Dilemma Over Deductibles: Costs Cripple the Middle Class

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Physician Praveen Arla is witnessing a reversal of health care fortunes: Poor, long-uninsured patients are getting Medicaid through Obamacare and finally coming to his office for care. But middle-class workers are increasingly staying away.

"It's flip-flopped," says Arla, who helps his father run a family practice in Hillview, Ky. Patients with job-based plans, he says, will say: " 'My deductible is so high. I'm trying to come to the doctor as little as possible. … What is the minimum I can get done?' They're really worried about cost."

It's a deep and common concern across the USA, where employer plans cover 60% of working-age Americans, or about 150 million people. Coverage long considered the gold standard of health insurance now often requires workers to pay so much out-of-pocket that many feel they must skip doctor visits, put off medical procedures, avoid filling prescriptions and ration pills — much as the uninsured have done.

A recent Commonwealth Fund survey found that four in 10 working-age adults skipped some kind of care because of the cost, and other surveys have found much the same. The portion of workers with annual deductibles — what consumers must pay before insurance kicks in — rose from 55% eight years ago to 80% today, according to research by the Kaiser Family Foundation. And a Mercer study showed that 2014 saw the largest one-year increase in enrollment in "high-deductible plans" — from 18% to 23% of all covered employees.

Meanwhile the size of the average deductible more than doubled in eight years, from $584 to $1,217 for individual coverage. Add to this co-pays, co-insurance and the price of drugs or procedures not covered by plans — and it's all too much for many Americans.

Holly Wilson of Denver, a communications company fraud investigator who has congestive heart failure and high blood pressure, recently went without her blood pressure pills for three months because she couldn't afford them, given her $2,500 deductible. Her blood pressure shot so high, her doctor told her she risked a stroke.

And LaRita Jacobs of Seminole, Fla., who gets insurance through her husband's job and has an annual family income of $70,000, says $7,500 a year in out-of-pocket costs kept her from dealing with an arthritis-related neck problem until it got so bad she couldn't lift a fork. She's now putting off shoulder surgery.

"How did we get to this crazy life?" asks Jacobs, 54. "We're struggling to pay our bills like we were struggling when we first got started."

Why is this happening? Many patients and doctors blame corporate greed — a view insurers and business leaders reject. Some employers in turn blame the Affordable Care Act, saying it has forced them to pare down generous plans so they don't have to pay a "Cadillac tax" on high-cost coverage in 2018. But health care researchers point to a convergence of trends building for years: the steep rise in deductibles even as premiums stabilize, corporate belt-tightening since the economic downturn and stagnant middle-class wages.

"It's a case of companies trying to offer workers health insurance and still generate profit," said Eric Wright, a professor of sociology and public health at Georgia State University. "But whenever costs go up for the consumers across the board … it promotes a delay in care."

Others disagree, saying that when people pay for their care, they shop more intelligently. Chris Riedl, Aetna's head of product strategy for its national accounts, says her company's research does not indicate that insured patients are showing up sick in emergency rooms with long-neglected illnesses — which to her means, "intuitively, they're not avoiding care."

But many doctors contend it's only a matter of time before the middle class begins crowding ERs. They say putting off care can be dangerous, exponentially more costly and, if it continues and spreads, can threaten the health of the nation.

Praveen's father, Mohana Arla, says being forced to pay so much out-of-pocket "is as good as not

having insurance" in an era of ever-rising health care costs. Inpatient care last year averaged $17,553, and insurance plans require people to pay a portion of that even after meeting their deductibles, up to an out-of-pocket maximum that can easily exceed $10,000 a year for families. Median household income in the U.S. is around $53,000, and the average American has less than $6,000 in savings, according to a 2012 report by Pitney-Bowes Software. A quarter have no emergency savings at all, Bankrate.com reported in June.

"Health expenses tend to come up unexpectedly, or if you have a chronic condition, they come up relentlessly," adds Karen Pollitz, a senior fellow at Kaiser. "People put off care or they split their pills. They do without."

Mounting evidence backs that up:

- Nearly 30% of privately insured, working-age Americans with deductibles of at least 5% of their income had a medical problem but didn't go to the doctor, the Commonwealth Fund found. Around the same percentage skipped doctor-recommended medical tests, treatments or follow-ups.
- Nearly half of middle-class workers skipped health care services or fell into financial hardship because of health expenses, according to a survey by the Associated Press and NORC Center for Public Affairs Research.
- Use of hospital care among insured workers has been dropping since 2010, and use of outpatient care, such as doctor visits, dropped slightly for the first time from 2012 to 2013, according to insurance claim data analyzed by the Health Care Cost Institute.
- Medical professionals across the USA see the reality behind the research. The Arlas' patient load used to be 45% commercially insured and 25% Medicaid; those percentages are now reversed. Stan Brock, founder of Remote Area Medical, which runs free clinics around the nation, says the group's volunteer workers found that around 7% of patients who came to one of the clinics had job-provided insurance — and some waited for days just to keep a prime spot in line.

