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Patients' Annual Income Adequacy, Insurance Premiums and Out-of-Pocket Expenses Related to Heart Failure Care

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BACKGROUND

In the U.S., families caring for members who have chronic illnesses reported that they spent more than 10% of their annual incomes on out-of-pocket costs for health services.¹ Among those with low incomes, 37% report family medical bill concerns, underscoring the limitations of private insurance alone in protecting people from the high costs of treating chronic conditions.² Furthermore, the American Heart Association (AHA) has identified heart failure (HF) as one of the most expensive illnesses for our society, costing over \$31 billion annually.³ Notably, HF patients and their families often pay more for health insurance to cover their multiple and specialty health services,⁴ which can put a disproportionate burden on families for non-reimbursed expenses.^{4,5} Those families who are

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unable to purchase more extensive or supplemental coverage are likely to pay higher health insurance premiums, deductibles, and co-payments and have restricted benefits.⁶ However, even people covered by comprehensive insurance are not immune to financial hardships from out-of-pocket expenses incurred while managing complex HF care.

These non-reimbursed out-of-pocket costs include a combination of expenditures for annual insurance premiums, deductibles, and co-payments for health services or for items not covered by insurance. Out-of-pocket expenses may also include homecare supplies (e.g., co-pays for the necessary prescribed medications, walkers), over-the-counter (OTC) medications, specific dietary needs such as low sodium foods, and transportation costs to obtain health services.^{5,6} Yet, the out-of-pocket costs of patients' HF care are rarely measured. This study was undertaken to tabulate the amount of money families report spending out-of-pocket on managing HF, to estimate annual average expenditures, and to describe the financial burden of HF.

PURPOSE

The purposes of this study were to (1) identify the amount patients spend for insurance premiums, co-payments, deductibles, and other out-of-pocket costs related to HF and chronic healthcare services and estimate their annual non-reimbursed health insurance and out-of-pocket costs; and (2) identify patients' concerns about non-reimbursed and out-of-pocket expenses.

METHODS

Research Design

This was a mixed methods approach with quantitative questionnaires as well as interview responses and collected comments.

Setting and Sample

Patients who had a recent HF hospitalization for physician-confirmed acute decompensated HF were invited to participate regardless of ethnicity, gender, or socioeconomic status. Included were those who were ≥ 21 years of age and who lived within the catchment area. Excluded were those on a waiting list for a heart transplant and patients diagnosed with a malignant disease or terminal illness.⁷ After approval from the Institutional Review Board (IRB), 198 patients were recruited through the cardiology practice of a Midwestern university-based medical center and signed consents to participate in this study. Of the 198 patients who enrolled in the study, 149 patients (75.3%) provided non-reimbursed and out-of-pocket cost data.

Data Collection Measures

Non-reimbursed and out-of-pocket cost questionnaires—Our investigator-designed questionnaires have been verified in previous research data.⁸ The questionnaire was mailed to each patient prior to data collection. Patients were asked to list the health services covered by insurance and record any non-reimbursed, out-of-pocket costs associated with HF health care during the previous year. The rationale for selecting the past

year was that most patients had HF over this time period, and they had the calendar record of their physician appointments, and recall of emergency department (ED) visits or hospitalizations for costly HF health care. These calendars also spurred patients' recall of transportation, medication, and other out-of-pocket expenses that were then reported and tabulated across the year. These cost questions are similar to those used in other national health cost surveys.⁹ Several studies have validated use of cost questionnaires for collection of the wide range of these patient expenses.^{10,11,12,13} Table 3 is a list of definitions of non-reimbursed and out-of-pocket costs collected in this study.¹⁴

In addition, the *Family Economic Stability Survey* was used to measure income adequacy in our sample.^{8,15,16,17} Using this survey, patients were asked to rate their ability to pay monthly bills. Ratings are (1) "Can't make ends meet," (2) "Have just enough no more," (3) "Have a little extra sometimes," or (4) "Always have money left over." Reliability of these ratings has been verified by comparing reports from patients and caregivers living in the same household, which were highly correlated in other HF studies^{18,19} and in chronic illness studies.¹⁶ Reliability of this simple scale was also based on individuals' awareness of monthly bills.

