

# Reframing the Unaffordability Debate: Patient Responsibility for Physician Care

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**T**he affordability of healthcare for those with insurance has become an increasingly important public issue. The most recent data from the Medical Expenditure Panel Survey (MEPS) show that 84.5% of private sector employees with health insurance had a plan with a deductible in 2016, compared with 77% in 2010. The average size of an individual deductible increased over the same time period from approximately \$1000 to \$1700.<sup>1</sup> A brief from the Kaiser Family Foundation showed a 66% increase in patient cost sharing between 2005 and 2015 for workers covered by employer health plans.<sup>2</sup> Many have written about “underinsurance” and affordability problems, particularly for those who participate in the Affordable Care Act (ACA) marketplace.<sup>3,4</sup>

On the other hand, much of the news on affordability is encouraging. A great deal has been done in the past several years to expand financial access to healthcare, with nearly 20 million gaining coverage as a result of the provisions of the ACA. For most of those gaining coverage, their access to affordable healthcare has greatly improved. More broadly, data from national surveys suggest that, by many measures, consumer perceptions of affordability are increasing. For example, the National Health Interview Survey found that the percentage of respondents who failed to obtain needed care due to cost in the preceding 12 months declined from 6.9% to 4.3% between 2010 and January to March 2017.<sup>5</sup> Similarly, the Health Reform Monitoring Survey, a quarterly online survey administered by the Urban Institute, found a decline in the percentage of respondents who reported having an unmet need for care due to affordability.<sup>6,7</sup> The prevalence of affordability problems varies by survey, but there is consistency in the direction of the trend. The Commonwealth Fund’s biennial survey similarly showed a decline in the share of respondents who reported difficulties paying medical bills or who were carrying medical debt.<sup>8</sup> A growing number of workers report being willing to trade health insurance benefits for higher wages, suggesting that healthcare costs are not the main monetary concern for many workers.<sup>9</sup> Finally, a J.D. Power and Associates study of 2016 Marketplace enrollees found that customer satisfaction in 2016 had

## ABSTRACT

**OBJECTIVES:** Public discussion suggests that rising out-of-pocket costs have dramatically reduced the value of insurance and led to patients doing without needed care. Our aim was to ascertain trends in patient responsibility for cost sharing.

**STUDY DESIGN:** We used data from an organization that serves over 78,000 healthcare providers and has access to visit-level data, including the amounts paid by patients. These practices are broadly representative of physicians and patients nationally.

**METHODS:** We analyzed trends in patient obligations among a cohort of about 21,000 providers in 1078 practices who had used athenahealth software since 2011, including primary care physicians, obstetricians and gynecologists, surgeons, and some other specialists. Our analysis focused on what commercially insured patients pay out of pocket when seeking ambulatory care.

**RESULTS:** The average patient obligation for approximately 2.5 million primary care visits each year rose from \$23.52 per visit in 2011 to \$26.40 per visit in 2015, for an overall increase of \$2.88, or about 3% annually. This rate of increase is moderate and below growth in overall healthcare spending during the same time period.

**CONCLUSIONS:** Average increases in patient obligations for outpatient visits in recent years have been fairly moderate, and multiple sources of survey data suggest that consumers’ concerns about overall affordability are decreasing. The high cost of healthcare continues to pose challenges, both at the individual level and for society as a whole. Nevertheless, it is important that potential strategies to improve affordability are informed by trends in patient obligations.

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increased from 2015, which itself was higher than in 2014. Satisfaction with coverage and benefits (among other plan attributes such as customer service and information and communication) has increased the most.<sup>10</sup>

Despite these concerns about affordability, there have been relatively little recent data on actual patient obligations for specific types of healthcare services. The MEPS Insurance Component Chartbook 2016, published in September 2017 by the Agency for Healthcare Research and Quality, is one of the few sources of information on patient cost sharing for employer-sponsored insurance.<sup>1</sup> Data presented here show trends in patient obligations for physician services in ambulatory settings. Patient obligation is defined as the amount of money a practice asks a patient to pay for the services provided to them after the primary source of insurance has paid its portion of the total cost. These data reflect obligations for patients choosing to come in for care and do not estimate obligations for patients who might have forgone care due to concerns about cost.

We use data from ACAView, a joint project between athenaResearch and the Robert Wood Johnson Foundation.<sup>11</sup> athenaResearch is the research division of athenahealth, a cloud-based technology company that serves over 78,000 healthcare providers and has access to visit-level data, including physician specialty, procedures rendered, patient diagnoses, insurance payments, and the amounts owed and actually paid by patients. These data provide a highly detailed view of trends in patient obligations for physician services.

Trends in patient obligations between 2011 and 2015 were analyzed among a cohort of about 21,000 providers in 1078 practices who had used the company's software since before 2011. The cohort includes primary care providers, obstetricians and gynecologists (OB-GYNs), surgeons, and other specialists. In the ACAView data, about 29% of visits are by patients who have Medicare coverage, 14% who have Medicaid, and 3% who are uninsured. The remainder, 54%, are privately insured through either employers or the individual market. The payer mix at these practices is weighted toward Medicare and somewhat undermeasures the uninsured compared with the National Ambulatory Medicare Care Survey (NAMCS), which is administered by the CDC and provides a statistical profile of ambulatory medical care in the United States.<sup>12</sup> However, in the following analyses, we limit our attention to out-of-pocket payments made by commercially insured patients when seeking ambulatory care. A majority of the physicians in the ACAView cohort are community-based practitioners, rather than

## TAKEAWAY POINTS

Despite concerns about rising cost sharing, on average patients face only moderately rising costs for physician care.

