Communication with Physicians about Health Care Costs: Survey of an Insured Population

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ABSTRACT

Context: Health care costs have increasingly shifted to patients, and financial distress caused by medical care has increased. Patients may wish to discuss costs with their clinicians.

Objective: Describe patient preferences for communication about cost in the clinical setting.

Design: Cross-sectional, self-administered survey of a stratified random sample of the population insured in an integrated health care system in Washington State. Our sampling frame was the entire membership aged 21 years or older. Sampling was stratified by sex and group practice enrollment.

Main Outcome Measures: Preference for discussing health care costs with one's physician. We conducted regression analyses to determine predictors of communication preference; potential predictors included demographic characteristics, financial burden, delay in seeking care because of cost, and socioeconomic variables. Survey responses were weighted to adjust for nonresponse and sampling.

Results: Of 7200 invitations sent, 2200 survey responses were returned. Ninety-two percent wished to know their out-of-pocket costs before beginning treatment. Most respondents preferred their physician talk with them about out-of-pocket costs (81.4%) and expressed comfort with discussing costs with their physician (75.6%). Overall, 43.7% reported any delay in seeking care in the previous 12 months. One in 5 respondents (21.6%) reported family medical debt. Delay in seeking care was positively and independently associated with preferring to discuss costs with one's physician; current medical financial burden was not.

Conclusion: Patient preferences for communication about costs with physicians are high, and medical debt and delay in care-seeking are prevalent. Delay in care-seeking independently predicts cost communication preferences.

INTRODUCTION

As health care costs increase, people using health care services face increasing out-of-pocket costs and medical financial burden.[1,2] In 2014, more than 22 million Americans delayed medical care because of costs, and in 2012, more than 1 in 4 US families experienced any medical financial burden.[3,4] Medical financial burden and delay in seeking care are related to higher comorbidity and lower quality of life,[5-7] and out-of-pocket costs can cumulatively have an impact on patients and families, regardless of insurance status.[8-10]

Patients' understanding of expected out-of-pocket responsibility at the time care is delivered may improve patient-centered care,[11] but discussions about health care costs have traditionally been kept out of the clinical arena. However, patients increasingly wish to discuss costs in the clinical setting.[12-14] Patient-centered communication is associated with improved treatment decisions, patient experience, and health outcomes.[15-17] Patient preferences for discussing costs with one's clinician have not been well described.

Our aim was to describe preferences for discussing cost in the clinical setting and to identify predictors of preferences for communication about cost in an insured population. We hypothesized that people experiencing either medical financial burden or delays in seeking care because of cost concerns would be more likely to report strong preferences for communicating about cost with their physicians. Therefore, we sought to 1) describe preferences for communication about health care costs in the clinical setting, 2) determine the association between communication preference about cost and the financial burden and delay of treatment because of cost, and 3) explore other patient characteristics associated with cost communication preference.

METHODS

We conducted a self-administered cross-sectional survey of a stratified random sample of the adult population insured by Group Health Cooperative (Group Health), an integrated health care system serving nearly 600,000 people in Washington State. Our sampling frame was the entire adult membership aged 21 years or older. Sampling was stratified by sex and health plan type. Members can choose a health plan to receive care exclusively at Group Health's primary care clinics (group practice), or at their choice of clinics within a broader contracted network (network). Study recruitment also included an oversampling of members with children aged 9 to 14 years for an unrelated study aim.

A 68-item survey (available online at: www.thepermanentejournal.org/files/16-070-survey.pdf) was mailed to 7200 people between August and November 2014. So we could investigate a second, unrelated study aim looking at predictors of survey response, the mode of recruitment approach varied; some groups received a $2 preincentive, reminder follow-up calls, or invitations to complete the survey online. The analyses reported here include all survey respondents, regardless of how they were approached.

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We obtained administrative data on the entire sample to determine factors related to survey response and control for potential response bias: age, sex, race, insurance type, enrollment duration, zip code, and comorbidity measured as expected health care resource utilization.[18] The study design and methods were approved by Group Health's institutional review board.