Following the completion of questionnaires about their health insurance premiums, deductible payments, and other out-of-pocket expenses, patients were asked an open-ended interview question: "Do you have any comments on these costs?" If the patient commented then the prompt questions used were: "Please explain how non-reimbursed and out-of-pocket expenses impact you or your family members." Additional prompt questions were posed: "Is health insurance coverage adequate for you and your family?" and "Do you have additional concerns about your health insurance coverage?"

Data Analysis

Descriptive statistics were used to summarize the health insurance premiums, deductible payments, and other out-of-pocket expenses. These data were tabulated by a nurse researcher (UP) experienced in financial data content analyses. The range, median, and estimated annual costs reported by each patient were tabulated by category of insurance premiums, deductibles, co-payments, and out-of-pocket expenses. Content analysis, a research technique,²⁰ was used to summarize the patients' responses and comments related to these questions.

Trustworthiness and credibility of the interview data collection and analysis was maintained throughout.²¹ Specifically, each interview was reviewed separately by two trained nurse researchers (UP & DY) who grouped the patients' statements with similar content into distinct categories using the patient's own words. Data saturation was achieved when no new topic was identified. These two researchers then met to compare content and resolve the few differences in topic categorization. Over 90% inter-coder agreement in themes was achieved, and the final categories and themes were reviewed by our team's cardiologist. To protect patients' confidentiality and privacy per HIPAA, the patient names or identifiers were removed from the transcribed information.

RESULTS

Of the original 198 enrollees, 38 (19%) patients were unable to or decided not to reveal this financial data, and 11 (5.6 %) were missing data; these 49 patients were excluded from the analysis. There were 149 patients who completed the family economic stability survey reported amounts paid monthly for their health insurance premiums and responded to the research nurses via telephone interviews. Of the 149 patients, only 15% (n=23) were employed; 33% (n=50) were retired; 28% (n=41) were disabled; 13% (n=19) were retired and disabled; and 11% (n=16) did not answer this question about employment. Almost half (48%) of the subjects (n=72) had a high school education or less, while over half (52%) had completed some college or higher education. (Table 1).

The sample (n=149) for this economic analysis included patients with HF ranging in age from 24 to over 80 years ($M = 61.1$, $SD = 13.6$). Eighty-seven (58%) of the patients were male, 50% (n=74) were white, and 47% (n=70) were African American. Patients in this sample had had a diagnosis of HF for an average of 6.1 years (range 4 days to 18 years, $SD = 7.3$ years); the mean left ventricular ejection fraction (LVEF) was 30.8% ($SD = 16.6$). The mean Charlson Comorbidity Index²² score was 6.6 ($SD = 2.9$); the most common comorbidities were hypertension, diabetes, chronic lung disease (COPD), and sleep apnea.

Family Economic Stability Survey Data

Patients reported annual family income ranging from zero (n=5) to a high of \$100,000 or more (n=3) per year; the median range was \$10,000 to \$19,000 per year. Three reported their family income for the year as \$2,000 to \$2,400, and five patients reported no annual income. When patients were asked to rate the adequacy of family income for paying monthly expenses, 34% reported having “just enough” money to pay monthly bills and “no more,” while 32% reported “having enough, with a little extra sometimes.” On the extremes of this rating scale, 20% reported they “can’t make ends meet,” while 14% “always have money left over.” Two subjects did not answer this question.

Health Insurance Coverage Data

All 149 patients reported on their single, multiple, or lack of any health insurance coverage. Overall, close to half had Medicare with the remainder on state-paid plans, such as Medicaid or military-based coverage. Many had a private or more than one insurance coverage and supplemental plans. Notably, 8% (n=12) reported having no insurance coverage. (Table 2).

