UCLA
UCLA Previously Published Works

Title
CJEM Debate Series: #Copayment – Medical insurance is for non-routine events

Permalink
https://escholarship.org/uc/item/6dr4z2q8

Journal
Canadian Journal of Emergency Medicine, 20(1)

ISSN
1481-8035

Authors
Hoffman, Geoffrey J
Hoffman, Jerome R
Howlett, Michael
et al.

Publication Date
2018

DOI
10.1017/cem.2017.411

Peer reviewed

eScholarship.org Powered by the California Digital Library
University of California

CJEM Debate Series: #Copayment – Medical insurance is for non-routine events

Geoffrey J. Hoffman, PhD*; Jerome R. Hoffman, MA, MD†; Michael Howlett, MD‡; Paul Atkinson, MB, BCh, BAO, MA‡

INTRODUCTION

Paul Atkinson

This series of editorials will provide *CJEM* readers with the opportunity to hear differing perspectives on topics pertinent to the practice of emergency medicine. The debaters have been allocated opposing arguments on topics where there is some controversy or perhaps scientific equipoise.

We continue with the topic of copayments for medical care. Should medical insurance, such as Medicare, be reserved for high cost medical care, with patients required to contribute towards the cost of routine, day-to-day, low cost care? Should we follow the model of home or car insurance, where individuals cover the cost of routine maintenance such as renovations, oil and tire changes, reserving insurance for unforeseen events such as flooding or accidents? Or must we as a society ensure that we share our resources to ensure that everyone has equal access to high-quality care, regardless of the ability to pay? It has been said that health care can be high quality, universally free at the point of care, and easily accessible in a timely manner, but that it can have only two of those three qualities in any one system. Dr. Michael Howlett, an experienced Canadian emergency physician and health care administrator argues in favour of the motion that insurance is for non-routine events – that universal coverage should be provided for expensive medical treatment, with a deductible copayment for low cost care, to introduce market controls into the medical system. But first, we begin with an argument against the motion from Dr. Geoffrey Hoffman, a health care researcher and expert on health policy at the University of Michigan in the United States, and Professor Jerome Hoffman, Professor Emeritus at UCLA, who argue that overuse and the resulting overburdening demands placed on the system cannot be fixed by cost-sharing, and that our profit-driven system cannot be tamed simply by the use of copayments.

Join the CJEM *debate: Follow @CJEMOnline or go to www.facebook.com/CJEMonline to participate in the online poll and to see the results!*

COST-SHARING ISN'T THE ANSWER – THE OVERWHELMING CASE AGAINST "SKIN IN THE GAME"

Against: Geoffrey J. Hoffman and Jerome R. Hoffman

At your annual check-up, you tell your doctor that you feel quite well, but mention a few recent aches and pains. She suggests that you sign up for a "Class A-300 trek" from Premier Trekking. When you ask why, she merely says, "It would be good for you," and adds "better safe than sorry" and "it'll give me valuable information" and "they use the latest and best technology." When you ask how much it will cost, she says she's not certain, but that it's probably covered by your insurer, with only a small copay. Unsure how to proceed, you scour the Internet and learn that there are multiple companies offering this type of trek. They all have testimonials claiming they're the very best, but no matter how hard you look, you can't find out where the companies actually do their treks, the level of training or experience of the trekking guides, the companies' safety records, or how many of each companies' trekkers improved their health. Amazingly, you can't even find out which companies' treks are more or less expensive, or which of the treks that your insurer will cover!

From the *Department of Systems, Populations and Leadership, University of Michigan School of Nursing, Ann Arbor, MI; †School of Medicine, UCLA, Los Angeles, CA; and the ‡Department of Emergency Medicine, Dalhousie University, Saint John Regional Hospital, Saint John, NB.

Correspondence to: Dr. Geoffrey J. Hoffman, Department of Systems, Populations and Leadership, University of Michigan School of Nursing, 400 N. Ingalls Street, Room 4352, Ann Arbor, MI 48109; Email: gjh@umich.edu

© Canadian Association of Emergency Physicians *CJEM* 2018;20(1):16-20 DOI 10.1017/cem.2017.411

Downloaded from https://www.cambridge.org/core. Univ of Michigan Law Library, on 15 Jan 2018 at 12:45:48, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/cem.2017.411

Overuse of medical services is a major problem in wealthy countries (especially in the United States, but also in Canada),[1-3] and contributes not only to skyrocketing expenditures, but also to major medical harm because of false-positive test findings, incidentalomas, and overdiagnosis.[4-6] At the same time, overuse may crowd out spending for needed medical services,[7] contributing to the parallel problem of underuse – particularly for those who most need such care such as the poor and those with chronic illnesses.

