

RESEARCH SPOTLIGHT

An Ounce of Prevention

BY HELEN FESSENDEN

Health care economists and policymakers have long focused on the role of prevention as a cost-saving investment. The 2010 Patient Protection and Affordable Care Act included, among other provisions, a requirement upon insurers that preventive care visits, such as checkups and basic screenings, have no co-payment. But what about low-income patients who don't have access to regular care or health insurance? One assumption that economists have long studied is that such individuals are more likely to use emergency department (ED) visits to treat preventable or chronic conditions. Such visits are not only far more costly, but less efficient in that they typically don't address long-term, follow-up care to handle conditions that can take months or years to treat. Whether the uninsured actually have more ED visits is another question; in a 2017 article in the journal *Health Affairs*, for example, researchers at the University of Chicago, Harvard University, and MIT found that the insured and uninsured tend to rely on emergency rooms with the same frequency and for similar kinds of care.

A broader question is whether improved access to primary care for at-risk groups is in fact one way to potentially reduce ED visits and ultimately drive down health care spending. In previous research, Cathy Bradley of the University of Colorado, Denver, David Neumark of the University of California, Irvine, and Lauryn Saxe Walker of Virginia Commonwealth University found that small incentive payments to low-income patients increased the chance that they would see a primary care provider (PCP). In a recent National Bureau of Economic Research paper, they have expanded on that study to look at whether such patients are also more likely to follow up after those first visits, whether ED visits fall, and whether overall health care spending is affected. To do this, they compared three groups — those receiving a free visit; a free visit plus a \$25 incentive payment; and a free visit plus \$50 — to a control group to assess health care use over 12 months and the resulting costs. They also divided the study into two six-month periods to analyze the results over time.

In terms of encouraging both PCP and follow-up outpatient or specialty care, the researchers found that the cash bonuses were tied to more visits across the two incentivized groups compared with the control group, especially in the

first six months. And the higher the incentive amount, the less time it took for the patient to schedule the first PCP appointment. But these increased visits didn't coincide with a drop in ED visits in those first six months. This finding seemingly runs against the assumption that increased access to primary care lowers overall ED use.

In the second six months of the study, the researchers noted several shifts. The number of PCP and follow-up outpatient or specialty visits fell among the cash-incentive groups, but it was still higher than visits among the control and \$0 groups. This time, ED visits slightly dropped in all the

three experimental groups compared with the first six months, regardless of the incentive sum — suggesting that participation in the experiment, not the dollar amount, might be a determining factor. Nonemergency ED visits also fell slightly.

As for the effect of all these extra primary care visits on health care costs, however, the results pointed to more spending,

not less. This jump was especially pronounced in the first six months, in which the control group's median per capita health care outlay was \$2,398, compared with \$3,394 for the three experimental groups. Spending fell across the board in the second half of the year, but it was still higher for the three treated groups (\$1,016) than the control group (\$582). In short, the jump in PCP visits and follow-up care didn't yield savings in that first year.

That said, the researchers cited several limitations to their study. One is that it was confined to 12 months, whereas many chronic health conditions can take longer to treat or manage. Another is that the jump in PCP and other visits in the first six months might simply reflect pent-up demand after years of irregular or inadequate care among the study's subjects. A related point, they noted, is that the increase in PCP visits was driven primarily by the less-healthy patients, who, in turn, would likely need more follow-up outpatient and specialty treatment — and therefore require more spending — in any event once they saw their PCP.

"In a low-income previously uninsured sample with poor baseline health, small cash incentives are effective at encouraging a PCP visit and perhaps effective at leading to a longer-term relationship with a PCP and fewer non-emergent ED visits," the authors concluded. But this outcome, they cautioned, "may result in higher health care costs in the short-term." **EF**

"The Effect of Primary Care Visits on Health Care Utilization: Findings from a Randomized Controlled Trial."

Cathy J. Bradley, David Neumark, and Lauryn Saxe Walker. National Bureau of Economic Research Working Paper No. 24100, December 2017.