Only nine patients (6%) were able to name the individual lifetime maximum benefit limit of their insurance policy. Of those subjects who knew their lifetime maximum coverage allowance, six reported a broad range of maximum benefits from \$120,000 to \$7 million, and three families reported they had no restriction on the lifetime maximum benefit amount that would be covered by their insurance plan.

Non-reimbursed Health Insurance Premiums, Deductibles, and Co-payments Expenses

Table 4 lists the monthly range, median, and estimated annual non-reimbursed expenses tabulated from patients' reported premiums, deductibles, co-payments, and other out-of-pocket expenses.

Health Insurance Premiums Data—Of 149 patients, about 38% (n=58) reported that health insurance premium costs ranged from \$20 to \$1,000 per month (median \$116 per month or \$1,392 annually). Another 53% (n=79) paid no medical insurance premiums as the patients were covered by military-based or a state-paid plan (i.e. Medicaid). Those patients who paid for their insurance premiums stated that their medical insurance plans included prescription and medical equipment.

Deductibles Cost Data—The majority of patients reported they were not sure about their deductible expenses. However, the most common deductible reported was for the patients was for hospital admission. Those on Medicare insurance pay about \$1,200 total for any hospitalizations in each new benefit period. In this study, an average of 1.77 hospital admissions annually was reported.²³ Each admission lasted 2 to 6 days, 1 to 2 days for cardiac device implantation or cardiac ablation and 4 to 7 days for intensive HF treatment. Typically, the amount of the hospitalization deductible was higher for out-of-network provider services. The Medicare reported reimbursement for the charges for one HF related hospital stay is \$10,448.^{24,25} Those on Medicaid and some other forms of insurance do not pay deductibles. Thus this summary excludes those on Medicaid or other insurances that do not require deductibles.

Co-payment Cost Data—Co-payments were shared costs or health services fees required at the time of service by most health plans.²⁶ Some co-payments were a specific percentage of the service charge, patients most frequently reported a 20% co-payment. About 24% (n=31) of the patients reported they did not have co-payments, while 25% (n=35) of the patients provided information regarding their co-payments. The calculation of co-payments was based on an annual average for types and frequencies of health services reported by HF patients.²³ These health services included physician or healthcare provider appointments; out-patient procedures appointments; hospital admissions; ED visits; and additional services such as allied health services and home health care. The most common co-payment was for a physician/healthcare provider appointment which ranged from \$10 to \$40 (median \$25). In this study, the average number of these visits was 11 annually, thus the co-payments for physician/healthcare provider appointments were calculated to be \$275 ($\$25 \times 11 = \275).

The Midwestern median costs for the health services each patient reported were used to calculate the co-payments for out-patient appointments, allied health services, and home health care services.²³ On average, HF patients had three yearly visits for out-patient procedures appointments, which included laboratory, echocardiograms, stress tests, EKGs, cardiac device checks (for implantable cardioverter defibrillators (ICD) or pacemakers). These visit costs ranged from \$200 to \$800 monthly or \$240 per year (20% co-payment of median \$400 $\times$ 3 appointments annually). Forty-two patients (28%) also reported co-payment rates for prescription drugs. The most common co-payments for generic drugs

prescriptions ranged from \$3 per medication to \$125 for other prescribed drugs (median \$20). Therefore these families reported the annual average co-payments for prescriptions as \$240 ($\20×12).

Additional Out-of-Pocket Costs—Thirty seven patients (25%) reported paying supplemental insurance premium costs ranging from \$3.50 to \$700 each month (median \$87). The overall average non-reimbursed annual cost for prescription supplemental premiums was \$1,044 annually. Another 16% (n=24) of the patients paid \$500 co-payments for ED visits.²²

Thirty one patients (21%) of the patients requested monthly visits by home health nurses; the co-payments were calculated at \$336 per year (20% of \$140 $\times$ 12). Another Twenty-five patients (17%) reported two yearly visits for allied health services (mental health services, physical therapy) at a median cost of \$90 per visit. Thus the co-payments for two visits were calculated at \$36 (20% of \$90 $\times$ 2).

