# CHARTBOOK ON CARE AFFORDABILITY

## National Healthcare Quality and Disparities Report


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# NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT CHARTBOOK ON CARE AFFORDABILITY

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# CARE AFFORDABILITY

## Background

This Chartbook on Care Affordability is part of a family of documents and tools that support the National Healthcare Quality and Disparities Report (QDR). The QDR includes annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the health care system along three main axes: access to health care, quality of health care, and priorities of the National Quality Strategy.

The reports are based on more than 250 measures of quality and disparities covering a broad array of health care services and settings. Data are generally available through 2013. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

## Key Findings of the 2015 QDR

- Access to care has improved dramatically.
- Quality of care continues to improve, but wide variation exists across the National Quality Strategy (NQS) priorities:
    - Effective Treatment measures indicate improvements in overall performance and reductions in disparities.
    - Care Coordination measures have lagged behind other priorities in overall performance.
    - Patient Safety, Person-Centered Care, and Healthy Living measures have improved overall, but many disparities remain.
- Despite progress in some areas, disparities related to race and socioeconomic status persist among measures of access and all NQS priorities.
- Improvements in access were led by sustained reductions in the number of Americans without health insurance and increases in the number of Americans with a usual source of medical care.
- Care Affordability measures are limited for summarizing performance and disparities.
- Disparities in access tend to be more common than disparities in quality.

## Chartbooks Organized Around Priorities of the National Quality Strategy

1. Making care safer by reducing harm caused in the delivery of care
2. Ensuring that each person and family is engaged as partners in their care
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
5. Working with communities to promote wide use of best practices to enable healthy living

**6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models**

Care Affordability is one of the six national priorities identified by the National Quality Strategy (http://www.ahrq.gov/workingforquality/index.html).

The National Quality Strategy has identified two long-term goals related to care affordability:

1. Ensure affordable and accessible high-quality health care for people, families, employers, and governments.
2. Support and enable communities to ensure accessible, high-quality care while reducing waste and fraud.

The National Quality Strategy recognizes that while this will be a challenge, the goal of reducing health care costs is important to everyone because of the impact of rising costs on families, employers, and State and Federal governments. Reducing costs must be considered hand in hand with the aims of better care, healthier people and communities, and affordable care.

## Chartbook on Care Affordability

- This chartbook includes:
  - Summary of trends across measures of Care Affordability from the QDR.
  - Figures illustrating select measures of Care Affordability.
- Introduction and Methods contains information about methods used in the chartbook.
- A Data Query tool provides access to all data tables (http://nhqrnet.ahrq.gov/inhqrdr/data/query).

## Care Affordability Trends

- Few measures of Care Affordability can be tracked over time.
- One measure of Care Affordability showed worsening over time from 2002 to 2013:
  - People without a usual source of care who indicate a financial or insurance reason for not having a source of care
- One measure of Care Affordability achieved 95% performance and was removed from the report this year:
  - People under age 65 with private insurance whose family's out-of-pocket medical expenditures were more than 10% of total family income
- No measures of Care Affordability improved quickly, defined as an average annual rate of change greater than 10% per year.

For more information, refer to the Introduction and Methods at http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/chartbooks/2015qdr_intro.pdf.

## Care Affordability Measures for Which Disparities Were Eliminated

- For the measure people under age 65 whose family's health insurance premiums and out-of-pocket medical expenses were more than 10% of total family income, disparities were eliminated for three groups:
  - Less than high school vs. at least some college
  - Micropolitan vs. large fringe metropolitan areas
  - Noncore vs. large fringe metropolitan areas
- For the measure people without a usual source of care who indicate a financial or insurance reason for not having a source of care, disparities were eliminated for three groups:
  - Female vs. male
  - Large central vs. large fringe metropolitan areas
  - Multiple race vs. White

## Care Affordability Measures for Which Disparities Were Growing

- For the measure people without a usual source of care who indicate a financial or insurance reason for not having a source of care, disparities were growing for two groups:
  - High school vs. at least some college
  - Uninsured vs. any private

## Care Affordability Measures for Which a New Disparity Was Identified

- For the measure people without a usual source of care who indicate a financial or insurance reason for not having a source of care, a new disparity developed between Blacks and Whites.

