The COMMONWEALTH FUND

Tracking Trends in Health System Performance

NOVEMBER 2014

Too High a Price: Out-of-Pocket Health Care Costs in the United States

Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014

Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel

Abstract Whether they have health insurance through an employer or buy it on their own, Americans are paying more out-of-pocket for health care now than they did in the past decade. A Commonwealth Fund survey fielded in the fall of 2014 asked consumers about these costs. More than one of five 19-to-64-year-old adults who were insured all year spent 5 percent or more of their income on out-of-pocket costs, not including premiums, and 13 percent spent 10 percent or more. Adults with low incomes had the highest rates of steep out-of-pocket costs. About three of five privately insured adults with low incomes and half of those with moderate incomes reported that their deductibles are difficult to afford. Two of five adults with private insurance who had high deductibles relative to their income said they had delayed needed care because of the deductible.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this brief, please contact:

Sara R. Collins, Ph.D.
Vice President, Health Care Coverage and Access
The Commonwealth Fund
src@cmwf.org

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1784
Vol. 29

OVERVIEW

Over the past decade, Americans—whether they receive health insurance from their employers or purchase it on their own—have seen a substantial increase in the amount of money they pay when they go to a doctor or fill a prescription.[1] The share of workers covered by employer-based health plans who faced a deductible climbed from 55 percent in 2006 to 80 percent in 2014, according to the Kaiser Family Foundation.[2] In 2014, the average deductible for a single policy in an employer plan was $1,217, more than double the 2006 average of $584. More than two of five covered workers—up from 10 percent in 2006—have deductibles of $1,000 or more.

Because median family income has grown very slowly over the past decade, these trends mean that the amount U.S. families spend on health has

grown as a share of income. For some families, this has led to underinsurance—their insurance coverage does not provide adequate protection from the costs of health care. Prior research by The Commonwealth Fund has found that when people are underinsured they delay getting needed care at similar rates as adults who lack coverage altogether.[3] This is why the Affordable Care Act requires health insurance policies sold in the individual and small-group markets to cover a comprehensive set of health benefits, and why it provides greater financial protection for lower-income people who buy plans through the marketplaces. But the law's reach is limited. More than 150 million Americans get their health insurance through an employer; 7.1 million bought plans through the marketplaces this year.

This issue brief assesses the financial protectiveness of health insurance coverage in the United States by examining survey results from The Commonwealth Fund that track the affordability of health insurance and health care among the nation's adult population. Between September 10 and October 5, 2014, the Commonwealth Fund Health Care Affordability Tracking Survey interviewed a nationally representative sample of 2,751 adults ages 19 to 64 about the costs of their health insurance and health care.

THE COMMONWEALTH FUND'S MEASURE OF UNDERINSURANCE

In 2003, Cathy Schoen developed a measure of underinsurance for the Commonwealth Fund Biennial Health Insurance Survey that takes into account an insured adult's reported out-of-pocket costs over the course of a year, not including premiums, and their health plan deductible. These actual expenditures and the potential risk of expenditures, as represented by the deductible, are then compared with household income. Specifically, someone who is insured all year is underinsured if:

- out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; or
- out-of-pocket costs, excluding premiums, are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level ($22,980 for an individual and $47,100 for a family of four); or
- the deductible is 5 percent or more of household income.

The Commonwealth Fund has reported changes in this measure every year it has fielded the biennial survey. We will report an update of this measure in January 2015. With this smaller and shorter tracking survey, we aim to periodically check in on what Americans are spending out-of-pocket on their health care, their views of these costs, and how costs are affecting their medical decisions.