Measures

The overall aim of the survey was to describe social determinants of health in a representative sample of the organization's membership; the survey covered a broad range of topics, but this report summarizes an analysis of the survey's questions pertaining to patients' communication preferences about cost. The measures used in this analysis include demographic characteristics, financial burden, delay in care measures, and other variables hypothesized to be associated with communication preferences.

Communication Preferences

We included seven items related to communicating about cost in the clinical setting, adapted from published work.[19] Our main item of interest was patient preference about communicating with physicians at the point of care ("I would like my doctor to talk with me about my out-of-pocket costs when s/he recommends a test or treatment"). A second item asked about communications from team members other than a physician. Other questions assessing communication preferences included two questions about the role of out-of-pocket costs in treatment decision making: one question about preferences for knowing out-of-pocket costs before treatment and one about the ease of finding cost information when needed. There was also an item about comfort discussing costs with a physician. Response options for all seven items were presented from "strongly agree" to "strongly disagree" on a five-point Likert scale.

Financial Burden and Delay in Care-Seeking

We included 4 dichotomous items adapted from the National Health Interview Survey.[3] The financial burden item asked about current medical debt for anyone in the family ("Does anyone in your family currently have any medical bills that are being paid off over time?"). Three questions asked about delay of care: "In the past 12 months, was there a time when you did not take your medication as prescribed because of cost?", "In the past 12 months, have you delayed seeking medical care because of worry about the cost?", "In the past 12 months, has anyone in your family delayed medical care because of worry about the cost?"[3] We combined the 3 delay items into a single composite dichotomous variable for "any delay in care," because of the correlation between the individual items, and for ease of interpretation in the multivariable model.

Other Potential Predictors of Communication Preference

Group Health administrative data provided information on age, sex, health plan type (group practice vs network), duration of enrollment with Group Health, insurance type (commercial, Medicare, or Medicaid), and comorbidity measured by expected health care utilization (resource utilization band [RUB] or The Johns Hopkins Adjusted Clinical Groups System).[18] These data were based on diagnostic and procedure codes in the prior year. The survey collected information on other potential predictors, including demographic and socioeconomic measures (race and Hispanic ethnicity, education, household income, marital status, employment status, and home ownership), likelihood of recommending Group Health to friends or family, and the number of days with poor physical or mental health in the previous month.

Table 1. Sample characteristics (N = 2220)

Characteristic	n[a]	Weighted % (SE)
Women[b]	1198	55.6 (1.2)
Age, years[b]		
18-44	551	38.5 (1.3)
45-64	914	39.4 (1.2)
≥ 65	755	22.1 (0.8)
Race		
White non-Hispanic	1802	81.5 (1.0)
Asian non-Hispanic	163	7.5 (0.6)
Other	227	11.0 (0.8)
Marital status		
Married or living with partner	1587	71.2 (1.1)
Divorced, separated, or widowed	420	15.0 (0.8)
Single	198	13.8 (1.0)
Home ownership		
Own	1696	72.2 (1.2)
Rent	374	22.3 (1.1)
Other	91	5.6 (0.6)
Insurance type[b]		
Medicare	617	18.2 (0.7)
Medicaid	32	2.5 (0.5)
Commercial	1571	79.3 (0.8)
Resource utilization band (RUB)[b]		
Low (0-2)	574	33.0 (1.2)
Medium (3)	1068	46.8 (1.2)
High (4-5)	521	20.2 (0.9)
Days in poor physical health		
0	1138	52.1 (1.2)
1-15	822	39.0 (1.2)
≥ 16	191	8.9 (0.7)
Days in poor mental health		
0	1191	52.3 (1.2)
1-15	818	39.8 (1.2)
≥ 16	146	7.9 (0.7)
Other characteristics		
Education, 4-year college or more	1165	51.8 (1.2)
Household income in 2013 of $75,000 or more	893	42.6 (1.2)
Not employed	915	34.9 (1.1)
Enrolled in group practice (yes)[b]	1642	65.3 (1.2)
Group Health enrollment duration ≥ 10 years[b]	1260	47.8 (1.2)
Would not recommend Group Health (score 0-7)	842	42.4 (1.2)

[a] Missing values: race (n = 28), marital status (n = 15), education (n = 15), income (n = 173), employment (n = 38), home ownership (n = 59), enrollment duration (n = 5), RUB (n = 57), physical health (n = 69), and mental health (n = 65).
[b] From administrative data.
SE = standard error.