One widely discussed approach to overuse and high medical expenditures is increased patient cost-sharing. Advocates' arguments for higher copayments, deductibles, and/or co-insurance are simple and seemingly intuitive: patients with increased "skin in the game" will think twice before agreeing to buy additional medical care, and then buy only care that is truly worth what it costs to them. Moreover, this will make health care utilization more efficient, by replacing unnecessary with necessary care.

We believe, however, that this approach fails on multiple levels. First, simply charging patients more fails to address the transformation of health care from a tool to maximize health outcomes into just another profit-driven business, which is the true cause of overuse.[8] One person's waste is another's profit; the money spent on unnecessary and indeed harmful care does not actually run down some drain, never to be seen again – it ends up fitting nicely in someone's pocket. Overuse is thus due not to governmental misallocation of health care dollars, but to the fact that profits are maximized when those who can pay, no matter the price, receive more and more "care," regardless of whether it improves or actually harms their health. (Profit-driven health care similarly drives the Siamese twin of underuse among the poor, because providers lose money when they provide poorly reimbursed or uncompensated care to low-income individuals.)

Making patients pay more out-of-pocket also fails to address technology proliferation, high prices, fee-for-service medicine, administrative costs, and medical specialization – each of which systematically drives unchecked spending when health care is a business.[9] In many cases, particularly in the United States, it is high prices, even more than excessive service volume, that really drive massive U.S. health care spending.[10-12] But even if we choose to address volume rather than prices and other systematic drivers, cost-sharing ignores the fact that a large amount of overuse is only slightly (and indirectly) driven by patients. After all, patients cannot order their own tests, including costly advanced imaging, or most any therapy, nor have themselves admitted for a massively expensive hospital stay, without at least the agreement of the person most responsible for such decisions – a physician. Also, physicians have strong incentives for greater volumes of care – to increase their own earnings, to decrease their own medical uncertainty, and to avoid making a mistake. Indeed, physicians are far more likely to order interventions that financially benefit them personally,[13-17] and acknowledge sometimes ordering medically unnecessary tests and treatments, because of malpractice concerns or the fear of being blamed if something goes wrong.[18,19]

Cost-sharing is also patently unjust, as it hits hardest the pocketbooks of the poor and older adults. Although truly substantial cost-sharing would likely deter most everyone other than the very wealthy, this would be politically unfeasible; relatively limited cost-sharing, on the other hand, can be expected to primarily deter the poor, and older adults on a fixed income, from accessing health care.[9] Taxation is typically progressive, but cost-sharing is inherently regressive, because it represents a larger share of the financial resources of poor people than it does for the wealthy.[20,21] So shifting more of health care financing away from taxation and to cost-sharing effectively redistributes resources from the poor to the rich!

Even worse, cost-sharing also redistributes health. Income and health are highly correlated in that low-income and older adults are those who most often need care.[9,22] But they are precisely the people most likely to decrease voluntary use of services because of economic exigency, not some cost-benefit calculation.[20] Cost-sharing leads to avoidance of necessary just as much as unnecessary care, so it can be expected to create poorer health in vulnerable patient populations, while having limited impact on those who are already in good health, which is the exact opposite of its intended effect.

Finally, the notion that cost-sharing could lead to beneficial changes in the use of services is fundamentally based on the assumption that health care represents a classic free market, where consumers (patients) voluntarily make rational choices, in a competitive market, based on transparent, accurate, and complete information about cost and product attributes. This would require that consumers are able to select the right product from the right provider, to meet their individual needs, based on an

Downloaded from https://www.cambridge.org/core. Univ of Michigan Law Library, on 15 Jan 2018 at 12:45:48, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/cem.2017.411

assessment of whether they consider the value of the health care product to be worth the cost at which it is offered. The absence of virtually each of these requirements from the actual health care purchasing process has been described in detail[9]; we will only note here that transparent pricing and accurate product information are essentially non-existent, there is often limited competition among insurers or providers, an increase in the supply of providers paradoxically results in *increased* prices, and patients can neither be certain about what they do or do not actually "need" for their health (unlike how they can decide whether they need a second car for their family) nor adequately assess the value of services being offered[8,23,24] – problems that are only exacerbated when patients are confronted with an overwhelming number of complex, time-sensitive choices that may greatly impact their health.[9]

