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Out of pocket hospital costs

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Grabowski, PhD Harvard Medical School June 2010 PDF Version: (20 PDF pages) U.S. Department of Health and Human Services National Invitational Conference on Home Care Quality: Issues and AccountabilityVolume I: Summary of Proceedings 1989 PDF Version: (88 PDF pages) U.S. Department of Health and Human Services U.S. Department of Health and Human Services Psychiatric Boarding Interview Summary David Bender, Nalini Pande and Michael Ludwig The Lewin Group January 9, 2009 PDF Version: (20 PDF pages) U.S. Department of Health and Human Services U.S. Department of Health and Human Services Caregiver Burden and Institutionalization, Hospital Use, and Stability of Care Baila Miller and Stephanie McFall University of Illinois at Chicago, College of Associated Health Professions November 1989 PDF Version (89 PDF pages) U.S. Department of Health and Human Services Assisted Living Policy and Regulation: State Survey Robert L. Mollica, Ed.D. 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January 1981 PDF Version: (122 P U.S. Department of Health and Human Services Tables Comparing Channeling to Other Community Care Demonstrations Robert A. Applebaum, Margaret N. Harrigan and Peter Kemper Mathematica Policy Research May 1986 PDF Version U.S. Department of Health and Human Services AIDS Children and Child Welfare Stephen Margolis, Ph.D., Lela Baughman, M.S.W., J. William Flynt, M.D. and Martin Kotler Macro Systems, Inc. March 31, 1988 PDF Version U.S. Department of Health and Human Services Caring for Frail Elderly People: Policies in Evolution Chapter 14: United States Pamela Doty, Ph.D. 1996 PDF Version (38 PDF pages) U.S. Department of Health and Human Services Overview of Long-Term Care in Five Nations: Australia, Canada, the Netherlands, Norway, and the United States RESEARCH FROM THE INTERNATIONAL COLLABORATIVE EFFORT ON AGING U.S. Department of Health and Human Services RESEARCH AGENDA: Disability Data Nancy N. Eustis, Ph.D., Robert F. Clark, D.P.A., and Michele C. Adler, M.P.H. U.S. Deparment of Health and Human Services August 1995 PDF Version (80 PDF pages) Amid increased scrutiny of the astronomical price hikes for drugs like EpiPens and insulin, it may come as a surprise that a new analysis finds that average out-of-pocket spending on prescription drugs has actually decreased in recent years. The report, conducted by the Kaiser Family Foundation, analyzed drug spending from 2004 to 2014 for individuals who get insurance through a large employer. The analysis finds that while overall prescription drug costs remained flat from 2004 to 2013 for people enrolled in large employer health plans, it spiked by 13% in 2014, to \$1,053 per enrollee. Yet average out-of-pocket spending for those same workers and their families fell from\$167 in 2009 (about \$185 in 2014 dollars) to \$144 per person in 2014, because insurance now covers more prescription drug costs than it did a decade ago. Read Next: EpiPen Rival's Return Could Mean Lower Prices for Consumers The analysis attributes this decline in spending to the increased prevalence of generic drug options, as well as the provision in the Affordable Care Act that stipulates that birth control be covered by insurance. In fact, the report says, "oral contraceptive pills account for 63% of the drop in average out-of-pocket spending on retail drugs since 2012." While 20.9% of women of reproductive age were spending out-of-pocket for oral birth control in 2012, just 3.6% were doing so two years later, and women experienced a much steeper decline in out-of-pocket costs than men did, the report notes. Read Next: 21 Incredibly Disturbing Facts About High Prescription Drug Prices While that may seem like good news, the reports also notes that the percentage of people paying more than \$1,000 out-of-pocket is on the rise: From 2004 to 2014, the portion of people spending more than \$1,000 outside of their insurance coverage nearly tripled, from 1.0% to 2.8%. That's not to say there aren't challenges: 8% of adults report foregoing prescriptions because they can't afford them. High prices are also a reason insurers give for raising premiums. You are in the hospital for tests after experiencing dizziness. You are nervous about what the tests will show, but at least you do not have to worry about hospital bills – you have Medicare, so you can relax about healthcare coverage. Or can you? Not if you are in the hospital under "observation status" – a Medicare designation applied to patients deemed insufficiently ill for formal admission, but still too sick to be allowed to go home. Observation status can result in thousands of dollars in higher costs – especially if you need post-hospital nursing care. Medicare covers care in skilled nursing facilities, but only for patients who were first formally admitted to a hospital for three consecutive days. Federal data shows that the number of Medicare patients classified as under observation has jumped sharply in recent years, and it has stirred a great deal of pushback from Medicare enrollees and advocacy groups. A new law – the Notice Act – requires hospitals to at least notify patients if they stay in the hospital more than 24 hours without being formally admitted. Patients will receive the warnings starting in January, but advocates argue the new protection does not go far