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Hiding in plain sight: The health care gender toll

Out-of-pocket cost for health care is estimated to be \$15B more per year for employed women than it is for employed men, widening the effects of a wage disparity between women and men. Businesses can examine benefit coverage to make health care more affordable for female employees.

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Executive summary

Our analysis indicates that based on current benefit coverage, women's out-of-pocket medical costs are disproportionately higher than men's for every single age grouping from 19 to 64, even when excluding pregnancy-related services. On average, under single coverage, female employees have approximately \$266 more out-of-pocket spending per year than male employees (just over 18% more than men's out-of-pocket costs), which excludes pregnancy-related services.

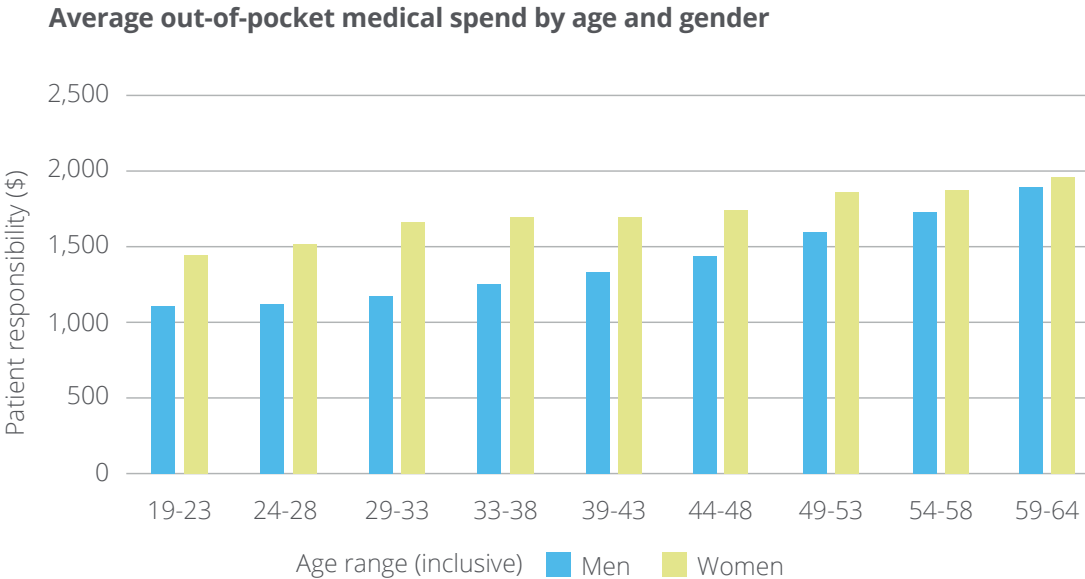
While employers are required to offer insurance premiums at equal costs to women and men, premiums are only part of the financial story.¹ To understand the full financial impact of the cost of health care benefits on income, Deloitte's health actuarial team examined the impact of the average benefit design on the out-of-pocket financial costs for women when accessing health care services. (Figure 1 shows the differences by age and gender.) Results of our analysis indicate that health insurance products may indirectly create a gap in net income for working women.

Numerous studies have already estimated the gender wage disparity, indicating that women earn approximately \$0.82 on the dollar relative to men, and Black and Latinx women earn \$0.70

and \$0.65, respectively, relative to White men.² This combination of higher health care expenditures and the gender wage gap can negatively impact the financial and health status for employed women, potentially creating a choice between the care women need and the care they can afford.

This is not the only consumer product that appears to be uneven for men and women. The exact same product marketed for women is often priced higher, colloquially referred to as the "pink tax," from travel kits and razors to laxatives and kids' bike helmets.³ Health insurance is a product, but the additional expenditures incurred by women, which have received relatively less attention in recent studies, are now becoming more apparent. Health care insurers and employers have an opportunity to examine and redesign benefit coverage to help reduce the financial burden placed on women. This can drive equity in organizations and help to achieve optimal health and well-being for women and men alike.

