



**SHIFTING HEALTH CARE FINANCIAL RISK TO FAMILIES
IS NOT A SOUND STRATEGY: THE CHANGES NEEDED
TO ENSURE AMERICANS' HEALTH SECURITY**

Karen Davis

President

The Commonwealth Fund

One East 75th Street

New York, NY 10021

kd@cmwf.org

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Executive Summary

The U.S. health care financing system is based on shared financial risk. Employers, federal and state government, and households all share in paying premiums for health insurance coverage. Such coverage is essential to protect individuals from potentially devastating medical bills and to ensure financial access to care. With rising health care costs, insurance is all the more important to prevent families' savings from being wiped out and to make sure that everyone can get the care they need.

Unfortunately, the rise in health care costs this decade has coincided with an erosion in health insurance coverage and with rising economic insecurity for American families caused by the shifting of a greater share of financial responsibility for coverage and health care directly to families. American's mixed system of private and public health coverage has its strengths and is worth preserving; however, the trend toward increasing the individual's responsibility for insurance and health care expenses is shifting an unacceptable level of risk onto families. As a consequence, the number of Americans without adequate protection from health care expenses has been on the rise:

- The number of uninsured Americans has jumped almost 20 percent between 1999 and 2007; today there are 45.6 million uninsured.
- The number of *underinsured*—people with inadequate coverage that ensures neither access to care nor financial protection—has jumped 60 percent between 2003 and 2007, from 16 million to 25 million.
- Low-income adults have been hardest hit. Nearly three-fourths (72%) of adults with incomes below twice the poverty level are uninsured or underinsured. Private markets are simply not working for low-income adults.

- The numbers of Americans who face difficulty paying medical bills and have accumulated medical debt have also risen substantially, with middle-income families earning less than \$60,000 a year being particularly squeezed. In a recent Commonwealth Fund survey, 79 million Americans reported difficulties paying medical bills or accumulated medical debt. About 60 percent of those experiencing medical bill problems were insured at the time they incurred their expenses.
- Managed care plans have increasingly used tiered prescription drug copayments that limit access to more expensive medications. In addition, most managed care plans place limits on mental health outpatient visits and inpatient days.
- It should be noted that private managed care plans come in many shapes and sizes. Nonprofit managed care plans that are part of nonprofit integrated delivery systems—the best-known include Kaiser Permanente, Geisinger Health System, Henry Ford Health System, and Intermountain Health Care—have been found in Commonwealth Fund–supported case studies to have superior performance on quality and have been among the leaders in adopting electronic information systems and quality improvement care processes to deliver better results for patients.
- Coverage for employees of small firms is eroding—both in terms of the proportion of firms offering any health benefits and the quality of those benefits. The rise in deductibles shifts risk to patients; premiums are shared between employers and workers and spread equally among all enrollees but patients are fully responsible for deductible amounts and uncovered services. Higher deductibles are particularly a burden for the sickest Americans, who have the highest medical expenses; they also undermine their ability to get needed care.
- Individual health plans represent the weakest part of the health insurance market. Such plans are characterized by high administrative costs and poor benefits, and, in most states, they exclude poor health risks. Because health expenditures are so skewed—with 10 percent of people accounting for 64 percent of health care outlays—health insurers have a strong incentive to avoid covering those with health problems, to charge much higher premiums, or to provide policies with very restrictive benefits.
- Fortunately, Medicare, Medicaid, and the State Children’s Health Insurance Program buffer some of the risk to families by covering the elderly, many of the

disabled, low-income children, and some very-low-income adults. In 1965, Medicare and Medicaid were enacted to cover those who were often left uncovered by private insurance: the elderly and low-income people. Medicare and Medicaid have low administrative costs. Medicaid expenditures per person are lower than costs for privately insured children and adults. Moreover, growth in Medicare spending has been somewhat lower than growth in spending by private insurers over time. Yet Medicare beneficiaries continue to report good access to health care services.

Ensuring stable, affordable health insurance coverage for all Americans will require a significant increase in the role of government to set the rules for the operation of private markets and reverse the trend toward shifting greater financial risk to families who are unable to bear that risk. Action is needed to guarantee affordable coverage that provides adequate financial protection and ensures that individuals can obtain needed care—the two essential functions of health insurance. Steps should include:

- Providing health insurance premium assistance to low-income and modest-income families who cannot afford family premiums, which now average over \$12,000 even under employer plans.
- Strengthening, not weakening, employer coverage.
- Setting national rules for the operation of individual health insurance markets or creating a national insurance connector, such as the one implemented by Massachusetts, that makes affordable health insurance policies available to those without access to employer coverage. Structuring insurance choices through rules governing the operation of private markets, or through a health insurance exchange or connector, could ensure the availability of quality, affordable coverage to a larger number of individuals who are either uninsured or have inadequate or unstable coverage, or for whom premiums create major financial burdens.
- Offering a public plan modeled on Medicare to small businesses and individuals would lower premiums by 30 percent and increase the stability of insurance coverage.

- Building on Medicare, Medicaid, and SCHIP to cover older adults, the disabled who are in the two-year waiting period for Medicare, and low-income adults, as well as children. Private insurance markets do not serve these populations well.

Finally, insurance reforms need to be part of a comprehensive strategy to bring about a high performance health care system that achieves better access, improved quality, and greater efficiency. This will require fundamental changes in the way health care providers are paid—changes that help align financial incentives with these goals and create a more organized health system that takes full advantage of modern information technology and evidence-based medicine and spreads best practices. Rather than shifting more financial risk to families, public programs and private insurers alike need to do more, both independently and in collaboration, to slow the growth in health care costs and transform the delivery of health care services to improve quality and enhance value for the money spent on health care.

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Thank you, Mr. Chairman, for this invitation to testify on private health insurance markets and how they are currently functioning within our nation's mixed system of private and public coverage; the major strengths and weaknesses of this system; and how private markets might be strengthened through the establishment of uniform rules governing the operation of insurance markets, including the benefit of an insurance connector to structure coverage choices for working families.

Unfortunately, the rise in health care costs this decade has coincided with an erosion of health insurance coverage and with rising economic insecurity for American families caused by the shifting of a greater share of financial responsibility for insurance and health care directly to families. The U.S. private–public insurance system has strengths and is worth preserving, but the trend toward increased individual responsibility for insurance and health care expenses is shifting an unacceptable level of risk to American families—with potentially serious consequences. Action is needed to guarantee affordable coverage that provides adequate financial protection and ensures that individuals can obtain needed care—the two essential function of health insurance.

Since most of the difficulties in the private market are experienced by employees of small businesses and by individuals without access to employer coverage, structuring insurance choices through rules governing the operation of private markets, or through a health insurance exchange or connector, could ensure the availability of quality affordable coverage to a larger number of individuals who are either uninsured or have inadequate or unstable coverage, or for whom premiums create major financial burdens.

Rather than shifting more financial risk to families, public programs and private insurers alike need to do more, both independently and in collaboration, to slow the growth in health care costs and to transform the delivery of health care services to improve quality and enhance value for the money spent on health care.

A Broken System: Growing Numbers of Uninsured Americans

Last month, the U.S. Census Bureau released the latest data on the number of Americans without health insurance. The number of uninsured individuals fell to 45.7 million in 2007, from 47.0 million in 2006.¹ While the new figure represents the first decline since 1999, there are still 7 million more uninsured people now than at the beginning of the decade. Moreover, the decline of 1.3 million uninsured people between 2006 and 2007 was entirely attributable to an equal growth in coverage under Medicaid, a shift that highlights the importance of the nation's safety-net insurance system. In contrast, employment-based coverage declined slightly, from 59.7 percent of the population to 59.3 percent.

The major bright spot in the last eight years has been the improved rate of coverage for children, with the proportion of uninsured children declining from 12.5 percent in 1999 to 11.0 percent in 2007. This improvement was a reflection of increased coverage for children under the State Children's Health Insurance Program (SCHIP). However, more than 8 million children remain uninsured, a figure that underscores the need to permanently reauthorize SCHIP and provide adequate funding to cover all low-income children.

By contrast, the proportion of uninsured adults ages 18 to 64 has increased markedly since 1999, from 17.2 percent to 19.6 percent. The gap between coverage rates for working-age adults and children has widened in the last eight years—in contrast with the 1990s, when rates for both rose in concert. The differential experience for adults, who are not covered by SCHIP, attests to the success of offering states fiscal incentives to cover low-income children. Extending federal financial assistance to states to cover low-income adults could have a similar impact in alleviating some of the most serious health care access problems created by gaps in coverage.

Some states have stepped up to the plate to find ways to cover both children and adults who are uninsured. Massachusetts, which enacted health reform in April 2006 with the help of a Medicaid waiver, has moved into first place, with the lowest uninsured rate in the nation in 2007. In that state, 7.9 percent of the population was uninsured in 2006–2007, compared with 24.8 percent in Texas, the state with the highest uninsured rate. A

¹ C. DeNavas-Walt, B. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (U.S. Census Bureau, Aug. 2008).

recent report from the Massachusetts Commonwealth Connector indicates that 439,000 residents have obtained coverage under the Massachusetts health insurance reforms.²

Inadequate Coverage: The Rise of the Underinsured

While numerous indicators point to the continued erosion of our employer-based system of health insurance coverage, these statistics fail to count the millions more who experience lapses in their coverage during the year, or the millions of “underinsured” people whose inadequate coverage ensures neither access nor financial protection.³ Deterioration in insurance coverage and access to care is not limited to the uninsured. Even individuals with insurance coverage are increasingly at risk of being underinsured, defined as deductibles exceeding 5 percent of income, or out-of-pocket expenses exceeding 5 percent of income for low-income families (10 percent of income for higher-income families).⁴

As of 2007, there were an estimated 25 million underinsured adults in the United States, up 60 percent from 2003. Low-income adults are hardest hit. Nearly three-fourths (72%) of adults with incomes below twice the poverty level are uninsured or underinsured. Private markets are simply not working for low-income adults.

Only about one-third of working age adults have quality, affordable coverage. Others are uninsured at some point during the year, are underinsured, or report problems obtaining access to needed care or paying medical bills. Together, an estimated 116 million adults fall into one or more of these groups.

Underinsured people—even though they have coverage all year—report access to care and bill problem experiences similar to the uninsured. Both those who are uninsured at some point during the year and those who are underinsured report major difficulties obtaining needed care. Sixty percent of those who are underinsured reported one of four access problems: did not see a doctor when needed medical care, did not fill a prescription, did not see a specialist when needed, or skipped a medical test, treatment, or follow-up service. Seventy percent of those uninsured at some point during the year

² J. M. Kingsdale, *Executive Director’s Monthly Message*, The Massachusetts Commonwealth Connector, Aug. 25, 2008.

