Consumerism in healthcare series (part II of III)

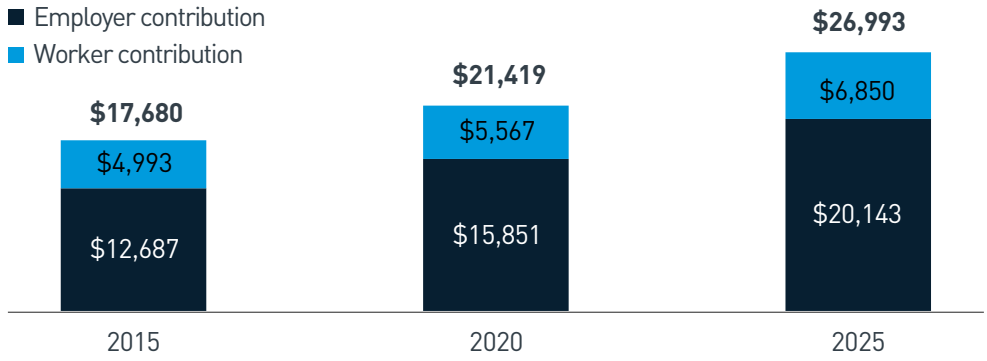
Rising costs, shifting healthcare policies empower consumer choice

In the first part of this three-part series, PNC Healthcare explored the current US macroeconomic backdrop, particularly as it impacts the individual consumer. Consumers' financial strength is in a nebulous state. "Affordability" seems to be the theme for the balance of the year and into 2027. At the core of the more complex and dynamic amalgam of economic factors informing it are the "Two Gs and Two Hs:" gas, groceries, housing, and healthcare.

Healthcare costs continue to rise across the board

Average family insurance premiums are up 6% in 2025 to $26,993, following consecutive 7% increases in the prior two years, with employers bearing roughly 75% of that burden to workers' 25% share.[1] In line with the growing individual responsibility, annually, more Americans find themselves in High Deductible Health Plans ("HDHPs"), whether by choice or by circumstance.[2]

Average Annual Worker and Employer Contributions for Family Coverage



Source: KFF

4 in 10 adults currently have medical and/or dental debt, and 77% of those are indebted at amounts north of $10,000. Nationally, total medical debt exceeds $200 billion.[3]

American consumers are enduring growing pressure across the four major categories of daily demand on their wallets. "Affordability" reigns as the defining theme of this economic cycle, and duress is being felt broadly, but unevenly, across the two prongs of the K-shaped economy: asset-owners building wealth in a rising stock market as the upper prong, and those in the lower prong with inflation-eroded purchasing power, whose wages comprise the bulk of their financial income/assets. For a deeper dive, refer back to Part 1 of this series.

Executive summary

- Rising healthcare costs are reshaping consumer behavior, as higher premiums, out-of-pocket expenses, and medical debt increase financial pressure and drive affordability concerns.
- Patients are shifting from passive recipients to active decision-makers, taking on more costs (~28% of spending) and increasingly comparing providers, prices, and care options.
- Industry competition and innovation are accelerating, with growth in telehealth, AI-enabled services, and new entrants responding to demand for more convenient, accessible, consumer-centered care.
- Policy and regulatory changes are reinforcing consumerism, with initiatives like price transparency and value-based care aimed at improving affordability, experience, and reimbursement structures.
- Care delivery is moving toward lower-cost outpatient and home-based settings, as providers and payors prioritize efficiency, convenience, and alternatives to traditional inpatient care.
- Insurance models are evolving under market pressure, with growth in high-deductible plans, emerging defined-contribution options, and instability in some markets increasing consumer responsibility and altering coverage choices.

In healthcare, that sensitivity matters most because the industry has achieved scale by which it can no longer be considered *just* a sector—it is a central force in household budgets, labor economics, and public policy.

As more of healthcare's cost burden shifts––directly or indirectly––to households, which already account for roughly 28% of healthcare spending, consumer behavior is beginning to change in ways that the system has not historically embraced (if not outright resisted). Considering the other household pressures that Americans are feeling (i.e., gas, groceries, and housing), the result is a fundamental shift. Gradually, unevenly, but unmistakably, healthcare is moving from a system in which the patient is a market-taker to one in which that same patient is a market-*maker*.

The question for healthcare leaders is no longer whether consumerism is real. It is how quickly trends in consumerism will prompt industry change, and whether those same leaders are prepared for it.