Figure 1: Employer-sponsored coverage: Average out-of-pocket medical expenditures in 2021, excluding maternity claims



Breaking down the gap: With and without maternity claims

Historically, health care benefits have generally been designed and regulated with more standardization and more consistent coverage. The passage of the Affordable Care Act in 2010 defined standards for essential health benefits and expanded coverage to include maternity care, pregnancy, newborn care, and mammograms as examples.⁴ While the expansion of coverage and inclusion of women's services seemed to be a step toward creating more consistent care in the United States, it did not solve for the higher out-of-pocket health expenses women experience.

While women and men tend to have many care needs that are comparable, there are numerous services that may only impact a particular gender. For women, this could be pregnancy and delivery of a child. It is possible that those financial burdens might be split with a significant other, but this does not reflect the births in America today. In a recently released study, 40% of births in the United States are from unmarried women.⁵ The average out-of-pocket cost for a single delivery is around \$2,900 for mothers.⁶ Maternity and delivery are an example demonstrating the extra financial burden placed on women, but maternity and delivery are not the only contributing factors to this financial gap.

For the purpose of this analysis, we are using women/female and men/male interchangeably, which is based upon the sex identified in claims data. We acknowledge that not all people are represented within this binary, and costs associated with women's health services can extend to individuals who do not identify as women.

Deloitte's analysis took a sample of more than 16 million lives under employer-sponsored coverage (ages 19 and older, including self-insured, fully insured, and a mix of employers by size) and applied the average medical benefit design to each employee as if they had single coverage, both with and without the inclusion of maternity-related care. The results show that maternity is only a small part of a much larger gap. On average in 2021 for all medical claims reviewed, women (from ages 19 to 64) paid 20% more than men in out-of-pocket expenditures. Removing all relevant maternity claims (defined in the appendix) closed this difference in out-of-pocket spend by less than 2%. Extrapolating this 18% difference and applying it to women

who are insured through their employer within the dataset⁷ finds that women are spending an additional \$15.4 billion out-of-pocket on health care expenditures annually.

This \$15.4 billion burden on women was not just the result of maternity claims, so we needed to understand it more. We validated that women seek more health care and more treatment than men. This utilization difference holds true even when excluding maternity claims from the analysis. In fact, women experience 10% more in total health expenditures relative to men when excluding maternity claims, but this would not explain why out-of-pocket expenditures are 18% higher. We followed up with an analysis on coverage (i.e., the actuarial value of benefits—see definition) between genders.

Our findings indicated that the actuarial value of benefits was lower for women compared to men in aggregate. This held true whether maternity claims were included or excluded from the analysis. Notably, the benefits were consistently lower for women across all age groups except for the range of ages between 30 and 51. This age range generally corresponds to the latter portion of women's childbearing years, perimenopause, and menopause. As women seem to be reaching their deductibles more frequently during these stages of life, we would expect their actuarial values to be higher. Nevertheless, beyond these years, a trend emerges when observing women's life spans in their entirety: Women consistently derive lesser value for each health care premium dollar spent. Employers may possess the ability to help close this \$15.4 billion expenditure gap—at the approximate cost of \$133 per enrolled employee annually—through enhanced benefit designs from health insurers, creating financial equity in their health care benefits.

Definition: Actuarial value

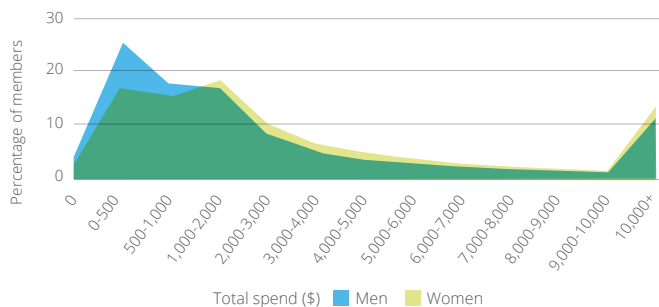
The ratio of average coverage provided by the insurance carrier for the population. For example, if the actuarial value is 80%, then a person who has a total amount of health claims of \$1,000 in a year would on average have out-of-pocket expenditures of \$200 = $\$1,000 * (100\% - 80\%)$

The analysis details

To determine the financial burden from out-of-pocket medical expenses, Deloitte’s health actuarial team applied the average deductible, coinsurance, and out-of-pocket maximums (excluding the required care covered under the Affordable Care Act as preventive from cost-sharing requirements)⁸ to a 25% sample derived from Komodo’s Healthcare Map™, a payer database that includes employer-sponsored member lives (more than 16 million lives used in the sample).⁹ These claims represent the full set of medical services for each enrolled member over the course of their enrolled months. The results were split for women and men. Figure 2 shows the overall spend for women and men, which has implications on the out-of-pocket spend.