³ C. Schoen, S. Collins, J. Kriss and M. M. Doty, “How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007,” *Health Affairs* Web Exclusive, June 10, 2008, 27(4).

⁴ C. Schoen, S. R. Collins, J. L. Kriss, M. M. Doty, [How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007](#), *Health Affairs* Web Exclusive, June 10, 2008.

reported one of these four access problems, contrasted with 29 percent of those who were insured all year and not underinsured.

The economic consequences of being uninsured or underinsured are now well documented. A recent study by The Commonwealth Fund found that 79 million Americans have problems paying medical bills or are paying off accumulated medical debt.⁵ About 60 percent of those experiencing medical bill problems were insured at the time the expenses were incurred. Adults who experienced medical bill problems face dire financial problems: 29 percent are unable to pay for basic necessities like food, heat, or rent because of their bills; 39 percent use their savings to pay bills; and 30 percent take on credit card debt.

These problems are widely reported by those who are uninsured or underinsured. Sixty percent of adults who are underinsured or uninsured report being unable to pay medical bills, being contacted by collection agencies for unpaid bills, changing their way of life to pay medical bills, or having accumulated medical debt.⁶ In contrast, only one-fourth of insured adults reported financial stress related to medical bills. Medical bill problems and accumulated medical debt were greater when plans did not include prescription drug or dental coverage and when the deductible exceeded 5 percent of income.

Managed care plans have increasingly used tiered prescription drug copayments that limit access to more expensive medications. In addition, most managed care plans place limits on mental health outpatient visits and inpatient days. These restrictions on benefits may not be known by enrollees at the time they choose a plan, especially those enrollees who have a new health condition, such as cancer, that requires costly drugs.

Underinsured adults also report more problems dealing with their insurance plans. Nearly two-thirds of underinsured adults report they had expensive medical bills for services not covered by insurance, the doctor charged more than insurance would pay and they had to pay the difference, or they had to contact the insurance company because they did not pay a bill promptly or were denied payment.

Inadequate coverage can also lead to more costly use of emergency rooms, as well as to hospitalizations that could have been avoided with better primary care. Uninsured

⁵ M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families* (New York: The Commonwealth Fund, Aug. 2008).

⁶ S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007* (New York: The Commonwealth Fund, Aug. 2008).

and underinsured people with chronic conditions, for example, are less likely to report managing their chronic conditions, more likely to report not filling prescriptions or skipping doses of drugs, and more likely to use emergency rooms and be hospitalized.⁷

It should be noted that private managed care plans come in many shapes and sizes. Nonprofit managed care plans that are part of nonprofit integrated delivery systems—the best-known include Kaiser Permanente, Geisinger Health System, Henry Ford Health System, and Intermountain Health Care—have been found in Commonwealth Fund–supported case studies to have superior performance on quality and have been among the leaders in adopting electronic information systems and quality improvement care processes to deliver better results for patients.⁸

Coverage Eroding in Small Firms

Any American is at risk of losing health insurance coverage, with employees of small businesses being particularly vulnerable. While 99 percent of firms with 200 or more employees continue to offer health insurance coverage, the corresponding rate for the smallest firms (those with fewer than 10 employees) is, at 45 percent, far lower.⁹ Coverage in such very small firms is down from 57 percent in 2000. Three of five workers who are uninsured are self-employed or working for a firm with fewer than 100 employees.

Smaller businesses face many disadvantages because they do not enjoy the economies of covering large groups with natural pooling of risks. Employees of smaller businesses, moreover, receive fewer benefits and often face higher premiums. For the same benefits, a firm with more than 1,000 employees paid an estimated premium of \$3,134 for single employee coverage, compared with \$3,579 for employers with fewer

⁷ S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007* (New York: The Commonwealth Fund, Aug. 2008).

⁸ R. A. Paulus, K. Davis, and G. D. Steele, “Continuous Innovation in Health Care: Implications of the Geisinger Experience,” *Health Affairs*, Sept./Oct. 2008 27(5):1235–45; A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008).

⁹ S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007).

than 10 employees.¹⁰ Small firms also pick up a lower share of the premium, further increasing costs to workers of small firms relative to those employed in larger firms.

Driven in part by a philosophy that individual responsibility for insurance and higher deductibles will slow the growth in health care costs, employer coverage and policies available in the private individual insurance market have shifted more of the cost of health care directly to households. Deductibles have risen particularly sharply in small firms with three to 199 employees—with the mean deductible for single coverage rising from \$210 in 2000 to \$667 in 2007. By contrast, for larger firms, deductibles increased from \$157 to \$382 over this period. Deductibles vary by type of plan, with high-deductible health plans having particularly large deductibles; health maintenance organization (HMO) plans which are more typically offered by larger firms, generally have lower deductibles than preferred provider organization (PPO) plans.

Not surprisingly, therefore, employees of larger firms are more likely to say that employers do a good job of selecting quality insurance plans. Of employees in firms with 500 or more employees, 76 percent give employers high marks for selecting quality plans, compared with 69 percent of workers in firms with fewer than 20 employees.¹¹

Individual Insurance Market Works Less Well than Employer Coverage

Faced with declining rates of coverage driven by the erosion of employer-sponsored coverage, the only recourse for many people is to turn to the individual health insurance market. However, this is the weakest link in the U.S. health insurance system. The Commonwealth Fund Biennial Health Insurance Survey found that of 58 million adults under age 65 who sought coverage in the individual insurance market over a three year period, nine of 10 did not purchase coverage, either because they were rejected, they were unable to find a plan that met their needs, or they found the coverage too expensive.¹² Serious health problems are also a significant barrier to gaining coverage in the non-group market. More than 70 percent of people with health problems or incomes

¹⁰ J. Gabel, R. McDevitt, L. Gandolfo et al., Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down, *Health Affairs*, May/June 2006 25(3):832–43.

¹¹ S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

¹² S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

under 200 percent of the poverty level surveyed by The Commonwealth Fund said that it was very difficult or impossible to find a plan they could afford.

Although increasing numbers of adults lost access to employer-based coverage from 2000 to 2006, there has been virtually no change in the number of people covered by individual-market insurance. Loss of employer coverage has led to higher levels of uninsured individuals, not to higher levels of individual coverage.¹³ Those who are covered by individual health insurance plans are much less satisfied with their coverage than those covered by employer plans, and they are likely to drop such coverage if and when more desirable coverage becomes available from employers or public programs. Only a third of those with individual coverage rate their coverage as excellent or very good.¹⁴

The fundamental problem with the individual insurance market is that insurers are concerned that only those expecting to have high medical expenses will seek out coverage. Health expenditures are highly skewed: 10 percent of individuals account for 64 percent of health care outlays.¹⁵ Avoiding those who are sickest results in substantially greater profits for insurers.

Except in a few states that require insurers to have open enrollment and community-rated premiums, insurers typically screen applicants for health risks and exclude high-risk individuals from coverage or charge higher premiums.¹⁶ By design, underwriting practices discriminate against the sick and disabled, making coverage often unavailable at any price, or only at a substantially higher cost than incurred by healthier individuals. Non-group premiums are 20 percent to 50 percent higher than employer plan premiums, and more than 40 percent of total premiums are estimated to go toward administration, marketing, sales commissions, underwriting, and profits.¹⁷ Premiums

¹³ C. DeNavas-Walt, B. D. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C.: U.S. Census Bureau, Aug. 2007).

¹⁴ S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

¹⁵ S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan/Feb 2007 26(1): 249–257.

¹⁶ N. C. Turnbull and N. M. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma or Regulating the Individual Health Insurance Market* (New York: The Commonwealth Fund, Feb. 2005).

¹⁷ D. Bernard and J. Bantlin, *Premiums in the Individual Insurance Market for Policyholders under age 65: 2002 and 2005, Medical Expenditure Panel Survey Statistical Brief #202*, Agency for Health Care Research and Quality, April 2008; M.A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs*, March/April 2000:173–184; M. V. Pauly and A. M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Policy, Politics and Law*, Feb. 2000 25(1):9–26.

typically climb steeply with age.¹⁸ Benefits are often inadequate, and premiums and risk selection practices are difficult for states to regulate.¹⁹

Those fortunate enough to have employer coverage are much better protected financially than those buying in the individual market—both because the employer pays a share of the premium and because the risks are pooled across the workforce. Only 18 percent of those with employer coverage pay premiums of \$3,000 or more, compared with 54 percent of those who buy on the individual insurance market.

Public Programs Work

As this Committee knows well, public programs today cover more than one of four Americans—83 million people—including elderly and disabled adults under Medicare; low-income families, the elderly, and the disabled under Medicaid; and low-income children under the State Children’s Health Insurance Program (SCHIP). Covering many of the sickest and poorest Americans, these programs have improved access to health care for people who typically do not fare well in a private insurance market.

Medicare and Medicaid have much lower administrative costs than private insurance—averaging around 2 percent, compared with 5 to 15 percent for larger employers, 15 to 25 percent for small employers, and 25 to 40 percent in the individual market. Medicaid expenditures are also comparable or lower than expenditures by private insurance. Medicaid spending on health services for those without health limitations is lower than for those covered by private insurance. Medicare expenditures are high because they cover the elderly and disabled—but the rate of increase over the period 1969 to 2003 has been one percentage point lower than under private plans for comparable benefits (annual increases of 9.0% vs. 10.1% for private insurance).

Extending a Medicare-like plan to small businesses and individuals without access to employer-sponsored coverage would provide them with a much more affordable option.²⁰ Estimated premiums for family coverage under a Medicare-like

¹⁸ D. Bernard and J. Bantlin, 2008.

¹⁹ K. Swartz, *Reinsuring Health: Why More Middle Class People Are Uninsured and What Government Can Do* (New York: Russell Sage Foundation, 2006).

²⁰ C. Schoen, K. Davis, and S.R. Collins, “Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance,” *Health Affairs*, May/June 2008 27(3):646–57; G. Claxton, “Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable,” *Health Affairs*, Sept./Oct. 2007 26(5):1407–16.

public plan (with benefits comparable to the standard Blue Cross Blue Shield option in the Federal Employees Health Benefits Program) would be \$8,424 annually in 2008, compared with \$12,106 in a typical employer private plan. This 30 percent reduction in premiums would go a long way toward making coverage much more affordable for small businesses and individuals than available either in the small business insurance market or in the individual insurance market.