## Measures of Care Affordability

- Depending on the data source, this chartbook tracks measures of Care Affordability through 2012 or 2013, overall and for populations defined by:
  - Age,
  - Race, ethnicity,
  - Income, education, insurance, and
  - Number of chronic conditions.
- Measures of Care Affordability include:
  - Access problems due to health care costs and
  - Inefficient care due to use of services associated with more harm than benefit.

One approach to containing the growth of health care costs and thus making health care more affordable is to improve the efficiency of the health care delivery system by reducing use of unneeded services, often referred to as overuse.

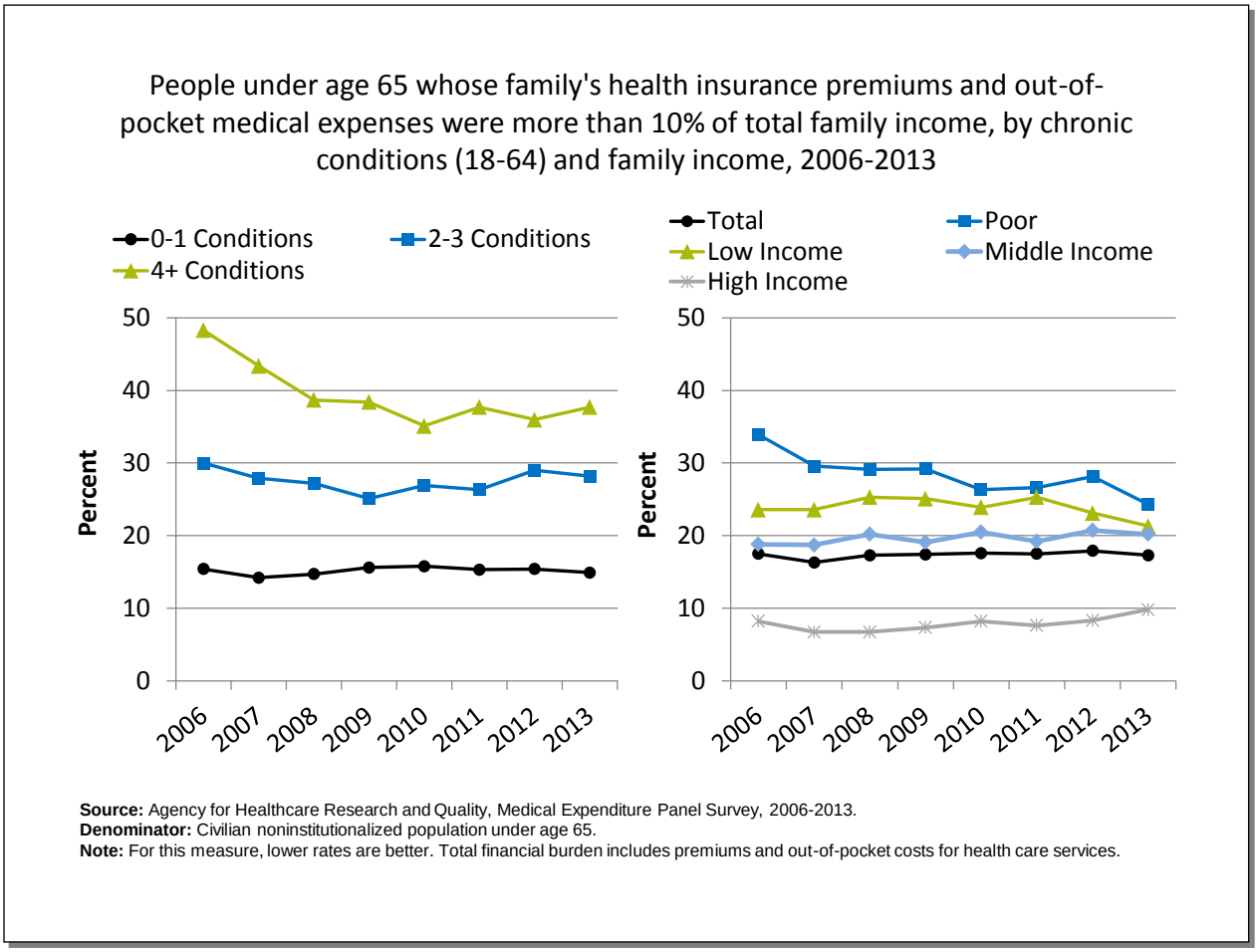
As noted in the *National Strategy for Quality Improvement in Health Care* (http://www.ahrq.gov/workingforquality/index.html), "Achieving optimal results every time requires an unyielding focus on eliminating patient harms from health care, reducing waste, and applying creativity and innovation to how care is delivered."