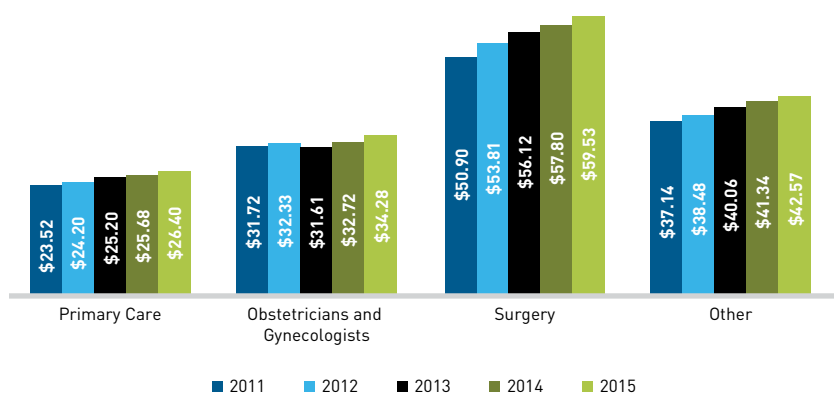
- ▶ Average increases in patient obligations for outpatient visits in recent years have been moderate for most specialties, especially primary care.
- ▶ Survey data suggest that consumers' concerns about unaffordability for healthcare services are decreasing.

affiliates of academic medical centers, with a larger proportion of visits from the South and a smaller proportion from the West compared with the NAMCS.<sup>12</sup>

Figure 1 shows the trends in out-of-pocket patient obligations for visits to a variety of specialist types between 2011 and 2015. Average patient obligations for approximately 2.5 million primary care visits each year rose from \$23.52 to \$26.40 per visit over this period, about 3% annually. Although greater than the rate of overall inflation, this rate of increase is moderate by most definitions and below the growth in overall national health expenditures, which have increased an average of 4.3% each year from 2011 to 2015, with more growth in 2014 and 2015 of 5.3% and 5.8%, respectively.<sup>13</sup> For OB-GYN visits, average patient obligations increased from \$31.72 to \$34.28 over the period, less than 1% annually. Patient obligations for visits to surgeons increased somewhat more, from \$50.90 to \$59.53, an annual increase of slightly more than 4%, or 16.9% from 2011 to 2015.

Patient obligations can be broken into 4 components of payment: co-pay, deductible, coinsurance, and any other payments not classified under the first 3. The increase in the average patient obligation was primarily a result of growth in the deductible, which made up 47% of the patient obligations in 2015 versus 41% in 2011.

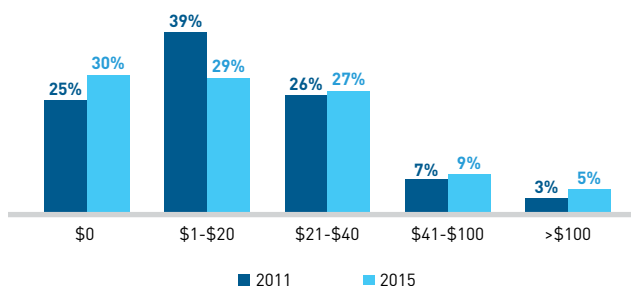
**FIGURE 1. Average Patient-Owed Amount Per Visit for Commercially Insured Adults (Aged 18 to 64 Years), By Specialty Category<sup>a</sup>**



<sup>a</sup>Sample: Approximately 8 million visits per year to practices active on the athenahealth network before 2011. These data come from athenaResearch, a department within athenahealth.

## TRENDS FROM THE FIELD

**FIGURE 2.** Distribution of Patient-Owed Amount for Commercially Insured Adult (Aged 18 to 64 Years) Primary Care Visits<sup>a</sup>



<sup>a</sup>Sample: Over 2.5 million visits per year to practices active on the athenahealth network before 2011. These data come from athenaResearch, a department within athenahealth.

A survey by Kaiser Family Foundation and the Health Research and Educational Trust found that deductibles for individual coverage increased 63% on average from 2011 to 2016 for people with health insurance through their employers.<sup>14</sup>

Although the average patient obligation for primary care visits increased moderately, the underlying distribution of payments at different cost levels shifted substantially. **Figure 2** shows that the share of primary care visits that were low cost (ie, less than \$20 but more than \$0) decreased from 39% of all visits in 2011 to 29% in 2015. No-cost visits increased from 25% to 30% of all visits, whereas visits costing more than \$20 increased from 36% to 41% of all visits. These trends reflect both the ACA requirement of no cost sharing for preventive visits and a moderate increase in the number of visits for which patients were responsible for higher costs. Despite the shift towards higher priced visits, only 14% of primary care visits cost patients more than \$40, whereas 30% of visits cost the patient nothing.

The data presented in this study are limited to a single type of healthcare service and exclude other important sources of patient cost sharing, such as prescription drugs, outpatient surgery, emergency care, and hospitalization. However, these data suggest that average increases in patient obligations for outpatient visits in recent years have been fairly moderate, and data from multiple surveys suggest that consumers' concerns about overall affordability are decreasing. The high cost of healthcare continues to pose challenges, both at the individual level and for society as a whole. Nevertheless, it is important that potential strategies to improve affordability are informed by trends in patient obligations. ■

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