

Dig deep: Impacts and implications of rising out-of-pocket health care costs

Executive summary

Even though more consumers are gaining health insurance coverage, they are by no means insulated from the burden of health care costs. Consumers are paying more of their health plan premium and experiencing higher out-of-pocket (OOP) cost-sharing for all types of health care services. These increases are expected to continue as employers shift to high-deductible offerings¹ and individuals gain coverage through insurance marketplaces² (also known as public health insurance exchanges). Moreover, government estimates of health care spending do not take into account discretionary consumer spending on a number of products and services; Deloitte's Hidden Costs Analysis shows these purchases add considerably to the total.

Increases in consumer OOP spending impact hospitals, life sciences companies, and health plans as well as consumers. In response, hospitals should consider strategies to help patients anticipate and pay their bills. Pharmaceutical companies should consider identifying ways to minimize consumers' cost-sharing for their products. Finally, health plans should consider developing tools to help consumers understand how to use their coverage and plan for care, including choosing high-value providers.



The increasing consumer health care cost burden

U.S. health care spending growth slowed during the recession and has continued to grow more slowly than historically,³ even as the U.S. emerges from the general economic slowdown. From a high of 9.7 percent in 2002, annual increases in expenditures stabilized at less than four percent per year during 2009-2012 (a period which includes and follows the economic downturn).⁴ However, projections show that the spending rate increase is expected to rise over time, even if it is at a lower trajectory than earlier estimates.⁵

The annually reported national estimates do not tell the whole story. Deloitte’s Center for Health Solutions has analyzed data from the Medicare Expenditure Panel Survey and other sources to develop a more complete picture of resources going to health care, including the OOP costs incurred by consumers. (See the appendix for a description of Deloitte’s methodology.)

This paper examines the impacts and implications of the increasing consumer health care cost burden. Rising cost-sharing over the past several years is largely attributable to employer strategies to reduce health care spending by increasing employee premiums, deductibles, and

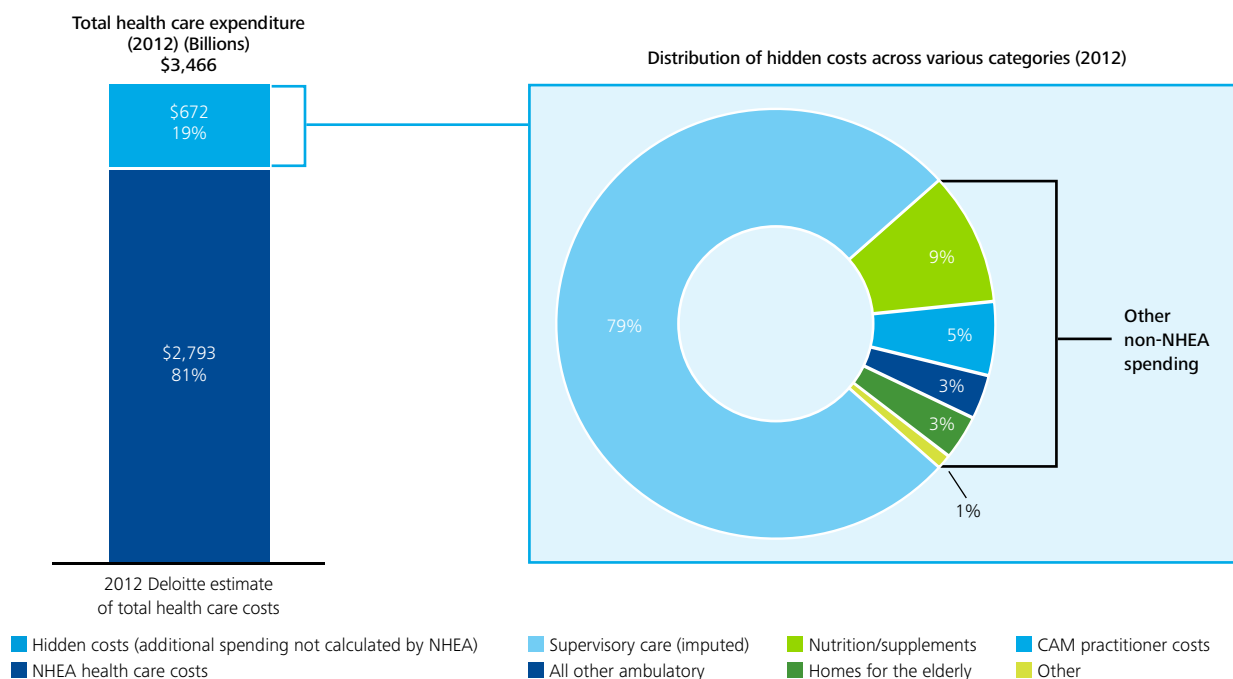
co-insurance or co-pays. Employers expect to continue using these strategies.⁶ Moreover, the insurance held by people buying individual coverage through marketplaces, starting in 2014, also features large deductibles and exposure to other forms of cost-sharing. Even as coverage expands (which will reduce OOP spending for those currently uninsured), consumer OOP spending for most types of coverage will likely rise. This, in turn, will affect other health care system stakeholders.

