

Episode: Ethics Talk – Health Hazards of Cost Sharing

Guests: Ziad Obermeyer, MD, MPhil

Hosts: Tim Hoff; Audiey Kao, MD, PhD

Transcript by: Cheryl Green

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[bright theme music]

TIM HOFF: Welcome to another special edition of *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This episode is an audio version of a video interview conducted by the Journal's Editor in Chief, Dr Audiey Kao, with Dr Ziad Obermeyer, the Blue Cross of California Distinguished Associate Professor of Health Policy and Management at the UC Berkeley School of Public Health. Dr Obermeyer joined us to talk about the potential impact on mortality of cost-sharing practices of health insurers. To watch the full video interview, head to our site, JournalOfEthics.org, or visit our [YouTube channel](#).

DR AUDIEY KAO: Dr Obermeyer, thanks for being a guest on *Ethics Talk* today. [music fades out]

DR ZIAD OBERMEYER: Oh, this is great. I'm happy to be here.

KAO: So, COVID-19 vaccines are free to reduce financial barriers to vaccination access. But it's still routine for health insurers to cost-share, such as requiring those they insure to cover out-of-pocket costs for medications and health care services. What do you see as the most important ethical problems with insurers making patients' access to care contingent upon cost-sharing practices?

OBERMEYER: I think if you look at the history of this cost-sharing, in many ways, the theory at least is very, it's on solid ethical foundations. And the way the argument is usually made is that, look, we know that insurance alters people's incentives to consume lots of things. And this is kind of like not a disputable fact, is that when you reduce the price of something, demand's going to go up. And in some cases, that's going to lead to unnecessary health care, in this case, being provided. And so, the theory is that by increasing the price, by having patients have so-called skin in the game, patients will actually think twice about maybe not getting that MRI, maybe not filling that unnecessary medication, not going to see the doctor for knee pain that's going to go away regardless. So, in a way, the traditional narrative at least is very empowering to patients because it means that that decision-making function is not placed in the hands of some bureaucrat making decisions about what the price of something should be. It's kind of giving that decision-making authority to the patient. And so, that's at least the theory.

I think the practice, though, is that as anyone who's helped a family member or a patient make decisions about health care knows, these decisions are not clear cut at all. And so, when you look at surveys of elders at pharmacies, even just asking them, "What medications are you on, and what do each of these medications do," is a non-trivial task because of the complexity of medical care. The complexity of medical care is good in many ways. We have lots of solutions to lots of problems. But it means that pushing that decision onto the patient, who is in many ways the least well-equipped to make the decision, can actually have some catastrophic consequences. And so, when we're thinking

about who pays for what in health care, we can't just be thinking about the total budget and the cost of health care. We need to be thinking about what are the effects of that cost-sharing on the patient's health, and how do we help that person make the best decisions they can possibly make?

KAO: So, charging \$10 more for prescription medications seems trivial to some of us and huge to some of us. Which conclusions should health insurers and policy makers draw from your study?

OBERMEYER: We were actually quite surprised by what we found in the study: that such a small increase in the out-of-pocket costs of medication had such a big effect. And as you point out, that small increase for some people is actually a really big increase for others. But one of the puzzling things that we found was that—we could only look at the level of zip codes when we tried to quantify someone's income or their just socioeconomic status in general—but what we found is that that increase of \$10 per drug, that discouraged people from filling in poor zip codes and rich zip codes at about the same rate.

KAO: Hmm.

OBERMEYER: That's a clue that there's something else going on besides just the fact that, you know, of course, poverty makes everything hard. It makes the \$10 co-payment hard. But there's something else going on here that means that even people who are, of course, there could still be within zip code affects where we're only capturing effects on poorer people living in zip codes.

KAO: Right.

OBERMEYER: So, we can't rule any of that out. But it at least raises the possibility that there's something else that's kind of a more psychological thing going on here, that that increase in cost catches people off guard, and it surprises them in a way that makes them react disproportionately. And I think that's a comment on kind of not just the cost of that medication, but also the complexity of going to the pharmacy, realizing that your whole set of medications has gotten much more expensive, wondering why, being confused, feeling that pressure at the pharmacy desk that even I, like when I go pick up a medication at the pharmacy, it's a very confusing experience. And I get confused by how much something is going to cost, how much it should cost, whether it's brand or generic. These things are super confusing for everyone. And so, when you add these very large, in relative terms at least, fluctuations in cost, it could very easily just put people off guard and cause them to make bad decisions.