Patients often do a sort of medical and financial triage when they get sick. Jacobs, a former college professor, says every time a doctor suggests a new test, procedure or medication for her severe arthritis, she asks herself: " 'Is it critical?' You're always playing the odds. ... And I'm constantly asking my doctor: Can I stop taking this medication?"

When her shoulder started hurting a couple of years ago, she had an X-ray but put off the recommended MRI for two years. It worsened, and she couldn't move her arm without pain or lift her right hand above her head. She finally got that surgery in October but is now forgoing a shoulder procedure, opting for less expensive physical therapy and planning to "tough out the pain."

"You don't want another surgery … another bill," she says. "It may be more of a problem later, but that's the risk you take."

While all out-of-pocket expenses play a role in such decisions, experts say the driving factor is the deductible, which averages $2,000 or more for single coverage for nearly one in five workers and from around $2,000 to $4,500 for families, depending on the type of plan. Companies may help fund health-savings accounts to pay some of these costs, sometimes with only a few hundred dollars.

"I can remember when $1,000 was considered a high-deductible plan. Now that's become kind of the norm," Pollitz says. "We're kind of in high-deductible land."

The cost shift extends to workers in government jobs, long known for bountiful benefit packages. Lee Curry, a sheriff's deputy in Bullitt County, Ky., says his county health plan comes with a $1,500 deductible, which keeps him from going to the doctor at all.

"Health insurance doesn't cover much of anything until you cover your deductible," says Curry, 54. "It puts a burden on you. You've got to have the money to be seen."

Since the ACA took effect, "there's been an accelerated movement" to these types of health plans, says Brian Marcotte, president and chief executive officer of the Washington, D.C.-based Business

Group on Health.

Marcotte, whose group represents 400 large employers, says that the looming Cadillac tax is one factor but acknowledged that managing health care costs is another.

Companies have cited the ACA for cutting medical benefits in other ways. For example, United Parcel Service partly blamed the law when it removed thousands of spouses from its plan because they are eligible for medical coverage elsewhere.

But DeAnn Friedholm, director of health reform for Consumers Union, says she's skeptical when employers point to the ACA. "This isn't new," she says. "Companies have been cutting back on benefits and cutting costs for decades."

Sara Collins, vice president for Health Care Coverage and Access at the Commonwealth Fund, says two ACA requirements — keeping children under 26 on their parents' plans and covering preventive care — didn't add much to companies' health care tabs, partly because most already covered preventive care such as physicals and mammograms. Pollitz says the ACA actually holds down the consumer burden by capping out-of-pocket expenses at $6,300 a person — which, although that amount is "more than most people have in the bank," is better than no cap at all.

Experts point out that the ACA requires preventive care to be covered fully and exempt from deductibles — although surveys show many workers still forgo screenings and physicals because they're unaware of this or know they can't afford follow-ups if illnesses are found.

Several experts say the consumer crunch has less to do with the health system overhaul than stagnant salaries. The average hourly wage is nearly identical to what it was 50 years ago in today's dollars: $19.18 in 1964 compared with $20.67 in 2014, according to U.S. Bureau of Labor data analyzed by the Pew Research Center. Meanwhile, U.S. health spending ballooned from 5% of gross domestic product in 1960 to 17% in 2013.

"People are very close to the line in terms of their budgets," Collins says. "What consumers are really seeing is their incomes have grown even slower than the slower growth in health care costs" in the past few years.

Insurers also blame the cost of care, saying that can't be absorbed just by premiums. But Wilson and other patients put much of the blame on insurers.

"Insurance is all about the dollar," Wilson says. The never-ending cost shift to consumers "is something that basically all kinds of people screwed up. … Obamacare is a step in the right direction. But it's not enough. I expected more out of it than I got."

When consumers skip care, they enter a downward spiral that imperils their physical and financial health.

Jennifer Ross, an arthritis sufferer in Florida insured through her husband's job, says she recently made the wrenching decision not to take a medication that might allow her to get around without her wheelchair. The $2,400-a-month medicine would cost her $600 a month out-of-pocket even with insurance, and she simply can't swing it. To make matters worse, Ross' 12-year-old daughter was recently diagnosed with arthritis, too.

"It's a no-win situation," Ross says.

Surgeon Paul Ruggieri of Fall River, Mass., says his patients with high-deductible plans often blanch at the out-of-pocket cost to electively treat two common ailments he sees regularly — gallstones and hernias — until they become potentially dangerous and costly emergencies.

If the procedures are done electively, patients are required to pay half of the cost upfront; a hernia repair done laparoscopically would cost about $4,000 at a surgery center. That's often about the amount of some patients' deductibles, so they would have to pay the full bill out-of-pocket. If the procedure is done at a hospital, even laparoscopically, it can cost as much as $17,000. If patients delay and are rushed to the emergency room for the procedure, the hospital would charge at least two to three times the amount of the surgery, Ruggieri says. It would also mean a two- to three-day hospital stay vs. two hours for the elective procedure, and much longer at-home recuperation.