This article, Part 2 in the series, centers the discussion on the following 5 of those themes:

1. The sheer scope and size of healthcare within the context of US GDP and the Federal budget (18% of GDP, or $5.3 trillion). Over the next decade, that figure is expected to grow to $8.6 trillion, exceeding 20% of GDP, continuing to outpace overall economic growth;[4]
2. An expanded competitive field that includes new, diversified corporate entrants and private markets firms;
3. CMS / Federal policies: price transparency, global payments, and site of service shift to lower cost (and arguably higher quality) venues;
4. Narrowing Affordable Care Act ("ACA") exchanges: as premiums rise following Enhanced Premium Tax Credit ("EPTC") expiration, fewer Americans will enroll, straining the system; and
5. Changing products and interactions with payors, and movement away from defined benefit (traditional health insurance) to defined contribution models

The fact of US healthcare's immensity within the US economy is central to informing the changing behaviors of patients, employers, and market participants broadly. With so much money on the table, cost for some, revenue for others, it is natural that market dynamics will shift over time to more efficiently spend or earn those dollars. We've seen this manifest in myriad ways.

High-Deductible Health Plans ("HDHPs") have expanded significantly, both as an available option from employers, and as the plan structure of choice for employees. Roughly 50% of workers have HDHPs available to them[5], and over 40% of privately insured Americans below retirement age are enrolled in some version of a HDHP.[6] Concurrently, out-of-pocket spend has grown materially over the years, most recently measuring $1,632 per capita ($557 billion in total).[7] As noted, total medical debt across the country stands north of $200 billion.

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To combat rising household expenses, consumers / patients are more frequently exploring options, evaluating costs, and becoming smarter shoppers of healthcare goods and services.

The competitive playing field among healthcare firms has ballooned in the last couple decades as well, supercharged by historically low interest rates, as well as the Pandemic.

While it's levelled off since pandemic-era highs, a new floor has been set for telehealth utilization. Compared with about 25% in 2018, about 71% of physicians reported weekly telehealth use in their practices in 2024.[8] Patients' preference for virtual visits, especially for routine and non-urgent check-ins, has created the latest generation of behemoth healthcare firms (Hims & Hers, Teladoc, GoodRx, Ro, Virta Health, et al.) capitalizing on convenience. Telehealth companies consistently earn high marks for patient satisfaction,[9] and the industry is being built and driven by patient preference.

Artificial Intelligence, too, has grown popular in just the last few years as a complement to traditional healthcare, driven as much by ease of access as generational attitudes toward technology. According to a survey conducted by PwC, 36% of Gen Z and Millennials trust tech and retail companies for care and advice. Contrasted with that, just 57% of Gen Z maintains trust in primary care providers (compare that with 85% for Baby Boomers). While Baby Boomers will be the greatest drivers of care demand and cost as they move through retirement, younger generations are sending clear signals to the market that they increasingly prefer digital, convenient, and on-demand access to healthcare guidance.

Private capital, both equity and credit, has accelerated the development of larger practice providers, whether through roll-ups of outpatient operations, development of ambulatory surgery centers ("ASCs"), or establishment of management services organizations ("MSOs") in partnership with physician owners.

On trend and in search of differentiated revenue streams,[10] hospitals and health systems have begun refining asset portfolios to shift mix in favor of outpatient. For example, Tenet Healthcare's United Surgical Partners International has driven positive operating leverage, as that outpatient business has materially grown, year-over-year, significantly contributing to topline on a narrower expense base.[11] Ascension Health has been particularly active in recent years, selling larger, acute care, inpatient hospitals and investing in ASCs and outpatient care.[12]

Notably, Ascension announced a $3.9 billion purchase of AmSurg, an operator of ASCs, last year in pursuit of this strategy and just received FTC approval for the merger, subject to divestiture of seven AmSurg facilities from the transaction.[13]

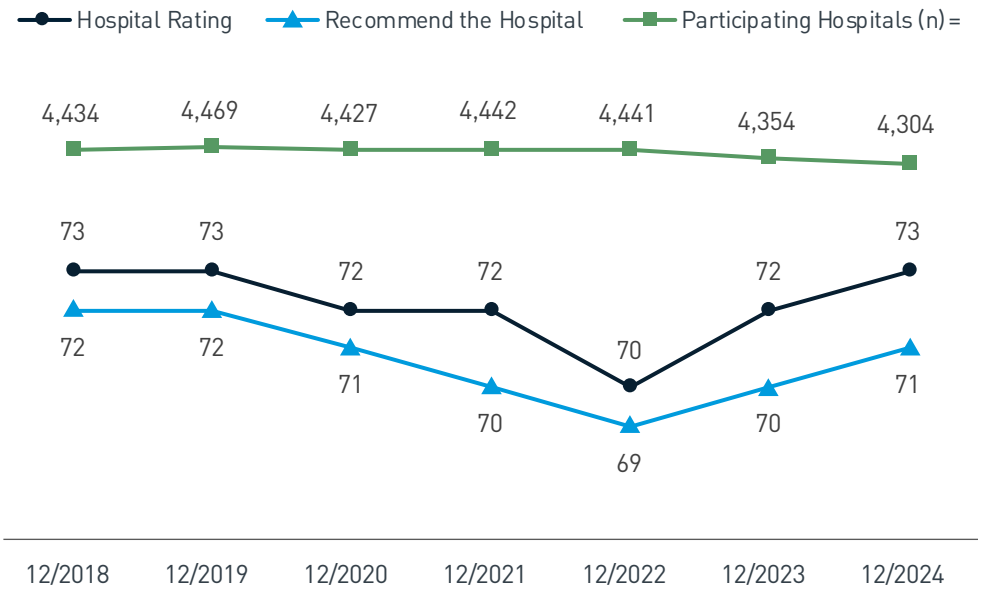
And finally, as a by-product of consumers in search of convenience and autonomy of their care, concierge medicine programs have evolved to becoming increasingly more popular. To meet building consumer demand, from 2018 to 2023, the number of concierge and direct primary care practices grew by 83%, and the number of clinicians in those practices increased by 78%, a trend continuing through the present.[14]