Findings from Deloitte’s Hidden Costs Analysis

Government data shows rising OOP spending for consumers, but excludes some types of health-related items and services that add significantly to the total amount and consumer share of spending. Examples include nutritional supplements and complementary and alternative medicine.

Our analysis shows that the “hidden costs” of health care account for almost one-fifth of total health care spending (Figure 1). Nutritional supplements make up the largest portion of the costs not included in the National Health Expenditures Accounts (NHEA) (nine percent), followed by spending for complementary and alternative medicine providers (five percent).

Figure 1: Total health care expenditure including hidden costs



CAM = Complementary and alternative medicine

Notes:

1. Numbers are rounded

2. Other = CAM products, health publications, and weight-reducing centers

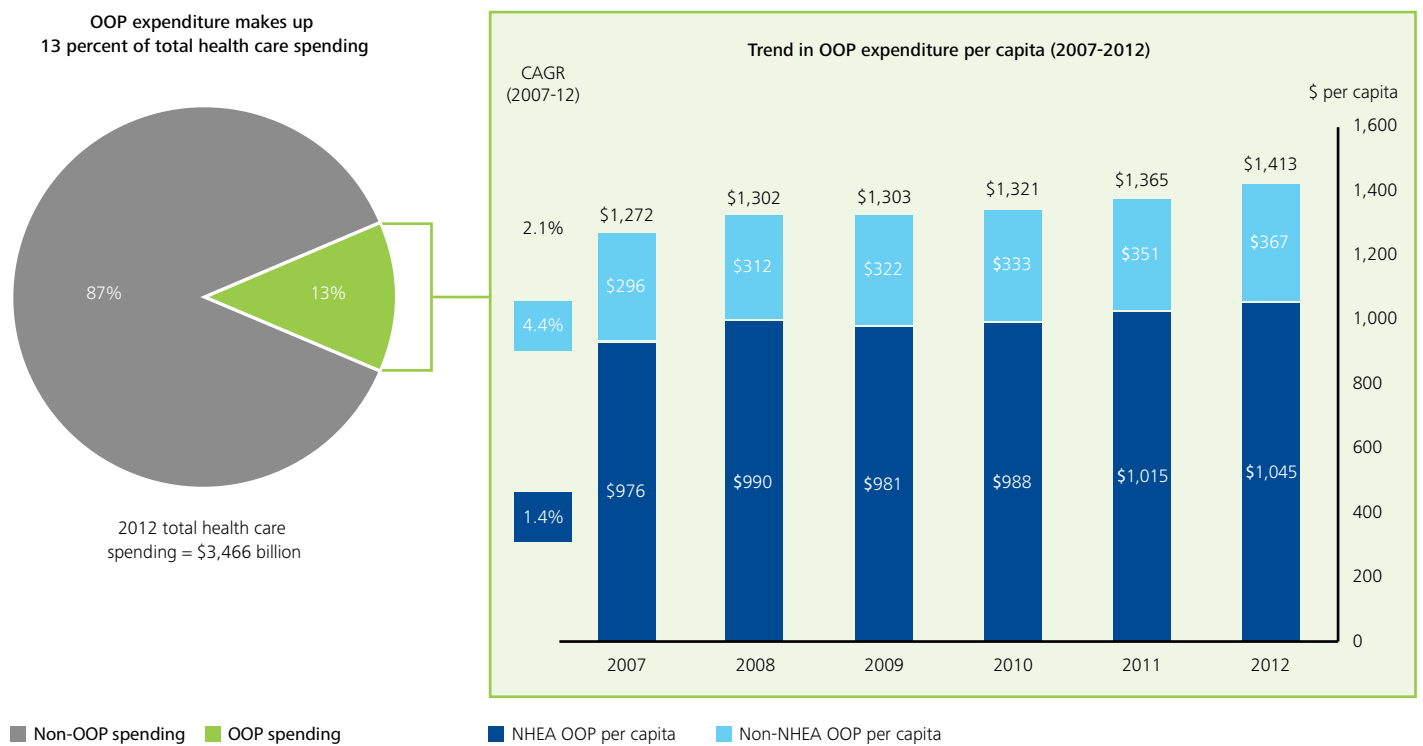
Sources: Center for Medicare and Medicaid Services, National Health Expenditures 2012 Highlights; U.S. Census Bureau, 2012 Population Estimates; 2009 National Alliance for Caregiving (NAC) Caregiver Survey; U.S. Department of Labor, 2012 National Compensation Survey; 2011-2012 Nutrition Business Journal data; U.S. Census Bureau, 2012 Services Annual Survey; Deloitte Hidden Costs Analysis, 2014. See appendix for calculation of hidden costs.