## Measures of Access Problems Due to Health Care Costs

- People under age 65 whose family's health insurance premiums and out-of-pocket medical expenses were more than 10% of total family income
- People without a usual source of care who indicate a financial or insurance reason for not having a source of care
- People under age 65 who were in families having problems paying medical bills in the past year

High health care costs can prevent some patients from receiving the care that they need.

**People Whose Family's Health Insurance Premiums and Medical Expenses Were More Than 10% of Family Income**

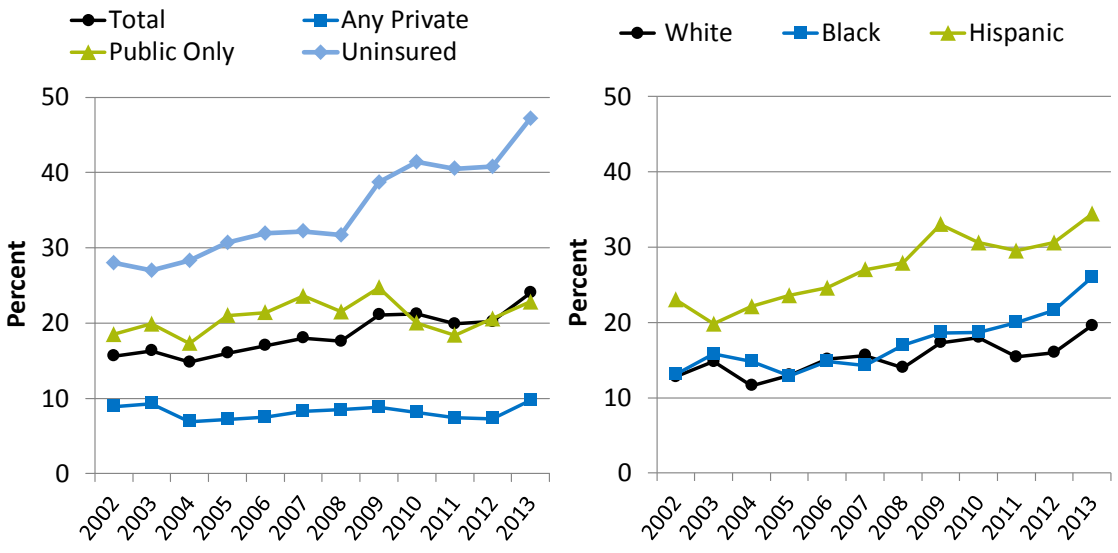



**Source:** Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2006-2013.
**Denominator:** Civilian noninstitutionalized population under age 65.
**Note:** For this measure, lower rates are better. Total financial burden includes premiums and out-of-pocket costs for health care services.

- **Importance:** Health care expenses that exceed 10% of family income are a marker of financial burden for families.
- **Overall Percentage:** In 2013, 17.3% of people under age 65 had health insurance premium and out-of-pocket medical expenses that were more than 10% of total family income.
- **Trends:**
  - From 2006 to 2013, there were no statistically significant changes in the overall percentage.
  - Among people with 4 or more chronic conditions and poor people, the percentage decreased.
  - Among high-income and middle-income people, the percentage increased.
- **Groups With Disparities:**
  - In all years, the percentage of adults under age 65 whose family's health insurance premium and out-of-pocket medical expenses were more than 10% of total family income was higher among those with 2-3 and 4+ chronic conditions compared with those with 0-1 chronic conditions. The gap between people with 4+ chronic conditions and 0-1 conditions narrowed over time.
  - In all years, the percentage was about 3 times as high for poor individuals and low-income individuals and more than twice as high for middle-income individuals compared with high-income individuals. The gaps between poor and high-income people and between low-income and high-income people were narrowing over time.