This premium differential occurs in part because Medicare buys physician and hospital services at a discount to rates paid by private insurers. Yet, a Medicare Payment Advisory Commission survey finds that, if anything, Medicare beneficiaries have a better experience than the privately insured in finding a physician and in getting an appointment promptly.²¹

The Way Forward: Rules Governing Private Markets and Role of Public Programs

We can no longer afford to ignore the fact that the U.S. is the only industrialized nation that fails to ensure access to essential health care for all its population. Yet, the U.S. spends twice per capita what other industrialized nations spend on health care. Since 2000, the most rapidly rising component of health care outlays has been the net cost of private health insurance administration.²² The U.S. leads the world in the proportion of national health expenditures spent on insurance administration, and the nation could save \$102 billion annually if it did as well as the best countries.²³

That expenditure does not buy us satisfaction. Americans are more likely to report hassles paying medical bills than those of other countries.²⁴ A survey of U.S. adults

²¹ MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p.85.

²² K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* (New York: The Commonwealth Fund, Jan. 2007).

²³ The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, The Commonwealth Fund, July 2008.

²⁴ C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, *Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007*, *Health Affairs* Web Exclusive October 31, 2007 26(6):w717-w734

found that 28 percent said that spending time on paperwork or disputes related to medical bills and health insurance in the past two years was a serious problem.²⁵

The growth in insurance administrative cost in the U.S. has coincided with a major consolidation of the insurance industry. Two-thirds of all managed care enrollees are now enrolled in the nation's 10 largest managed care plans. The largest three health plans control over 50 percent of the market in all but four states.²⁶ Operating earning margins for major insurers have also increased during this period, as increases in premiums have substantially outstripped increases in medical outlays.

Massachusetts has shown how organizing an insurance connector, offering choices of plans, and reviewing premiums for reasonableness as a condition of being included in the connector can improve benefits and lower premiums. For example, a typical uninsured 37-year-old male faced a monthly premium of \$335 pre-reform, compared with \$184 post-reform, with a \$2,000 deductible instead of a \$5,000 deductible pre-reform.²⁷ To provide choices but simplify decision-making, Massachusetts has offered three tiers of benefits—labeled gold, silver, and bronze—with actuarially equivalent policies within each tier.

Insurance market reforms—including minimum requirements on insurers to cover everyone, the sick and healthy alike, at the same premium—could ensure the availability of coverage in all states. By organizing a national insurance connector that builds on the experience of Massachusetts, we could expand insurance choices to small businesses and individuals.

The Federal Employees Health Benefits Program is another example of offering multiple plans. The most popular option is the Blue Cross Blue Shield standard option plan, which covers 58 percent of all enrollees.²⁸ However, FEHBP does not establish minimum benefits for all plan offerings. It has offered high-deductible plans that qualify for health savings accounts; only 30,000 individuals out of the 8 million covered have elected these plan options.

²⁵ S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

²⁶ J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Nov./Dec. 2004 23(6):11–24.

²⁷ Jon Kingsdale, Executive Director, Commonwealth Health Connector, "Design of Connector as an Element of NHI," July 23, 2008.

²⁸ Mark Merlis, Personal Communication, September 16, 2008.

Offering small businesses and individuals without access to employer-sponsored coverage choice of insurance plans through an insurance connector has advantages as well as serious pitfalls. Attention needs to be given to how to design a framework for choice among plans that best achieves the goals of insurance—ensuring access to essential care and providing financial protection against burdensome medical bills—in a manner that is equitable and efficient. Structuring choices within such an insurance connector works best when:

1. A standard benefit adequate is defined and available to all. The benefits should be adequate to meet the two basic functions of insurance—ensuring access to essential care and providing financial protection from burdensome medical bills. A small number of choices of benefit packages can let enrollees pick plans closer to their needs, but a profusion of benefit packages undermines effective comparisons and choices. The Massachusetts system of three levels of benefits—gold, silver, and bronze—has much to commend it.
2. Premiums to the enrollee for a standard plan are affordable, regardless of income. Income-related premium assistance—whether sliding-scale premiums or tax credits set to ensure that no one pays a standard plan premium in excess of a given threshold of income—is essential to guarantee affordability.
3. Enrollees have and use comparable information on benefits, expected out-of-pocket costs, adequacy of physician and other provider networks, and premiums across plans to make informed decisions.
4. Marketing practices which mislead or discriminate against the sick are prohibited and strictly enforced.
5. Market rules set the framework for efficiency and equity, including that insurers cover everyone (guaranteed issue and guaranteed renewal) and charge the same premium regardless of health status of enrollee (community rating or age bands), and that all individuals obtain health insurance (individual mandate). To prevent adverse selection, market rules should apply to both plans sold in the connector and those sold outside the connector. To ensure a diverse risk pool, premium subsidies should be permitted for use only for plans sold through the connector.

6. Premiums are risk-adjusted to ensure that insurers do not have a financial incentive to enroll healthier people and enrollees do not have an incentive to avoid plans with sicker enrollees.
7. Insurers compete on the basis of the added value they bring in fostering quality and efficiency in the delivery of health care services and administration of claims.
8. Premiums are reasonable and have low administrative overhead; this can be ensured through negotiation or review of premiums or offer of a competitive public plan alternative.

To ensure stable, affordable health insurance coverage for all Americans will require a significant increase in the role of government to set the rules for the operation of private markets and reverse the trend toward shifting greater financial risk to families who are unable to bear that risk. Action is needed to guarantee affordable coverage that provides adequate financial protection and ensures that individuals can obtain needed care—the two essential functions of health insurance. This should include:

- Health insurance premium assistance to low-income and modest-income families who cannot afford family premiums, which now average more than \$12,000 even under employer plans.
- Strengthening, not weakening, employer coverage.
- Setting national rules for the operation of individual health insurance markets or creating a national insurance connector, such as the one in Massachusetts, that makes affordable health insurance policies available to those without access to employer coverage. Structuring insurance choices through rules governing the operation of private markets, or through a health insurance exchange or connector, could ensure the availability of quality, affordable coverage to a larger number of individuals who are either uninsured or have inadequate or unstable coverage, or for whom premiums create major financial burdens.
- Offering a public plan, modeled on Medicare, to small businesses and individuals would lower premiums by 30 percent and increase the stability of insurance coverage.

- Building on Medicare, Medicaid, and SCHIP to cover older adults, the disabled who are in the two-year waiting period for Medicare, and low-income adults, as well as children. Private insurance markets do not serve these populations well.

Finally, insurance reforms need to be part of a comprehensive strategy to bring about a high performance system that achieves better access, improved quality, and greater efficiency. This will require fundamental changes in the way health care providers are paid, so that financial incentives for providers are aligned with these goals, as well as a more organized health care system that takes full advantage of modern information technology and evidence-based medicine and spreads best practices. Rather than shifting more financial risk to families, both public programs and private insurers need to do more, both independently and in collaboration, to slow the growth in health care costs and transform the delivery of health care services to improve quality and enhance value for the money spent on health care.



Shifting Health Care Financial Risk to Families Is Not a Sound Strategy: The Changes Needed to Ensure Americans' Health Security

Karen Davis
President
The Commonwealth Fund
kd@cmwf.org

Invited Testimony
House Committee on Ways and Means
Subcommittee on Health
September 23, 2008



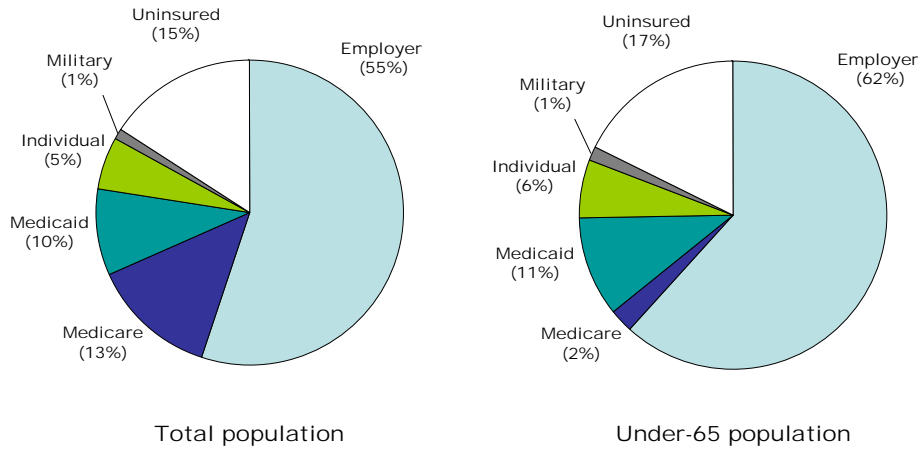
A Broken System: The Growing Numbers of Uninsured



Health Insurance Coverage

3

45.7 Million Uninsured, 2007

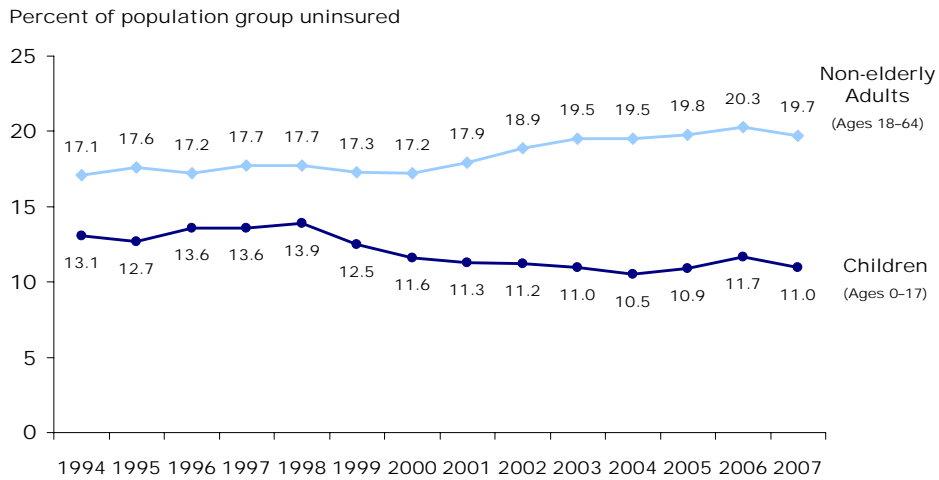


Source: Authors' estimates based on S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007) and analysis of the Current Population Survey, March 2008, by Bisundev Mahato of Columbia University.