In summary, cost-sharing is popular because it does not force difficult choices, except for low-income patients (particularly older adults). The idea of cost-sharing is politically palatable because it paints these and other patients as being responsible for frivolous health care use that drives outsized health care expenditures, while subtly playing on the companion notion that it is irresponsible of the poor to demand care that they cannot afford. But with health care – as with the story of the Three Bears – we don't want too much, and we don't want too little; the amount we get should be just right! Simply decreasing the amount of care, based on an economic disincentive that affects the neediest segment of the population far more than others, is obviously the wrong approach. Although this essay cannot address "what should be done" in any detail, we will merely suggest that a reasonable solution must first and foremost address the root cause of overuse: a profit-driven system where providers benefit from ever-increasing prices and from the ordering of tests and treatments that not only *cost* far more than they are worth, but, in many cases, actually cause substantial *harm* to public health.

USER FEES IN HEALTH CARE: EVERY CLOUD HAS A SILVER LINING

For: Michael Howlett

I do not know how anyone could argue against the virtue of health care and wellness for everyone, regardless of their ability to pay. Patients and their families face unexpected life-altering illness and injury, and many will, if required, pay with everything they have, to ensure that they or their loved ones can then live on in good health. Others would choose to go without health care as a result of the inability to afford it, so as a society we attempt to promote the welfare of all. As such, we have chosen to share a proportion of our wealth in an attempt to avoid illness leading to individual bankruptcy and poverty, decline, and death. Our government representatives have enacted legislation to ensure that we as a society share this burden and do not discriminate against those without adequate means to pay their way.

So cost is the problem, and looking after each other is the solution. I get it. But even an entire society's resources are limited; there is a fiscal boundary, where spending on one resource leads to the inability to spend somewhere else. This is known as opportunity cost. In the developed world, even within the wealthiest nations, there exist such trade-offs. A recent review by C.D. Howe predicted that in 20 years, health care could swallow two thirds of the entire provincial expenditure of the province of Quebec, with similar consequences expected elsewhere in Canada.[25] Such a rapid rise in cost did not exist and was not foreseen when universal health care was first implemented in Canada in the 1960s. Health systems are vastly different and more complex than when the often quoted RAND Health Insurance Experiment was performed from 1974 to 1982.[26] Universal health care today is a partial mirage, an oasis quickly fading. The increasing age demographic is placing higher demands on acute care systems, with chronic disease and long-term care rising at a rate never before seen. Pharmaceutical and technological advances are coming even faster, with expenses that will far outstrip our ability to pay. Coupled with high expectations and low population growth to support future societal productivity, we risk a meltdown of our social fabric.[27]

In fact, every socialized medical system must limit access to universality in some manner to control costs. Some systems limit or do not provide free access to prescription drugs, or home care, or certain procedures. Others permit access to parallel private care, regulate health practitioner access, or require users to make copayments.[28] In Canada, the emergence of hospital crowding, long wait times for care, and limited access to primary care resources[27] demonstrate a major problem with guaranteed access: it can mean guaranteed mediocrity.

Timely, higher cost, and state-of-the-art treatment can be delayed or denied in favor of cheaper but less

Downloaded from https://www.cambridge.org/core. Univ of Michigan Law Library, on 15 Jan 2018 at 12:45:48, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/cem.2017.411

desirable options. An article in the *New York Post*, published on October 24, 2016 by Andrea Peyser was titled: "Terminally ill mom denied treatment coverage – but gets suicide drug approved." Perverse choices can be created by variations in provincial drug formularies, delays to access by regulators, and excessive waiting times. Witness the 90-year-old who needs elective orthopedic surgery to remain independent in her home, but who must wait 1 to 2 years, by which time she has fallen and broken her hip. In the days of Tommy Douglas, universal health care was implemented to improve access to costly hospital care; we are now in a future reality where rapid free care for self-limiting minor conditions is guaranteed, while access to hospital care and advanced technology is endangered due to crowding, restricted surgery wait lists, and medically discharged patients with nowhere to go.[27] Is this what we mean by universal care?