enough. "It does half of what we would like to see," said Toby Edelman, senior policy attorney at the Center for Medicare Advocacy. "The notice should also allow patients to appeal their status." Hospitals have been motivated to use the status to avoid costly penalties from Medicare for improper admissions under a well-intentioned effort by Medicare to control costs through a program that audits hospitals for possible overpayments. The program began during the George W. Bush administration. Sign up to receive key retirement news and advice. The number of patients cared for under observation status doubled to nearly 1.9 million in 2014 compared with 2006, according to figures from the Centers for Medicare & Medicaid Services (CMS). The majority (54 percent) were for observation stays of less than 24 hours; another 38 percent of the stays were 48 hours or less, CMS reports. Facing higher costs The new notifications will require hospitals to inform patients orally and in writing if they are on observation status for more than 24 hours. The written notification, developed by CMS, is called the Medicare Outpatient Observation Notice (MOON). The MOON also explains the cost implications of receiving hospital services as an outpatient. The costs of observation status can affect any enrollee on traditional fee-for-service Medicare. (Beneficiaries using Medicare Advantage, which provides all-in-one care, will also receive the MOON, but some Medicare Advantage plans will cover a stay in a skilled nursing facility without first requiring that patients have a three-day inpatient hospital stay.) Calculator: What are my long-term care insurance needs? Medicare normally covers up to a maximum of 100 days of care in a skilled nursing facility following a hospital admission – it pays 100 percent for the first 20 days, and patients are responsible for a daily \$161 co-pay for the next 80 days. But patients leaving the hospital for a nursing facility after an observation pay the full cost out of pocket. Rising nursing home costs The cost of skilled nursing care is substantial, and rising quickly. This year, the national median monthly cost of a private nursing room is \$7,698, according to a Genworth survey, and it runs much higher in states such as New York (\$11,330 per month) and California (\$9,338). Medicaid would cover the stay if the patient meets the program's low-income requirements (a status called "dual-eligible"). A commercial long-term care policy might provide some coverage, although many of these policies have "elimination" features (deductibles) that require patients to pay the first 90 days out of pocket. Read: 5 Ways to Save on Medicare Observation status also affects coverage of drug usage in the hospital. Medicare Part B would cover drug usage for the specific problem related to the hospitalization, subject to Part B's typical 20 percent copay); for routine drugs that you take at home (say, a statin for high cholesterol), practices vary. Some hospitals allow patients to bring their own drugs from home, others do not, and charge much more than you would pay at a typical pharmacy. Some – but not all – Part D drug plans will cover some of these prescription drug costs. A broader fix to the observation status has garnered broad support from organizations ranging from AARP to the American Medical Association, elder law groups and Medicare advocacy groups. Legislation that has bipartisan support has been introduced in the U.S. House and Senate that would require that time spent in observation be counted toward meeting the three-day prior inpatient stay that is necessary to qualify for Medicare coverage. "The bill is simple," said Edelman of the Center for Medicare Advocacy. "Count the time in hospital, no matter what. If you are in the hospital for three midnights, you have met this requirement." A single hospital stay can cost a patient tens of thousands of dollars. This is driving many people to crowdfunding in order to pay for their medical bills.Share on PinterestIf it weren't for Medicaid, the parents of a 3-year-old child born with a rare disorder would have owed more than \$200,000 for their son's one-week stay in the hospital.Last month the child's mother, Alison Chandra, posted an image of the hospital bill on Twitter. She followed up with a summary of the details. "I'll save you some math; without insurance we would owe \$231,115 for 10 hours in the OR, 1 week in the ICU, and 1 week on the cardiac floor," she wrote.Chandra's son was born with heterotaxy syndrome, which required him to have four open-chest surgeries before his third birthday.Chandra told the Philadelphia Inquirer that Medicaid picked up the tab for her prenatal care and her son's first two surgeries. After insurance, they ended up owing \$500.Now, the family's medical expenses are covered by insurance that her husband gets through his new job.Without Medicaid, though, the parents might have ended up like many other Americans who file for bankruptcy each year due to overwhelming medical bills.With complicated health problems that require intensive hospital care, medical bills can quickly add up.In the United States, septicemia (blood poisoning) accounted for \$23 billion in inpatient hospital costs in 2013, according to a report by the Agency for Healthcare Research and Quality. This represented 6 percent of all inpatient hospital costs for that year.Other high-cost hospitalizations included newborn infant