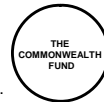


Percentage of Uninsured Children Has Declined Since Implementation of SCHIP While Uninsured Working-Age Adults Have Increased, 1994-2007

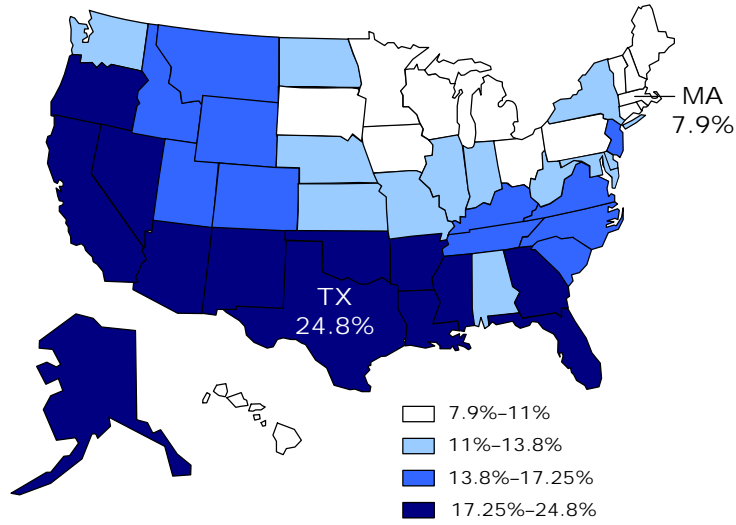
4



Source: P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey" Issue Brief No. 321 (Washington, D.C.: Employee Benefit Research Institute, Sept. 2008).



Uninsured Rates, by State, Two-Year Average, 2006-07



Source: DeNavas-Walt C, Proctor B, and Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Washington: Census Bureau, 2008.

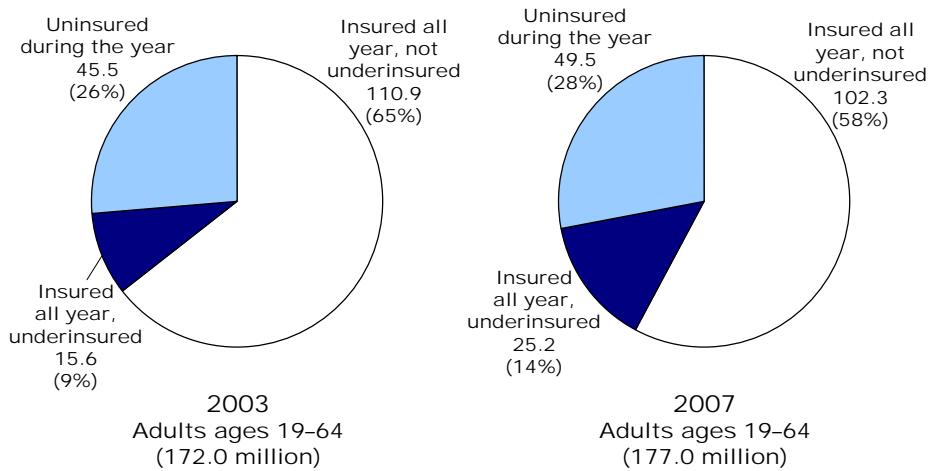


Inadequate Coverage: The Rise of the Underinsured



25 Million Adults Underinsured in 2007, Up from 16 Million in 2003

7

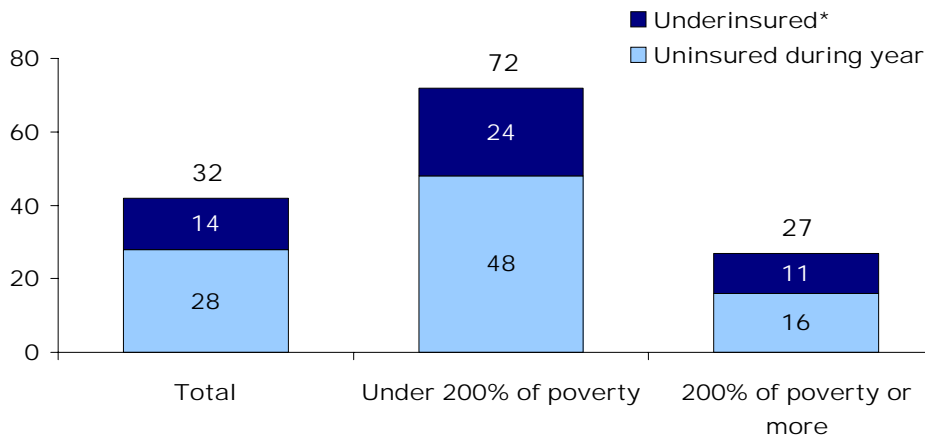


*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
 Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).



Almost Three-Fourths of Low-Income Adults Ages 19-64 Are Uninsured and Underinsured, 2007

8

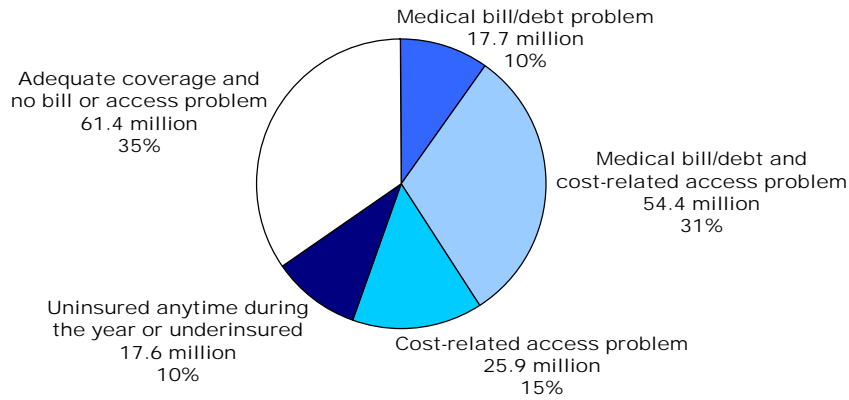


* Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of incomes if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
 Data: 2007 Commonwealth Fund Biennial Health Insurance Survey (Schoen et al. 2008).



An Estimated 116 Million Adults Were Uninsured, Underinsured, Reported a Medical Bill Problem, and/or Did Not Access Needed Health Care Because of Cost, 2007

9



177 million adults, ages 19-64

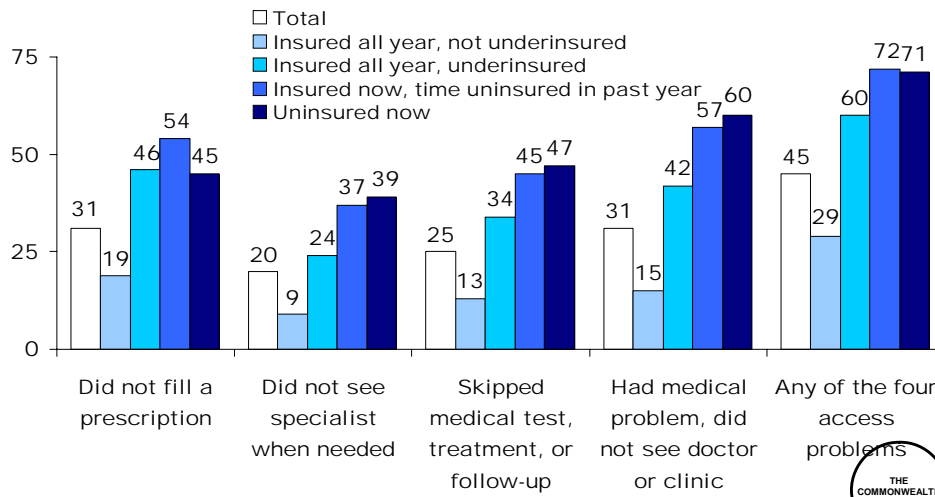


Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Uninsured and Underinsured Adults Report High Rates of Cost-Related Access Problems

10

Percent of adults ages 19-64 who had cost-related access problems in the past 12 months

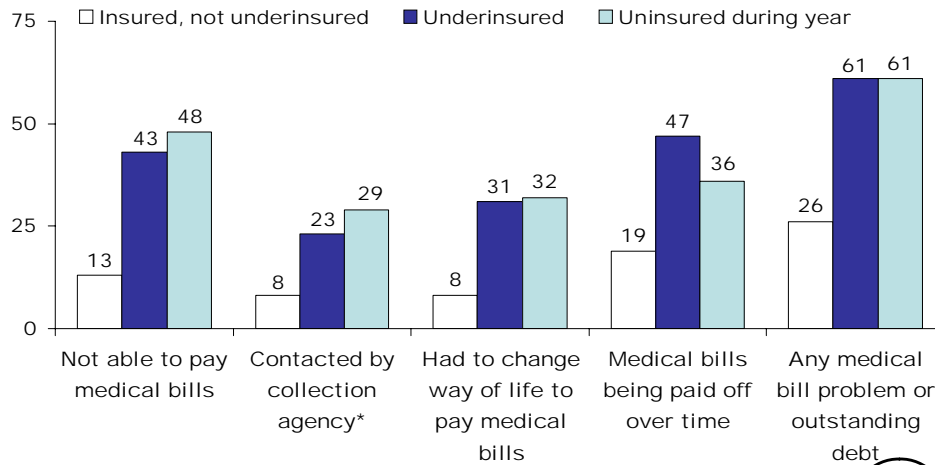


Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).



Sixty Percent of Adults Who Were Underinsured or Uninsured Reported Medical Bill Problems or Debt ¹¹

Percent of adults ages 19-64

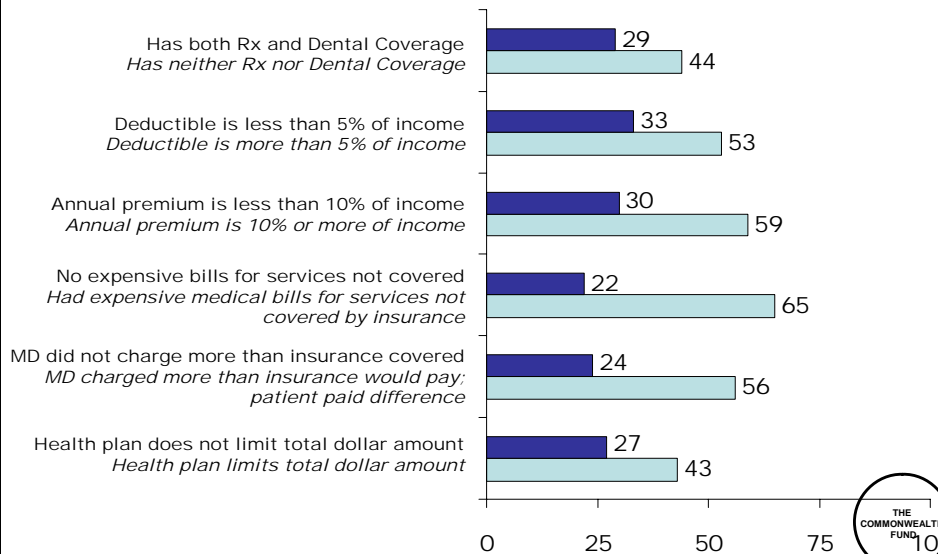


* Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).