The NHEA data shows that OOP spending comprised 13 percent of total health care spending in 2012 (Figure 2). Per-capita OOP spending rose over the most recent years reported – from \$976 in 2007 to \$1,045 in 2012. Factoring in the additional sources of spending (excluding estimates for supervisory care), OOP spending rose from \$1,272 to \$1,413 per capita over the five-year period ending in 2012. OOP spending for the non-NHEA

categories rose 4.7 percent (compared with three percent for NHEA OOP costs alone).

It is interesting to see that even during a period of economic hardship that led to a general slowdown in health care use, consumers continued to value and spend money on services such as nutritional supplements and complementary and alternative medicine.

Figure 2. NHEA data shows rising OOP expenditures; amounts are higher when hidden costs are included



CAGR = Compound Annual Growth Rate

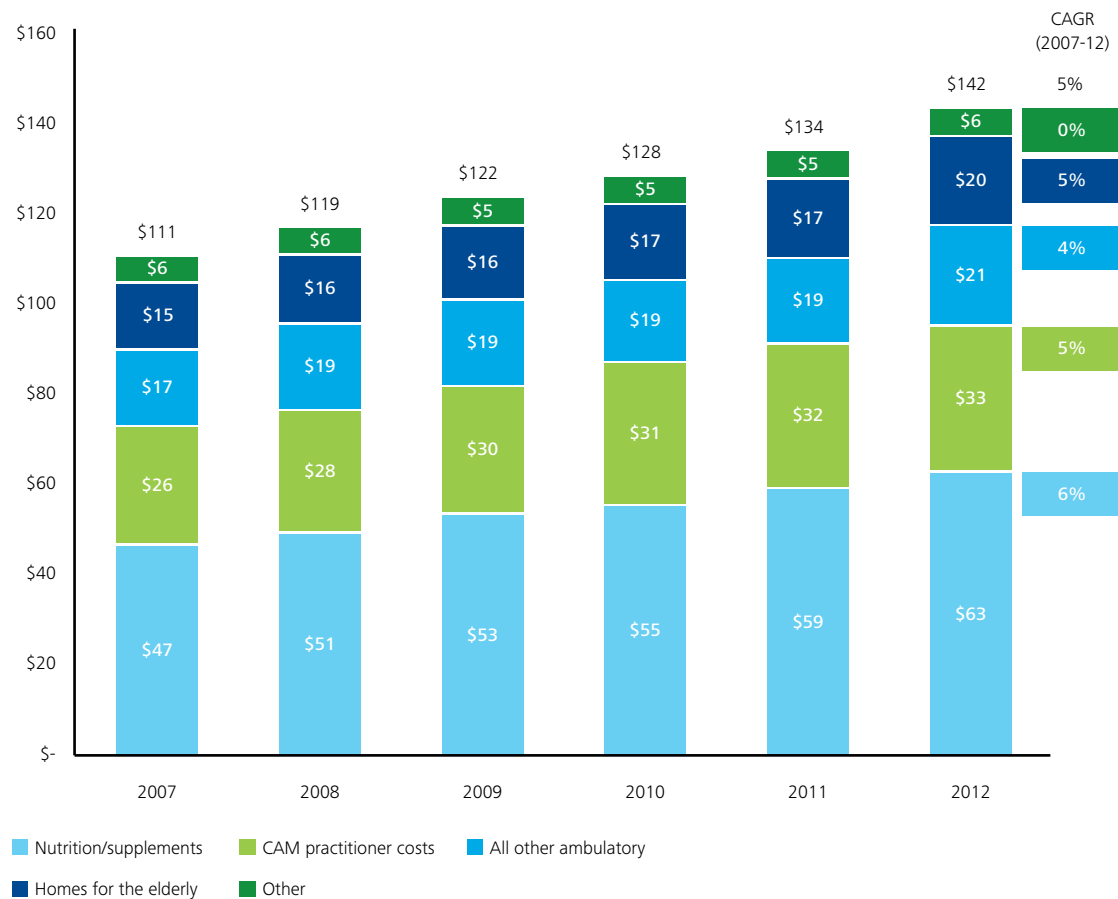
Notes:

1. Numbers are rounded
2. Since completion of this study, NHEA has published health care expenditure forecasts for 2013-23 along with minor revisions in the historical data.