Statistical Analysis

We used administrative data on the entire Group Health-enrolled population to compute sampling probabilities in each of our sampling strata, defined by sex, health plan type (group practice vs network), and parent of an enrolled child aged 9 to 14 years. From the original sample of 7200, we received 2220 responses (30.8%). The probability of responding to the survey adjusting for characteristics related to survey response, including age, sex, group practice, and parental status, was estimated using logistic regression. We used the product of the inverse of the sampling and the estimated response probabilities to create a combined weight to use in our analyses, to control for response bias, and to create estimates generalizable to the entire sampling frame.

To summarize the demographic and socioeconomic characteristics as well as the financial burden, delay in care, and communication preference measures of the study population, we used descriptive statistics computed using the analytic weights described earlier. Spearman rank correlation coefficients were used to assess the correlation between the 7 cost communication measures. We examined the bivariate distributions between all study covariates and preference for communication with one's physician about costs. To identify variables independently associated with our primary communication outcome, we fit modified Poisson regression models to directly estimate unadjusted relative risks associated with each variable. Next, we fit a multivariable model with all covariates significantly related to our communication item at p value ≤ 0.10. Age and sex were retained in the model regardless of their bivariate associations, as were financial burden and delay in seeking care because of their hypothesized relationship to communication preference. Analytic weights were used throughout the analysis.

Analyses were conducted using STATA version 13 statistical software (StataCorp LLC, College Station, TX).[20]

RESULTS

With use of weighted estimates, the study population (N = 2220) was predominantly women, married, and white, and more than 60% were aged 45 years or older (Table 1). Fifty-two percent (51.8%) reported having earned a 4-year college degree or greater. Most were private insurance holders (79.3%) rather than recipients of Medicare or Medicaid; 65.3% were enrolled in the group practice division compared with the external contracted network, and nearly half were enrolled with Group Health for 10 years or more. Most reported owning their own home and being employed. Forty-two percent reported a household income of $75,000 or more (see Table 1).

Communication Preferences

Responses to the cost communication items appear in Table 2. Most (81.4%) either strongly agreed or agreed with preferring that their physician talk with them about their out-of-pocket costs when treatment is recommended, and most (92%) wished to know their out-of-pocket costs before beginning treatment. Three-fourths (75.6%) reported being comfortable discussing the costs of care with their physician; 20.9% preferred to

Table 2. Cost communication items

Survey item wording and response option	n	Weighted % (SE)
I would like my doctor to talk with me about my out-of-pocket costs when s/he recommends a test or treatment. (Primary outcome)		
Strongly agree	771	37.1 (1.2)
Agree	977	44.3 (1.2)
Neutral	301	12.7 (0.8)
Disagree	110	4.6 (0.5)
Strongly disagree	36	1.3 (0.2)
Missing	25	
I am comfortable talking about the cost of my care with my doctor.		
Strongly agree	667	31.1 (1.1)
Agree	996	44.5 (1.2)
Neutral	350	15.4 (0.9)
Disagree	159	8.0 (0.7)
Strongly disagree	24	1.1 (0.3)
Missing	24	
I would prefer to discuss the cost of my care with someone other than my doctor, such as a nurse, social worker, or financial counselor.		
Strongly agree	129	6.2 (0.6)
Agree	303	14.7 (0.9)
Neutral	1039	48.0 (1.2)
Disagree	549	23.9 (1.0)
Strongly disagree	168	7.2 (0.6)
Missing	32	
I prefer to know about the out-of-pocket costs for my treatment before I am treated.		
Strongly agree	1319	62.7 (1.2)
Agree	663	29.3 (1.1)
Neutral	160	6.0 (0.5)
Disagree	42	1.4 (0.2)
Strongly disagree	14	0.5 (0.2)
Missing	22	
I can find information about the cost of my health care when I need it.		
Strongly agree	289	12.5 (0.8)
Agree	800	34.8 (1.2)
Neutral	574	27.1 (1.1)
Disagree	409	19.7 (1.0)
Strongly disagree	119	5.9 (0.6)
Missing	29	
My doctor should consider my out-of-pocket costs as s/he makes a medical decision.		
Strongly agree	544	26.7 (1.1)
Agree	804	36.2 (1.2)
Neutral	421	19.3 (1.0)
Disagree	302	12.7 (0.8)
Strongly disagree	123	5.1 (0.5)
Missing	26	
I consider my out-of-pocket costs when I make a decision about my care.		
Strongly agree	672	34.5 (1.2)
Agree	885	40.3 (1.2)
Neutral	298	12.6 (0.8)
Disagree	266	10.2 (0.7)
Strongly disagree	72	2.4 (0.3)
Missing	27	