Insured Adults with Less Comprehensive Coverage and Benefit Limits Are More Likely to Face Medical Bill and/or Debt Problems ¹²

Percent of continually insured adults ages 19-64 with bill and/or debt problems

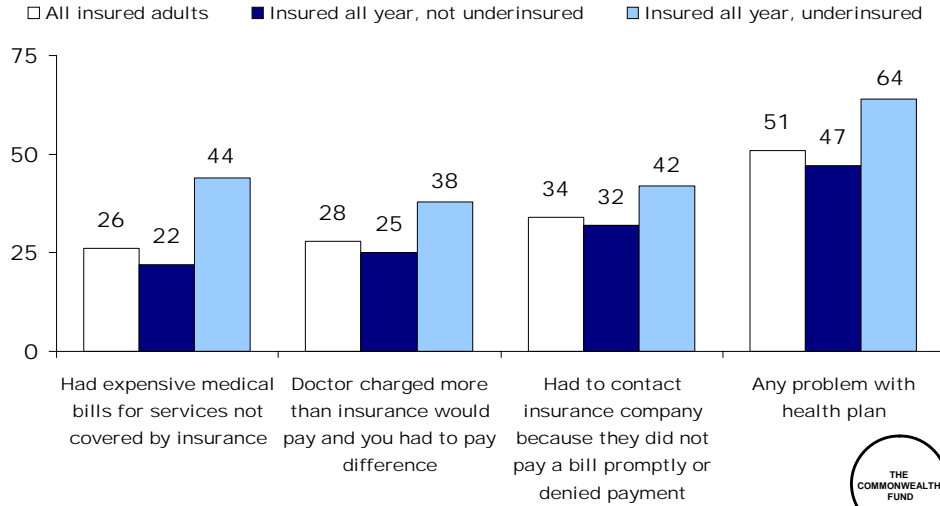


Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.



Underinsured Adults Report Higher Rates of Health Insurance Plan Problems than Adults with Adequate Insurance ¹³

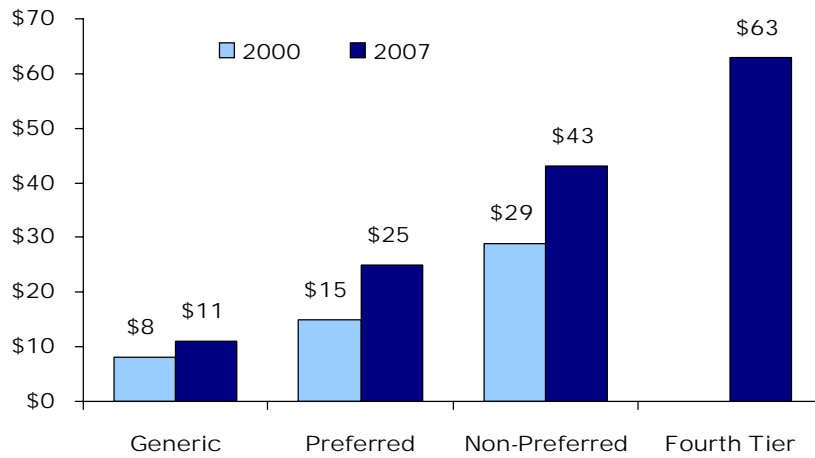
Percent of adults ages 19–64 who were insured all year and had problems with health insurance plan



Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).



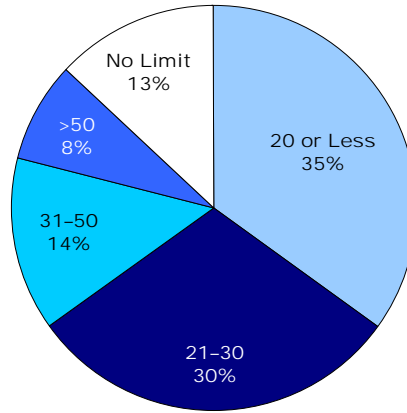
Prescription Drug Cost-Sharing, Average Copayments Among Covered Workers, 2000–2007 ¹⁴



Source: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2007 Annual Survey.



Annual Outpatient Visits Coverage Among Workers with Mental Health Coverage, 2006 ¹⁵



All Plans

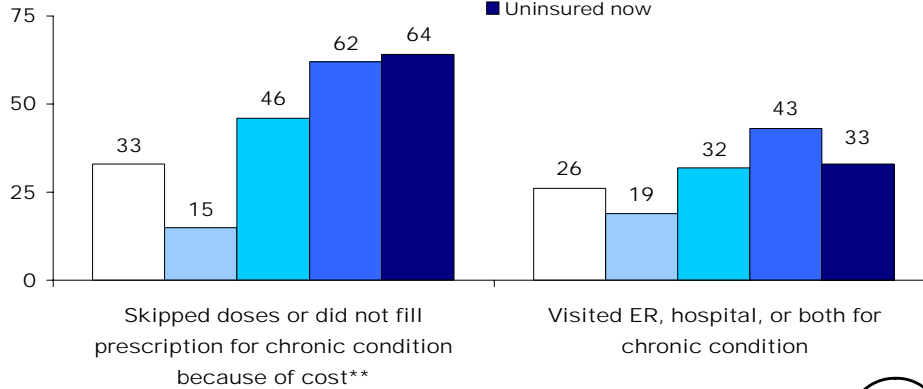
Source: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2007 Annual Survey.



Uninsured and Underinsured Adults with Chronic Conditions Are More Likely to Visit the ER for Their Conditions ¹⁶

Percent of adults ages 19-64 with at least one chronic condition*

Total
 Insured all year, not underinsured
 Insured all year, underinsured
 Insured now, time uninsured in past year
 Uninsured now



* Hypertension, high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease.

** Adults with at least one chronic condition who take prescription medications on a regular basis.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

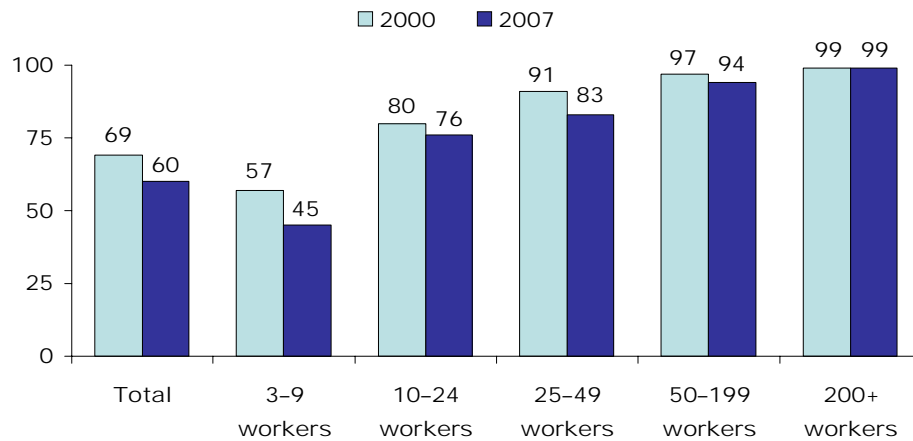


Coverage Is Eroding in Small Firms



Employer Coverage Continues to Erode for Employees of Small Firms

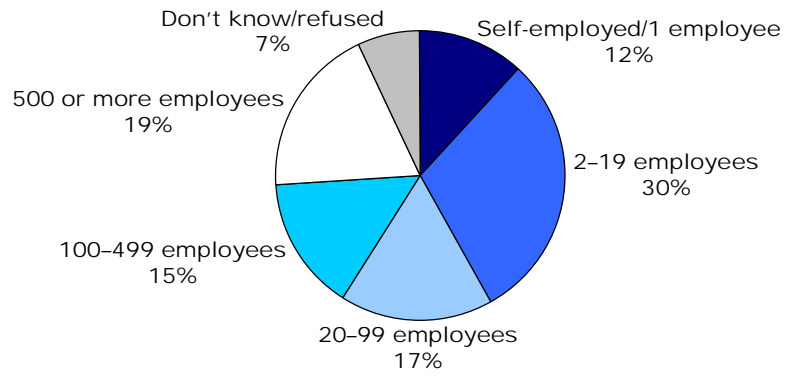
Percent of firms offering health benefits



Source: S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007). Data: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2007 Annual Surveys.



Three of Five Workers with Any Time Uninsured Are Self-Employed or in Firms with Fewer than 100 Workers

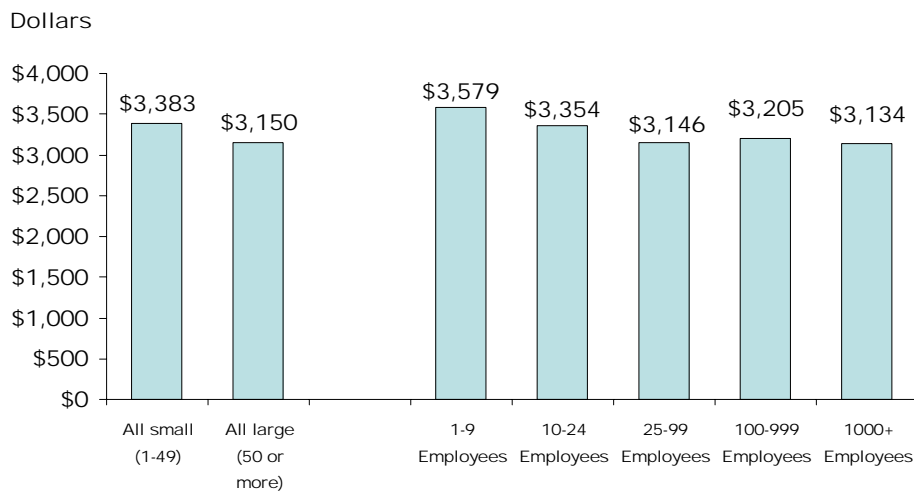


Full-time or part-time working adults ages 19-64 with any time uninsured, by employer size (27.5 million)



Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Single Premium by Size of Firm, Adjusted for Actuarial Value

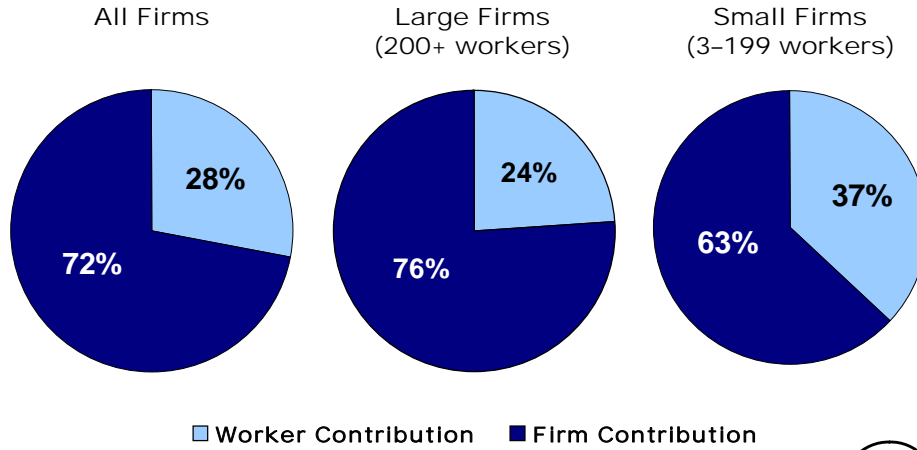


Source: J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs*, May/June 2006 25(3):832-43.