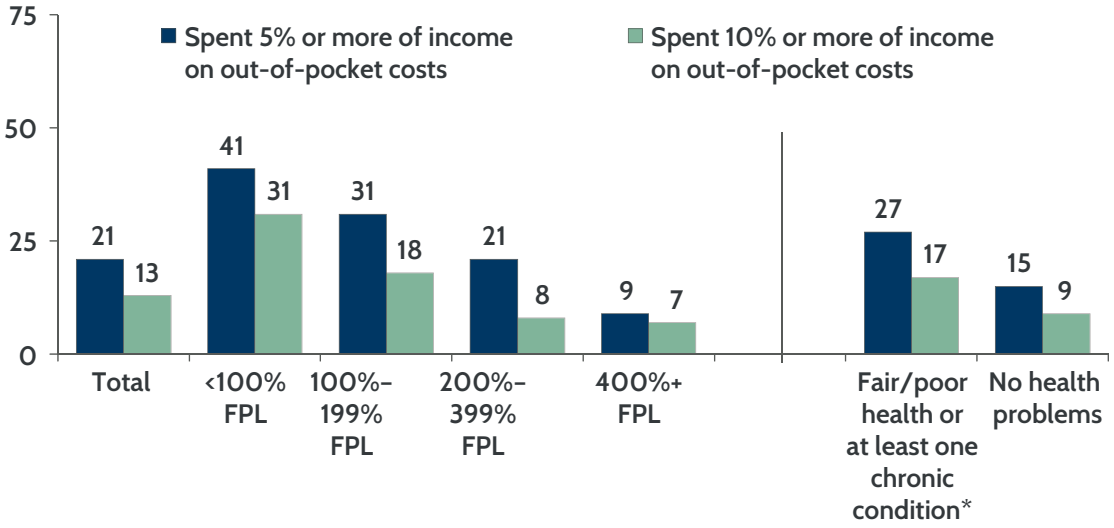
SURVEY FINDINGS

Low-Income Adults Are the Most Likely Among Those Insured All Year to Spend Large Shares of Their Income on Health Care

In the survey, people were asked how much they spent out-of-pocket for medical treatments and services that were not covered by their health insurance over the prior 12 months. They were asked to think of all their expenditures, including copayments, when they went to the doctor or hospital, as well as their costs for prescriptions and vision and dental care. We then calculated their estimates as a share of their income. Among adults who had had health insurance for the full 12 months, more than one of five (21%) spent 5 percent or more of their income on out-of-pocket costs and 13 percent spent 10 percent or more (Exhibit 1).

Exhibit 1. Two of Five Insured Adults with Incomes Below the Federal Poverty Level Spent 5 Percent or More of Their Income on Medical Out-of-Pocket Costs

Percent of adults ages 19–64 who were insured all year



Note: FPL refers to federal poverty level. * Respondent reported having at least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; high cholesterol; or depression or anxiety.
Base: Respondents who were insured all year and reported their income level and out-of-pocket costs.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

Adults with low-incomes were the most likely to spend a large share of their income on uncovered health care costs.[4] Two of five (41%) adults with incomes under 100 percent of poverty ($11,490 for an individual and $23,550 for a family of four) who had insurance for the full year spent 5 percent or more of their income on out-of-pocket medical costs and 31 percent spent 10 percent of their income. In the next-higher income category, 100 percent to 199 percent of poverty ($22,980 for an individual and $47,100 for a family of four), 31 percent of adults spent 5 percent or more of their income on medical services not covered by their health plans.

People with health problems have higher costs than those who are healthier, and the survey finds that some of that extra cost is shouldered by patients and their families. Insured adults in fair or poor health or those who reported at least one chronic condition were more likely to spend large shares of their income on medical costs not covered by their insurance than insured adults in better health.[5]

