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The Affordability Crisis in Modern American Healthcare: A Community-Based Review

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ABSTRACT

This paper goes into depth regarding the prevalent issue of healthcare affordability in modern-day America. Our research explores the substantial impact of emergency and prolonged medical care expenses on diverse American families, particularly those in rural areas or those struggling financially. Beyond numerical analyses, we navigate the landscape of healthcare billing, questioning the complexity behind understanding medical expenses. Furthermore, we examine recent legislative measures, such as the No Surprise Act, to unravel their implications for individuals struggling with the burden of expensive medical bills. Our study is able to intertwine the facets of health insurance, healthcare costs, and accessibility, whilst focusing on their intersectionality with race and ethnicity. Through the examination of empirical evidence and well-examined studies, this paper advocates for an equitable and transparent healthcare system, envisioning a future where quality healthcare is accessible to all without the worry of financial issues.

INTRODUCTION

Our paper dives into the heart of a pressing concern in today's society: the affordability of healthcare. We take a closer look at how the steep costs of emergency and long-term care are impacting families across the United States, especially those in rural areas or from lower-income backgrounds. Beyond just the numbers, we explore the murky waters of healthcare pricing – why is it so hard to understand what we are paying for? We also discuss recent laws like the No Surprise Act and what they mean for everyday people struggling with medical bills. Through our

examination, we uncover the complex relationship between health insurance, affordability, and access to care, and examine how these factors intertwine with race and ethnicity. This paper is an invitation to understand the real-life implications of healthcare costs and the search for paths towards more equitable and transparent healthcare systems.

DISCUSSION

Health insurance poverty is one of the main contributors to affordability and inaccessibility of healthcare. In the article, “The Impact of Health Insurance on Poverty in California”, Caroline Danielson, Patricia Malagon, and Shannon McConville share the facts. Medi-Cal, a medicaid program based in California, specializes in supporting lower-insured children and adults [1]. Eligibility requirements do not restrict on race, sex, age, veteran status, marital status, disability, nor gender orientation. Medi-Cal is California’s largest expenditure and offers subsidies under the Affordable Care Act for lower-income Californian families to gain insurance. Alongside Medi-Cal is Covered California (CC), another health insurance agency that allows eligible individuals to buy private health insurance through federal subsidiaries. Among both agencies lie different reasons for the steady increase in insurance costs. For one, the number of people and relative age within households can increase costs as it is “cheaper to cover children than adults…two-person coverage costs twice as much as single-person coverage”. Secondly, geographic differences can also influence the cost. For instance, the cost of health insurance is relatively lower in Southern California than it is in Northern California. Expanding Medi-Cal to lower-income families could reduce poverty overall, as it is more comprehensive than CC, has less out-of-pocket spending, and provides long term care. However there lies concern that providers would choose not to treat those under Medi-Cal in fear of receiving lower insurance payment rates. Covered California on the other hand “provide[s] health coverage to about 1.6 million people, with nine in ten enrollees receiving premium subsidies”, helping an additional 350,000 Californians. This raises questions on how public health spending can run efficiently and with new eligibility requirements taking into action this year, how many more citizens would be deprived of proper coverage? How would this affect the state budget and how do we avoid faltering health spending in the face of economic downturns? Which is worth the price and services overall, Covered California or Medi-Cal? With more research and resources provided from institutions like the Office of Health Care Affordability, we can raise awareness about such

issues and understand how to better address them while providing tailored solutions to each individual.

In correlation with the previous paragraph, the affordability of healthcare is moving beyond our reach. In specifying the populations of individuals who are most impacted, it is important to note that children must also face the consequences that come with it as well. Health outcomes in children depend not only on socioeconomic status, but dually on the accessibility of healthcare. Children made up 21% of emergency room (ER) visits between 1997 and 2015 [2], a statistic associated with nonadherence to health supervision to a greater extent than to poverty. A case study investigated the influence of low income and absences at health supervision visits on ER utilization in Eastern Brooklyn, New York [2]. They concluded that widespread inaccessibility to care visits was associated with further disease progression in children. Within the sample size studied, nearly one third of participants received ER services within the past year, a statistic higher than that of a 2010 national study that accounts for 14% of children visiting the ER within the same period. The implications of status quo preventative healthcare have critical effects on federal ER expenses as much as on the wellbeing of children and families facing inequitable health accessibility. The American Academy of Pediatrics recommends periodic primary care visitation for adequate assessment of developmental health, safety and immunization updates. Younger children with long-term health concerns and household incomes of less than $20,000 are the most vulnerable to frequent ER visits, exacerbated by transportation inaccessibility and low rates of preventive care appointment scheduling. Reliable, low-cost, and accessible long-term preventative care is therefore a high-demand gateway to deconstructing barriers to health supervision visit adherence and reducing inappropriate ER utilization. Case studies, such as those investigating the functionality of urban healthcare, reveal the criticality of shaping medical policy through heightened equity for an expanded population. Increased accessibility to preventative medical visits would increase immunization and medication adherence rates, as well as support the implementation of health education. Young children are at the greatest risk of frequent ER visits, necessitating directed initiatives to centralize facets of preventative health policy on community-based needs [2].