Source: Deloitte Hidden Costs Analysis, 2014.

Looking more closely at the individual spending categories in the hidden costs group, it is apparent that spending on nutritional supplements comprises almost half the total (Figure 3). According to the most recent data available, spending increases on supplements accelerated to nearly seven percent in the most recent year, even as spending growth for traditional medical care services slowed.⁷

Figure 3. Growth in hidden costs spending, 2007-2012 (excluding supervisory care) (in \$ billions)



CAGR = Compounded Annual Growth Rate; CAM = Complementary and alternative medicine.

Notes:

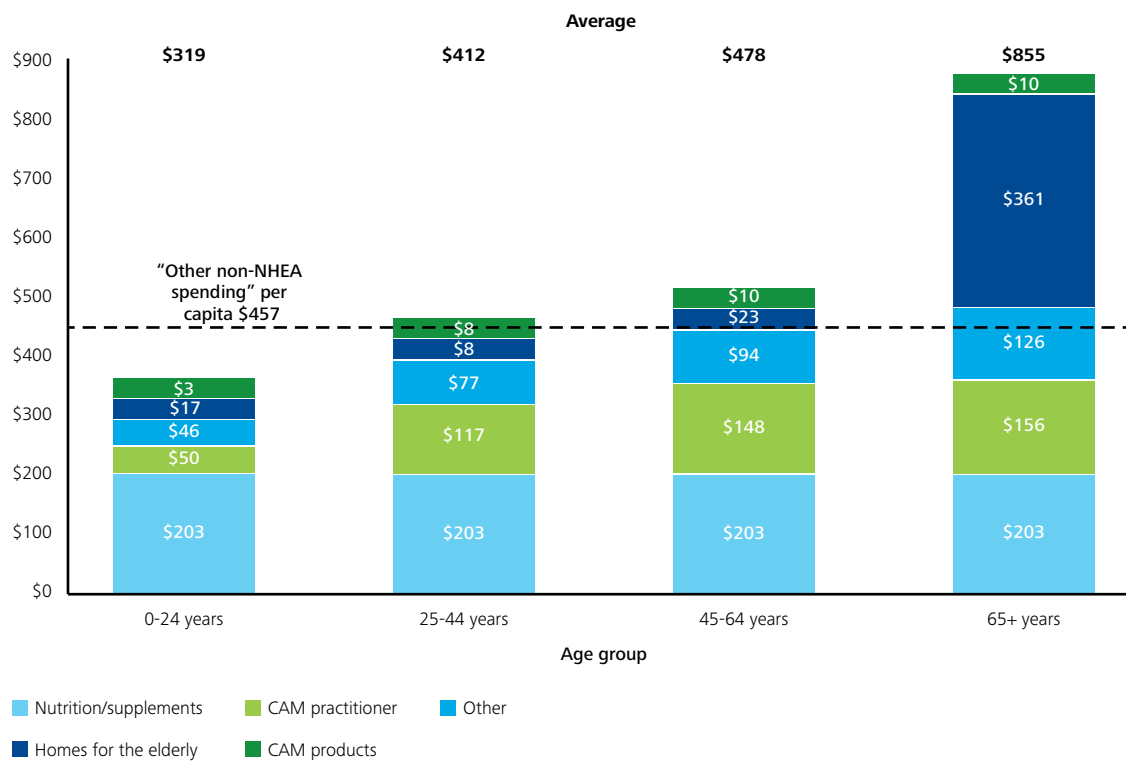
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2. Other = CAM products, health publications, and weight-reducing centers
3. Since completion of this study, NHEA has published health care expenditure forecasts for 2013-23 along with minor revisions in the historical data.

Sources: 2011-2012 Nutrition Business Journal data; U.S. Census Bureau, 2012 Services Annual Survey; Deloitte Hidden Costs Analysis, 2014

As one might expect, older populations (those aged 65+) have the highest personal spending level for OOP and other costs due to more illnesses and, therefore, more frequent use of health care. However, our analysis found that younger populations, especially those between 45 and 65

years old, also have high spending levels for these services (Figure 4). On average, 2012 OOP costs per capita were \$457; for people 65 years old or older, spending for these services was \$855.

Figure 4. Older people have higher hidden costs (2012)



CAM = Complementary and alternative medicine

Note: Other = All other ambulatory, health publications, and weight-reducing centers.