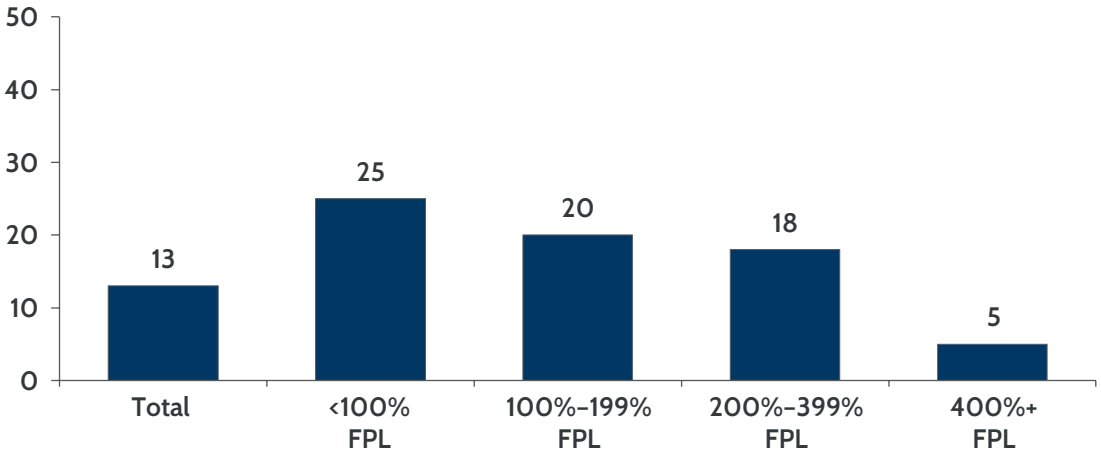
Thirteen Percent of Privately Insured Adults Have Deductibles Equal to 5 Percent or More of Income

When people use their health insurance, they incur out-of-pocket costs. A health plan's deductible provides an indicator of the financial protection a plan offers and the risk of incurring costs even before a person uses their plan. Adults in the survey were asked whether their plan had a per-person deductible and, if so, what the size of the deductible was. We then calculated the deductible as a share of their income.

Since few people with Medicaid have deductibles, we looked at adults' experience with deductibles among those who reported having a private plan at the time of the survey. Among adults with private insurance, 13 percent had a deductible of 5 percent or more of income (Exhibit 2). Adults with low and moderate incomes were the most likely to have deductibles that were high

Exhibit 2. Privately Insured Adults with Low Incomes Were the Most Likely to Have Deductibles That Could Potentially Use 5 Percent or More of Their Annual Income

Percent of privately insured adults ages 19–64 whose deductible is 5% or more of income*



Note: FPL refers to federal poverty level.
* Base: Respondents who reported their income level and deductible for their private insurance plan (includes those who are currently covered by employer-provided insurance, a marketplace plan, or a plan they purchased through the individual market outside of the marketplaces).
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

relative to their income: one-quarter of privately insured adults with incomes under poverty and about one of five with incomes between 100 percent and 399 percent of poverty had deductibles that equaled 5 percent or more of income.

Many Adults Say Their Deductibles Are Unaffordable

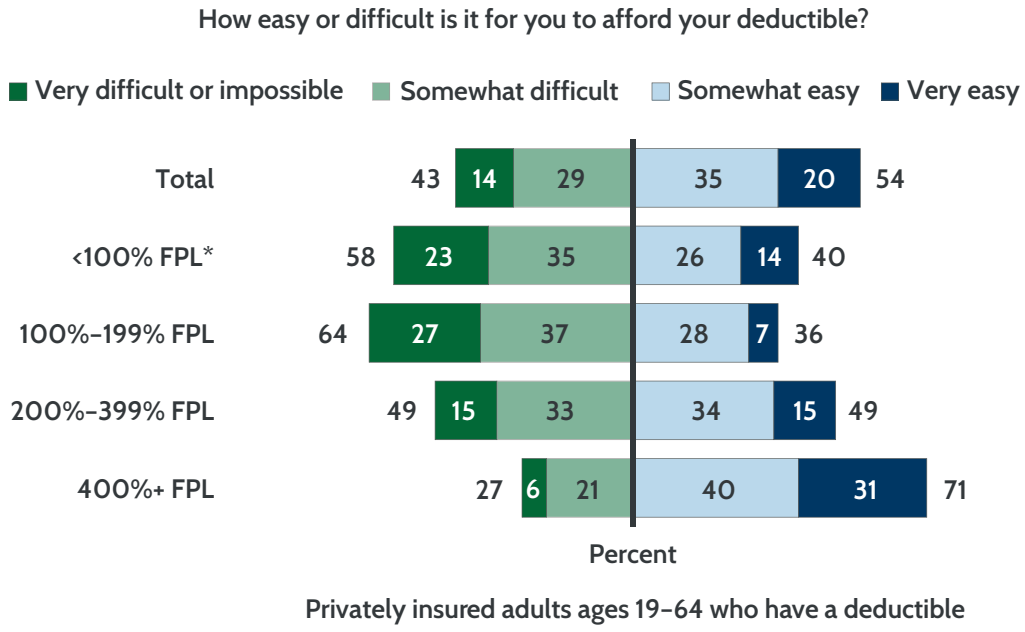
When we asked privately insured adults with deductibles if they could afford them, more than two of five (43%) said their deductible was somewhat, very difficult, or impossible to afford (Exhibit 3). People with low and moderate incomes were more likely to report difficulties. Nearly three of five (58%) adults with incomes under 100 percent of poverty and two-thirds (64%) of those with incomes between 100 percent and 199 percent of poverty reported it was difficult to afford their deductibles. About half (49%) of adults with incomes in the next higher income category—200 percent to 399 percent of poverty—reported difficulty affording deductibles, compared with one-quarter (27%) of those with incomes above 400 percent of poverty.