Out-of-pocket Health Costs Related to HF and Other Comorbid Conditions

All families reported costs paid for a variety of out-of-pocket HF and other comorbid conditions care that were not covered by insurance. As shown in Table 4, these costs included OTC medications, supplies, equipment, transport devices, travel costs for health services, and home care assistance. About 68% (n=101) of patients reported spending \$0.25 to \$500 a month (median=\$300 per year) on OTC medications (e.g., analgesics for headaches or arthritis, vitamins/supplements) and on OTC supplies (e.g., blood pressure equipment, medicine organizers, support stockings, air humidifiers, canes, walkers, wheelchairs).

To calculate travel costs to obtain health services, we averaged costs for all patients who lived within 100 miles of the medical center where most services were obtained. The average round-trip distance to the medical center was 21.9 miles (range from 2.4 to 85.8 miles). Using common mileage guidelines (\$0.59/mile), the average cost of travel per each round-trip was \$12.9 (21.9 miles $\times$ \$0.59; $SD=8.8$, range \$1.4 to \$50.6). Therefore, in this study the total travel cost for seeking annual medical care, which on average was 11 physician visits, three visits for outpatient procedures appointments (i.e. laboratory), and two hospital admissions, was \$206 ($\12.9×16 round-trips) as reported in another cost article.²³

In addition, the cost of monthly travel to a pharmacy was calculated. Based on an estimated 3 miles round-trip to a local pharmacy, the travel cost was \$21 (3 miles $\times$ \$0.59 $\times$ 12 annual visits). As reported by 17% of patients (n=25), additional travel costs were calculated for visits to other healthcare professionals, i.e., mental health services or physical therapy (21.9 miles $\times$ \$.59 $\times$ 2 visits = \$26), and another \$12.9 for one annual ED visit, as reported by 16% (n=24) of patients. Thus, the total travel cost could add up to \$266/year (excluding any charges for parking).

Summary of All Non-reimbursed and Out-of-Pocket Costs

For patients who were not on a state-paid plan such as Medicaid, and who reported out-of-pocket expenses, the average annual non-reimbursed costs for health insurance premiums

(\$1,392), deductibles (\$1,200), and co-payments (\$755). Other out-of-pocket costs including travel costs for medical services (\$266), and OTC medications and supplies (\$300), were estimated to be \$566 annually. Thus, the total estimated non-reimbursed costs for HF patients add up to \$3,913 per year. Additional annual out-of-pocket expenses could be incurred upon the use of other additional services, such as supplemental prescription plan (\$1,044), deductible for ED visit (\$500), home care assistance (\$336), and allied health services (\$36). This additional expense could be \$1,916 annually. Therefore, the total annual out-of-pocket for HF-related health services use could range from \$3,913 to \$5,829.

Only eight (6%) of these patients reported that some or all of their supply costs and OTC medications were tax deductible or met criteria for reimbursement from their Flexible Spending or Health Saving Accounts. Two of these patients had Flexible Spending Accounts, and another two patients had Health Saving Accounts. The remaining families either did not know if they were eligible for plans or if they could use them for their cost (for example, tax-saving plans could cover some of out-of-pocket healthcare costs).

Content Analysis of Interview Data

Patients were asked to comment or describe how non-reimbursed costs (health insurance premiums, deductibles, and co-payments) and out-of-pocket expenses impact themselves or their family members. Sixty-three of 149 patients (42%) shared comments and concerns. Content analyses of patients' verbal comments revealed numerous financial burdens. The themes and topic subcategories that emerged from this analysis, including quotes in the patient's own words, are presented in the following sections.