**People Without a Usual Source of Care for Financial or Insurance Reasons**

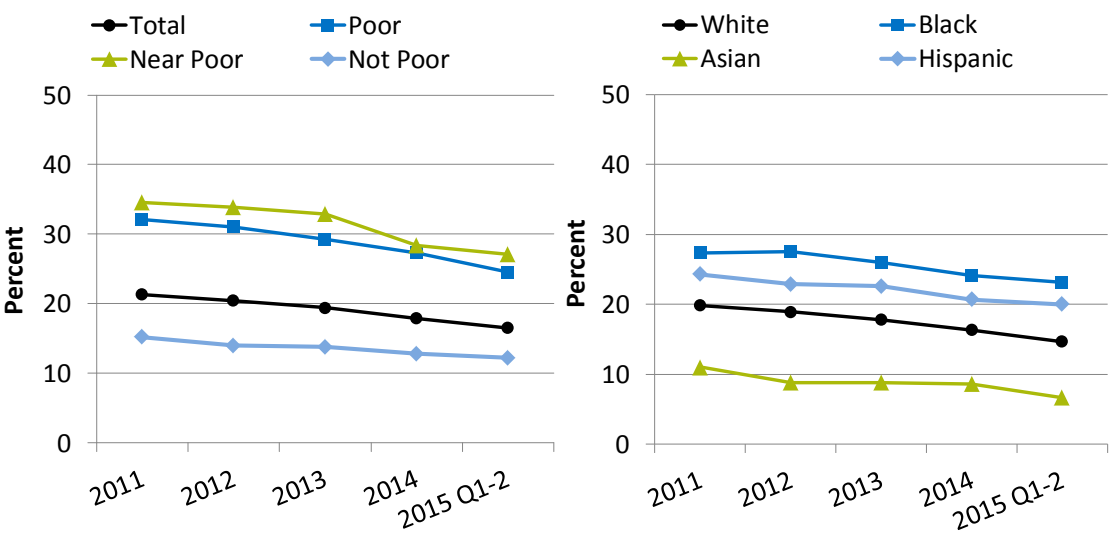
People without a usual source of care who indicate a financial or insurance reason for not having a source of care, by insurance (under age 65) and race/ethnicity, 2002-2013




**Source:** Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2013.
**Denominator:** Civilian noninstitutionalized population without a usual source of care.
**Note:** For this measure, lower rates are better. White and Black are non-Hispanic. Hispanic includes all races.

- **Importance:** High-quality health care is facilitated by having a regular provider, but some Americans may not be able to afford one.
- **Overall Percentage:** In 2013, 24.0% of people without a usual source of care indicated a financial or insurance reason for not having a source of care.
- **Trends:**
  - The overall percentage worsened from 2002 to 2013.
  - The percentage worsened among uninsured people and among Whites, Blacks, and Hispanics.
- **Groups With Disparities:**
  - In all years, the percentage of people without a usual source of care who indicated a financial or insurance reason for not having a source of care was higher:
    - Among uninsured people and people with public insurance compared with people with any private insurance. The gap between uninsured people and people with any private insurance was growing larger over time.
    - Among Hispanics compared with Whites.
  - From 2011 to 2013, the percentage of people without a usual source of care who indicated a financial or insurance reason for not having a source of care was higher among Blacks compared with Whites. This represents a new disparity that is growing larger over time.

**People With Problems Paying Medical Bills**




**Key:** Q = quarter.
**Source:** Cohen RA, Schiller JS. Problems paying medical bills among persons under age 65: early release of estimates from the National Health Interview Survey, 2011-June 2015. Hyattsville, MD: National Center for Health Statistics; 2015. http://www.cdc.gov/nchs/nhis/releases.htm.