SE = standard error.

discuss costs with a nonphysician team member. The majority (62.9%) indicated that their physician should consider the patient's out-of-pocket costs when making medical decisions, and 74.8% reported considering out-of-pocket costs before making decisions for their own care. However, less than half (47.3%) reported that they could find information about health care costs when needed.

The cost communication questions tended to be moderately correlated (Table 3), particularly the questions about wanting to know about, talk about, and consider costs before treatment. The questions on preferring to discuss costs with someone other than their physician and being able to find information about costs were not meaningfully correlated with other questions.

Financial Burden and Delay in Care-Seeking

One in 5 people (21.6%) reported current family medical debt (Table 4). One in 10 (10.9%) reported delaying using medication because of cost in the previous 12 months; nearly one-third reported having delayed medical care because of worry about cost, either care for themselves (31.5%) or for a family member (32.3%). Overall, 43.7% reported one or more care-delaying behaviors. In unadjusted analyses, people with current medical financial debt were slightly more likely to prefer talking about out-of-pocket costs with their physician at the point of care compared with people who did not; this difference was not statistically significant. In contrast, people with delay in seeking care were significantly more likely to want to talk about costs with their

Table 3. Correlation between cost communication items

Communication item	Spearman rank correlation coefficient by item						
	1[a]	2	3	4	5	6	7
1. I would like my doctor to talk with me about my out-of-pocket costs when s/he recommends a test or treatment.	1.00	0.49[b]	-0.12[b]	0.45[c]	-0.03	0.53[b]	0.45[b]
2. I am comfortable talking about the cost of my care with my doctor.		1.00	-0.14[b]	0.28[b]	0.15[b]	0.32[b]	0.27[b]
3. I would prefer to discuss the cost of my care with someone other than my doctor, such as a nurse, social worker, or financial counselor.			1.00	0.04	0.04[c]	0.02	0.06[b]
4. I prefer to know about the out-of-pocket costs for my treatment before I am treated.				1.00	-0.03	0.32[b]	0.48[b]
5. I can find information about the cost of my health care when I need it.					1.00	-0.01	0.02
6. My doctor should consider my out-of-pocket costs as s/he makes a medical decision.						1.00	0.48[b]
7. I consider my out-of-pocket costs when I make a decision about my care.							1.00

[a] These questions appear with different numbers in the survey.
[b] $p < 0.01$.
[c] $p > 0.01$ but < 0.05.

Table 4. Bivariate associations: Communication preferences and medical financial burden and delay in care-seeking