So how do we address this problem? The only way forward is to change the opportunity cost equation. We know that system-wide user fees reduce the use of medical services; however, both high- and low-value services are reduced, often to the disadvantage of the poor or working poor.[26,29] Yet we are faced with this new reality, where escalating cost threatens access not only to effective care, but also to every other social good that we value. Recent work comparing several European, Australian, and Canadian health systems demonstrated that the use of various copayments, private services, and shifting of payments from medical and hospital services to other types of care was associated with similar or better performing population health indicators, and satisfaction that was often higher, with lower expenses than in Canada.[27,28] In other words, socialized health systems in first world countries perform similarly, and better, in some cases, than Canada regardless of the system priorities or types of copayments. In fact, studies used to support the rhetoric against these system tools[29] actually provide evidence to support various forms of copayment.[25,28,30] The Robert Wood Foundation published a review[30] suggesting that when uniformly applied, copayments are blunt instruments that, while reducing resource utilization, can lead to increased use of more expensive care with poorer outcomes. However, more sophisticated "value based" cost-sharing may increase efficiency while improving use of higher value care. The C. D. Howe Institute's analysis of Quebec's aborted copayment plan in 2010 asserted that cost-sharing should encourage the use of high-value services and discourage the use of low-value ones involving both the patient and providers in the discussion of cost and benefit.[25] Copayment is not good or bad; it is simply one tool in the armamentarium of health planners.

Some cost can be borne by those who can easily afford care; many national health care systems in Europe successfully use parallel private systems. Although differential access may seem unfair, it reduces pressure on the public system, increases choice, encourages innovation, generates economic spin-offs, and adds funding to health care without a blanket increase in the tax burden in an already high taxation environment. Many universal systems in Europe have copayments that link costs with services. The key is to design copayment systems as incentives that reward health resource choices, with more emphasis on major morbidity and mortality and less emphasis on treating a minor illness that does not improve population health outcomes. Blanket copay systems are not the answer, because these may unfairly target those with limited resources. But appropriately designed and targeted copayments can be useful tools to facilitate how people access health services. Copayments applied in concert with regulation or incentives could reward primary care teams instead of walk-in care or frequent emergency department use, and could enhance the focus on better public health policy to address care of the elderly, poverty, housing, and other major determinants of health. Medicolegal reform could help limit the huge cost of liability insurance and civil actions, which is passed on to taxpayers through physician fee negotiations. In Saskatchewan, one promising cost-sharing reform requires private magnetic resonance imaging (MRI) clinics to provide equivalent public access in exchange for the right to operate their private service. The recent health transfer payment agreement with the federal government excluded this plan from regulated penalties, with early results demonstrating effectiveness to reduce MRI waiting time.[31] This kind of creative planning must become the norm.

We are being stretched at the seams by the illusion of free care in the face of demographic change, increasing crowding, longer wait lists, and the spiraling costs of technology. We can either continue to react in survival mode while we slowly suffocate, or resuscitate our social network with innovative and targeted solutions. Let's stop pretending that everything is fine, remove our rose-coloured glasses, and take a fresh look at preserving a healthy future for future generations, using all of the tools at our disposal.

Downloaded from https://www.cambridge.org/core. Univ of Michigan Law Library, on 15 Jan 2018 at 12:45:48, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/cem.2017.411

Competing interests: None declared.