Uncertainty about Health and Disability Coverage—The majority of patients stated that health insurance does not cover all their needs. For example, some patients were fearful of any changes in the system; another wanted “*portability of insurance*” in the event of a job change or retirement. Unwelcome coverage changes were reported by four patients and two were specifically worried about “potential changes in Medicare” and did not want any expansion of entitlement programs, stating “I do not want to give it away to people who haven't worked for it.”

Several patients commented on the need for restructuring the healthcare system. Specifically, 12 patients recommended “*government-sponsored universal healthcare*.” Eleven patients supported “*universally available insurance*,” and five of those respondents further commented that “premium charges should be based on one's ability to pay.” Five patients stated that “streamlining the process for disability determination” was important. Of these five, three had applications for disability pending review; one application pending was a resubmission after a denial of the first application; and another had already been declared disabled following the review process but had a mandatory waiting period between determination and access to benefits.

Inadequacy of Health Insurance Coverage Due to Cost—When asked questions what they thought about their health insurance coverage, 118 patients (79%) stated they had “ok” or adequate health coverage, while 31 patients (21%) stated that they had inadequate coverage due to high non-reimbursed healthcare costs. For example, “The insurance

premium cost is too expensive and it doesn't cover even basic needs" (i.e., transportation for elderly, medications). Twenty-six patients pinpointed high out-of-pocket costs for medications as a significant problem. Nineteen indicated that they needed a reduction in their co-payments and deductibles, stating that "*insurance should cover medical with less costs.*" Others commented about "...lack of money to pay for the insurance premiums.... I would use money to buy food and over-the-counter medications."

Six patients stated that they need "*more comprehensive coverage,*" which would include medical care and prescription benefits. Four patients commented on dental care coverage; two of the four had no dental insurance due to its expense, they stated that "Medicare paid for teeth extractions but would not pay for needed preventative care." Other comments addressed the need for comprehensive health coverage with no maximum limit on policy: "*bumper to bumper - - as is automobile coverage;*" "too many supplemental plans, which are too costly to achieve adequate coverage," and "my maximum limit on the policy had been reached, so all costs were increasing." Some patients were unable to work due to a HF condition and were paying out-of-pocket COBRA premiums to maintain insurance coverage.

Several patients noted that the out-of-pocket costs were unaffordable. For example, one uninsured patient wanted to "receive more medication samples dispensed by physicians." Several patients addressed "*the high costs of over-the-counter medications,*" "costs of transportation to medical service providers," "*medical supply coverage,*" and wanting "a third party payer to help with employing someone to perform household chores since I can no longer do [then] because of HF conditions."

Inadequate Insurance Coverage for Family Members—Thirty-five patients (24%) reported the insurance coverage was inadequate for their families. Of these 35 patients, three reported that their insurance did not cover their spouses, one reported it did not cover a child, and another reported the insurance did not cover her brother who lived with her to help with her HF care.

DISCUSSION

The costs of managing HF healthcare needs are substantial and vary greatly for patients depending on annual insurance premiums, deductibles, co-payments, and other out-of-pocket costs. In this study, the median of annual non-reimbursed and out-of-pocket costs per patient was ranging from \$3,913 to \$5,829 depending on insurance coverage. More than half of the HF patients in this study might be unable to pay these out-of-pocket costs that would likely represent 50% or more of the reported median family income (between \$10,000 to \$19,000) in lower ranges. Most patients were on state and/or federal insurance plans (i.e., Medicare, Medicaid, or military), which have required co-payments and deductibles. In addition, patients reported other out-of-pocket expenses related to their HF. These expenses included OTC medications that insurance did not cover, low sodium foods, and travel expenses for medical appointments.