Because of consumerism's growing pervasiveness in healthcare, regulators and policymakers have championed bipartisan measures to improve access and affordability. As the single largest healthcare payor in the country, the Federal government wields an enormous degree of power in shaping market behaviors, and Washington has demonstrated a desire to wield that power for voters in recent years.

Price transparency, site neutrality, and value-based care models (among others) have all been aimed at improving consumer experience with the US healthcare system (while simultaneously reducing cost to the government). Perhaps the most obvious example of this is the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") Survey[15] conducted by CMS. Intended to draw apples-to-apples insights about the patient experience across providers, HCAHPS survey scores directly impact reimbursement to hospitals from CMS, directly tying quality of consumer experience to organizational financial health.

From an in-person visit perspective, patients and payors alike are driving a structural shift towards outpatient care and home health.[16] Inpatient care, by contrast, is expensive, less convenient, and a relatively worse patient experience as evidenced by years of stagnating HCAHPS survey scores for hospital rating and recommendation.[17]

Annual HCAHPS Survey Results (Aggregate Scores Across US Hospitals)



Source: CMS

The counterpoint to governmental advocacy for access to quality care is the need to balance it with judicious financial management on behalf of the taxpayer. As a reminder, the pandemic-era EPTCs, part of broader Affordable Care Act ("ACA") subsidies, were at the crux of the government shutdown. The tax cuts provided affordable access to health insurance for millions of Americans and were funded by federal tax revenues collected from the American public.

Ultimately, the tax credits were not renewed and lapsed on December 31, 2025, leaving millions of exchange participants to choose, albeit reluctantly, between significantly more expensive exchange plans (to the tune of 100%+ premium increases), or to become uninsure.[18] EPTC expiration underscores the importance and impact of consumer choice and will have significant implications for the health of the exchanges going forward.

Rising insurance costs have created demand for a previously under-utilized segment of the insurance industry landscape as well. Just as the government does through CMS, commercial payors are instrumental in shaping consumer preference and behavior, especially as those consumers, both workers *and* retirees, bear the increasing costs of insurance products.

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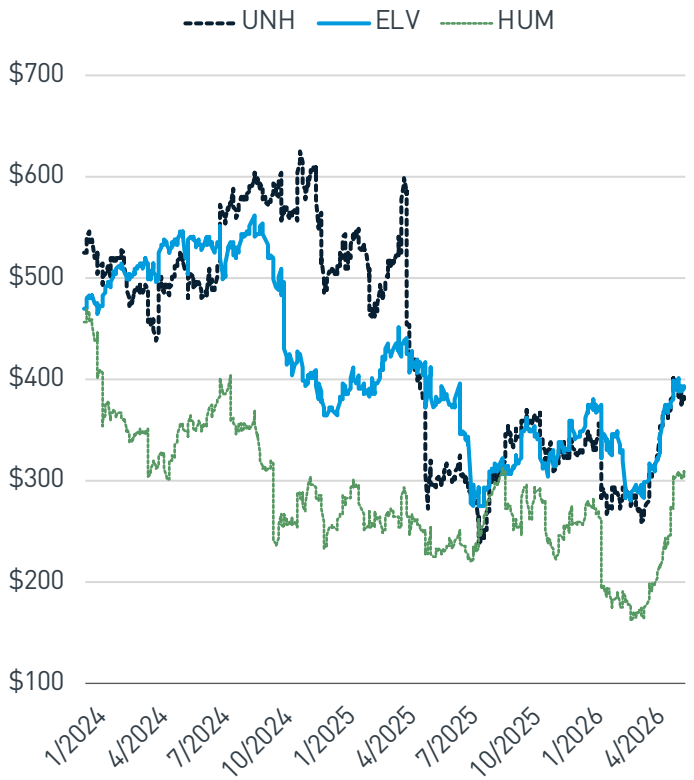
Over the last year or two, Individual Coverage Health Reimbursement Arrangements ("ICHRAs") have generated significant interest among employers and employees. Instead of offering traditional, defined-benefit health insurance, employers can offer ICHRAs as a defined-contribution option instead. Through ICHRAs, employers can provide employees with a pre-tax lump sum of funds to take into the marketplaces in search of their own, chosen health insurance plan.[19] However, ICHRAs rely on robust individual exchanges. As different payors exit the ACA exchanges (Cigna recently), and the EPTCs have expired, the broader market is left to wonder how viable ICHRAs will be in the long-term.