Sources: 2011-2012 Nutrition Business Journal data; U.S. Census Bureau, 2012 Services Annual Survey; 2010 Medical Expenditure Panel Survey; Deloitte Hidden Costs Analysis, 2014

OOP spending relative to other household expenses: Another perspective

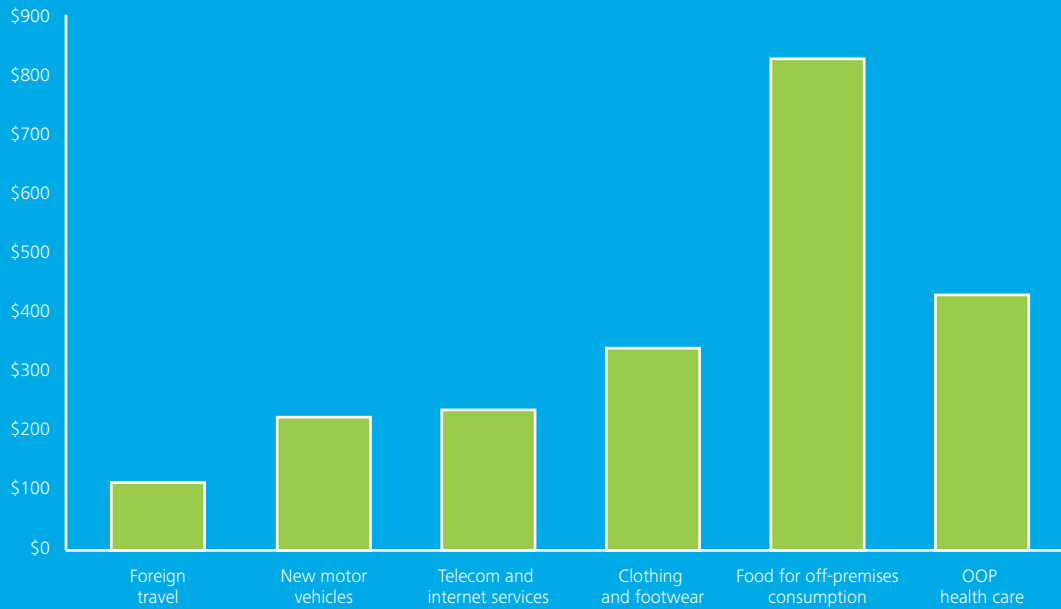
Health care spending is comparable to other major consumer spending categories, as illustrated in the figure below.

OOP expenses for health care account for almost twice as much as spending on new motor vehicles. However, total cash spending on health care is only about half the amount that consumers spend on food and beverages for off-premises consumption (e.g., groceries).

Consumers may perceive OOP health care spending to be lower than these comparisons indicate. OOP health care spending is fragmented among a variety of different suppliers and services, so consumers will not generally pay for health care OOP spending all at once (as they would for a car), unless they have a major episode like a hospitalization.

The relatively small share of cash income spent on health care is indicative of the U.S.'s high level of insurance coverage – most health care spending is indirect. However for some consumers – especially those who cannot afford insurance – OOP health care costs can be significant; even crushing.

Figure 5. Aggregate spending on selected categories, U.S. \$ billions, 2012



Source: Bureau of Economic Analysis and Deloitte calculations

OOP spending likely to change with health care coverage

Because this analysis uses 2012 data (the most recent year available), it does not reflect anticipated changes from the expansion of coverage through marketplaces and Medicaid that started in 2014. On the one hand, OOP spending for people who were uninsured should go down in the aggregate, especially for those with Medicaid. On the other hand, exposure to significant cost-sharing will continue for those covered by marketplace plans – many of which feature large deductibles – and for those with employer-based coverage.

An April 2014 Department of Health and Human Services (HHS) report shows that eight million people obtained coverage through marketplaces during open enrollment (October 2013-March 2014).⁸ The June 2014 press release on Medicaid stated that, as of April, six million more individuals were enrolled in Medicaid/Children's Health Insurance Program (CHIP) compared with the period before open enrollment began.⁹ The number of newly covered individuals is expected to affect total and OOP health care spending.

Coverage through marketplaces: About 65 percent of people obtaining coverage through marketplaces chose a Silver plan, which has actuarial value of 70 percent, meaning these members will have to pay the remaining 30 percent OOP in the form of co-insurance, deductibles, and co-payments.¹⁰ According to a May 2014 Milliman report, members with a Silver plan will have 38 percent higher OOP costs compared with people who have employer coverage. The average deductible amount for a Silver plan is \$2,907 for an individual enrollee and \$6,078 for a family.¹¹ This compares with average deductibles of \$1,135 for an individual and \$4,079 for families with employer coverage in 2013.¹²

Many people obtaining coverage through marketplaces are low income, so they are likely to be challenged by high health care costs at the point of service. Overall, eight in 10 enrollees will likely seek federal financial assistance in premium payments,¹³ which raises the question of whether they will be able to pay the OOP requirements for expensive health care when they need it. If not, they may forgo care; get care but not pay for the cost-sharing (leaving providers to try to collect the difference); or use other strategies from when they didn't have coverage.