Question	Reported burden or delay because of costs		I would like my doctor to talk with me about my out-of-pocket costs when s/he recommends a test or treatment ("Agree" or "Strongly agree")		
	n[a]	Weighted % (SE)	Weighted % (SE)	Relative risk (95% CI)	p value
Burden					
Does anyone in your family currently have any medical bills that are being paid off over time?					
No	1781	78.4 (1.1)	80.6 (1.0)	Referent	0.15
Yes	417	21.6 (1.1)	83.9 (2.0)	1.04 (0.99-1.10)	
Delay					
In the past 12 months, was there a time when you did not take your medication as prescribed because of cost? Do not include over-the-counter medication.					
No	1988	89.1 (0.8)	80.6 (1.0)	Referent	0.01
Yes	212	10.9 (0.8)	87.8 (2.5)	1.09 (1.02-1.16)	
In the past 12 months, have you delayed seeking medical care because of worry about the cost?					
No	1625	68.5 (1.2)	78.5 (1.1)	Referent	< 0.01
Yes	572	31.5 (1.2)	87.7 (1.5)	1.12 (1.07-1.17)	
In the past 12 months, has anyone in your family delayed medical care because of worry about the cost?					
No	1582	67.7 (1.2)	78.0 (1.2)	Referent	< 0.01
Yes	608	32.3 (1.2)	88.7 (1.4)	1.14 (1.09-1.19)	
Any delay due to cost[b]					
No	1392	56.3 (1.2)	77.8 (1.2)	Referent	< 0.01
Yes	818	43.7 (1.2)	85.9 (1.3)	1.10 (1.06-1.15)	

[a] Missing values: burden (n = 22), delay medications (n = 20), delay care-self (n = 23), and delay care-family (n = 30).
[b] Ten respondents did not respond to any of the delay items and were coded as missing.
CI = confidence interval; SE = standard error.

physician, with relative risks ranging from 1.09 (95% confidence interval [CI] = 1.02-1.16, delayed medication) to 1.14 (CI = 1.09-1.19, delayed care for family member).

Characteristics Associated with Preference for Talking about Out-of-Pocket Costs

Characteristics associated with wanting to talk about costs with one's physician included younger age, nonwhite race, annual household income below $75,000, currently employed, Medicare/Medicaid insurance, shorter enrollment duration, low likelihood of recommending Group Health, and low resource utilization (Table 5).

In multivariable analysis, delay in seeking care remained an independent positive predictor of communication preference (relative risk = 1.06, 95% CI = 1.01-1.12; Table 6); lower income and low likelihood of recommending Group Health were the only other independent predictors. Current financial burden, age, sex, employment, home ownership, enrollment duration, insurance type, and predicted resource utilization were not independently associated with communication preferences.

DISCUSSION

We conducted a cross-sectional, self-administered survey of a population-based sample of an integrated health care system membership in the Pacific Northwest. We found that most participants prefer communication about cost with their physicians. Delays in seeking care because of cost and current medical financial burden were notably prevalent in our sample, and preferences for physician communication of out-of-pocket costs were higher among patients reporting delay in seeking care. In multivariable analyses, delay in care emerged as an independent predictor of communication preferences, whereas current medical financial burden did not. Other independent predictors of preferring communication with one's physician about out-of-pocket costs were lower income and lower likelihood to recommend Group Health.

We found higher levels both for wanting to know costs before treatment (92%) and preferences for discussing costs (81%) than in previous reports.[19,21] A survey of people with cancer found high preferences for knowing costs before treatment initiation (68%) and for discussing costs with one's physician

Table 5. Bivariate estimates: Characteristics associated with communication preferences[a]

