

Statewide Assessment of Cost-Related Healthcare Access Barriers in Rhode Island

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ABSTRACT

Although co-payments and deductibles are means of keeping health expenditures low, they have also been cited as barriers that inhibit patients from accessing necessary healthcare. We aimed to evaluate Rhode Island residents' experiences with cost-related access challenges within the state's healthcare system. We conducted a cross-sectional survey of resident experiences with healthcare in Rhode Island. Our survey instrument was composed of the RAND Corporation "Short-Form Patient Satisfaction Questionnaire (PSQ-18)", questions developed by the Rhode Island Office of the Health Insurance Commissioner, and ranking of health priorities based on prior community assessments conducted by the Rhode Island Department of Health. Data were collected at venues across the state as part of the Rhode Island Department of Health 2015 Statewide Health Inventory. From July to August 2015, 404 surveys were completed. We found that 40% of respondents had a co-pay of \$20–\$50, while 35.7% of respondents had a deductible of greater than \$500. Further, one-third of respondents delayed receiving care due to financial barriers. This decision resulted in a worsening condition or hospital visit for nearly half of those respondents. Co-pays and deductibles pose challenges to Rhode Islanders accessing health care. Cost-related barriers to healthcare access should continue to be addressed, especially in the context of preventive care services, which are now being built into health insurance premiums through the Patient Protection and Affordable Care Act.

KEYWORDS: Rhode Island healthcare, financial barriers, co-payments, deductibles, preventative care

INTRODUCTION

Health insurance cost sharing is often described as a barrier that prevents patients from accessing healthcare.^{1-2,3} In fact, 45% of patients with a deductible of greater than \$500 reported a new or worsening condition due to cost-related access challenges; conversely, 32% of patients with a deductible of less than \$500 reported a new or worsening condition due to financial barriers.¹ Further evidence suggests that individuals with no cost sharing are 15% more likely to utilize emergency department services than individuals with co-pays and deductibles.⁴ Although cost sharing is intended to keep

healthcare costs low, it also induces a variety of cost-related access challenges. Individuals burdened by such financial challenges are less likely to consult a physician, fill necessary prescriptions, or complete indicated follow-up procedures.¹

On a national scale, it is known that co-payments and deductibles prevent both families and individuals from accessing the care that they require. This challenge is particularly pronounced in low- and middle-income families.^{2,5} Low- and middle-income populations are both significantly less likely to receive preventative care than high-income populations.^{6,7} However, the decision to forgo preventive care due to financial barriers is not solely linked to socioeconomic status. Income level aside, Medicare enrollees with supplemental insurance coverage are two to three times more likely to undergo breast cancer screenings than those without additional insurance benefits who pay additional costs to access care.⁸ The tendency to delay, skip, or forgo preventive care due to cost is present across multiple socioeconomic levels, and can lead to worsening conditions.^{9,10}

In order to increase access to preventive care it is important that public experience with healthcare cost and coverage is assessed. We surveyed patients and community members in Rhode Island (RI) in order to gather information that reflected actual resident experiences with the state healthcare system. This primary data collection was completed as part of the Rhode Island Department of Health (RIDOH) 2015 Statewide Health Inventory, with the intent of evaluating cost-related access issues.¹¹ The aim of this study was to evaluate the financial challenges associated with healthcare access for RI residents.

METHODS

Survey Design

We used a cross-sectional survey designed to examine three cost-related access issues from the perspective of RI residents. In order to do so, the survey was composed of three sections. The first section consisted of questions from the Validated RAND Corporation "Short-Form Patient Satisfaction Questionnaire (PSQ-18)".¹² These questions were incorporated in order to assess residents' experiences with RI healthcare. The second section consisted of questions designed by the Office of the Health Insurance Commissioner, and were used to evaluate financial barriers that limited residents' access to healthcare. Finally, the third

section presented health priorities that were found to be consistent across communities based on prior assessments conducted by the RIDOH,^{13-14,15,16} participants were asked to rank these priorities based on perceived importance in their communities. The described priorities included drug and alcohol abuse, and access to healthcare. The survey could be accessed online or over the phone. Respondents noted that it took less than five minutes to complete.⁸

This survey was administered as part of the RIDOH 2015 Statewide Health Inventory in order to provide information about the financial barriers that currently prevent Rhode Island residents from accessing healthcare. The RIDOH 2015 Statewide Health Inventory was a comprehensive assessment of health service capacity and access to care for a variety of health services across the State.¹¹

Data Collection

Our team of eight interns distributed both English and Spanish copies of the survey directly to RI residents at a variety of locations throughout the state. Distribution venues included local farmers markets, Oakland Beach in Warwick, and Kennedy Plaza (the central bus terminal in Providence). Surveys were also distributed directly to patients and community members by many federally qualified health centers (FQHCs); Women, Infants, and Children (WIC) programs; and several community-based multiple service organizations.

In addition to direct distribution, surveys were also placed outside of the RIDOH's Office of Vital records for individuals wishing to participate while waiting to be assisted. Furthermore, both an English and Spanish version of the survey was posted to the RIDOH website in August 2015. The posting of the survey was followed shortly after by a press release that encouraged residents to complete the online version.