Adults with High Deductibles Report Delaying Needed Health Care

One rationale for adding deductibles to health plans is that they will create disincentives for consumers to use health care that might be of limited value, thereby lowering costs and limiting premium growth over time. But the survey finds evidence that deductibles also create disincentives for people to get needed care.

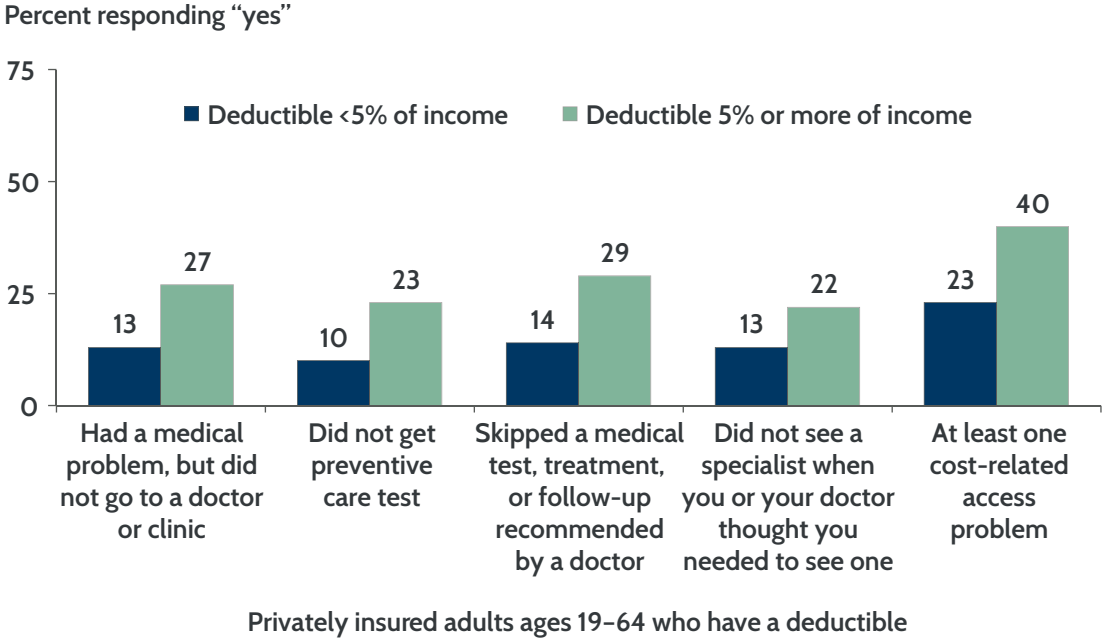
Privately insured adults with high deductibles relative to their income were significantly more likely to report delaying or avoiding needed health care than those with lower deductibles. Two of five (40%) adults with deductibles of 5 percent or more of income reported that because of their deductible, they had not gone to the doctor when sick, did not get a preventive care test, skipped a recommended follow-up test, or did not get needed specialist care (Exhibit 4). Adults who had deductibles that were smaller relative to income reported avoiding care at lower rates. Still, nearly one-quarter (23%) of privately insured adults who had deductibles that were less than 5 percent of income said they did not get needed care because of their deductible.