Ruggieri sees the same issues with gallstones, which are simple to treat electively before they get so painful a patient can't stand it anymore and heads to the ER.

When patients do get needed care, some find

themselves in massive debt. Kim Brown, an administrative assistant in Louisville who was earning about $40,000 a year, owes many thousands — the bills are still coming, so she doesn't know exactly how much — after battling thyroid cancer. She says her annual out-of-pocket costs are $7,500, and she also has to pay 15% for things like hospital stays. No longer able to work because of her illness, she reluctantly signed up for Medicaid and will likely declare bankruptcy.

"I've worked for 35 years. I never wanted to go on Medicaid," says Brown, 50. "It's horrible. I paid for insurance for all those years, and still ended up in this situation."

But insurers, employers and others say that such stories are the exception and that high deductibles generally encourage consumers to seek the best value for their dollar.

"By having deductibles, it puts skin in the game," says Divya Cantor, senior clinical director for the insurer Anthem in Kentucky.

Joel Diamond, a Pittsburgh primary care doctor, thinks high-deductible plans are a smart choice for people who can't afford higher premiums and are generally in good health.

He cites the case of a young woman who couldn't afford insurance on her own who stopped having periods and went to the emergency room with severe headaches. Diamond discussed doing testing for possible ovarian and endocrine problems. When blood work showed abnormal levels of the hormone prolactin, he recommended an MRI to rule out a pituitary tumor. Her bill for just a few hours in the emergency room was $15,000, something that will take her years to pay off.

If she had had a high-deductible plan, he says, it would have paid for a large chunk of the cost, and her debt could have been a third to half as much.

"We don't have car insurance for windshield wipers and oil changes, but we need it for the catastrophic stuff, just like our health care," says Diamond, who is also chief medical officer for the health care IT company dbMotion.

Aetna's Reidl says her company allows people to compare prices easily on its website. Some tests, for example, could cost hundreds of dollars or less at some hospitals and thousands at others.

Aetna, the first national insurer to move to high-deductible plans — which it coined "consumer-directed plans" — more than a decade ago, says the plans help employees and employers save money.

Reidl says she has heard the criticism that they "may cause some individuals to put off care," but counters that Aetna members with these plans get routine preventive care and screenings at higher rates than those with other plans. And their employers save an average of $208 per employee per year after they switch to high-deductible plans.

"We've seen that over 10 years consistently," she says.

Aetna recommends companies pair the plans with health reimbursement or savings accounts — which allow employees to set aside tax-free money to use for cost sharing — to ease the burden of out-of-pocket costs on employees.

But Wendell Potter, who used to work in public relations in the insurance industry and has since written a book about the experience called Deadly Spin, says insurers who study high-deductible plans are "not disclosing everything they find."

"They do these reports based on their populations to try to sell more of these plans to employers," he says. Population-based reports don't necessarily reflect the fact that "individuals and families are having to file for bankruptcy because they are in their plans."

Potter left his public relations job at Cigna in 2008 in part because "I was expected to be a champion" of high-deductible plans. He says these plans are "taking us in the wrong direction ... back to a system that we would have thought the ACA prevented."

There are no signs high deductibles are going away.The Centers for Medicare and Medicaid Services last month cited these plans as one of the reasons health care spending hit a record low in 2013. But CMS statistician Micah Hartman says his office is "not looking forward to what the impact would be going forward" if consumers who delay care need far more expensive emergency care later.

Meanwhile, experts say Americans will need to take further steps to control their health costs.

Wilson, the Denver patient, says that after her doctor scolded her for stopping her blood pressure pills, she now takes them daily. But keeping up with her six medications is a constant struggle given her $33,000-a-year income, so she copes by asking for samples from the doctor, using a prescription discount plan and sometimes buying just a few pills at a time.

Doctors and doctor groups say such individual coping strategies can be helpful, but action is needed on a national level. The American Academy of Pediatrics recently came out with a policy statement saying high-deductible plans "may be a less desirable way to lower health care costs than other means … even if 'other means' require more work by government, insurance companies and other health policy participants."

They say policymakers should consider requiring that the plans cover only adults, not children, as adults may suffer more from reduced care. The group also suggests exempting outpatient care from deductibles and requiring employers to put a lot more money in health-savings accounts that go with the plans.

Oncologist Ezekiel Emanuel, the former special adviser for health care policy to the director of the Office of Management and Budget, says insurers and employers moved to high-deductible plans rather than trying to come up with "a more intelligent plan design."

Emanuel, who is considered an architect of Obamacare, says that he is "not a fan of high-deductible plans" and that what's needed are "smart deductibles" that don't discourage people from using the services they really need to stay healthy. He cites the preventive care visits that aren't subject to deductibles under the ACA.

Higher deductibles, he says, should apply to "discretionary services" like knee replacements and low or no deductibles should be for important treatment such as for insulin or ophthalmologist visits.

But Wright, the Georgia professor, says he doesn't see any major changes on the near horizon.

"I wish I could be optimistic, but I'm not sure," he says. "There's a lot of reason to be worried about the future."

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