Aside from the topic of targeted communities, it is important to discuss the patient care systems in place that keep healthcare as expensive as it is. A significant contributor to the issue of unaffordability in healthcare is the Out of Network patient care system. Privately insured

individuals, in the case of an emergency, may be directed to receive care from an out-of-network physician working at the respective hospital. This ultimately leaves the patient with a huge unexpected bill. Though it may seem that occurrences such as these are rare, on average, 20% of emergency visits result in at least one surprise bill, with this statistic growing close to 30% in states such as Texas, California, and New York. In order to combat this equity issue, the federal government has passed legislation, the No Surprise Act (NSA), in which it is illegal for providers to bill patients more than what their in-network cost would be under their own insurance, with ground ambulance transport being a notable limitation. Under the NSA, a final arbitration process is created in which a third party compares the final offers between the patient and the billing party, making the final decision on cost. This process is often called the Independent Dispute Resolution (IDR). It is important to note that prior to the passing of the NSA, 29 states had already established internal legislation to address this issue of surprise billing, with Texas's plan often noted to be the "gold standard", used as a template for other states and even the federal government as it balances disparities between both parties fairly. The NSA has successfully addressed various issues, as following its passing, billed and paid prices to providers have dropped significantly. In addition, the NSA allows for price sharing transparency, and more regulatory complexity within the billing process. However, this process is far from perfect, and many stakeholders are still dissatisfied. The arbitration process currently in place still allows for equity issues within bill balancing for out of network patients and for hospital reimbursement. For example, compared to the process of Medicare Allowed Reimbursement, the arbitration process has been recorded to inflict about 314% higher payment for commercial insurance dispute resolutions. With this, there still must be more price sharing rules, and arbitration policy implementation needed to close the payment gap [3].

Single treatment emergency department (ED) visits are the main contributor to catastrophic health expenditure (CHE) among the uninsured. In a study titled "Assessing Catastrophic Health Expenditures Among Uninsured People Who Seek Care in US Hospital-Based Emergency Departments," CHE is defined as healthcare costs exceeding 40% of one's post-subsistence income [10]. 18% of uninsured "treat-and-release" ED patients are at risk for CHE [10]. The uninsured rely on ED because they likely don't have more cost-efficient alternatives. The uninsured are in the lowest income quartile defined by the study and have a disproportionate share of financial risk. 28.5% of individuals in the lowest income quartile faced

CHE risk in 2017, a 10% increase from 2006 [10]. ED services are usually more expensive because of the high costs required to staff and maintain an ED. Additionally, services provided in an ED are usually of greater intensity and complexity which increases prices and ED spending over time. From 2006-2017, the median ED charge for a single "treat-and-release" visit increased 141% [10]. The uninsured are most vulnerable to financial hardship because of medical bills, and this is further compounded by the rising costs of ED care. High medical bills can inhibit individuals from providing for their basic needs, compromise credit scores, cause intense psychosocial stress, and most importantly, affect future behavior in seeking care. 51% of uninsured adults report postponing care because of medical costs [10]. The authors propose that policies that broaden financial risk protection for the uninsured may help mitigate CHE. Additionally, future policies that improve access for unscheduled care must consider the role of ED as a fallback for the uninsured so they are not at continual financial risk. After the Affordable Care Act was passed, there was a stagnation and overall drop in the number of uninsured "treat-and-release" ED visits. There was a 41% decrease in the number of uninsured people due to the Affordable Care Act [8]. Thus, policies that expand healthcare access can improve the risk of CHE. Though, it is more important to have policies that decrease ED costs before trying to expand insurance access due to the high reliance on ED for unscheduled visits. However, this study used a very conservative estimate for CHE risk and used the highest possible income when determining THE risk for a particular income bracket. Additionally, the ED charges used only reflected facility charges not professional or lab fees. CHE risk also only increased for individuals that sought ED care multiple times in one year [8]. There are also other variables that can contribute to income and thus CHE risk, like race and ethnicity, and geographic region. Finally, the uninsured might not have paid the full amount of what they were actually charged, thus their CHE would be less. Due to a lack of access to proper, cost-efficient healthcare, individuals without insurance are turning to EDs and facing greater financial risk. Policies that both decrease ED costs and expand healthcare insurance are the first steps in combating CHE among the uninsured.