Our investigation revealed variations in health care consumption patterns between women and men. Men are generally more than twice as likely as women to wait more than two years between visits to see a health care professional.¹⁰ And when they do seek care, men more often have fewer services: 46% of men in the study have less than \$1,000 in claims annually compared to 35% for women. Women generally encounter medical services that surpass the typical deductible, leading to higher out-of-pocket payments.

Figure 2: 2021 commercial total medical claims spend



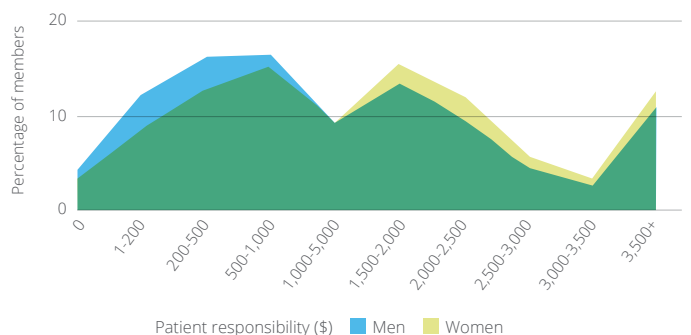
Additionally, they tend to reach their out-of-pocket maximums more frequently. Several factors appear to contribute to this divergence in health care utilization patterns, including early-age recommendations for annual checkups, high frequency of gynecological examinations,¹¹ the relatively high cost of breast cancer imaging compared to other types of cancer,¹² and the effects of menopausal transitions, among various others.

When our actuarial team ran the spend against the average benefit design, the results showed the contrast of two important elements: total expenditures for women and men and *actuarial value*. Figure 3 shows the differences between men and women’s out-of-pocket expenditures.

For employer-sponsored plans, women spend more in health care costs than men on average, but their actuarial value is lower on average and lower for a majority of age bands. Women pay more dollars out-of-pocket than men and tend to get less coverage for every premium dollar spent.

If solving for only the difference in actuarial value for women covered under employer-sponsored coverage, defined as ages 19 to 64 in this case, the value needed to close this gap is \$1.34 billion when excluding maternity claims and applying to the entire working population. While the amount is large, closing this gap using enhanced products that modify cost sharing for certain services would likely cost the average employer offering coverage less than \$12 per employee per year, or less than \$1 per month.

Figure 3: Employer-sponsored coverage: Out-of-pocket spend by percentage of members (excluding maternity)



What could be the solution?

Deloitte's examination underscores an opportunity within the health care industry, yet it establishes a foundational step toward addressing this gap. The team delved into the services, based on the same 16 million covered lives (using the same methodology outlined in the appendix), that women tend to seek or receive at a higher frequency compared to men. The investigation revealed the following categories as the predominant ones (figure 4).

Figure 4: Employer-sponsored plans

Key categories of spend for women (beyond maternity)

Radiology
Laboratory
Mental health
Emergency room
Office visits
Physical therapy/occupational therapy
Chiropractic

After conducting a detailed analysis of these categories, we have identified some proactive measures that health care insurers can undertake to help enhance financial well-being. This, in turn, could foster improvements in physical health and overall well-being:

- Perform the analysis on your own members and benefits—understand the unique and universal needs of your membership based on demographic and health needs.
- Modify and update benefits for all members—cost-sharing design should be tailored to the needs of your membership to help advance financial and health equity.
- Work with health care providers to understand how to reduce the financial burden for identified benefits and services.
- Create a communication plan for your plan sponsors, sales agents, and brokers on why this investment can have a positive impact.
- Continuously monitor the intended and potentially unintended consequences of your benefit and coverage design with an eye toward creating financial equity.

- While there are some limitations on the agency that health insurers have on benefits, such as the rules regulating benefits for high-deductible health plans,¹³ work to create advocacy for change that can enable more fair and equitable products and out-of-pocket expenditures across all genders.