Our content analysis findings were consistent with the results of a Kaiser 2010 annual survey. This survey was conducted among employers, asking whether they reduced health benefits or increased cost-sharing with their employees due to the economic downturn. In the survey, about 33% of employers and companies reported “reducing the scope of health benefits or increasing cost-sharing,” and 23% reported increasing the share of the premiums employees pay for coverage.²⁷

The most vulnerable populations are chronically ill patients with low incomes. In this study 20% of the sample reported “can’t make ends meet” on their monthly incomes. This result was similar to another HF study¹⁸ in which 24% indicated they “can’t make ends meet.” Other studies of chronically ill patients showed significant relationships between the perceived inadequacy of income (inability to pay monthly bills) and rehospitalization and poorer quality-of-life measures for both patients and their family members.^{8,16} The inability to pay bills, coping with new lifestyle changes, and other financial constraints were the leading causes of depression among HF patients.²⁸

The high non-reimbursed costs, out-of-pocket expenses, and restricted benefits may impact families’ decisions to not seek proper healthcare services in order to make ends meet.^{3, 29} As reported in this study, 16% (n=24) of our sample reported stopping medications due to cost. Inability to adhere to prescribed medication due to cost may also lead to poor health outcomes and costly hospital readmissions.³⁰ Many patients in this study made medical healthcare decisions based on the cost or their ability to pay rather than on their health needs.³¹ A recent Cochrane review reported that direct co-payments had a major impact on reducing medication use, including life-sustaining or essential drugs to treat chronic conditions, across studies.³²

Another considerable cost is proper nutrition. Heart failure patients must adhere to low-sodium diets. Unfortunately, the cost of purchasing healthy low-sodium foods is often economically unfeasible. Patients purchase items they can afford, which are often highly processed, sodium enhanced foods. Patients often report they must choose between paying for their medications or for food, both of which impact the HF patient’s quality of life.

Transportation costs for medical care services are also sizeable expenses not recognized by providers who expect patients to make frequent visits for close monitoring in an attempt to prevent rehospitalization. Possible options to help defray this cost and promote continuity of care are education by telephone, Telemedicine or Internet interactive websites, and/or remote device monitoring that can be done at home without travel. Telephone assessment and follow-up by a nurse can also detect HF decompensation symptoms and prevent rehospitalization. Patients should be informed about the Internal Revenue Service tax deduction that can be taken for transportation expenses.³³

LIMITATIONS

The limitations to this study include the caution about generalizing beyond this largely low income population group of patients. However, all patients regardless of income level, have out-of-pocket expenses related to their chronic illnesses, of which HF is known to be expensive.³⁴ In this sample, there were five patients who reported no annual income. These

patients may have never worked and thus had no Social Security benefits. However, it is more likely they did not consider Social Security, pension, or food stamps as an “income,” and thus did not report it. Another limitation is data were not collected on public transportation costs to healthcare services. The actual cost of transportation, including public transportation, should be collected in further studies. In addition, specific costs of cardiac devices and co-payments related to these were not collected. Although the charges for the annual hospitalizations were tabulated, the costs for any cardiac rehabilitation should also be collected.

IMPLICATIONS

Health insurance resources for patients are vital factors in effective HF home care.^{28,34,35} Economic impact studies that include data collection on non-reimbursed costs should be continued among chronically ill populations, especially for African Americans and Hispanics who are likely uninsured and report worse health compared to whites.³⁶ Financial assessment and patient referral to social services to assist with expenses could provide some relief of the burden of medication costs and improve medication adherence.^{8,37} Educating providers regarding the financial burden of long-term care for chronic HF patients should be emphasized, so that referrals to social workers can take place at the point of care.

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Table I

Patient Clinical and Demographic Characteristics (n=149)

Patient Characteristics	Frequencies (n)
<i>Demographics</i>	
Age, mean years (SD)	61.1 (13.6)
Male gender, n (%)	87 (58)
Race:	
African American, n (%)	70 (47)
White, n (%)	74 (50)
Other race, or more than one race, n (%)	5 (3)
Hispanic, n (%)	10 (6.8)
Employed, n (%)	23 (15)
<i>Comorbidities</i>	
Hypertension, n (%)	135 (91)
Diabetes, n (%)	71 (48)
Chronic lung disease, n (%)	60 (40)
Sleep apnea, n (%)	47 (32)
Current smoker, n (%)	42 (28)
Charlson Comorbidity Index, mean (SD)	6.7 (2.8)
<i>Cardiac Function</i>	
Ejection fraction, mean % (SD)	30.3 (16.1)
EF>=40, n (%)	14 (7.1)
Duration of HF, mean years (SD)	6.1 (7.3)

