Cost and Access to Care

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Michael R. Cousineau
Keck School of Medicine of USC
Los Angeles CA
Cousineau@usc.edu

There are at least two groups to consider: those covered by ACA CC plans who are subject to the deductibles and co-payments, and the uninsured, those who are eligible who remain uncovered and those who are ineligible. Both groups face difficult financial barriers to needed care. In the ACA Covered California, many people have chosen bronze plans attracted by its low premiums. While choice is good, we know little about the experiences of individuals who try to gain access while facing q serious health problem, particularly those below 250% of the federal poverty level. Many may not sufficiently understand the complexities of navigating the cash system of care and the different pricing systems that providers might have for the uninsured, the insured with a deductible, and those on Medicare or other type of coverage. Many of our clinics are reporting that literacy rates are low for many new patients entering the health care system. Many of these patients do not know how to find this information or perhaps negotiate for an affordable price. Patients below the deductible limit may theoretically have some incentive to shop around but will find considerable variation in prices and lack the knowledge to differentiate quality among providers when considering a choice based on costs. Few people do. A major concern are those with ongoing chronic conditions who may accumulate considerable debt as they seek care from their primary care physicians,

require and need ancillary care such as lab and X-Ray, procedures from a specialist, and pharmaceuticals possibly even an inpatient stay. It is imperative that these patients remain engaged in the health care system to prevent their conditions from worsening. Concerns are that many of these patients will be unable to meet the deductible especially low and medium income families and individuals. These are not restricted to those with CC plans. A study by published by the Kaiser Family Foundation of people with employment based coverage with different deductibles (low and high) shows that just under two thirds of households had enough liquid financial assets to meet the lower deductible amounts while one-half (51%) can meet the higher deductible amounts. This was particularly a problem for low income policy holders: Only 32% of households with incomes between 100% and 250% of poverty can meet the lower deductible amounts, while one-in-five can meet the higher deductible amounts. In contrast, 88% of households with incomes over 400% of poverty can meet the lower deductible amounts and three-in-four (79%) can meet the higher amounts. An even smaller percentage can meet the out of pocket maximum.

Many people are choosing wrong. While less than 20% of individuals in the Covered California are choosing a bronze plan many of these are eligible and would benefit from an enhanced silver plan with reduced cost sharing but attracted away from them by their higher premiums. However there is no assistance with cost sharing for those with higher incomes or for those obtaining coverage through work.

Networks. The other driver is of course the size and scope of networks available to patients particularly in the low cost plans. Small and inadequate networks could result in access problems as patients search for

accessible primary care physicians and either cannot find them or face very long waits for appointments. This might force patients to seek care out of their network or at the hospital ED where face excessive costs not only for the visit but for ancillary services. A physician at LAC USC recently described a case of a CC Bronze plan policy holder and ED patient seeking care for a non urgent condition because the next primary care appointment available to the patient was six months and the plan instructed her to go to the ED.

A second group for concern are the remaining uninsured particularly those ineligible for Covered California or Medical. Most will receive little or no assistance in navigating care outside of the county programs that have been established such as My Health LA and other county waiver sponsored programs. These individuals remain subject to full charges services which are quite high and variable. A brief survey of southern California EDs and primary care programs show a range from $65 for a visit only to over $300 just for the initial visit to see a primary care physician or visit the ED . A UCSF study in 2013 showed Out-of-pocket patient charges in ED ranging from $4 to nearly 30,000 for similar health problems. Safety net providers, public hospital systems and community health centers are a viable alternative and may have lower prices. However, I remain concerned about limited capacity and the inability of these facilities to find and retain enough practicing clinicians. This serves as a huge impediment to expanding care. When faced with these high prices, or long waits, many people will simply not go until things have worsened. Too many will decide not to get care fearing huge debt after leaving the ED or other provider.

Overall, co insurance can help to control health spending by requiring people to pay a greater share of their costs and perhaps serve as an incentive for people to look for a less expensive plan. But if people are unable to easily obtain information about costs and quality or understand how to interpret data that might be available, many patients will simply delay or forgo care. I applaud the expansion of programs and websites that expand transparency, - anything that can help turn patients into more informed consumers is a good thing. But unit costs are just too high for many who will perceive few options and will instead question whether services are needed or could be deferred. For the chronically ill patient with lower and moderate incomes, we need alternatives that encourage patients with chronic conditions to develop on going relationships with primary care clinicians and navigators that connect them with the wrap around services they need.

Moving forward

While our outreach and navigator programs have been successful in identifying eligible and assisted in enrolling many, I think navigators should incorporate messages that help patients choose appropriate plans, especially those who choose bronze but would better off with an enhanced silver plan.

- Need to also consider whether the tiered metal system is too complex, - is it confusing many people especially those with limited literacy skills. Many would we be better off with fewer options perhaps a maximum of three, eliminating the bronze and platinum.

Simplifying could go along way to better align patients with plans that better meet their needs.

- Unit prices are simply too high, but short of reengineering care to develop a more cost effective approach based on value and outcomes, Covered California could move to become a more active purchaser, negotiating a narrower range of prices for primary care and specialty services, prescription drug, and ancillary services.
- Enhance the safety net who many have lower prices for many services but little capacity for expansion. This could include the identification and expansion of community providers to become part of networks.
- Leverage certain services (such as primary care) for the uninsured for providers as part of Covered California negotiated plans.
- Continued monitoring or perhaps commissioning a study to document utilization deferred utilization, and prices to determine problems and identify solutions.

Gary Claxton, Matthew Rae and Nirmita Panchal, Consumer Assets and Patient Cost Sharing Kaiser Family Foundation, February 15, 2015 http://files.kff.org/attachment/issue-brief-consumer-assets-and-patient-cost-sharing

Christine Buttorff, et al,Comparing Employer-Sponsored And Federal Exchange Plans: Wide Variations In Cost Sharing For Prescription Drugs. Health Aff. March 2015 vol. 34 no. 3467-476

Nolan Caldwell et al How Much Will I Get Charged for This?" Patient Charges for Top Ten Diagnoses in the Emergency Department. PLOS, February 27, 2013. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055491