Small-Firm Workers More Likely than Large-Firm Workers to Contribute Large Share of Premium for Family Coverage

21



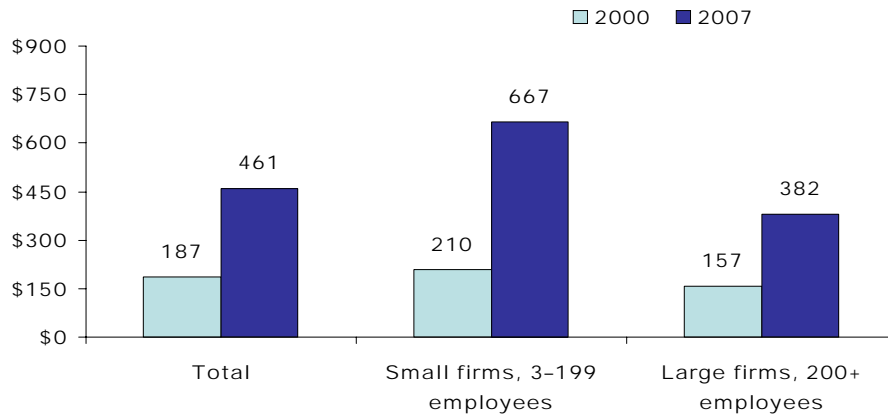
Source: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2007 Annual Survey.



Deductibles Have Risen Sharply, Especially in Small Firms, Over 2000-2007

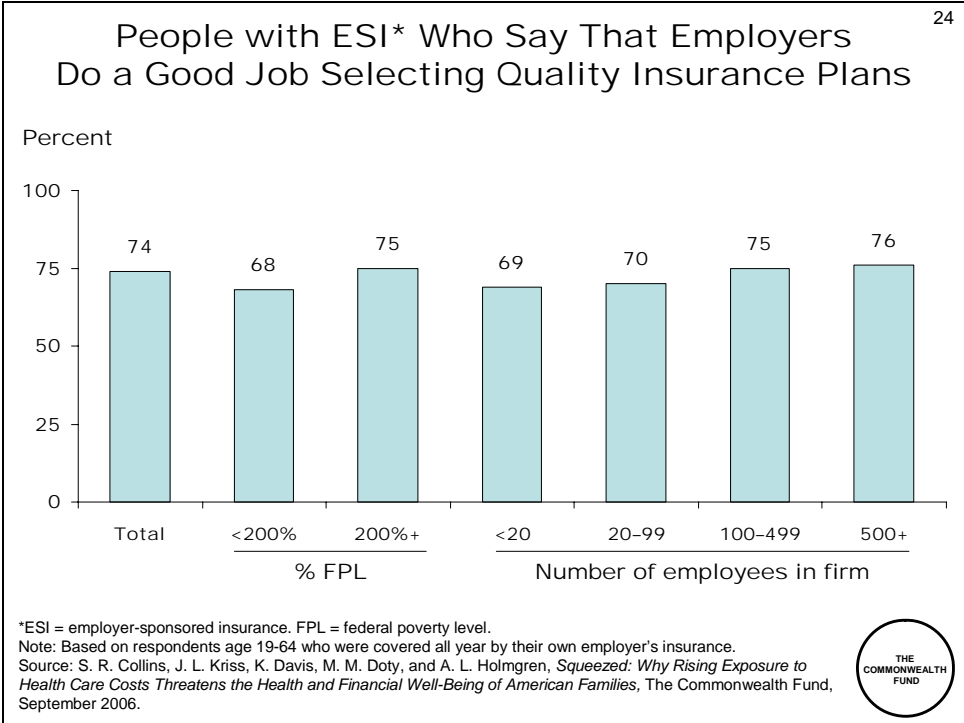
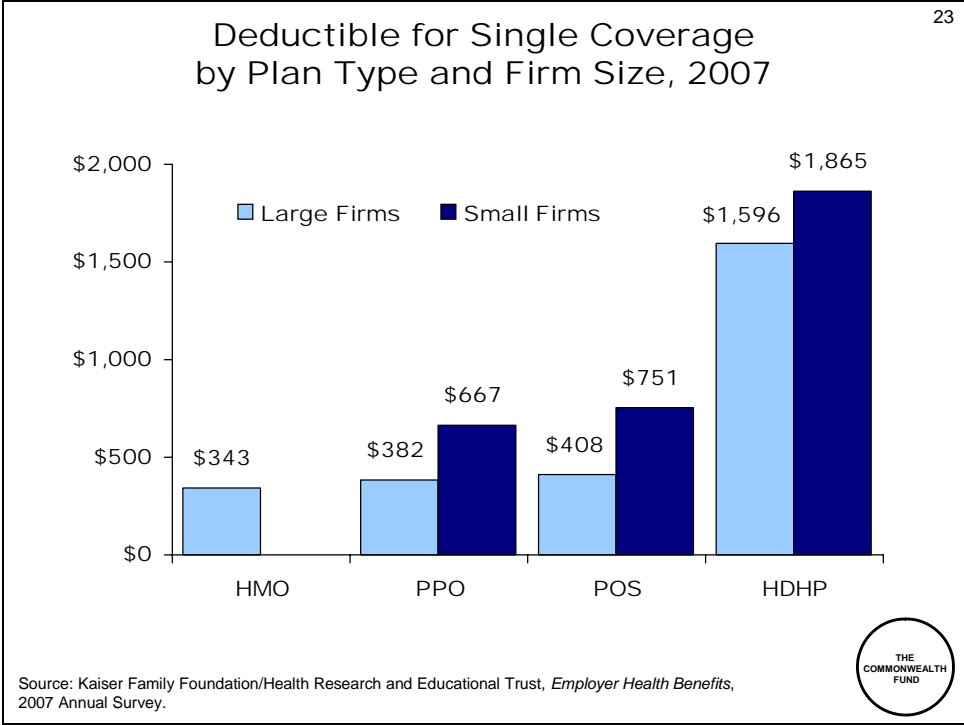
22

Mean deductible for single coverage (PPO, in-network)



PPO = preferred provider organization. PPOs covered 57 percent of workers enrolled in an employer-sponsored health insurance plan in 2007.
Source: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2007 Annual Surveys.





Individual Insurance Market Works Less Well than Employer Coverage



Individual Market Is Not an Affordable Option for Many People

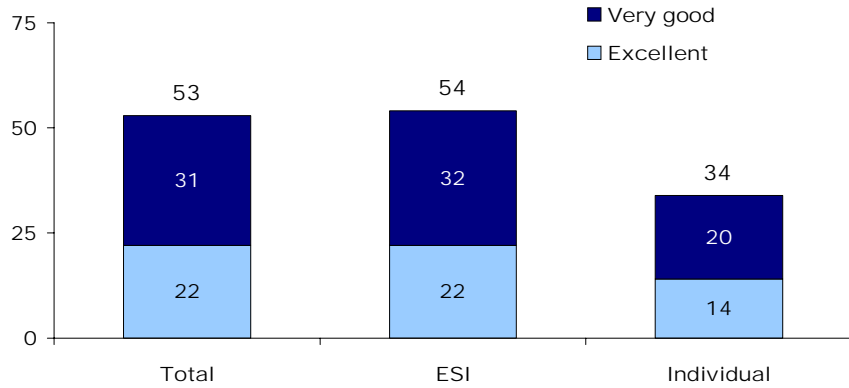
Adults ages 19–64 with individual coverage or who thought about or tried to buy it in past three years who:	Total	Health Problem	No Health Problem	<200% Poverty	200%+ Poverty
Found it very difficult or impossible to find coverage they needed	34%	48%	24%	43%	29%
Found it very difficult or impossible to find affordable coverage	58	71	48	72	50
Were turned down or charged a higher price because of a pre-existing condition	21	33	12	26	18
Never bought a plan	89	92	86	93	86

Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, The Commonwealth Fund, September 2006.



Adults with Employer Coverage Give Their Health Plans Higher Ratings Than Those in the Individual Market

Percent of adults ages 19-64 insured all year with private insurance

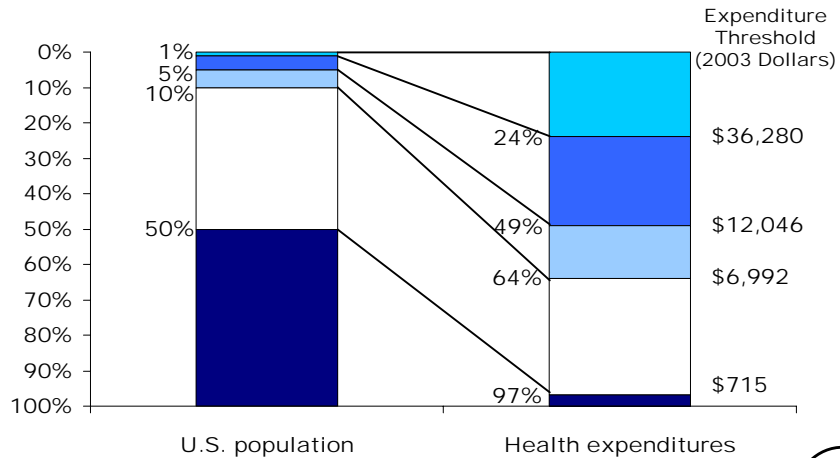


Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, The Commonwealth Fund, September 2006.



Health Care Costs Concentrated in Sick Few—Sickest 10% Account for 64% of Expenses

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2003

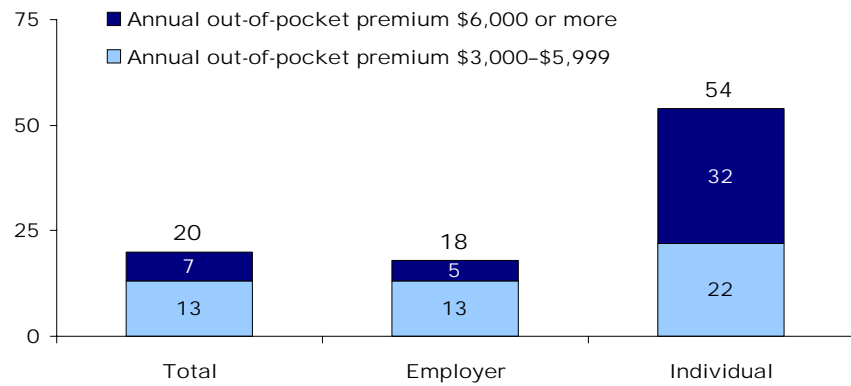


Source: S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan/Feb 2007 26(1): 249-257.