Retirees, on the other hand, are experiencing a retrenchment in option and choice as it relates to their own health insurance plans. Medicare Advantage ("MA"), commercial insurers' Medicare plan offerings, have long been touted as preferential to traditional Medicare given the number of benefits, options, and broad coverage offered. In the past, commercial insurers raced to achieve scale across that population, enticing seniors with even more benefits to generate the largest, stable pool of lives covered possible. However, in recent years, it's become evident that many insurers lost the ability to accurately forecast cost of care across the Medicare population, driving up Medical Loss Ratios ("MLRs") and pressuring margins across those insurers that do participate in the MA program.[20]

Since 2023, several large commercial insurers have exited the MA market, leaving seniors adrift in a contracting marketplace. Where once there was seemingly limitless choice, much of the Medicare population is left to choose among only a few plan options with reduced benefits and higher cost. And while those that remain have continued to amass covered lives at scale, profitability will be pressured until there can be a return to accurate cost of care forecasting and stronger reimbursement. We have seen this margin pressure on display publicly in changing earnings forecasts and depressed share prices among the largest MA insurers.

Healthcare is not impacted by free market forces alone. Even when working to be innovative, degrees of separation created by patient-provider-payor dynamics, the influence of policy and government funding, and the fundamental need to always care for the patient create unique market dynamics that present in healthcare like no other sector of the economy.

Largest Medicare Advantage Insurers' Daily Share Prices (January 2024 - May 2026)



Source: S&P Capital IQ

Given structural shifts overtime creating higher patient influence and responsibility, "affordability" no longer comprises just gas, groceries, and housing. Now more than ever, Healthcare is inextricably linked to financial stability.

Consumers' choices and preferences are repricing the market for healthcare. Marketplace winners will have to be nimble, innovative, accessible, convenient, cost-effective, and high-quality. They will have to develop asset-light, consumer-facing care platforms designed to meet the patient where they are. Those that are not or cannot are competing in a race to the bottom.

Without sacrificing access, equity, and clinical integrity, can the industry redesign itself around consumer-defined value? In a world where Americans are actively comparing the costs of the next tank of gas and the weekly grocery bill with the money it takes to get timely medical advice, operators cannot afford to try and bend the consumer to their existing structures. To do so is futile.

Keep an eye out for Part 3 of the Consumerism in Healthcare series at pnc.com/healthcare

1 Annual Family Premiums for Employer Coverage Rise 6% in 2025, Nearing $27,000, with Workers Paying $6,850 Toward Premiums Out of Their Paychecks (kff.org)

2,5 High deductible health plans and health savings accounts (bls.gov)

3 Health Care Costs and Affordability (kff.org)

4 National Health Expenditure Projections 2024-2033 (cms.gov)

6, 7 Enrollment in High-deductible Health Plans Among People Younger Than Age 65 With Private Health Insurance: United States, 2019–2023 (cdc.gov)

8 New data details how telehealth use varies by physician specialty (ama-assn.org)

9 A Review of Patient and Provider Satisfaction with Telemedicine (pmc.ncbi.nlm.nih.gov)

10 What to expect in US healthcare in 2026 and beyond (mckinsey.com)

11 Financials & SEC Filings (investor.tenethealth.com)

12 After hospital divestitures, Ascension bets on outpatient and ancillary growth (beckershospitalreview.com)

13 FTC Requires Divestiture of Ambulatory Surgery Centers to Protect Patients from Anticompetitive Effects of Ascension Health-AmSurg Deal (ftc.gov)

14 How Much Are Concierge Medicine and Direct Primary Care Growing? (hms.harvard.edu)

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18 Higher Premium Payments or Higher Deductibles: The Tradeoffs ACA Enrollees Face (healthsystemtracker.org)

19 Individual coverage HRAs (healthcare.gov)

20 From growth to margin challenge: Navigating the forces shaping Medicare Advantage (pwc.com)