Pharmaceutical companies have been raising concerns about marketplace enrollees' access to their products.¹⁴ The Affordable Care Act (ACA) requirement to include drug coverage as an essential benefit will expand the population with prescription drug coverage. Before ACA implementation, nearly one out of five health plans in the individual insurance market did not include this type of coverage, so many with coverage through marketplaces will be better off than when they were uninsured or under individually purchased policies. However, consumers who used to have drug coverage through employers and who enroll in marketplace Bronze or Silver plans likely will see higher OOP liability for drugs.

Coverage through Medicare: Medicare benefit design has been largely unchanged since drug coverage was added to the benefit package. Most Medicare beneficiaries have supplemental coverage or Medicare Advantage for OOP liability. However, a recent study found rising OOP costs for Medicare beneficiaries.¹⁵

In 2013, more than 35 million Medicare beneficiaries had pharmaceutical coverage for drugs.¹⁶ Nearly all Medicare drug plans use tiered cost-sharing; two-thirds have five cost-sharing tiers. Many enrollees are in plans with a 33 percent co-insurance rate for specialty-tier drugs. Plans usually have a tiered cost-sharing structure with incentives for enrollees to use less expensive generic and "preferred" brand-name drugs.¹⁷

Coverage through Medicaid: As the population with Medicaid coverage grows, OOP spending for those who qualify will be lower. People with Medicaid have limited exposure to cost-sharing. While certain Medicaid groups (children, terminally ill individuals, and those residing in an institution) are exempt by law from OOP costs;¹⁸ most other enrollees can be charged a minimal cost-sharing amount.¹⁹ Medicaid covers long-term services and supports but coverage of home- and community-based care is usually limited to target enrollee populations.

Coverage through employers: About 15.5 million individuals were enrolled in high-deductible plans in January 2013, with an annual growth rate of about 15 percent over the past several years.²⁰ The trend towards high-deductible plans is expected to continue – Deloitte's 2012 Survey of U.S. Employers found that 52 percent of employers were planning to shift their employees into health plans with high deductibles over the next three to five years.²¹

Implications for hospitals

While hospitals should benefit from reductions in the percentage of uninsured individuals, they may see continued prevalence of high deductibles in people with employer and marketplace coverage. In response, hospitals may need to develop new strategies to capture a greater proportion of payment up front. Low-income patients who cannot pay their share of hospital care may increase pressure on providers to furnish charity care. Bad debt (incurred from payments that hospitals anticipated receiving from consumers but did not) is likely to rise from patients whose income and resources are above the charity care limits but who are unprepared or unwilling to meet increased OOP expenditures for their care.

The American Hospital Association (AHA) reported that uncompensated care (the combination of bad debt and charity care) totaled \$45.9 billion in 2012 (the most recent estimate available), comprising 6.1 percent of total expenses, an all-time high.²² Based on an analysis of 2011 HHS Medicare and Medicaid statistics, bad debt for providers is estimated to reach \$200 billion by 2019.²³

Although many hospitals still use the traditional system of billing patients after services are provided (risking subsequent payment), hospitals could implement a number of revenue cycle strategies to address the challenge of rising patient cost-sharing.²⁴

1. **Patient access:** Numerous hospitals processes and technology to capture revenue at key patient access touchpoints before the patient leaves the hospital, including pre-service, during initial registration, and at check-out:
 - Before a patient receives care for a scheduled visit, the hospital uses a pre-clearance process to identify the correct payor, determine eligibility and benefits, and collect patient liability/co-pay for the scheduled procedure. This due diligence also helps reduce the rate of preventable denials from payors. If the patient is self-pay or uninsured, staff may refer the patient to financial counselors to determine eligibility for Medicaid or marketplace plans, or to the charity care team. Many hospitals develop self-pay policies for elective procedures that require an upfront partial to full payment. Pre-service collections can also be conducted via phone using a secure payment method.
 - Patient Liability Estimators are programs that use fee schedules/contracts to approximate patient OOP expenses. Leading practice is to run these programs for each visit to proactively inform the patient of their

expected OOP costs. If a patient was not pre-registered for their appointment, registration staff at check-in can offer another potential collection point.