Health insurers are not alone in working toward equity in this area. Organizations that offer or support the coverage of an individual should be evaluating the equity of out-of-pocket expenditures. Business leaders and employers can consider taking the following actions to help advance health and well-being:

- Examine benefit coverage (premiums and out-of-pocket expenditures together) as it applies to the needs of men, women, and nonbinary individuals in your workforce. Understand the financial and accessibility impact of the choices based on sex and gender.
- Work with your health insurance carrier(s) to understand how benefits could be modified and revised to help close any gaps or disparities in financial or health outcomes.
- Create a process and communication plan to drive adoption and enrollment for benefit coverage that represents the broad range of needs across population cohorts in your workforce.
- Evaluate the trade-offs of making this an investment in your employees. Organizations could embrace this move as a way to drive equity and purpose in the organization.

Don't forget maternity

Coverage of maternity claims creates a different scenario. Our analysis shows an increase in actuarial value during childbearing years because women who deliver a child tend to reach their out-of-pocket maximum during pregnancy and therefore start receiving 100% of their care covered through insurance. Given this is one of the experiences that generally has no comparable experience for a man, any recommendations to change out-of-pocket expenditures should be inclusive of maternity.

Closing the benefit gap can help drive health equity

In collaboration with the Deloitte Health Equity Institute, Deloitte's Life Sciences and Health Care practice is committed to advancing health equity to make an impact that matters. In our commitment to health equity, we are creating cross-sector collaborations and tools aimed at addressing disparities in the drivers of health, racism and bias, and structural flaws in the health system. An aspiration is to create exponential change that will lead to a world in which health is not determined by race, gender, ability status, or ZIP code, to name a few. One in which all people have the fair and just opportunity to achieve their full potential in every aspect of their health and well-being.

There may be a strong link between income and health and well-being. Our analysis highlights a challenge and opportunity for US women who are facing disproportionate out-of-pocket health care costs in comparison to men. Health care and business leaders have a real opportunity to create meaningful change for their workforce. Based on the data on medical costs for women, we recommend an intentional review of benefit design coverage with focused analysis of impact on men, women, and individuals of any gender. This could contribute toward making better health and well-being more accessible to all.



The health benefit gap: summary of key analysis findings

Overall, women have disproportionately more out-of-pocket health expenses than men



Overall, women pay

\$15.4 billion more

than men in annual out-of-pocket health care expenses, not including premium costs.

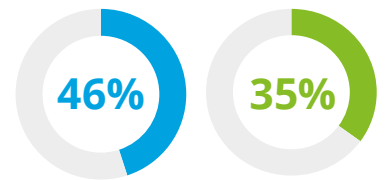


This generally translates to **18% more** than men in annual out-of-pocket expenses



For all ages from **19 to 64**

the average woman pays more out-of-pocket than the average man of the same age, even when excluding maternity claims.



46% of men tend to have \$1,000 or less in out-of-pocket expenditures, as opposed to only **35%** of women.



The actuarial value of US employer-sponsored coverage for women is

\$1.34 billion less

than coverage for men of the same age (19–64)

To cover this actuarial value gap, it would generally cost employers less than

\$12

per employee per year

Appendix

The methodology employed in our study involved the utilization of health insurance data from the Komodo Healthcare Map™. This dataset encompasses enrollment history and health care claims for medical benefits (excluding pharmacy) from all settings of care sourced from payers nationwide 2017–2022.

Within the Komodo database, we accessed information pertaining to the type of service received based on codes (DRG, CPT, HCPC, ICD-10), the place of service (inpatient, outpatient, professional), and the total medical allowed amounts. We categorized by gender (male or female) and age. The analyses performed included and excluded maternity-related claims. In all scenarios, the analysis excluded preventive services (see appendix table B for a list of excluded preventive services) from any medical patient responsibility. We analyzed the data against the average commercial benefit design for single coverage using continuance tables applied to each member included in the analysis.