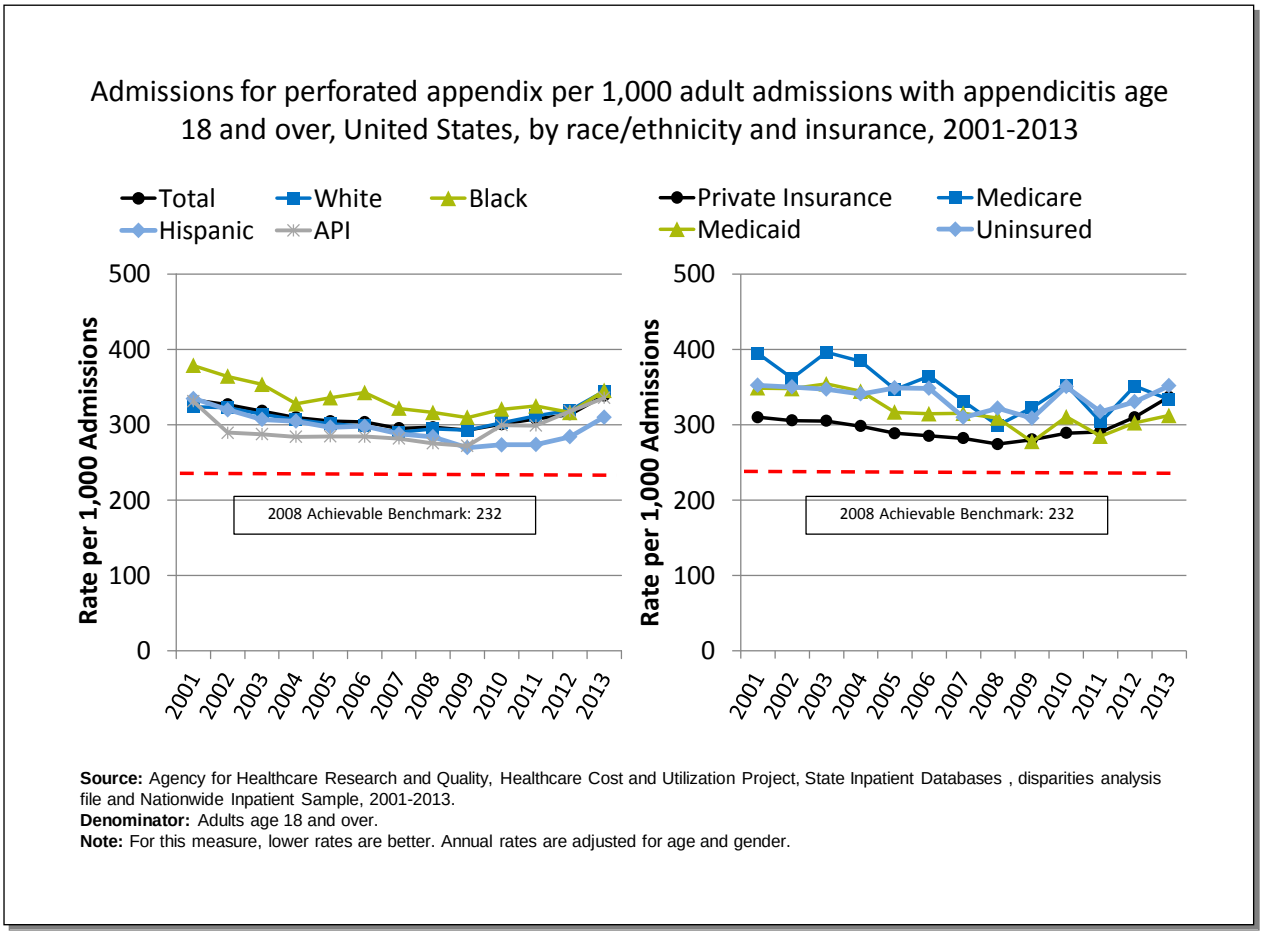
- **Trends:** From 2011 to the first half of 2015, the percentage of people under age 65 in families having problems paying medical bills decreased overall and for all poverty status and racial/ethnic groups.
- **Groups With Disparities:**
  - In all years, people in poor and near-poor families were more likely to have problems paying medical bills than people in families that were not poor. The gaps between people in poor and not poor families and between near-poor and not poor families have narrowed over time.
  - In all years, compared with Whites, Blacks and Hispanics were more likely to have problems paying medical bills while Asians were less likely to have problems. None of these gaps were changing over time.