stays, complications stemming from osteoarthritis or a medical device, an implant or tissue graft, and acute heart attack.However, when looking at the average cost per hospital stay, heart valve disorders topped the list at \$41,878.Heart attack and complications from a medical device, implant or tissue graft comes in at an average of about \$20,000 per stay. Septicemia is about \$13,000 per stay.People with health insurance may never have to pay the full costs, even though they see the hospital charges on their medical bills.But research last year from the University of Michigan found that for people with private health insurance, the out-of-pocket cost for a hospital stay was more than \$1,000 in 2013. This was a 37 percent increase over 2009.The rise was mainly due to increases in deductibles, or how much of the medical expenses someone has to pay before most services are covered by their insurance plan.People also paid a larger percentage of their medical expenses after they met their deductible, a process known as coinsurance.A 2015 study by the Kaiser Family Foundation also found that insurance premiums rose 4 percent over the past year. People with a plan that included coinsurance paid about 18 percent of the cost of primary care and specialty care visits.When people lose their insurance coverage, they risk being slammed with medical bills.This can happen when a person leaves a job due to illness, or other reasons like having to take care of a sick child or spouse.A 2009 study published in The American Journal of Medicine found that almost two-thirds of bankruptcies in the United States had a medical cause.About 78 percent of people had insurance at the start of the illness. By the time of bankruptcy, the share of people with private insurance had fallen, while those with Medicare or Medicaid had increased.On average, uninsured families bankrupted due to medical expenses owed almost \$27,000, while those with private insurance owed more than \$17,000.Families who started with private coverage, but lost it by the time of bankruptcy, ended up owing an average of around \$22,000.Hospital bills were the largest out-of-pocket expense for people who filed for medical bankruptcy, followed by prescription drugs, doctor bills, and insurance premiums.In almost 40 percent of families, someone had lost or quit a job because of the illness. In one-quarter, a family member was fired as a result of the illness.In recent years, there are signs that the Affordable Care Act (ACA) has eased some of the burden of medical bankruptcies.A study earlier this year by Consumer Reports found that bankruptcy filings in the United States dropped 50 percent to 770,846 between 2010 and 2016 — the lowest since 1997. The costs of observation status can affect any enrollee on traditional fee-for-service Medicare. (Beneficiaries using Medicare Advantage, which provides all-in-one care, will also receive the MOON, but some Medicare Advantage plans will cover a stay in a skilled nursing facility without first requiring that patients have a three-day inpatient hospital stay.) you — or another member of your family — to continue working during the illness.According to a 2015 survey by the Robert Wood Johnson Foundation, more than one-quarter of American adults said that they have major financial problems as a result of healthcare costs.That's why some people are turning to crowdfunding sites to raise money to pay for their medical expenses.Crowdfunding involves seeking donations from family, friends, and others through online campaigns. People use crowdfunding websites to raise money for creative projects, new businesses, and now healthcare costs.A 2015 analysis by NerdWallet found that 41 percent of crowdfunding campaigns on four sites were for medical costs.On crowdfunding site GiveForward, 70 percent of medical campaigns were for people recently diagnosed with cancer.Out-of-pocket medical expenses account for the bulk of the crowdfunding requests, but people also seek money to cover transportation, child care, and lost wages.Crowdfunding can work for some people, but it is no cure-all.Only 11 percent of those campaigns analyzed by NerdWallet met their funding goal.In a 2016 study, published in the journal Social Science & Medicine, University of Washington Bothell (UWB), researchers found similar success rates on GoFundMe. On average, 200 campaigns brought in only 40 percent of their funding goals.That means some people may still be struggling to pay their medical bills.Crowdfunding seems like the epitome of the free market system touted by many politicians. But the UWB researchers found that medical crowdfunding may simply be a symptom of inequalities in health insurance coverage in the United States.About 54 percent of the medical crowdfunding campaigns they looked at were from people living in states that didn't expand Medicaid as part of the ACA. These states account for only 39 percent of the country's population.The researchers also suggested that people who are successful at crowdfunding campaigns may not be the ones most in need. Instead, people's success at crowdfunding may depend on how comfortable they are with "self-marketing for financial survival," as well as using online crowdfunding sites and social media.The researchers wrote that this may "increase the likelihood that crowdfunding for healthcare is exacerbating severe population health disparities."

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