

**IN REPLY:**

As our commentary in the July issue of the *Journal* suggested, we consider assessing the impact of rising patient cost sharing on utilization and health to be an important topic for both managers and policy makers.<sup>1</sup> In response to our commentary, Kathleen Fairman has taken issue with some of the facts as we reported them, and given the interest of open discussion, we have decided to publish her letter in this issue. Although our commentary was not intended to be a formal literature review, it is clear we have a fundamental disagreement with Ms Fairman about the interpretation of the literature.

In our opinion, there are 3 salient issues. First, to what extent do individuals respond to cost sharing? We believe the RAND Health Insurance Experiment (HIE) provides the gold standard answer to this question, suggesting a demand elasticity of about  $-0.2$ . Because elasticities for prescription drugs are particularly salient today, and because Ms Fairman's letter focuses on them, it is worth noting that the RAND HIE reports a similar elasticity for prescription drugs,<sup>2</sup> although that estimate does not hold cost sharing for other services constant. Two recent literature reviews we cited report elasticities for prescription drugs in the range of  $-0.1$  to  $-0.6$ .<sup>3,4</sup> We thank Ms Fairman for bringing a third literature review to our attention, which supports our position that utilization of prescription drugs responds to patient copays.<sup>5</sup> While it is true that not all studies demonstrate a response to copays, and in fact, in some settings unobserved factors may mitigate the response, we believe the bulk of the evidence suggests higher copays cause utilization to fall.

Ms Fairman would have us believe that there is a response only after a certain threshold of cost sharing is reached. We agree that the response to large increases in cost sharing will be greater than the response to small increases in cost sharing. Moreover, perhaps the effect of copays is not linear. However, plausibility suggests a continuous response to copays, without discrete thresholds. For example, imagine the "threshold" for a utilization response was a \$20 copay increase. It seems unlikely that an increase of \$19.50 would have no effect but an increase of \$20.50 would have the effects reported in the literature (and if there is a response to a \$19.50 copay increase, why not a response to a \$19.00 increase, etc). We believe it is more likely that the effects of smaller copay increases are smaller and more difficult to detect. In any case, empirical evidence exists suggesting smaller copay changes do affect utilization.<sup>6,7</sup>

The second issue relates to whether the response to copays extends to important services or whether the foregone consumption offered no benefit. Again, we believe the gold standard is the RAND HIE, which demonstrated that consumers reduced the use of both high- and low-value services in response to higher copays. In fact, the literature reviews cited above are all generally consistent with this view. Again, exceptions can be found (eg, emergency department use in the RAND HIE), but we believe identification of one setting or situation in which consumers appear to have responded to increases in costs by reducing only inappropriate use does not negate the evidence that often they also reduce their use of valuable services.

The third, and most important, issue is whether the reduction in the use of high-value services causes adverse health consequences. The RAND HIE suggested that adverse health consequences were small and concentrated in low-income individuals with chronic disease. This presents somewhat of a paradox given the first 2 points. This has been explained by the RAND study authors as reflecting an offsetting impact of

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harm from reduced use of important services and benefit from reduced use of potentially harmful services.

As we note in our commentary, it is unclear if this finding applies to today's environment, which is more reliant on services for chronic disease management, including prescription drugs. We certainly think the evidence, which includes several well-controlled studies, suggests cause for concern.<sup>6,8</sup> Even the article by Lu et al cited by Ms Fairman expresses concern that formulary-based interventions (including, but not limited to, increased cost sharing) may have deleterious health consequences.

Yet more importantly, we argue that Value-Based Insurance Design benefit packages can be created that mitigate the risk of adverse health consequences from higher cost sharing. Research increasingly allows us to identify situations in which care adds value (relative to alternatives) and situations where value is less certain. Thus we believe it is unnecessary, and likely counterproductive, to address concerns about costs by requiring patients to pay more for those services we would like them to consume.

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