## Measures of Inefficiency

- Ruptured appendix per 1,000 adult admissions with appendicitis
- Men age 40+ who had a screening prostate-specific antigen test in the past year

Inefficient care includes delayed care that is more costly and care with risks that exceed benefits. This inefficiency can raise health care costs and make it harder for people to afford care.

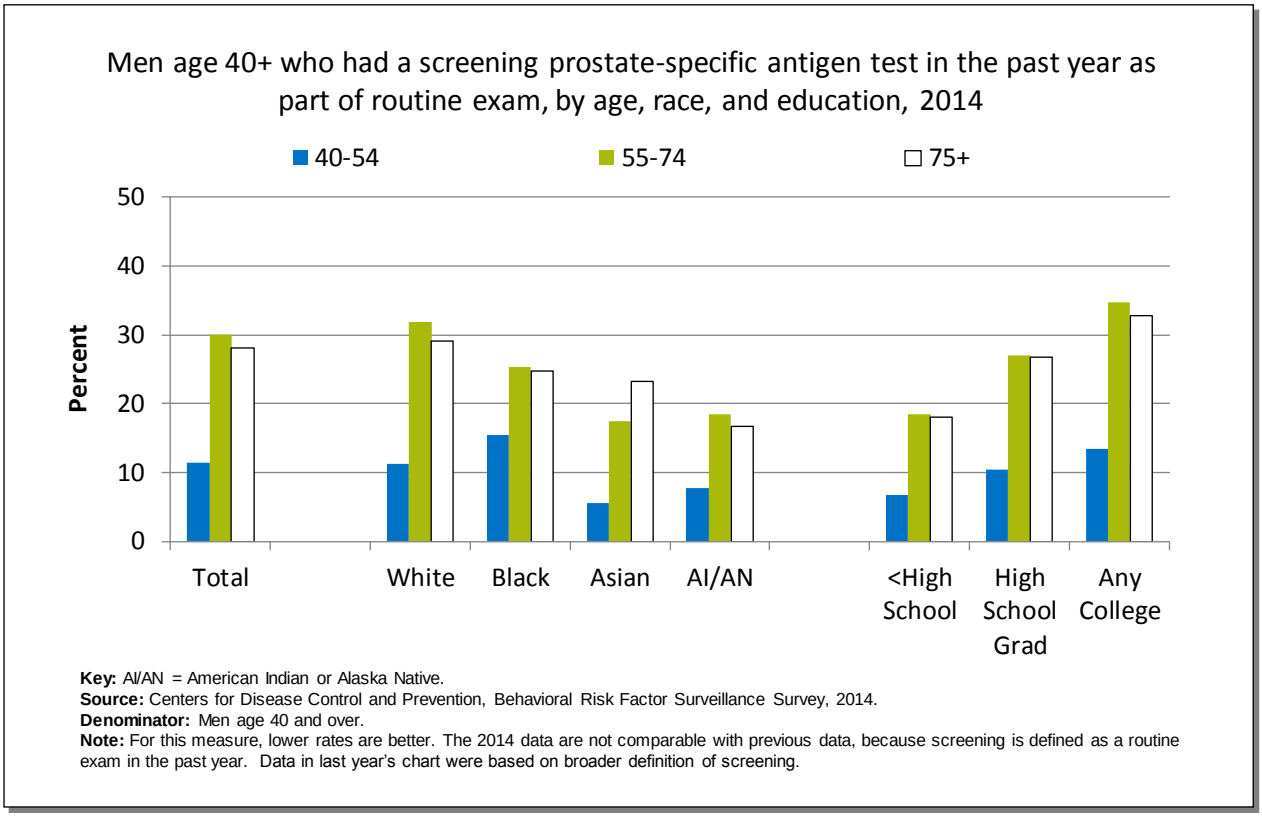
### Admissions for Perforated Appendix




**Source:** Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, State Inpatient Databases , disparities analysis file and Nationwide Inpatient Sample, 2001-2013.
**Denominator:** Adults age 18 and over.
**Note:** For this measure, lower rates are better. Annual rates are adjusted for age and gender.