Exhibit 3. About Three of Five Privately Insured Adults with Low Incomes Reported That It Was Difficult or Impossible to Afford Their Deductible



Notes: FPL refers to federal poverty level. Bars may not sum to 100% because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
* Sample size n=94.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

Exhibit 4. Two of Five Privately Insured Adults with Deductibles That Comprise 5 Percent or More of Their Income Reported Delaying or Avoiding Needed Health Care Because of Their Deductible



Base: Respondents who reported their income level and deductible for their private insurance plan (includes those who are currently covered by employer-provided insurance, a marketplace plan, or a plan they purchased through the individual market outside of the marketplaces).
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

WHY THE AFFORDABLE CARE ACT IS EXPECTED TO REDUCE THE NUMBER OF UNDERINSURED AMERICANS

The Affordable Care Act aims to improve the quality of health insurance sold in the individual and small-group markets and expand eligibility for Medicaid, which includes little or no cost-sharing.

The law improves the comprehensiveness of coverage by requiring that health plans sold in the individual and small-group markets cover an essential health benefits package, which may vary only by the degree of cost-sharing consumers bear–for example, the size of deductibles, copayments, and coinsurance. To further protect consumers and help them understand the costs they might be responsible for, the law requires insurance plans to be sold at four distinct levels in those markets: bronze, silver, gold, and platinum. Bronze plans cover an average of 60 percent of the medical costs incurred by enrollees in a plan; silver plans cover 70 percent; gold plans cover 80 percent; and platinum plans cover 90 percent. This is also known as the actuarial value of a plan. The law also provides cost-sharing subsidies for people with incomes under 250 percent of poverty ($28,725 for an individual and $58,875 for a family of four) who enroll in silver plans through the marketplaces.

Prior to the Affordable Care Act, as many as half of plans sold in many state individual insurance markets had actuarial values of less than 60 percent.[6] In addition, health insurers in most states excluded conditions they expected would be costly, such as maternity care, or limited what health plans would pay in a year and over a lifetime. The law has banned all of these practices.

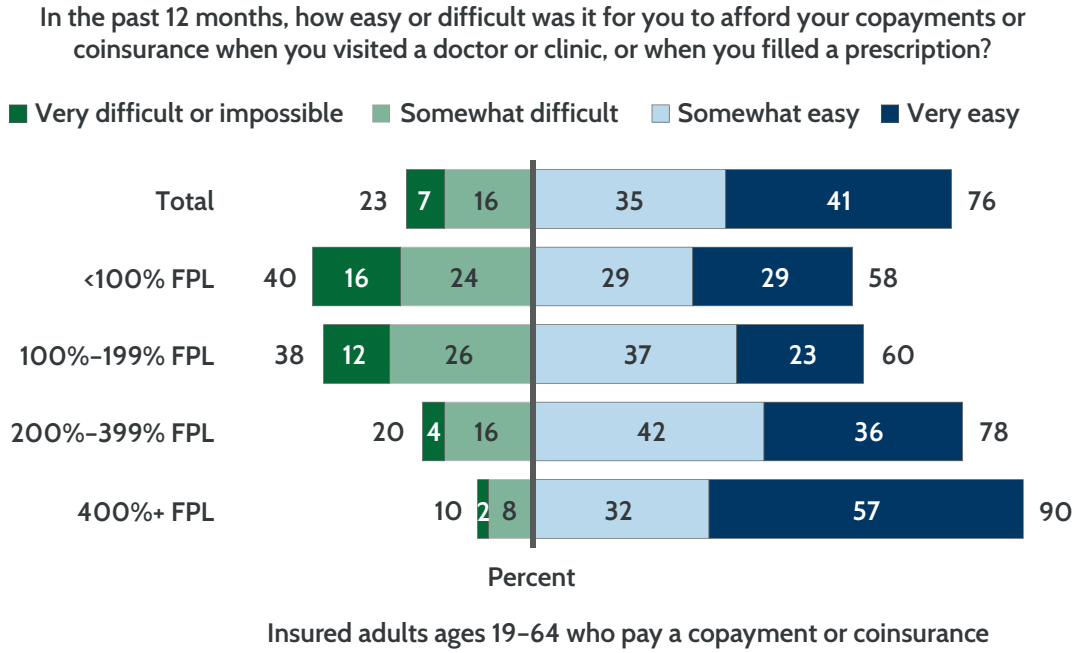
Employer plans have traditionally been far more comprehensive than individual market plans.[7] But the law includes provisions aimed at protecting people with employer coverage. Workers with incomes under 400 percent of poverty are eligible for tax credits for plans purchased in the marketplaces if they are offered a plan by their employer that has an actuarial value of less than 60 percent, and large employers that do this will pay a penalty. In addition, employers are now required to provide all federally recommended preventive care services without cost-sharing.