Data Analysis

The John Snow Research and Training Institute, Inc. worked to clean and standardize the collected data. Descriptive statistics were generated in order to represent several attributes of interest. The standardized findings were aggregated into appropriate tables, and, in one case, a statistical map, in order to display the desired information. Analyses were conducted using SAS software.

RESULTS

From July to August 2015, surveys were distributed both online and in person. During this time, 404 surveys were completed; 258 respondents completed a paper version of the survey, and 146 completed an online survey. Responses were collected from 84% of RI zip codes. Only two municipalities were excluded entirely from our convenience sample: North Smithfield and New Shoreham.

Of the 400 participants who reported on the cost of their co-pay, 40% stated that they had a co-payment of between \$20 and \$50 per doctor's office visit. Furthermore, 17.3%

of respondents had a co-pay of less than \$20, while an additional one-third (31.3%) stated that they had did not have any co-payment (**Table 1**).

The cost of deductibles was also examined. Of the 404 respondents who provided information regarding their deductibles, 33% claimed to have a deductible of at least \$500. Conversely, 30.4% of participants reported having no deductible whatsoever (**Table 2**).

In order to assess the effects of cost sharing on access to care, participants were also asked whether they or a member of their household had to delay or forgo receiving medical care due to cost. Slightly less than one-third (31.1%) of respondents said yes. Furthermore, of the 31.1% who answered yes, 46.7% reported that their condition either worsened or that they went to the emergency room as a result of their decision to delay or forgo receiving care (**Table 3**).

Table 1. Cost of patient co-pay per visit to a physician, 2015.

Doctor's Office Co-Pay	Percent of Respondents n=400
Less than \$20	17.3%
\$20-\$30	30.3%
\$30-\$50	9.8%
\$50-\$100	2.8%
More than \$100	0.3%
Don't know	8.5%
No co-pay	31.3%

Source: RIDOH 2015 Statewide Health Inventory.

Table 2. Average patient deductible, 2015.

Deductible	Percent of Respondents n=404
\$100	4.7%
\$250	4.7%
\$500	11.4%
\$1,000	4.0%
Under \$1,000 (cannot specify)	2.7%
Between \$1,000 and \$2,500	9.7%
Between \$2,500 and \$5,000	5.7%
Over \$5,000	2.2%
Don't know	24.5%
No deductible	30.4%

Source: RIDOH 2015 Statewide Health Inventory.

Table 3. Outcomes of respondents who delayed seeking medical care because of cost barriers, 2015.

Outcome	Percent n=126
I became sicker before seeking care	28.2%
Nothing – I got better on my own	27.4%
Don't know	25.8%
I went to the emergency room	18.5%

Source: RIDOH 2015 Statewide Health Inventory.

DISCUSSION

Our survey results reflected healthcare experiences from 84% of RI zip codes. Our findings show that nearly half of RI residents are burdened by deductibles of greater than \$500 and co-payments of \$20-\$50. Furthermore, approximately one-third of respondents substituted or forwent receiving necessary care, suggesting a correlation between cost and the decision to delay care. This decision ultimately resulted in a worsening condition or hospital visit for 46.7% of patients. These results exemplify a heightened tendency to make cost-saving decisions due to insurance cost sharing, and are consistent with those of previous studies.

Trivedi *et al.* gathered investigated the effects of cost sharing on screening mammographies.¹⁷ The study compared screening rates between participants who were subjected to gradual co-payment increases over the course of three years relative to those who maintained full-coverage plans. Investigators found that screening rates for individuals with rising co-payments were 7.2 percentage points lower than those enrolled in full-coverage plans. The effects of cost sharing were also more pronounced for women residing in lower-income areas. These results also demonstrate that individuals with high co-sharing responsibilities are less likely to seek necessary care, and suggest a correlation between income level and access challenges.

In assessing our results, we found that one-third of RI residents made decisions due to financial barriers, which caused nearly half of these respondents to report a worsening condition or an emergency room visit. In order to prevent similar outcomes, potential strategies to address such financial barriers should be considered. Exempting certain preventive care exams from cost sharing could be an effective means of reducing subsequent medical expenditures. This notion served as the foundation for the Essential Health Benefits Plan under the Affordable Care Act (ACA). Essential Health Benefits work to remove the effects of cost sharing on preventive care recommended by the United States Preventive Services Task Force. Examples of preventive services now included in insurance premiums are indicated mammography and colonoscopy exams.

Despite our consistent conclusions, there were several limitations to our study. First, we did not receive evaluations from every community in RI, nor did we collect an equal number of responses from each zip code. Indeed, even though we collected responses from 84% of RI's zip codes, our *convenience sample* cannot be considered representative of the entire Rhode Island population. Furthermore, we did not actually monitor patients in order to assess the outcomes of their delaying or forgoing necessary care. Regardless of these limitations, however, our conclusions paralleled those of previous studies.

Overall, our findings suggest that insurance cost-sharing measures present cost-related access challenges for many RI residents. In the setting of the ACA, which supports a reduction in the population of uninsured, the financial and

access-to-care barriers faced by the underinsured due to certain cost-sharing concerns should not be underestimated. Our results inform future policy decisions related to improving access barriers based on cost burden to patients.

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