



FactSHEET

Cost-Sharing and Medicaid

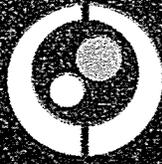
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The RAND Health Insurance Experiment Revisited

Those who support increased cost-sharing in Medicaid often cite a classic 1982 study conducted by RAND. The study, called the Health Insurance Experiment, was a large-scale multi-year study that tracked the effect of different levels of cost-sharing on participants' use of health care services.¹² Proponents of cost-sharing say that the study showed that cost-sharing reduced use of health services and made people more prudent and better consumers. However, that interpretation oversimplifies the study findings.

Because the study has been used so often, RAND scholars revisited the study in 2006 and 2007 to further explain the meaning of their previous Health Insurance Experiment results and explore what subsequent studies

have said.¹³ In their paper, *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, the authors point out that cost-sharing has mixed results. It can reduce the use of health services, but that is true for both necessary as well as unnecessary services. The authors say that cost-sharing “reduced both needed and unneeded health services. Indeed, subsequent RAND work on appropriateness of care found that economic incentives by themselves do not improve appropriateness of care or lead to clinically sensible reductions in services use.”¹⁴ The paper also notes that among lowest-income and sickest study participants, the individuals who had no cost-sharing had better health outcomes on some key variables, including control of hypertension.



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Conclusion

As noted throughout this brief, handling premiums with care really matters. Administering premium payment and collection in ways proven to encourage enrollment and retention of coverage is an essential aspect of mitigating the coverage and health disparities that exist for low-income individuals and families and people of color.

Flexible payment options will help to meet the needs of all consumers. Making sure that consumers, and particularly those who are unbanked or underbanked, have viable options for paying premiums is crucial to their enrollment and retention of coverage.

Implementing consumer-friendly payment and collection policies will boost retention. Communication with enrollees using best practices in plain language and friendly collection processes will help identify people who may be eligible for lower premiums and improve the likelihood that enrollees understand payment requirements and the consequences of nonpayment.

All consumer assisters, including call center representatives, eligibility workers, navigators, certified application counselors, should be well trained and knowledgeable about the premium policies and how they impact different individuals and families.

From payment options to collection procedures to cancellation rules, there are many circumstances where consumers need to be educated about how premiums and cost-sharing work and the potential impact of their choices and actions.

Collecting, analyzing and acting on premium and payment experience data are key to maximizing the effectiveness of our coverage programs. As states implement coverage expansions, either through the marketplace or Medicaid, reviewing how they administer premiums and monitoring the impact on low-income families should be a priority. Just as the level of premiums can be a financial burden and enrollment barrier for low-income families, a lack of flexible ways to make payments and nowhere to turn when a temporary financial crisis hits can make it difficult for families to retain coverage. Evaluating and using data to drive policy and program improvements will help ensure that all eligible individuals can benefit from health coverage.