To establish a benchmark for our analysis, we referred to the 2022 KFF Employer Health Benefit Survey. According to the survey, the typical medical benefit design for individuals with single coverage encompassed an annual coinsurance rate of 20%, an annual deductible amounting to \$1,763, and an annual out-of-pocket maximum of \$4,355.¹⁴

Maternity has a large influence on women's health care expenditures, so our analysis evaluated medical expenses both with and without the inclusion of maternity claims. To identify inpatient, outpatient, and professional maternity claims, we employed specific diagnosis-related groups (DRGs) and procedure codes (see appendix table A).

The Deloitte health actuaries examined the distribution of allowed amounts and patient responsibility to evaluate any disparities. Information on total health care allowed and total out-of-pocket patient responsibility was performed across all ages split between men and women to produce our findings.

Appendix code tables

Table A. Maternity: Diagnosis-related groups (DRGs) and procedure codes

DRGs	Procedure codes
765, 766, 783, 784, 785, 786, 787, 788, 767, 768, 774, 775, 796, 797, 798, 805, 806, 807, 792, 793, 795, 789, 791, 794, 769, 770, 776, 777, 778, 779, 780, 781, 782, 817, 818, 819, 831, 832, 833	≥59000 and ≤59399, ≥59400 and ≤59414, ≥59415 and ≤59509, ≥59510 and ≤59515, ≥59610 and ≤59614, ≥59618 and ≤59622, ≥59812 and ≤59866, 59525, 59870, 59871, 59897, 59898, 59899, 99381, 99391, 99432, 99461

Table B. Preventive services: Procedure codes¹⁵

Preventive service	CPT/HCPCS code
Abdominal aortic aneurysm screening	G0389
Alcohol misuse screening and counseling	G0442, G0443
Aspirin use	G8598
Annual wellness visit	99381, 99382, 99382, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99497, 99498, G0402, G0438, G0439, G0468
Blood pressure screening, cardiovascular disease screening, cholesterol screening, and statin preventive medications	80061, 82465, 83718, 84478
Bone mass measurements	76977, 77078, 77080, 77081, 77085, G0130
Breast cancer screening	77067, 77063
Cervical cancer screening	Q0091, G0476
Colorectal cancer screening	81528, 82270, 00812, G0104, G0105, G0106, G0120, G0121, G0327, G0328
Counseling to prevent tobacco use	99406, 99407
Depression screening	96127, G0444
Diabetes screening	82947, 82950, 82951, 82952, 82962, 83037
Diabetes self-management training (DSMT)	G0108, G0109
Glaucoma screening	G0117, G0118
Hepatitis B virus (HBV) screening	86704, 86706, 87340, 87341, G0499
Hepatitis B virus (HBV) vaccine and administration	90739, 90740, 90743, 90744, 90746, 90747, G0010
Hepatitis C virus (HCV) screening	G0472
Human immunodeficiency virus (HIV) screening	80081, G0432, G0433, G0435, G0475
Influenza virus vaccine and administration	90662, 90756, 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90689, Q2034, Q2035, Q2036, Q2037, Q2038, G0008
Initial preventive physical examination (IPPE)	G0402, G0403, G0404, G0405, G0468
Intensive behavioral therapy (IBT) for cardiovascular disease (CVD)	G0446
Lung cancer screening counseling and annual screening for lung cancer with low-dose computed tomography (LDCT)	G0296, G0297
Medical nutrition therapy (MNT)	97802, 97803, 97804, G0270, G0271
Medicare Diabetes Prevention Program expanded model	G9873, G9874, G9875, G9876, G9877, G9878, G9879, G9880, G9881, G9882, G9883, G9884, G9885, G9890, G9891
Obesity screening and counseling	G0447, G0473
Pneumococcal vaccine and administration	90670, 90732, G0009
Prolonged preventive services	G0513, G0514
Prostate cancer screening	G0102, G0103
Screening for cervical cancer with human papillomavirus (HPV) tests	G0476
Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling (HIBC) to prevent STIs	86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800, 87590, 87591, 87850, 86592, 86593, 86780, 87340, 87341, G0445
Screening mammography	77063, 77067
Screening pap tests	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
Screening pelvic examinations (includes a clinical breast examination)	G0101
Tuberculosis screening	86580
Ultrasound screening for abdominal aortic aneurysm (AAA)	76706

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Endnotes

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