Characteristic	Weighted % (SE)	Relative risk (95% CI)	p value
Age, years			
18-44	86.1 (1.6)	Referent	< 0.01
45-64	80.2 (1.4)	0.93 (0.89-0.98)	
≥ 65	75.1 (1.6)	0.87 (0.83-0.92)	
Sex			
Men	79.9 (1.4)	Referent	0.16
Women	82.5 (1.2)	1.03 (0.99-1.08)	
Race			
White non-Hispanic	80.7 (1.0)	Referent	< 0.01
Asian non-Hispanic	89.9 (2.6)	1.11 (1.05-1.18)	
Other	83.4 (2.8)	1.03 (0.96-1.11)	
Marital status			
Married or living with partner	81.0 (1.1)	Referent	0.30
Divorced, separated, or widowed	80.9 (2.1)	1.05 (0.99-1.12)	
Single	85.1 (2.5)	1.05 (0.99-1.12)	
Education			
Less than 4-year college degree	82.6 (1.3)	Referent	0.21
4 years college or more	80.3 (1.3)	0.97 (0.93-1.02)	
Income			
< $75,000	84.0 (1.2)	Referent	< 0.01
≥ $75,000	78.3 (1.5)	0.92 (0.89-0.98)	
Employed			
Yes	84.1 (1.1)	Referent	< 0.01
No	76.3 (1.5)	0.91 (0.86-0.95)	
Own home			
No	84.8 (1.8)	Referent	0.02
Yes	79.9 (1.1)	0.94 (0.90-0.99)	
Insurance type			
Commercial	74.2 (1.8)	Referent	< 0.01
Medicare/Medicaid	83.0 (1.0)	1.12 (1.06-1.18)	
Enrolled in group practice			
No	82.8 (1.7)	Referent	0.27
Yes	80.6 (1.1)	0.97 (0.93-1.02)	
Enrollment duration, years			
< 10	84.7 (1.3)	Referent	< 0.01
≥ 10	77.6 (1.3)	0.92 (0.88-0.96)	
Would recommend Group Health			
Yes (score 8-10)	78.7 (1.3)	Referent	< 0.01
No (score 0-7)	85.1 (1.3)	1.08 (1.04-1.13)	
Resource utilization band			
Low (0-2)	84.5 (1.7)	Referent	< 0.01
Medium (3)	82.1 (1.3)	0.97 (0.93-1.02)	
High (4-5)	74.3 (2.1)	0.88 (0.82-0.94)	
Days in poor physical health			
0	83.2 (1.2)	Referent	0.13
1-15	79.7 (1.6)	0.96 (0.91-1.00)	
≥ 16	78.8 (3.0)	0.95 (0.87-1.03)	
Days in poor mental health			
0	81.4 (1.3)	Referent	0.88
1-15	81.0 (1.5)	1.00 (0.95-1.04)	
≥ 16	82.7 (3.1)	1.02 (0.94-1.10)	

[a] Communication preference defined as responding "strongly agree" or "agree" to the survey statement, "I would like my doctor to talk with me about my out-of-pocket costs when s/he recommends a test or treatment."

CI = confidence interval; SE = standard error.

(59%)[19]; other surveys of cancer populations have found similar results.[13,22] Prior work on clinic-based cost communication has focused on people with cancer, whereas our sample is a broad sample of an insured population. Because more than half of Americans have tried to locate cost information before receiving care,[12p11] it is not clear whether the higher levels of preference for cost communication in our study reflect temporal changes in patient preferences over time, or differences between the preferences of an insured population overall compared with cancer-specific populations. The reasons for these differences should be explored in future studies.

One in 5 enrollees reported medical debt, comparable with national estimates.[21] We found higher rates (31.4%) of cost-related delay in seeking care compared with estimates from the Centers for Disease Control and Prevention of 7.1% in an insured population,[22] although this may reflect Washington State's higher estimates compared with national estimates (12.5% vs 9.9% in 2011-2012).[23] Delay in seeking care may be as high as 57% in people with low income and health insurance deductibles greater than $500, although financial burden measures may be only moderately reliable in this population.[24] One in 10 people (10.9%) in our sample experienced a delay in using a prescribed medication compared with 6.1% of adults aged 18 to 64 years with private coverage reported in the 2013 National Health Interview Survey.[3]

Table 6. Multivariate model: Characteristics associated with communication preference[a]

Characteristic	Relative risk (95% CI)	p value
Any financial burden	0.99 (0.93-1.05)	0.65
Any delay in care because of cost	1.06 (1.01-1.12)	0.03
Women	1.02 (0.97-1.07)	0.40
Age, years		
21-44	Referent	0.65
45-64	0.98 (0.92-1.03)	
≥ 65	0.96 (0.86-1.08)	
Race		
White	Referent	0.24
Asian non-Hispanic	1.06 (0.98-1.15)	
Other	0.98 (0.90-1.06)	
Resource utilization band (RUB)		
Low (0-2)	Referent	0.24
Medium (3)	1.00 (0.95-1.06)	
High (4-5)	0.94 (0.87-1.02)	
Other characteristics		
Household income ≥ $75,000	0.93 (0.88-0.99)	0.01
Not employed	0.95 (0.90-1.01)	0.12
Own home	0.99 (0.93-1.04)	0.62
Medicare/Medicaid	1.00 (0.90-1.12)	0.93
Enrolled ≥ 10 years	0.96 (0.91-1.01)	0.11
Would not recommend Group Health	1.07 (1.02-1.13)	0.01

[a] Communication preference defined as responding "strongly agree" or "agree" to the survey statement, "I would like my doctor to talk with me about my out-of-pocket costs when s/he recommends a test or treatment."