Lower-Income Adults Report Difficulty Affording Copayments, Delaying Needed Care

In addition to deductible size, another indicator of the financial protection a health plan offers is the amount of copayments or coinsurance a health plan requires when people go to the doctor or fill a prescription. The survey asked people whether their health plan included copayments or coinsurance and, if so, how easy or difficult it was for them to afford these potential costs. In this analysis, we include all insured adults because people with Medicaid and other public insurance plans also may have copayments. Three-quarters (76%) of insured adults who have copayments or coinsurance said it was very or somewhat easy to afford them (Exhibit 5). Adults with lower incomes were significantly more likely to say it was difficult to afford their copayments or coinsurance than were adults with higher incomes.

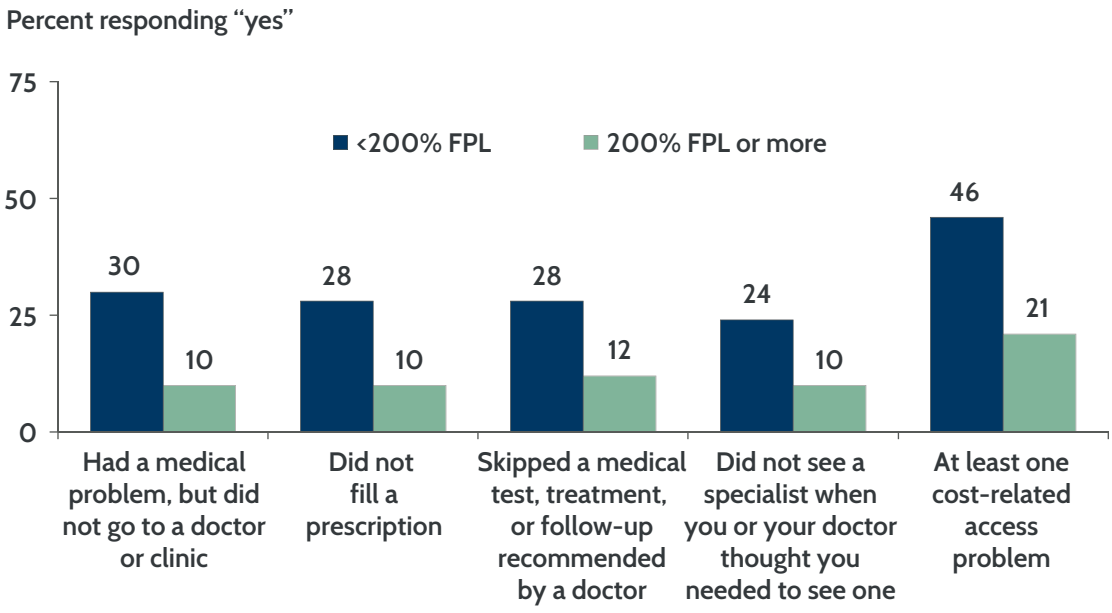
Difficulty in affording copayments appears to affect people's health care decisions. People with low incomes who had copayments or coinsurance were more likely to say they had delayed or avoided needed care because of these costs than were those with higher incomes. Nearly half (46%) of insured adults with incomes under 200 percent of poverty said that because of their copayments or coinsurance, they had either not filled a prescription, not gone to the doctor when they were sick, skipped a medical test or follow-up visit recommended by a doctor, or not seen a specialist when they or their doctor thought they needed one (Exhibit 6). Overall, lower-income adults delayed or avoided care because of their copayments at twice the rate of adults with higher incomes. However, adults with relatively higher incomes also reported issues: one of five (21%) adults with incomes of 200 percent of poverty or more reported not filling a prescription or delaying care because of copayments.

