



Prevention under the Affordable Care Act (ACA): has the ACA overpromised and under delivered?

Comment on “Interrelation of preventive care benefits and shared costs under the Affordable Care Act (ACA)”

Carol Molinari*

Abstract

This policy brief discusses preventive care benefits and cost-sharing included in health insurance provisions of the Affordable Care Act (ACA) legislation and highlights some consequences to Americans and the country in terms of healthcare costs and value.

Keywords: Consumer Cost-Sharing, Value-Based Cost-Sharing, Healthcare Costs and Benefits, Affordable Care Act (ACA), US Healthcare Reform

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*Correspondence to:

Carol Molinari

Email: cmolinari@ubalt.edu

This commentary will address:

1. Cost effects of cost-sharing;
2. Value-based cost-sharing especially re: preventive care; and
3. Reforms in the Affordable Care Act (ACA) legislation.

Value of cost-sharing

This brief calls into question the extent that consumer cost-sharing promotes the use of health services that provide “value” in terms of benefits and costs. For health services to provide value, the cost to the consumer needs to be affordable. Dixon and Hertelendy accurately noted the only level of prevention with known and documented cost savings is primary prevention (1). Examples include lifestyle changes like exercise, healthy nutrition, and smoking cessation. In contrast, early detection and treatment (aka secondary prevention) of a chronic health problem does not usually provide cost savings to the individual. Continued and long-term treatment of chronic disease can become costly when recurrent treatment costs are shared by the consumer/patient. Thus preventive screenings and other forms of secondary prevention can be costly under cost-sharing and thus diminish the use of such preventive care.

Dixon and Hertelendy explain that benefits need to extend beyond cost savings to include some level of quality of life (e.g. productivity, morale) (1). However, they correctly note the difficulty of measuring quality outcomes coupled with the fact that outcomes can and do vary among different populations. So consumers do not have adequate information re: benefits resulting in reliance on costs to assess “value”.

An important point to also consider re: cost-sharing involves differential effects that cost-sharing has on certain consumers/patients. Are those who are sickest and/or with low incomes

more likely to reduce their use of services due to cost-sharing? There is some evidence from the RAND Health Insurance Experiment to indicate that the sickest and low-income populations are less likely to use health when costs are shared (2). Thus the level of cost-sharing under ACA health plans may be disproportionately less valuable to those with greater health need; making the legislation less optimal to those from a societal or social welfare perspective (3).

Effects of cost-sharing on health outcomes

As the costs of care shift to the individual under cost-sharing health plans, the value of care can diminish thus resulting in less demand for services. Cost-sharing has both short and long term effects on health spending. Over 40 years ago, the RAND Health Insurance Experiment provided strong evidence related to the effects associated with cost-sharing on healthcare utilization. For individuals, higher co-payments lowered demand for healthcare. These results have been corroborated among California public retirees (4).

The effects of cost-sharing on health outcomes are more limited. This is due to the modest influence of medical care on public and population health. The authors correctly note that primary prevention in the form of immunizations, risky behavior counseling, cardiovascular prevention etc. can lower costs and improve individual and population health status. While the authors argue for a preventive approach that combines primary and secondary prevention, the absence of incentives to enrollees for health promotion and primary prevention in the ACA health plans will likely not improve America’s public health.

Reforms in the Affordable Care Act legislation

Dixon and Hertelendy assert that insurance providers need

to assume a greater part of costs associated with preventive care to help reduce individual's healthcare spending (1). It is unclear whether and how less cost-sharing by consumers will control overall national costs in the US health system. Consider the following:

- Increasing patient cost-sharing does lower individual utilization and spending. For individuals, higher copayments lowered demand for healthcare (4). However it does not take into account health needs of low and high users and thus can discourage the vulnerable to seek needed care.
- National health spending is directly related to the organization and delivery of services.
- Evidence supports that greater managed care penetration is associated with slower diffusion of expensive medical technology (5). Managing and coordinating care to reduce costly duplication has been associated with lower system health costs.

An important point to iterate re: the priority goal of the ACA of 2010 was to improve financial access to healthcare via private health insurance plans. This legislation primarily intends to offer those without insurance an option for health insurance coverage. It provides financial access by subsidizing premiums to enrollees based on eligibility. The use of consumer cost-sharing is likely to reduce individual utilization.

To a lesser degree the ACA addresses systemic changes in the delivery of care. For example, it proffers incentives for voluntary changes (e.g. creation of accountable care organizations). Without a mandate for widespread organizational reform, national healthcare costs are not

expected to decline. In contrast, cost-sharing is likely to have less effect on national health costs and spending than organizational and delivery change (3).

As the health plans from ACA continue to be implemented across the country, its promise of increased financial access to healthcare will be assessed. However, promises of cost reductions based on the ACA legislation and its provisions re: preventive care and cost-sharing seem somewhat overstated.

Ethical issues

Not applicable.

Competing interests

Author declare that she has no competing interests.

Author's contribution

CM is the single author of the manuscript.

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