- In areas like the Emergency Department (ED), coupling clinical and financial information through a clear check-out process provides another potential revenue collection point prior to a patient leaving the hospital.
2. **Charge integrity:** Once a patient receives care, the goal is to accurately bill all services so that insurance will cover them appropriately. For people without coverage, hospitals should make their charity care policy clear, implement it consistently, and assure the accuracy of the community service adjustment, which reduces charges for self-pay patients so they do not have to pay charge mark-ups.
 3. **Patient financial services:** Opportunities may exist for improving revenue collection by consistently using multiple communication channels, including mail and telephone. Hospitals might also consider offering financing at a reasonable interest rate in response to higher OOP costs. While this approach may be controversial, it could help a hospital obtain at least some of a patient's payment up front.

Some hospitals are using analytical programs and technologies to support collection efforts.²⁵ These programs and technologies allow them to better predict patient liability; drill down to the root causes of denials; view trends across payors, procedures, and facilities; and make data-driven decisions to enhance revenue cycle performance. Analytical programs also help hospitals move towards monitoring outcomes and linking them to reimbursement rates, particularly under value-based payment models like Accountable Care Organizations (ACOs).

Implications for pharmaceutical companies

The burden of rising OOP pharmaceutical costs is increasingly falling on patients, especially ones enrolled in the less expensive Bronze or Silver marketplace insurance plans, which typically have lower monthly costs but higher deductibles. For example, a recent PhRMA study found that patients suffering from chronic conditions such as Rheumatoid Arthritis might pay between \$2,500 and \$4,300 OOP, including for prescription drugs, before the cost of any treatment is covered.²⁶ High cost-sharing increases the chances that patients will not fill their prescriptions and not adhere to recommended therapies, which can adversely affect patients' health.

In response to changing market conditions, pharmaceutical companies increasingly are developing strategies to advantageously position their products for payor formulary and benefit designs. Many pharmaceutical companies offer co-payment cards, coupons, and other types of discounts to help some patients afford medicines that they otherwise could not – this strategy is designed both to help people without insurance gain access to certain drugs, and to reduce influence on patients by formulary designs that steer them away from certain brands. Not surprisingly, insurers and other payors generally are not in favor of co-payment cards and coupons because their share of a brand-name drug's cost is much higher than for a generic pill, and coupons undermine incentives for patients to take generic drugs or brand-name drugs for which the insurers have negotiated the discounts. Pharmaceutical companies are considering strategies that better position their products as health care solutions. Disease management, adherence, real-world evidence generation, and risk-sharing programs all seek to accomplish this objective.

Implications for health plans

Health plans are a primary originator of product designs that incorporate higher cost-sharing for consumers. These organizations are responding to employer requests to use cost-sharing to keep premium costs down and incorporate ACA actuarial equivalent requirements that dictate fairly significant cost-sharing. To help enrollees make the best use of their health care dollars, the major health plans have developed transparency tools²⁷ and cost calculators to help enrollees understand, for example, where they are in their deductible level. In a recent survey of health plans, 43 percent said they have such tools, another 24 percent are investing in the tools this year, 26 percent will invest in one to three years, and by 2017, 93 percent of plans will have these tools.²⁸ Of interest, some tools are available for mobile devices.

Health plans also are continuing efforts to make their communications about cost-sharing easier to understand. Examples include Explanation of Benefits improvements, consolidated statements, and financial visualization tools.

Most health plans must cover U.S. Preventive Task Force-recommended preventive services with no cost-sharing; however, high deductibles and other cost-sharing formats can pose issues for plans' disease management programs, as patient compliance can be challenging when cost-sharing is high. Furthermore, health plans that are trying to improve quality ratings (e.g., blood pressure control, cholesterol control) may have a more difficult time encouraging people to take their medications when they face high cost-sharing.

Some plans are offering value-based benefit design, which can reduce enrollees' cost-sharing exposure for target therapies. Some plans also are using a "step-therapy" approach for medication to encourage the use of less expensive drugs with potentially equivalent results prior to moving to more expensive ones if necessary. Enrollees with high-cost sharing plans are likely to appreciate benefit and management approaches that reduce their OOP spending.

Implications for consumers

Consumers are finding it increasingly difficult to bear the burden of mounting OOP costs and many are searching for ways to manage the expenditure. For example, in Deloitte's surveys of U.S. consumers, respondents have shown a willingness to skip care and/or use over-the-counter products to avoid the cost of doctors' office and hospital visits.²⁹ Some opt to not fill prescriptions, take less than the prescribed amount, or have trouble getting behavioral health care.³⁰

A growing number of individuals are buying health plans that have lower premiums (so are less expensive on a monthly basis) but have high deductibles, without understanding that these plans will not pay for a doctor visit or for prescription drugs before the consumers meet their annual deductible. These choices can result in thousands of dollars of OOP medical expenses each year. The challenges of insurance illiteracy are great: A study by *Consumer Reports* found that many consumers were not aware of basic insurance concepts.³¹ (HHS is running a campaign to help people understand how to use their insurance.³²) Among potential implications of insurance illiteracy, some consumers in future rounds of marketplace purchases may choose to "buy up" when they learn about their financial exposure under some of the less-expensive plans.