Exhibit 5. Most Insured Adults with Plans That Require a Copayment or Coinsurance Said It Was Somewhat or Very Easy to Afford Them



Notes: FPL refers to federal poverty level. Bars may not sum to 100% because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

Exhibit 6. Insured Adults with Lower Incomes Were More Likely to Report They Had Delayed or Avoided Getting Care Because of Their Copayments or Coinsurance



Note: FPL refers to federal poverty level.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

CONCLUSION AND POLICY IMPLICATIONS

Changes in health benefit design over the past decade across all forms of insurance have emphasized greater consumer cost-sharing through higher deductibles, copayments, and coinsurance. Recently, some policymakers have suggested that insurers should be allowed to sell health plans in the Affordable Care Act's marketplaces that require even greater cost-sharing than the least protective bronze-level plans.[8]

The results of this survey show that these trends toward greater cost-sharing, combined with little or no growth in median family income, have left many working Americans in the middle and lower end of the income distribution with large health care cost burdens. About three of five adults with low incomes and half of those with moderate incomes say that their deductibles are difficult or impossible to afford.

Cost-sharing in health plans is affecting people's medical decisions in ways that should be of concern to policymakers and the medical community. Two of five adults who had deductibles that were high relative to their income said they had delayed or avoided needed care because of the deductible. Nearly one-quarter of people with high deductibles cited them as the reason they had not gotten a preventive care test, even though by law these tests are excluded from deductibles.

The Affordable Care Act has the potential to reduce the number of Americans who are underinsured though reforms aimed at improving the comprehensiveness of coverage in the individual and small-group markets. But the underlying rate of growth in health care costs relative to income growth also will have an impact on the number of underinsured people in the coming years. More than 400 pages of the Affordable Care Act are devoted to new programs and payment methods aimed at improving the quality of health care and lowering costs. While these provisions are directed at Medicare, it is expected they will stimulate change throughout the delivery system, and there is evidence this is occurring. A systemwide effort to reduce health care cost growth will be needed to ensure the affordability of both insurance and health care for working Americans over time. Future waves of this survey, along with other Commonwealth Fund surveys, will help gauge the nation's progress on these efforts through the eyes of consumers in the years to come.

Notes

[1] G. Claxton, M. Rae, N. Panchal et al., "Health Benefits in 2014: Stability in Premiums and Coverage for Employer-Sponsored Plans," *Health Affairs,* Oct. 1, 2014 33(10):1851–60; and C. Schoen, J. Lippa, S. Collins, and D. Radley, *State Trends in Premiums and Deductibles, 2003–2011: Eroding Protection and Rising Costs Underscore Need for Action* (New York: The Commonwealth Fund, Dec. 2012).

[2] Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 10, 2014), http://ehbs.kff.org/.

[3] C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs,* Sept. 2011 30(9):1762–71; C. Schoen, S. R. Collins, J. L. Nicholson, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008, w298–w309; C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005, w5-289–w5-302; and S. R. Collins, R. H. Robertson, T. Garber, and M. M. Doty, *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act* (New York: The Commonwealth Fund, April 2013).

[4] All reported differences are statistically significant at the p<= 0.05 level or better unless otherwise noted.