- **Importance:** Timely assessment of abdominal pain and diagnosis of appendicitis reduces rates of perforated appendix.
- **Overall Rate:** In 2013, there were 338 perforated appendixes for every 1,000 adult admissions with appendicitis.
- **Trends:**
  - From 2001 to 2013, there were no statistically significant changes in the overall rate.
  - The rate improved among Blacks and Hispanics and among people with Medicare and Medicaid.
- **Groups With Disparities:**
  - Until 2007, Blacks tended to have higher rates than Whites, and people with Medicare, Medicaid, or no insurance tended to have higher rates than people with private insurance.
  - Since 2007, only the gap between uninsured and privately insured people has persisted.
  - The disparities between Blacks and Whites and between people with Medicaid and those with private insurance were eliminated.
- **Achievable Benchmark:**
  - In 2008, the top 4 State achievable benchmark for perforated appendix per 1,000 admissions with appendicitis was 232. The States that contributed to the achievable benchmark were Connecticut, Hawaii, Massachusetts, and New Jersey.
  - No group had reached the benchmark by 2013.

**Men Who Had a Screening Prostate-Specific Antigen Test**




**Key:** AI/AN = American Indian or Alaska Native.
**Source:** Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance Survey, 2014.
**Denominator:** Men age 40 and over.
**Note:** For this measure, lower rates are better. The 2014 data are not comparable with previous data, because screening is defined as a routine exam in the past year. Data in last year's chart were based on broader definition of screening.

- **Importance:** Finding more harm than benefit, in 2008, the U.S. Preventive Services Task Force recommended against screening men age 75 and over with prostate-specific antigen (PSA) tests. In 2012, this recommendation was extended to all men.
- **Overall Rate:** In 2014, 21.1% of men age 40 and over reported a PSA test in the past year (data not shown).
- **Groups With Disparities:**

  - In 2014, men ages 40-54 were less likely to receive a PSA test in the past year compared with those ages 55-74 and 75 and over.
  - Among men ages 40-54, Asians were less likely than Whites to receive PSA testing and Blacks were more likely to receive the test.
  - Among men ages 55-74, Blacks, Asians, and American Indians and Alaska Natives (AI/ANs) were less likely than Whites to receive PSA testing.
  - Among men age 75 and over, AI/ANs were less likely than Whites to receive PSA testing.
  - Across all age groups, men with less than a high school education and those with a high school education were less likely than men with any college to receive PSA testing.