Studies completed on the relationship between cost and quality have largely not shown a clear indication of whether reducing spending would necessarily have a negative impact on quality. Findings have overall indicated that making healthcare visits less affordable does not necessarily guarantee an improvement in quality — a correlation between the two is not strongly

demonstrated across studies. Approximately one-third of studies evaluating data throughout the United States indicate that there is a positive correlation between healthcare cost and its quality, another one-third found no difference, and the last third reported a negative corollary relationship. When focusing on hospitals in particular as compared to other healthcare settings, a slightly higher likelihood of discovering a positive relationship between cost and quality existed. On the other hand, when analyzing broader geographic regions, a negative association between cost and healthcare quality was observed. This study uses a variety of evaluation methods for both the metric of cost and healthcare quality, posing some limitations in terms of consistency across the study as a whole.

Without a doubt, the unaffordability of emergency and long term hospital visits affects most households within the United States. One major issue within this realm is the lack of transparency regarding the pricing of medications, equipment, tests, and any other medical supplies used during these visits. According to the American Hospital Association, in 2021, it became federal law for hospitals to make publicly available the different standard charges which include gross charges, payer-specific negotiated rates, de-identified minimum and maximum negotiated rates, and discounted cash prices. This is known as the Hospital Transparency Rule. However, according to KFF, an organization dedicated to healthcare policy research, there are discrepancies within the prices released to the public, making comparison a difficult process. In a separate article, "Hospital Price Transparency: Making it Useful for Patients" by Lovissa Gustafon and Shawn Bishop, the Affordable Care Act (ACA) is discussed [9]. The ACA makes it mandatory for hospitals to make prices transparent through chargemasters, which are lists of all services they provide. The article claims that these lists are not necessarily beneficial since patients do not purchase individual services and patients are unaware of the quality and/or importance of the different services for their needs. The argument here is that this may ultimately lead to poor healthcare choices without much improvement in overall cost or services. Different solutions were posed in this article, such as combining the data of the prices of different services with the data of the different quality of the services, giving patients a more well rounded idea of what they are paying for. Another posed solution was focusing transparency efforts on items that patients would understand more, such as prescription drugs or diagnostic imaging. Going along with this, providing pricing information to physicians who are most likely unaware of the prices

of the services they provide. With all this being said, price transparency is incredibly important when it comes to working towards a more affordable healthcare system for all.

An idea to decrease expenses via emergency department visits includes mediating this with intervention and community health care workers to provide counseling and navigation for underserved communities. It is stated that about 13 to 27% of emergency department visits in the US could be transferred to alternative care [11]. This would save individuals about $4.4 billion dollars each year. State-certified health workers should and are being trained in order to aid with scheduling and educating patients for healthcare visits. In consideration of costs, the cost of the navigation program was less than the money saved by reduced emergency department visits. Furthermore, by reducing these PCR-ED visits, as just mentioned, patients will spend less money. It is important to note that this study does pose many limitations, including the fact that it was not a randomized controlled trial as well as there being instances of systematic differences between groups.

CONCLUDING REMARKS

In conclusion, our journey into healthcare affordability has shown us just how tangled and urgent this issue has truly become. We have seen how different groups face unique challenges and how current solutions are not cutting it. Despite positive steps like the "No Surprise Act" and more transparent pricing, inequalities persist. What has become crystal clear is that the price tag on healthcare does not guarantee top-notch care. Solutions that truly fit each community are a necessity when it comes to healthcare. Education for patients, local support, and ongoing modifications to policies are key. Keeping up the fight for fairness and making sure everyone can access great care without breaking the bank is top priority. It is a journey we should all be in together; pushing for a healthcare world where quality is no longer a luxury, but a right for everyone.

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