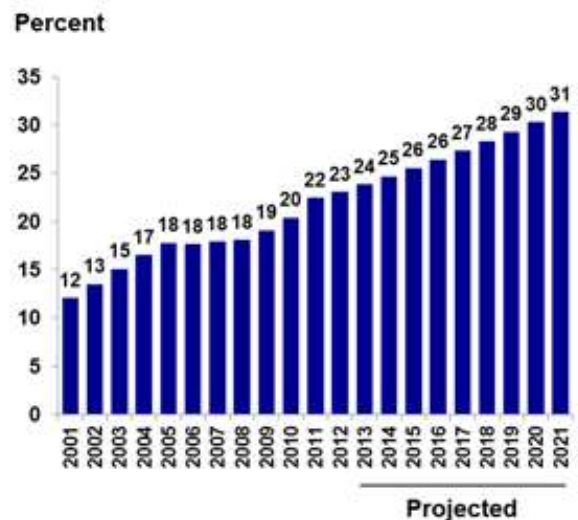
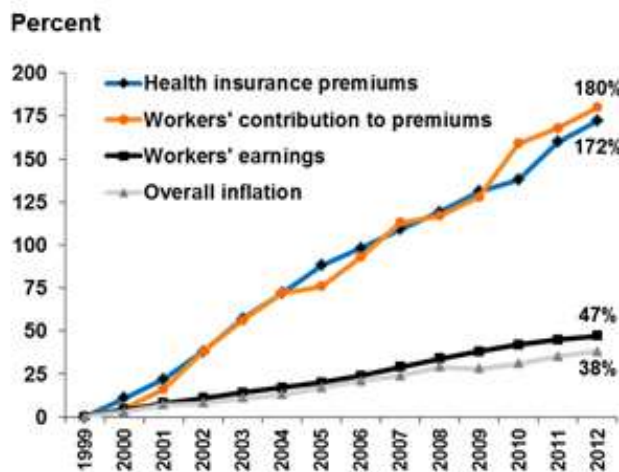


Over the past several years there has been rapid growth in the portion of medical bills that is not covered by insurance, and that instead is the patient’s responsibility to pay directly. The amount that becomes the patient’s responsibility comes from three main categories: copays, co-insurance, and deductibles. A copay is usually a flat fee per visit, co-insurance is a percentage of the covered amount that is due directly from the patient, and the deductible is the amount that must be paid by the patient before the insurance coverage is triggered.

Higher patient responsibility amounts have been driven by the faster growth of healthcare premiums relative to wages. The graphs below display (left) the increase in health insurance premiums relative to wages and (right) the increasing percentage of median family income that the average premium has taken up. Between 1999 and 2012 median wages increased by 47%, while healthcare premiums increased by 172%.



Both employers and workers have been looking for ways to hold down premium growth and high deductible health plans (HDHPs), which have deductibles of at least \$1,300 for single coverage and \$2,600 for family coverage, are an effective way of decreasing utilization. When consumers know that they will have to pay out of pocket for care, they are more likely to shop around and also to question whether they really need certain tests or procedures. According to a 2014 Kaiser Family Foundation Employer Health Benefits Survey, 18% of employees now face single coverage-deductibles of \$2,000 or more.

Tax code changes in 2003 created tax advantaged Health Savings Accounts (HSAs) that provided significant incentives for the use of HDHPs and fueled their growth. Between 2005 and 2014, enrollees in HDHPs surged from 1 million to over 17 million enrollees. This trend was helped by the passage of the

Affordable Care Act in 2010, which provides large subsidies for premiums purchased on government health exchanges. Significant subsidies are available for workers with incomes of up to 400% of the Federal Poverty Line, which in 2014 was \$95,400 for a family of four. According to a 2014 Congressional Budget Office report, 87% of plans purchased through an exchange qualify for a subsidy. Although subsidies provide for significant help with the payment of premiums, the plans offered on the exchanges also have high levels of built-in enrollee direct out-of-pocket financial responsibility for payment.

The exchanges provide subsidies geared towards “silver plans,” and as a result 65% of enrollees are enticed to choose the silver plan. The silver plans have large deductibles, and even after the deductible is met the patient is responsible for paying 30% of the covered amount. If the patient selects a cheaper plan, such as a bronze plan, the amount that becomes the patient responsibility is even greater. Twenty percent of patients choose the less expensive bronze plan, which has even less coverage than the silver plans, and the remaining 15% choose gold, platinum, or catastrophic coverage.

### **Emergency Department Impact from the High-Deductible Health Plans**

Currently, 92% of the United States population is insured compared with only 84% prior to passage of the Affordable Care Act. Affordable Care Act coverage via exchanges, in conjunction with commercial insurance plans that were already moving in the direction of higher deductibles, copays, and coinsurance, has resulted in more of the insured ED population being responsible for directly paying for an increasing share of their care. In addition, many employers are limiting coverage for employees (such as not covering a spouse), and thus some enrollees are shifting from more comprehensive commercial insurance to government exchanges. The contracted amounts in exchanges are far less than with commercial plans, and there are additional patient cost-sharing burdens. According to the Kaiser Family Foundation, the percentage of covered workers enrolled in a company-sponsored plan with single-coverage and a deductible greater than \$1,000 has risen from 10% in 2006 to 41% in 2014. This same survey showed that in the past 5 years deductibles have grown on average by 47%. For a typical 40,000 volume ED that has seen in the range of 3%-5% of their commercial insurance move to a HDHP this would result in about 1,500 patients now having lower contracted rates and significant cost-sharing responsibilities. This means that more and more of the charges are written off because of the contractually lower “allowed amount,” and what is covered is more often the responsibility of the patient to pay. If an additional \$50 of the average patient balance is now the patient’s responsibility that means that \$75,000 that previously would have been paid directly by insurance now needs to be collected from the patient.

Unlike office-based practices, ED providers are limited by EMTALA requirements and do not have the opportunity to collect patient payments up front. ED groups are responding to the increased out-of-pocket patient responsibilities by making the collections process as easy as possible for patients. Such strategies include expanded call center hours, offering online payments, accepting credit cards, and even trying point-of-service collections (post EMTALA-mandated screening) in collaboration with their hospitals.

### **Summary**

Analysis from members of the task force suggests that the trend over the past five years since ACA passage shows a decrease in the number of uninsured patients as more find coverage through Medicaid expansion or ACA exchange plans. The volume of patients has similarly increased along with expanded coverage, as previously uninsured patients are more willing to seek needed care. On balance, the increased coverage and higher patient volumes have offset the slow payment or unreimbursed care from patients in high-deductible plans. However, investment in an efficient and accurate revenue cycle management system can improve collections of these higher patient balances. ACEP will continue to monitor this trend as private payers transition to higher deductible plans in an effort to offset rising premiums.

### **Resources**

Kaiser Family Foundation/Health Research & Educational Trust (HRET) 2014 Employer Health Benefits Survey.

Mercer's National Survey of Employer-Sponsored Health Plans 2014