29
 Risk Pooling and Employer Premium Contributions Lower the Cost of Health Benefits for Adults with Employer Coverage Relative to Those with Individual Market Coverage

Percent of adults ages 19-64 insured all year with private insurance



Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, The Commonwealth Fund, September 2006.

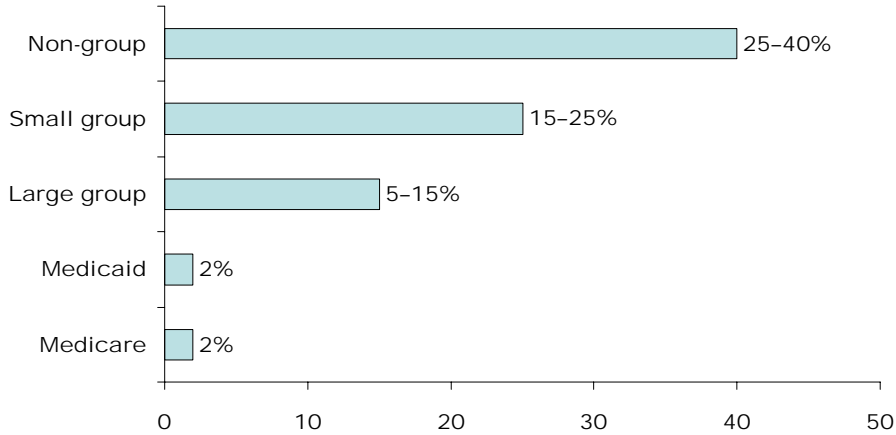


Public Programs Work



Only Two Percent of Premiums in Medicare and Medicaid Are Spent on Non-Medical Expenditures

Percent of premiums spent on non-medical expenditures

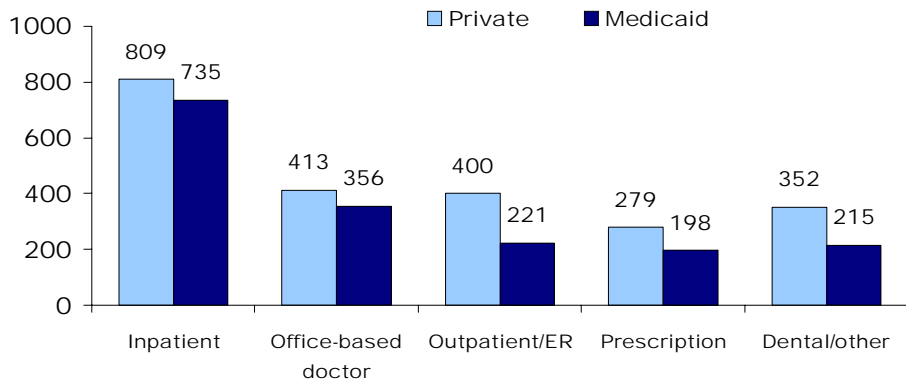


Source: K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employees Health Benefit Program: A Model for Workers, Not Medicare*, The Commonwealth Fund, November 2003; M. A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs*, March/April 2000 19(2):173-84.



Medicaid's Spending on Health Services Is Lower Than That of Private Coverage

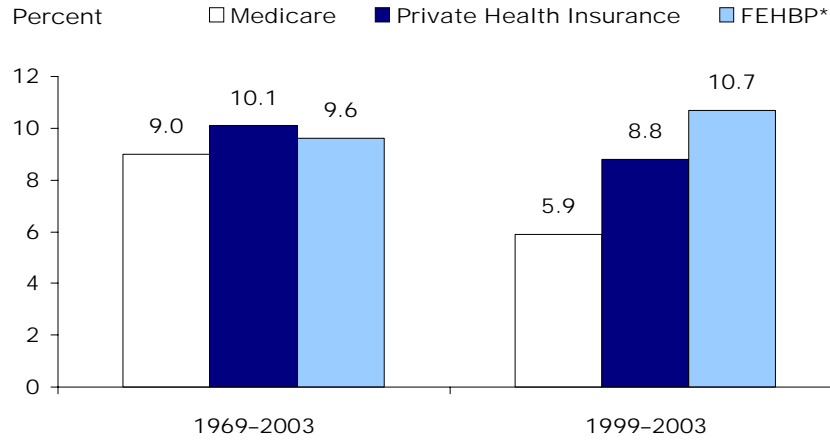
Expenditures (\$) on health services for people without health limitations in private coverage and Medicaid



Source: J. Hadley and J. Holahan "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry*, Winter 2003 40(4):323-42.



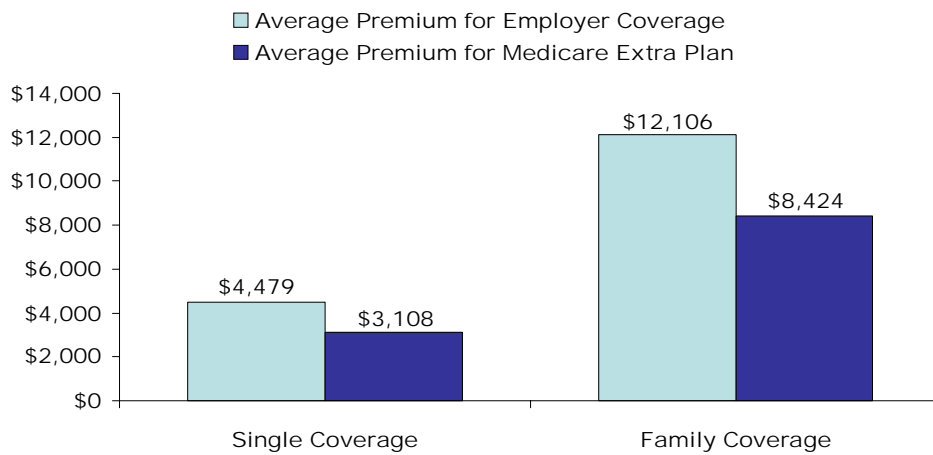
Percent Annual Per Enrollee Growth in Medicare Spending and Private Health Insurance and FEHBP Premiums for Common Benefits



* FEHBP estimates are for 1969-2002 and 1999-2002 from Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23 (January/February 2004):147-59.
 Source: Analysis by Office of the Actuary, Centers for Medicare and Medicaid Services, January 2005.



Medicare Extra Plan Would Lower Annual Premiums for Individuals and Families

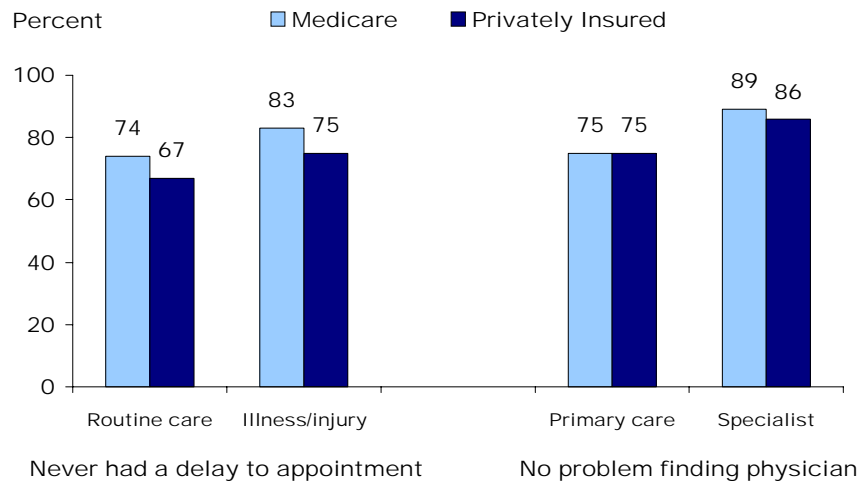


Source: C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May/June 2008 27(3):646-57; G. Claxton, "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs*, September/October 2007 26(5):1407-16.



Medicare Beneficiaries Have Better Access to Physician Services than Privately Insured People, 2005

35



Source: MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p. 85.

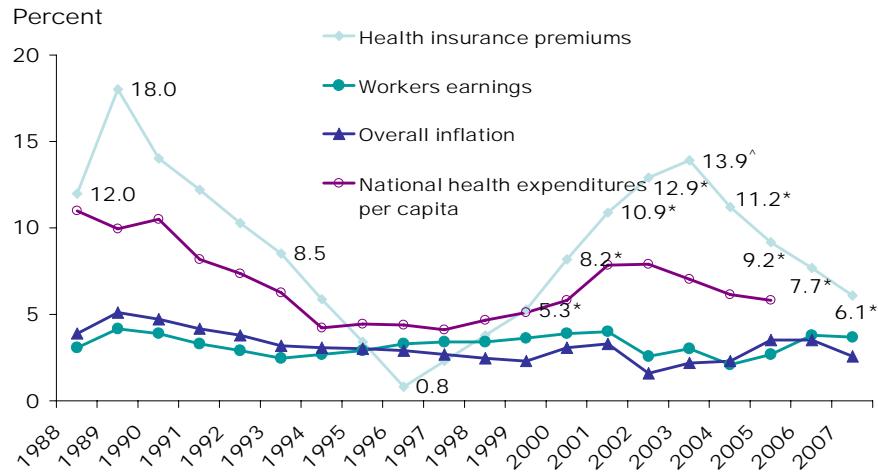


Rising Premiums and Insurance Administrative Costs

36



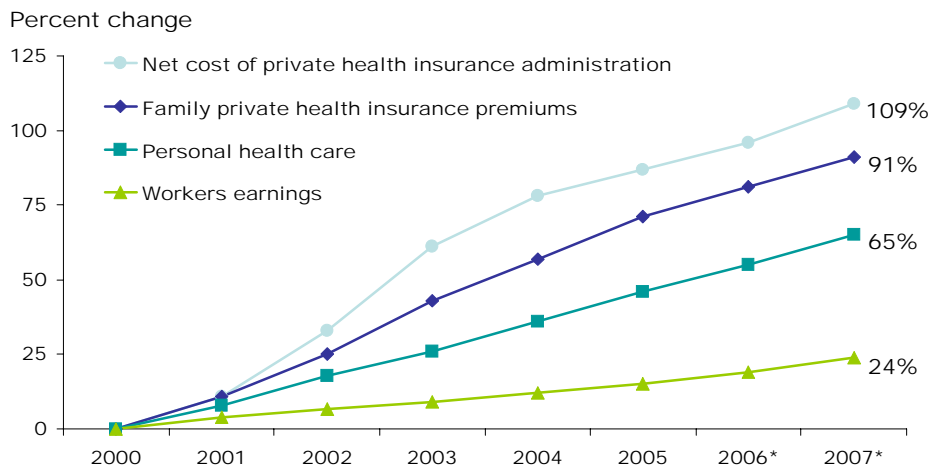
Increases in Health Insurance Premiums Compared with Other Indicators, 1988-2006



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007, and Commonwealth Fund analysis of National Health Expenditures data.
 * Estimate is statistically different from the previous year shown at p<0.05.
 ^ Estimate is statistically different from the previous year shown at p<0.1.
 Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).