Table 2

Type of Health Insurance Coverage (n=149)

Type of Health Insurance Coverage	Frequencies (%)
Private	26 (17.4)
Medicare	77 (51.7)
Medicaid	33 (22.1)
Military-based	12 (8.1%)
No insurance	12 (8%)
Had more than one insurance	21 (14%)
Had supplemental plans	37 (25%)

Table 3

Definition of Non-reimbursed and Out-of-pocket Health Insurance Terms

Terms	Definitions
Insurance Premium	Fees charged for medical coverage for a benefit period.
Health Insurance Deductibles	Out-of-pocket fee that is paid by the insured before the insurance coverage will begin to cover the cost of services. The deductible will apply per policy year or per occurrence (for each illness).
Health Insurance Co-payments	Fixed dollar amount or a percent of the fee for health services that is paid by the insured at the time the services are received. A co-payment is required each time a specific service such as a lab test is provided.
Co-health Insurance	The percentage of medical expenses to be paid by the insured after the deductible is exceeded.
Flexible Saving Accounts for Health Insurance	An account to set aside pre-tax money from a paycheck to pay for qualified medical expenses.
Health Savings Account	Employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year.
Lifetime Maximum Limit Benefit	The maximum dollar amount that will be covered by an insurance plan during insurer's lifetime.
Other Out-of-pocket Cost	The costs individual pays with their own funds for OTC supplies and travel/parking to health services, long distance phone calls to professionals, and other miscellaneous health-related expenditures.

Source: Health Terms available at www.bls.gov/ncs/ebs/sp/healthterms.pdf.

Table 4

Monthly Range and Median of Reported Expenses and Estimated Annual Non reimbursed Health Insurance, Out-of-pocket Costs and Additional Costs for Non-Medicaid Patients.

Reported Non-reimbursed and Out-of-pocket Cost for the HF Family	Monthly Range of Costs Reported	Monthly Median of Costs Reported	Estimated Annual Out-of-pocket Costs
Insurance Premiums			
Medical with prescription	\$20 to \$1,000	\$116	\$1,392
Insurance Deductibles			
for various health services HF rehospitalization (average 1.77 visits/year) ¹	\$1,200/yr	\$1,200/yr	\$1,200
Co-payments			
Physician visits (11 Visits/year)	\$10 to \$40	\$25	\$275
Outpatient procedures (3 visits/year)	\$200 to \$800	\$80	\$240
Prescriptions related to HF	\$3 to \$125	\$20	\$240
Out-of-pocket Expenses			
Travel ² (for medical care, pharmacy, ED, rehospitalization)	\$13/round-trip	---	\$266
OTC Medications and supplies	\$.25 to \$500	\$25	\$300
Subtotal			\$3,913
Additional Out-of-pocket Expenses (if use)			
Supplemental Prescription Plan	\$3.5 to \$700	\$87	\$1,044
Emergency (ED) visits ³	\$500/visit	\$500/visit	\$500
Emergency (ED) visits ³	Not applicable	20%	\$336
Home care assistance ⁴ (20% of \$140×12)	Not applicable	20%	\$36
Allied health services ⁵ (20% of \$90 × 2)			
Subtotal			\$1,916
Total Annually			\$5,829

¹ Medicare patients only pay for one hospitalization per benefit period.

² The guideline for estimating round-trip travel cost to health services was \$.59 per mile.

³ About 16% (n=31) of patients reported emergency (ED) visits.

⁴ About 21% (n=31) of patients reported using home health assistance.

⁵ About 17% (n=31) of patients reported using allied health/alternative care (i.e., mental health, physical therapy).