## Supplemental Measures of Care Affordability

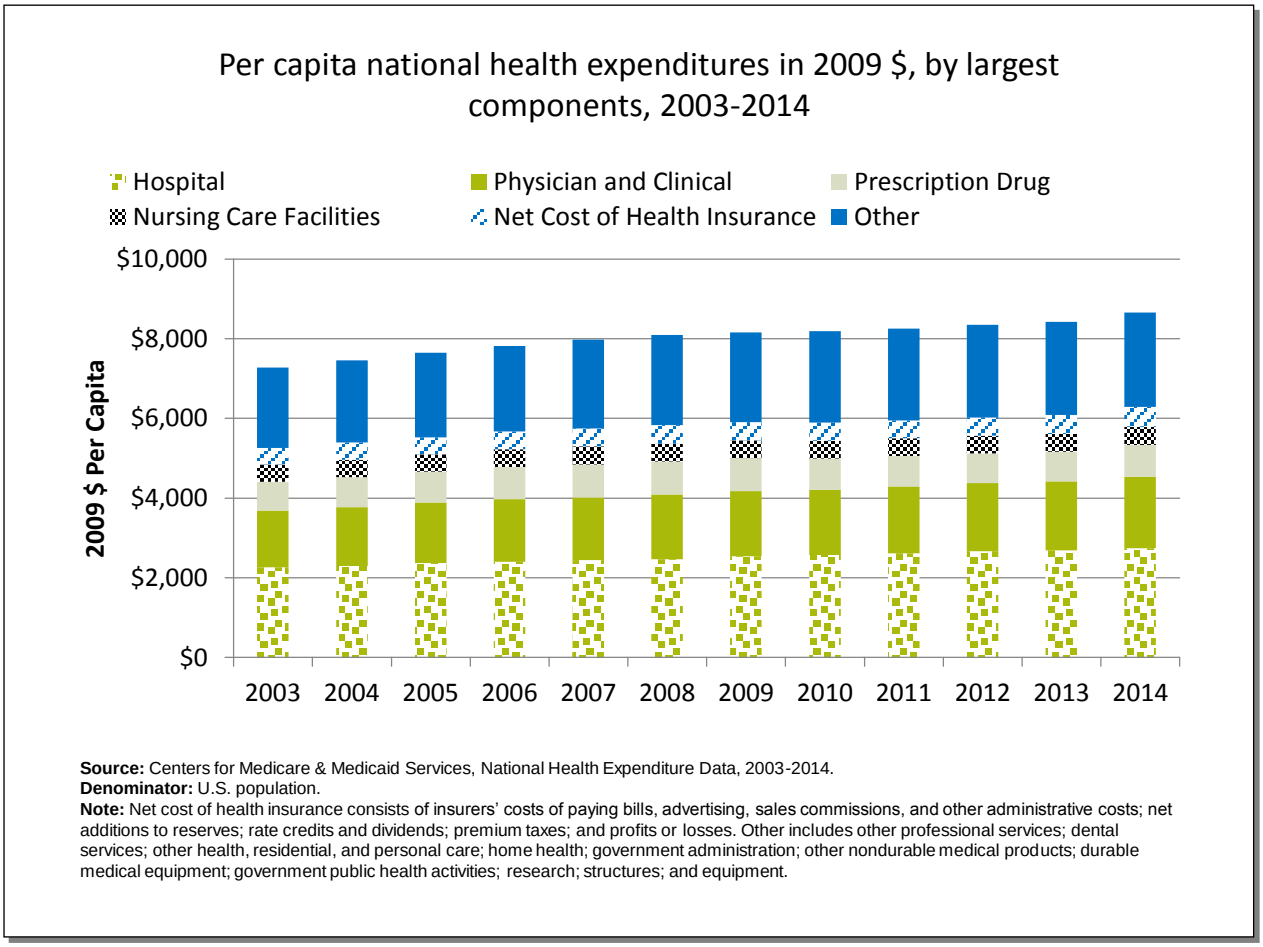
- Supplemental measures:

  - May provide contextual information related to health care quality.
  - Are not part of the measure set tracked in the QDR because they are difficult to interpret.

- Supplemental measure of Care Affordability:

  - Per capita national health expenditures

**Per Capital National Health Expenditures**




**Source:** Centers for Medicare & Medicaid Services, National Health Expenditure Data, 2003-2014.
**Denominator:** U.S. population.
**Note:** Net cost of health insurance consists of insurers' costs of paying bills, advertising, sales commissions, and other administrative costs; net additions to reserves; rate credits and dividends; premium taxes; and profits or losses. Other includes other professional services; dental services; other health, residential, and personal care; home health; government administration; other nondurable medical products; durable medical equipment; government public health activities; research; structures; and equipment.

- **Importance:** Increases in national expenditures on health care can affect costs for consumers.
- **Trends:**
  - Total per capita national health expenditures in 2009 dollars rose from $7,271 in 2003 to $8,653 in 2014.
  - Expenditures on hospitals and physicians rose an average of 2% per year while expenditures on prescription drugs changed little.
  - The five largest components of national health expenditures were hospital, physician and clinical, prescription drug, and nursing care facilities, along with net cost of health insurance (revenues minus expenses).