Cumulative Changes in Annual National Health Expenditures and Other Indicators, 2000-2007

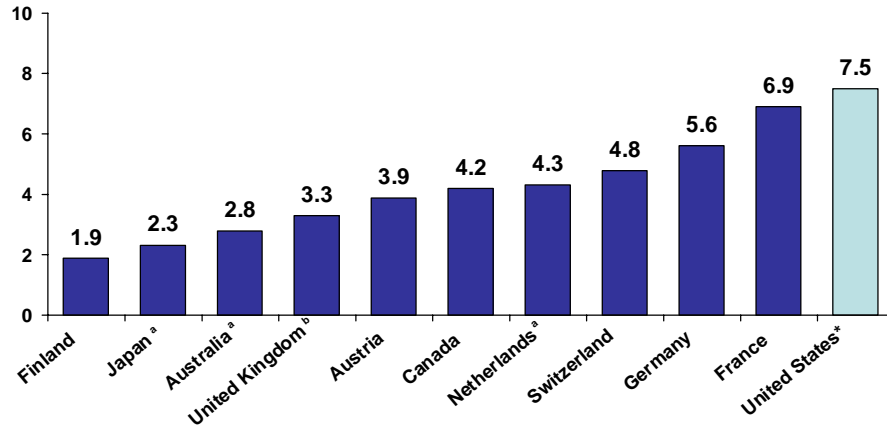


Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four/the average premium increase is weighted by covered workers. * 2006 and 2007 private insurance administration and personal health care spending growth rates are projections.
 Sources: A. Catlin, C. Cowan, S. Heffler et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):143-53; J. A. Poisal, C. Truffer, S. Smith et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs* Web Exclusive (Feb. 21, 2007):w242-w253; Henry J. Kaiser Family Foundation, Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000-2007* (Washington, D.C.: KFF/HRET).



Percentage of National Health Expenditures Spent on Insurance Administration, 2005

Net costs of health insurance administration as percent of national health expenditures



^a 2004 ^b 2001

* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.

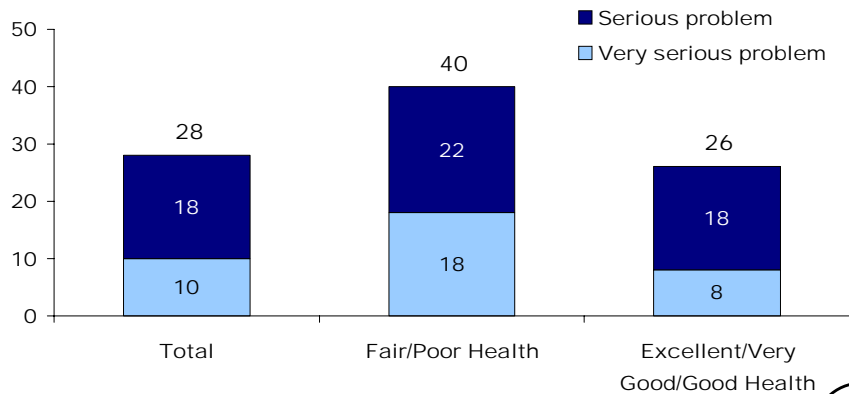
Data: OECD Health Data 2007, Version 10/2007.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008



Administrative Hassles Related to Medical Bills and Insurance Are Serious Problems for More Than a Quarter of Adults

Percent reporting serious problems spending time on paperwork or disputes related to medical bills and health insurance in past two years



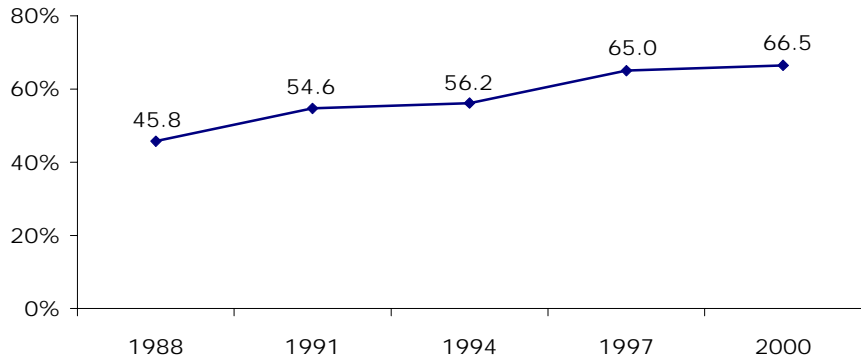
Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, The Commonwealth Fund, September 2006.



Concentration of Managed Care Enrollment, 1988-2000

Two-thirds of managed care enrollees are enrolled in the nation's 10 largest managed care firms.

Percent enrolled in 10 largest firms

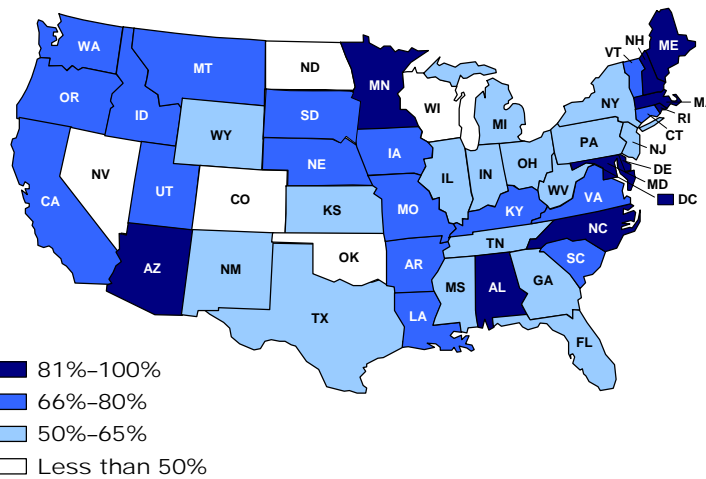


Note: The largest national managed care firms include Blue Cross and Blue Shield plans, Aetna US Healthcare, Kaiser Permanente, United Health, and PacifiCare. HMO enrollment includes enrollees in both traditional HMOs and point-of-service plans.

Source: Centers for Medicare and Medicaid Services, CMS Chart Series, Table 1.17.



Market Share of Three Largest Health Plans, by State, 2002-2003



Note: No data are available for Alaska and Hawaii.
 Source: J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, November/December 2004 23(5):11-24.



Operating Earnings Margin in Largest U.S. Health Plans, 2000-2003

43

Year	WellPoint (excluding Anthem)	Anthem	UnitedHealth Group	Aetna	CIGNA
2000	4.9	8.5	5.7	2.3	3.6
2001	6.6	5.1	6.7	-0.8	8.0
2002	7.1	6.6	8.7	3.2	5.9
2003	8.1	7.8	10.2	7.7	8.9

Note: Operating earnings = earnings before interest and taxes.
 Source: J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance,"
Health Affairs, November/December 2004 23(5):11-24.



Massachusetts Connector Has Improved Choices and Lowered Premiums

44

Typical uninsured 37-year-old, pre- and post-reform

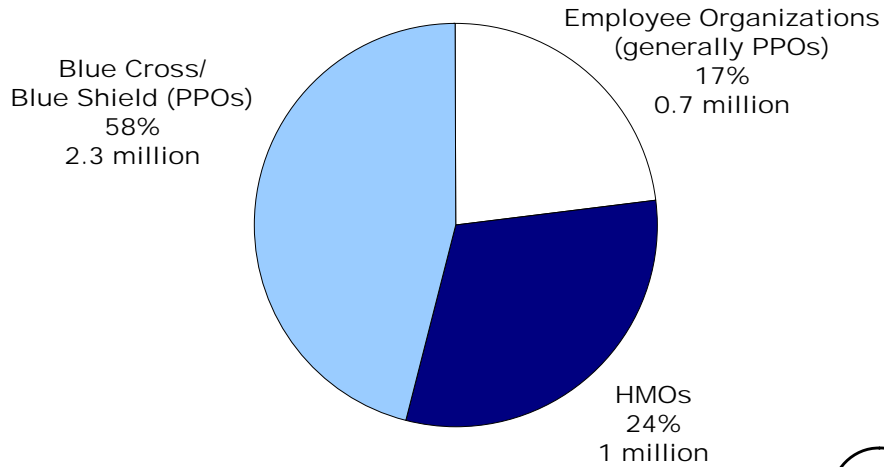
	Pre-reform	Post-reform
Monthly premium	\$335	\$184
Rx coverage	None	\$100 deductible
Deductible	\$5,000	\$2,000

Source: Jon Kingsdale, Executive Director, Commonwealth Health Connector,
 "Design of Connector as an Element of NHI," July 23, 2008.



FEHBP Enrollment by Type of Plan

45



Note: Excludes an estimated 4 million dependents.
Source: Mark Meris, Personal communication, September 16, 2008.



Rules to Improve Functioning of Insurance Markets

46

1. A standard benefit adequate is defined and available to all
2. Premiums to the enrollee for a standard plan are affordable regardless of income
3. Enrollees have and use comparable information
4. Marketing practices which mislead or discriminate against the sick are prohibited and strictly enforced
5. Market rules on guaranteed issue and renewal, community rating
6. Risk-adjustment of premiums
7. Insurers compete on the basis of value-added they bring in fostering quality and efficiency
8. Premiums are reasonable and have low administrative overhead



Conclusion

47

Action is needed to guarantee affordable coverage. This should include:

- Health insurance premium assistance to low-income and modest-income families who can not afford family premiums that now average over \$12,000 even under employer plans.
- Strengthening not weakening employer coverage
- Setting national rules for the operation of individual health insurance markets
- Creating insurance connectors, such as the one in Massachusetts, that make affordable health insurance policies available to those without access to employer coverage
- Offering a public plan modeled on Medicare to small businesses and individuals would lower premiums by 30 percent and increase the stability of insurance coverage.
- Building on Medicare, Medicaid, and SCHIP to cover older adults, the disabled now in the Medicare two-year waiting period, and low-income adults as well as children. Private insurance markets do not serve these populations well.