KAO: So, given some of the limitations that you articulate in your own study about analysis at the zip code level, how should future research inform policy responses to your finding that, again, as little as \$10 can make a life or death difference to some of us?

OBERMEYER: I think for me, there are maybe two policy implications from this research. The first is that right now, we set our cost-sharing policies, and in fact, a lot of our policies in health in a way that treats everyone the same. So, everyone across the country is basically facing the same cost structure of their Medicare drug benefit, even though some people are really, really high risk for things like heart attack and stroke and other people are not. As we learn more and more about exactly who is at high risk, it means that we shouldn't be treating all of these people equally. Why is someone who's at very, very high risk of a heart attack and stroke being charged the same amount for their statin as

someone who is sort of on it because they're over a certain age threshold, but they're actually quite low risk? And so, that personalization of policy to the particular needs of a person, I think, is really important. And I think that's a direction a lot of my own research is going into, is how do we use the algorithms that have proved so useful in other parts of society based on prior data and using those data to forecast future results? How do we unleash that same type of analysis to get better medications to the people who need it most? So, that's the first implication is more personalized policies.

The second is that historically, when we think about insurance, and if you look just at the history of Medicare Part D and what people were thinking about when that legislation was passed and implemented, everyone is very, very focused on health care costs. And of course, that's appropriate because we pay a lot for health care. It's growing, and it's growing in the US just like everywhere else. And we need to be focused on cost. But there's no corresponding line item in the budget of, for example, Medicare Part D for health, even though the cost decisions that are made on the cost side to save money actually might have huge implications for people's health. So, if we valued the life years lost, the life years that we caused to be lost by raising the price of drugs in an effort to save money over here, we should be accounting for that somewhere. And right now we're not doing that. And so, I think having the accounting of our health care take into account not just the cost of health care, but also the life years that we lose or gain by making different cost decisions seems very important to me.

KAO: So, given the health inequity laid bare by the COVID-19 pandemic, what do you think health professionals should take away from your work that can help them advance health equity in their own practices and organizations?

OBERMEYER: It's a great question. And I think for the purposes of our discussion, I'll focus just on the one thing that we studied here, which is filling a medication that you're prescribed. I think when I would write a patient a prescription, I'd often think that my job ended once that prescription was in their hands because I had figured out the right answer to fix their medical problem. But of course, as we're increasingly learning, that's just the beginning of the journey that is required to get that compound into their bloodstream and to close the loop. To go from handing them the prescription to actually them showing up at the pharmacy desk, paying the copay that it takes to buy the drug, and then taking it every day, a lot can go wrong. And I think that one very striking finding from the research is how often that goes wrong in doctor/patient relationships that are marked by distrust, which are much more common along income gradients, education gradients, language gradients, and race gradients.

And so, I think this is a particular issue where if doctors take a little bit more time to really understand, OK, what is the patient's concern about this? Do they trust me to do the right thing for them? How can I build that trust? How can I make them think that I really care about them in the way that I do so that they're more likely to go fill that medicine at the desk? I think that would actually have a huge impact, because the one thing we know is, if you're giving a patient a medication for a reason, you want them to take that drug. And about 50 percent of the time that doesn't happen. So, anything that we can do to convey that message that we care, that we can be trusted, and that we're doing the right thing for patients, I think would really help in general, but also in particular for that equity consideration.

KAO: Well, on that call to build greater trust between patients and their physicians, I want to thank Dr Ziad Obermeyer for sharing his insights and expertise with our audience today. Ziad, thanks again for being a guest on *Ethics Talk*.

OBERMEYER: Thank you so much. This was a pleasure.

KAO: For more COVID ethics resources, please visit the *AMA Journal of Ethics*, [JournalOfEthics.org](https://www.journalofethics.org). Thank you for being with us today. We'll see you next time on *Ethics Talk*. [theme music plays]