Keywords: health insurance, universal care, health care cost, co-payments

REFERENCES

1. Brownlee S, Chalkidou K, Doust J, et al. Evidence for overuse of medical services around the world. *Lancet* 2017; 390(10090):156-68.
2. Glasziou P, Straus S, Brownlee S, et al. Evidence for underuse of effective medical services around the world. *Lancet* 2017;390(10090):169-77.
3. Levinson W, Kallewaard M, Bhatia RS, et al. “Choosing Wisely”: a growing international campaign. *BMJ Qual Saf* 2015;24(2):167-74.
4. Hoffman JR, Cooper RJ. Overdiagnosis of disease: a modern epidemic. *Arch Intern Med* 2012;172(15):1123-4.
5. Moynihan R, Doust J, Henry D. Preventing overdiagnosis: how to stop harming the healthy. *BMJ* 2012;344:e3502.
6. Wagner J, Aron DC. Incidentalomas: a “disease” of modern imaging technology. *Best Pract Res Clin Endocrinol Metab* 2012;26(1):3-8.
7. Chandra A, Gruber J, McKnight R. Patient cost-sharing and hospitalization offsets in the elderly. *Am Econ Rev* 2010; 100(1):193-213.
8. Rosenthal E. *An American sickness: How healthcare became big business and how you can take it back*. New York: Penguin Press; 2017.
9. Rice T, Unruh L. *The economics of health reconsidered*. 4th ed. Chicago: Health Administration Press; 2015.
10. Laugesen MJ, Glied SA. Higher fees paid to US physicians drive higher spending for physician services compared to other countries. *Health Aff (Millwood)* 2011; 30(9):1647-56.
11. Anderson GF, Reinhardt UE, Hussey PS, et al. It’s the prices, stupid: why the United States is so different from other countries. *Health Aff (Millwood)* 2003;22(3):89-105.
12. Fuchs VR, Hahn JS. How does Canada do it? A comparison of expenditures for physicians’ services in the United States and Canada. *N Engl J Med* 1990;323(13):884-90.
13. Hillman BJ, Olson GT, Griffith PE, et al. Physicians’ utilization and charges for outpatient diagnostic imaging in a Medicare population. *JAMA* 1992;268(15):2050-4.
14. Levin DC, Rao VM. The effect of self-referral on utilization of advanced diagnostic imaging. *Am J Roentgenol* 2011; 196(4):848-52.
15. Mitchell JM, Scott E. Physician ownership of physical therapy services. Effects on charges, utilization, profits, and service characteristics. *JAMA* 1992;268(15):2055-9.
16. Swedlow A, Johnson G, Smithline N, et al. Increased costs and rates of use in the California workers’ compensation system as a result of self-referral by physicians. *N Engl J Med* 1992;327(21):1502-6.
17. MedPAC. *Report to the Congress: improving incentives in the Medicare program: impact of physician self-referral on use of imaging services within an episode (chapter 4)*. Washington, DC: Medicare Payment Advisory Commission; 2009.
18. Hoffman JR, Kanzaria HK. Intolerance of error and culture of blame drive medical excess. *BMJ* 2014;349:g5702.
19. Kanzaria HK, Hoffman JR, Probst MA, et al. Emergency physician perceptions of medically unnecessary advanced diagnostic imaging. *Acad Emerg Med* 2015;22(4):390-8.
20. Evans R, Barer ML. User fees for health care: why a bad idea keeps coming back (or, what’s health got to do with it?). *Can J Aging* 1995;14:360-85.
21. Evans RG. Reform, re-form, and reaction in the Canadian health care system. *Health Law J* 2008;16:265-86.
22. Tamblyn R, Laprise R, Hanley JA, et al. Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *JAMA* 2001;285(4):421-9.
23. Hsu J, Reed M, Brand R, et al. Cost-sharing: patient knowledge and effects on seeking emergency department care. *Med Care* 2004;42(3):290-6.
24. Reeder CE, Nelson AA. The differential impact of copayment on drug use in a Medicaid population. *Inquiry* 1985; 22(4):396-403.
25. Stabile M, N-Marandi S. Fatal flaws: assessing Quebec’s failed health deductible proposal. C. D. Howe Institute Working Paper; 2010. Available at: http://www.cdhowe.org/pdf/Working_Paper_Stabile.pdf.
26. RAND Health. The health insurance experiment – a classic RAND study speaks to the current health care reform debate; 2006. Available at: http://www.rand.org/content/dam/rand/pubs/ research_briefs/2006/RAND_RB9174.pdf.
27. MacKinnon J. “Health care reform from the cradle of Medicare”. Ottawa (ON): Macdonald-Laurier Institute; 2013.
28. Thomson S, Osborn R, Squires D, et al. (eds.) *International profiles of health care systems*. New York: The Commonwealth Fund; 2012.
29. CFHI. Myth: User fees ensure better use of health services by admin. *Mythbusters*; 2012. Available at: http://www.cfhi-fcass.ca/sf-docs/default-source/mythbusters/Myth_User_Fees_EN.pdf?sfvrsn=0.
30. Swartz K. Cost-sharing: effects on spending and outcomes. Robert Wood Johnson Foundation. The Synthesis Project; 2010. Available at: http://www.rwjf.org.
31. Graham J. Saskatchewan, Ottawa reach health funding deal. The Canadian Press; 2017. Available at: http://www.ctvnews.ca/politics/saskatchewan-ottawa-reach-health-funding-deal-1.3245002.

Downloaded from https://www.cambridge.org/core. Univ of Michigan Law Library, on 15 Jan 2018 at 12:45:48, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/cem.2017.411