[5] Chronic conditions included hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema or lung disease; high cholesterol; or depression or anxiety.

[6] J. R. Gabel, R. Lore, R. D. McDevitt et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs* Web First, May 23, 2012.

[7] Ibid.

[8] Senator Mark Begich (D-Alaska) and six cosponsors, S.1729, "A bill to amend the Patient Protection and Affordable Care Act to provide further options with respect to levels of coverage under qualified health plans," introduced on November 11, 2013, https://www.congress.gov/bill/113th-congress/senate-bill/1729/all-info; and America's Health Insurance Plans, *Continuing Our Commitment to Consumers: Solutions That Will Enhance Affordability, Stability and Accessibility in the New Health Care Marketplace* (Washington, D.C.: AHIP, June 2014), http://www.ahip.org/News/Press-Room/2014/Policy-Solutions/.

SURVEY METHODOLOGY

The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014, was conducted by SSRS from September 10 to October 5, 2014, as a part of SSRS' weekly nationally representative omnibus survey. The survey consisted of a 15-minute telephone interviews in English or Spanish and was conducted among a random, nationally representative sample of 2,751 adults ages 19 to 64 living in the continental United States. Overall 1,127 interviews were conducted with respondents on landline telephones and 1,624 interviews were conducted on cellular phones, including 1,012 with respondents who live in households with no landline telephone access.

The data are weighted to adjust for the fact that not all survey respondents were selected with the same probabilities, the overlapping landline and cellular phone samples, and disproportionate nonresponse that might bias results. Data are weighted to the U.S. 19-to-64 adult population by age, race, gender, region, marital status, education, and population density, based on the U.S. Census Bureau's 2014 March Supplement to the Current Population Survey (CPS) and household telephone use using the CDC's National Health Interview Survey. The resulting weighted sample is representative of the approximately 190.7 million U.S. adults ages 19 to 64.

The survey has an overall margin of sampling error of +/–2.1 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 9.9 percent response rate and the cellular phone sample achieved a 5.7 percent response rate. The overall response rate was 7.3 percent.

About the Authors

Sara R. Collins, Ph.D., is vice president for Health Care Coverage and Access at The Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, she has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine. Earlier in her career, she was an associate editor at *U.S. News & World Report,* a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. Dr. Collins holds a Ph.D. in economics from George Washington University.

Petra W. Rasmussen, M.P.H., is senior research associate for the Fund's Health Care Coverage and Access program. In this role, Ms. Rasmussen is responsible for contributing to survey questionnaire development, analyzing survey results through statistical analysis, and writing survey issue briefs and articles. In addition, she is involved in tracking and researching emerging policy issues regarding health reform and the comprehensiveness and affordability of health insurance coverage and access to care in the United States. Ms. Rasmussen holds an M.P.H. in health policy and management from Columbia University's Mailman School of Public Health.

Michelle McEvoy Doty, Ph.D., is vice president of survey research and evaluation for The Commonwealth Fund. She has authored numerous publications on cross-national comparisons of health system performance, access to quality health care among vulnerable populations, and the extent to which lack of health insurance contributes to inequities in quality of care. Dr. Doty holds an M.P.H. and a Ph.D. in public health from the University of California, Los Angeles.

Sophie Beutel is program assistant in the Health Care Coverage and Access Program. In this role, she is responsible for providing daily support for the program with responsibilities ranging from daily administrative and grants management tasks to writing and research responsibilities, including tracking developments in the implementation of the Affordable Care Act. Prior to joining the Fund, she was a summer intern with the State of Rhode Island Department of Health. Ms. Beutel graduated from Brown University with a B.A. in Science and Society, on the Health and Medicine track.

Acknowledgments

The authors gratefully acknowledge the contributions of Robyn Rapoport and Erin Czyzewicz of SSRS; and David Blumenthal, Barry Scholl, Chris Hollander, Deborah Lorber, Paul Frame, and Rose Kleiman of The Commonwealth Fund.

Editorial support was provided by Deborah Lorber.

The
COMMONWEALTH
FUND

www.commonwealthfund.org