Ideally, consumers seeking to reduce OOP costs will take time to research options and use available tools to select low-cost, high-quality providers in their health plan's network. OOP costs may even encourage some consumers to take extra steps to stay healthy. But even consumers who are fully committed to healthy living will at some time or another need health care and this may involve high prices. Finally, people facing high cost-sharing may be discouraged from using many of the health services they need, including help managing chronic health conditions, and may not see the value in paying premiums for future coverage.

Appendix

Total health care spending: Deloitte Center for Health Solutions' methodology

Deloitte's 2014 analysis of the hidden costs of health care follows the same methodology as earlier studies and draws on a number of sources, with the most recent data being from 2012. U.S. health care spending consists of that reported in the NHEA and the hidden costs of health care – spending that occurs outside of the NHEA that is not

routinely or completely captured. Deloitte's analysis, described in the figure below, provides a more comprehensive estimate of U.S. spending on all health-related goods and services. Our methodology takes a broad view of direct and indirect costs as well as specific items such as alternative medicines, functional foods, and the imputed cost of providing supervisory care to a family member or friend.

Total health care expenditure

**81%
NHEA**

Health care spending in the United States reported in the NHEA

26% Professional services
Physicians and clinical services, other professional services, dental services, and other personal health care

25% Hospital care
Services provided by hospitals to patients

12% Government and other administrative costs
Government administration and public health activity, the net cost of private insurance (premiums) and investment in research, structures, and equipment

8% Prescription drugs
Human-use dosage-form drugs, biologicals, and diagnostic products

7% Long-term care
Home health care and nursing home care

3% Retail products and service
Durable medical equipment and other nondurable medical products

**15%
Supervisory care (imputed value)**

Deloitte's estimate of the imputed value of unpaid care at home provided by a family member or friend to someone with limited capacity to self care

**4%
Other Non-NHEA spending**

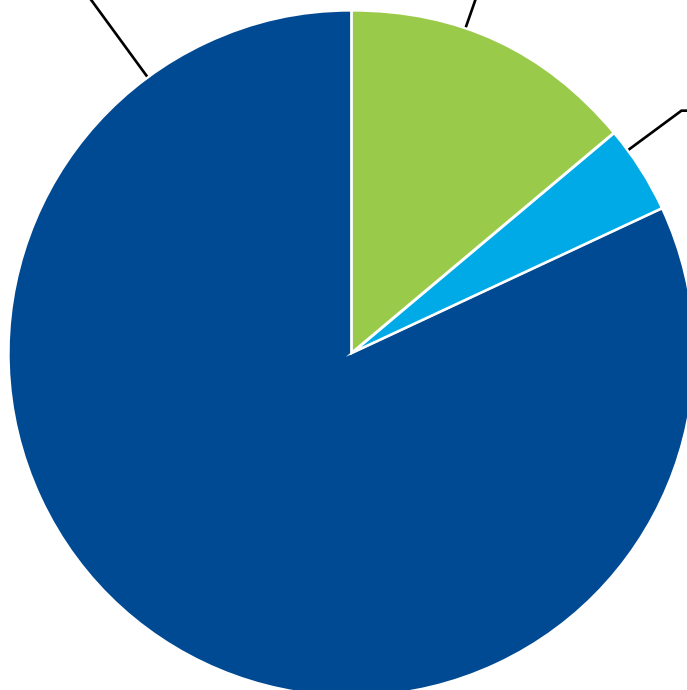
Spending (excluding supervisory care) that is not conventionally reported in the NHEA.

2% Nutrition and supplements
Vitamins, minerals, functional foods, and other specialty supplements

1% CAM services and products
Naturopathy, yoga, acupuncture, spinal manipulation and massage, and other CAM practices like movement therapies, traditional healers, manipulation of energy fields and traditional medicine systems like Chinese medicine and Ayurvedic medicine

1% Homes for the elderly
Community care homes for the elderly

1% Other
Ambulatory care, weight-reducing centers, and health publications



Note: Numbers are rounded



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Acknowledgements

We wish to thank Moher Iskander, Susan Novak, Kristen Schultz, Jessica Skinner, Sheryl Coughlin, Leslie Korenda, Casey Korba, Niha Bhattairi, Maria Abrica-Gomez, Jaya Agarwal, Maulesh Shukla, and the many others who contributed their ideas and insights to this project.



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Endnotes

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