February 2001.[1]

Additional research examining the impact of premiums on low-income people illustrates the strong inverse relationship between participation in public programs and premium levels.[2] Ku and Coughlin's analyses of data from Washington state, Hawaii, Minnesota, Tennessee and the Census Current Population Survey found that 57 percent of the uninsured would participate when premiums were 1 percent of income but *if premiums rise to 5 percent of income, only 18 percent would participate*.[3]

A study conducted by the Lewin Group found that, when premium contributions in Washington State's health insurance program for the uninsured were 7 percent of income, only 10 percent of eligible people bought the plan; when premiums reached 11 percent of income, only 8 percent bought the plan.[4] Another Lewin Group study, using a health benefits simulation model, estimated that participation in subsidized health insurance programs would drop from 70 to 45 percent when premium costs reach 5 percent of income.[5]

Cost-Sharing

Researchers refer to deductibles, copayments, and coinsurance collectively as "cost-sharing." Research shows that cost-sharing discourages the use of health services. The most rigorous research on cost-sharing was the RAND Health Insurance Experiment (HIE).[6] This longitudinal study randomly assigned families to one of 14 health plans, which covered identical services but varied by level of cost-sharing. *Yet even with cost-sharing limited to the lesser of 5 percent of income or $1,000*, the RAND findings uniformly demonstrate the significant negative impact on use of necessary acute and preventive care. Among adults with incomes under 200 percent of poverty, those subject to this limited cost-sharing were: 59 percent as likely as those with no cost-sharing requirements to seek timely and effective health care[7] and 65 percent as likely to seek care for their children as those who were not subject to cost-sharing.[8] Further, adults with any copayments were less likely to purchase prescription drugs and, as cost-sharing increases, the number of prescriptions per person drops.[9]

The RAND study findings have been confirmed by subsequent research. An exhaustive 1994 review of the literature on cost-sharing found five other studies that confirm that even limited cost-sharing reduces health care utilization among low-income populations.[10]

A 1996 survey of TennCare (Tennessee's Medicaid waiver program) documented the negative impact of copayments on visits to doctors and use of prescription drugs on beneficiaries *with incomes above 100 percent of poverty*:

- 11 percent of beneficiaries said they could not make copayments if they had to go to the doctor today; another 39 percent said they could afford only $3 - $5.
- 20 percent of beneficiaries said they had not been able to pay a required copayment at the time of an office visit.
- 22 percent were unable to make a copay-ment for medication and more than half of these (62 percent) had gone without their prescription because of inability to pay.[11]

Another study looking at the impact of copayments on use of services by state employees and their dependents in Group Health Cooperative of Puget Sound found that a $5 copayment resulted in an 11 percent decline in primary care visits and a 14 percent decline in physical examinations—with a 20 to 25 percent decline in physical examinations for children.[12] A $1.50 prescription drug copayment resulted in an 11 percent decline in use of prescription drugs (with a decline of 18 percent for drugs prescribed for symptomatic relief).[13]

Endnotes

[1] S. Duerksen, "Low-Cost Insurance Program Can't Keep Healthy Enrollment," *San Diego Union-Tribune*, March 4, 2001. News article is based on data from Healthy Families Program Report # 9 as of February 19, 2001, which is on file at Families USA, Washington, D.C.

[2] Judith Feder and Larry Levitt, *Choices Under the New State Child Health Insurance Program: What Factors Shape Cost and Coverage?* Policy Brief #2140 (Menlo Park, CA: The Henry J. Kaiser Family Foundation, January 1998).

[3] Leighton Ku and Teresa Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington: The Urban Institute, March 1997). Available online at (http://www.urban.org/entitlement/premium.htm).

[4] Lewin-VHI, Inc, *Options and Recommendations Paper: Cost-Sharing for Low-Income Populations: Task Order B-21*, Prepared for State of Washington, Health Services Commission, August 22, 1994.

[5] Mary Jo O'Brien, Meghan Archdeacon, Midge Barrett, Sarah Crow, Sarah Janicki, David Rousseau, and Claudia Williams, *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions*, Publication No. 385 (New York: Commonwealth Fund, May 2000).

[6] Key findings of the RAND Health Insurance Experiment Study (HIE) are described in Geri Dallek, *A Guide to Cost-Sharing and Low-Income People* (Washington, DC: Families USA, October, 1997).

[7] Kathleen Lohr, et al., "Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis-and-Service-Specific Analyzes," *Medical Care* 24, no. 9 (September 1986): Supplement, pp. S1-S80.

[8] Ibid.

[9] Arleen Leibowitz, Willard Manning Jr,, and Joseph Newhouse,. October, 1985. *The Demand for Prescription Drugs as a Function of Cost-Sharing*. Prepared for the U.S. Department of Health and Human Services (RAND: Santa Monica, CA, October 1985).

[10] Thomas Rice and Kathleen Morrison, "Patient Cost-Sharing for Medical Services: A Review of the Literature and Implications for Health Care Reform," *Medical Care Review* 51(Fall 1994): 235-287.

[11] Celia Larson, *TennCare and Enrollee Cost-Sharing: A Survey of the Previously Uninsured and Uninsurable Enrollees in Davidson County*. Prepared by the Health Care Services Evaluation Division of the Metropolitan Health Department of Nashville and Davidson County. September, 1996. As cited in Geri Dallek, *A Guide to Cost-Sharing and Low-Income People* (Washington, DC: Families USA, October, 1997).

[12] Thomas Rice and Kathleen Morrison, "Patient cost-sharing for medical services: A review of the literature and implications for health care reform," *Medical Care Review* 51 (Fall 1994): 235-287.

[13] Brian Harris, Andy Stergachis, and L. Douglas Ried, "The Effect of Drug Co-Payments on Utilization and Cost of Pharmaceuticals in a Health Maintenance Organization," *Medical Care* 28, no. 10 (October 1990): 907-917.

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