CI = confidence interval.

We hypothesized that financial burden and delay in seeking care would both be independently related to communication preferences, but only delay in seeking care emerged as an independent predictor. This finding may suggest that it may be "too late" to intervene with cost communications in those who have already incurred medical debt, but it may also suggest an opportunity for physicians to intervene during clinical encounters, which is supported by other studies.[25,26] It may also suggest opportunities for outreach to patients to reassure that cost concerns will be addressed proactively, and to encourage timely care. Further prospective studies can examine the best ways to meet patients' needs for financial information at the point of care without adversely affecting clinic flow or patient experience.

We acknowledge several limitations. The response rate to the survey was low, but it was similar to large national surveys[27] and offset by our use of sampling frame data to conduct weighted analyses accounting for nonresponse and for unbalanced sampling probabilities.[28] Although we adjusted for age, the main predictor of response, and comorbidity in the multivariable model, unmeasured sources of bias could remain. For example, people who had experienced medical financial burden or delay in care may have been more likely to respond to the survey. However, financial burden and delay are more prevalent in younger age groups, whereas older people were most likely to respond to the survey. Furthermore, these questions were embedded in a larger survey, so we do not expect differential response rate based on financial burden or delays in seeking care alone.

Our data reflect the experiences of people in a single integrated care system and may have limited generalizability to other populations. However, we were intentionally as minimally restrictive in our sampling strategy as possible to increase generalizability, the organization's membership mirrors the socioeconomic demographics of the state's insured population, and we found no differences in preferences on the basis of whether care is provided in Group Health group practice clinics. Nonetheless, our findings should be explored in other populations.

Finally, our use of items from previously published studies was intended to ease benchmarking to other work, but biases in the interpretation or design of specific items designed for other surveys may remain.

CONCLUSION

Our study findings add to the growing evidence base that people are comfortable with and want direct communication about their costs in the clinical setting. Communication about costs is associated with medication adherence and out-of-pocket spending[11,29] and may affect health outcomes over time.[30,31] Physicians are increasingly in favor of cost data being available in the clinical setting[29] and in the expansion of the traditional medical role to include screening for and assistance with financial distress.[25,32-37] Early evidence suggests that it is feasible to present costs in the clinical setting,[38-40] and multiple organizations have implemented price transparency initiatives that provide pricing for planned or bundled services. However, strategies for assessing patients' financial need, optimal clinical workflow and physician health care team access to prices, and presentation of

price information are still not well understood and likely vary across health care systems. Our study results affirm that health insurance does not protect from financial hardship or delay in seeking care because of medical expenses,[41,42] even in an era after the Affordable Care Act,[43] and these patient-reported situations remain prevalent. Our study findings also affirm that a significant portion of patients have difficulty locating information about health care costs; most prefer communication about out-of-pocket costs at the point of care, and most prefer it with a physician and not another member of the team. The degree to which assurance of communication about costs with one's physician can reassure patients and avoid either delay in seeking care or medical debt deserves further study. However, given these clear patient preferences and the mounting evidence that physicians themselves are willing to help address patients' financial considerations, health care systems and organizations have a clear mandate for action, and clinic-based tools to aid in communication about costs should be available. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

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A Social System

A physician and a patient taken together make up a social system. They do so because they are two and because they have relations of mutual dependence. Also they are heterogeneous, they manifest sentiments, they have economic interests, they talk, reason, pretend to reason, and rationalize.

— Lawrence Joseph Henderson, 1878-1942, American physiologist, chemist, biologist, philosopher, and sociologist