INSURANCE DESIGN MATTERS: UNDERINSURED TRENDS, HEALTH AND FINANCIAL RISKS, AND PRINCIPLES FOR REFORM

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EXECUTIVE SUMMARY

Thank you, Mr. Chairman, for the invitation to testify on the underinsured and the implications for national health reform. Rapidly rising health care costs and stagnant incomes have fueled steep erosion in insurance coverage across the nation. In addition to steady increases in the number of people uninsured during the year, we are seeing a surge in the number of adults and families who are "underinsured"—those who are poorly protected in the event of illness although they are insured all year long. In the midst of a severe recession, current trends are saddling individuals with medical debt that can last for years. Although employer coverage remains the mainstay and primary source of insurance for working families, rising costs are stressing private businesses and public employers, leading to shifts of significant financial risk back onto families or drops in coverage. As a nation, we urgently need health reform to provide a more secure foundation for the future.

Insurance reform is essential and central to improving national health system performance. Design matters. To provide a more secure foundation, coverage reforms must be designed to facilitate the two primary goals of health insurance—increasing access to care and providing financial protection. Insurance reforms are also key for providing a strong base for payment and other system changes needed to sustain coverage over time and improve the performance and value we get in return for our nation's unparalleled expenditure on health. Moreover, insurance reforms could focus competition on better outcomes and added value. My remarks this morning and prepared testimony present recent trends, summarize studies regarding the consequences of inadequate coverage and gaps, and discuss design principles with the potential to move our system in new, more positive directions.

Erosion in Coverage: Rising Number Underinsured and Uninsured

- From 2000 to 2007, a time of relatively low unemployment, the number uninsured increased by 7 million. The number of uninsured is projected to reach 61 million over the next decade, assuming recovery from the current recession. Moreover, these estimates do not include all of those who lose coverage for at least part of the year.
- From 2003 to 2007, the number of adults who were insured all year but were underinsured increased by 60 percent. Based on those who incur high out-of-pocket costs relative to their income not counting premiums despite having coverage all year, an estimated 25 million adults under age 65 were underinsured in 2007.
- Erosion in benefits is moving up the income scale. The percent underinsured nearly tripled among adults with annual incomes in the middle-income range. Although low-income adults are most at risk, more than one of four adults with incomes above 200 percent of the federal poverty level were underinsured or uninsured in 2007. In total, 42 percent of *all* adults were either uninsured or underinsured.
- The underinsured were more likely to report limits on benefits, gaps in benefits, and higher deductibles than those without high costs relative to income. At the same time, underinsured adults devoted a high share of their income to premiums.

Access, Quality, and Health at Risk: Consequences of Inadequate Insurance

- Compared with adults with more adequate coverage, underinsured and uninsured adults were far more likely to go without needed care because of costs—over half of the underinsured and two-thirds of the uninsured went without recommended treatment, follow-up care, or medications, or did not see a doctor when sick. Half of both groups faced financial stress, including medical debt. Indeed, experiences among the underinsured and the uninsured were often similar.
- The share of adults under age 65 who went without needed care because of costs increased sharply from 2001 to 2007, rising from 29 percent to 45 percent. Rates were up across all income groups, providing evidence of the breadth of coverage erosion. Middle-income adults, although typically insured all year, reported the steepest increases, jumping from 24 percent to 43 percent.
- Among adults with chronic diseases, half of the underinsured and more than 60 percent of the uninsured skipped medications for their conditions because of cost. Both groups were at higher risk of going to the emergency room or hospital than chronically ill adults who were insured all year and not underinsured.
- In the 2008 Commonwealth Fund eight-nation survey of adults with chronic conditions, the U.S. stands alone with half of all adults forgoing medications, not following up on recommended care, or not going to a doctor when sick because of costs. Rates were high for the insured as well as the uninsured.
- These experiences reflect an ongoing insurance design shift away from pooling risk through premiums toward higher deductibles, limits, and cost-sharing.
- Although the design shift in part aims at incentives to avoid unnecessary care, studies repeatedly find that reductions are about equally likely to occur for effective as more discretionary care. Moreover, low-income individuals are most likely to forego care.
- Recent studies focused on medications find that caps and cost-sharing that do not take the value of care into account lead to adverse health outcomes, including complications from chronic disease, increased hospitalization, and spikes in deaths.
- A study of low-income Medicaid beneficiaries found that interruptions in coverage lead to increases in hospital admissions for ambulatory care-sensitive (potentially preventable) conditions. Yet, we fail to design such programs for continuity.
- Poor access undermines quality and effective care. The U.S. is falling behind other countries in reducing deaths from conditions amenable to health care. As of 2003, we ranked last among 19 industrialized nations. Although the U.S. mortality rates declined marginally (4%), other countries improved faster with an average 16 percent decline in mortality.

Financial Stress and Economic Insecurity

The sharp increase in the number of adults finding it difficult to pay medical bills or in debt is perhaps the most visible consequence of the deterioration in insurance coverage.

- In 2007, 41 percent of adults—72 million people—said they had problems paying their medical bills, faced bill collectors, or were in debt for medical care, up from 34 percent or 58 million in 2005. The majority reported having insurance at the time these bills were incurred.

- The increase occurred across all income groups, though rates were highest among low- and moderate-income families. Underinsured or uninsured adults were most at risk.
- Among those reporting difficulty paying bills or debt, 29 percent were unable to pay for necessities because of medical bills, 39 percent had used up their savings, 30 percent took on credit card debt, and 10 percent added mortgages against their home.

It is important to remember that this stress occurred during a time of relatively low unemployment, well before the current severe recession.

Moving in New Directions: Insurance and Health System Reform

To move in a more positive direction, it is critical that we extend affordable insurance to all and do so in a way that ensures access and provides financial protection. Coverage expansion and insurance reform are essential to addressing rising costs as well as concerns about wide variations in quality and health care delivery system performance. Fractured insurance makes it difficult to develop coherent payment policies that could align incentives with better outcomes and prudent use of resources. Unstable coverage, complex benefit variations, and fragmented markets also increase administrative costs and erode incentives to invest in population health for the long term.

Attention to insurance design is essential to provide affordable coverage for all in a manner that ensures access to health care and financial protection. Needed reforms include:

- Setting a minimum floor and standard for health insurance with benefits designed to support access to effective care and protection when sick or injured.
- Providing income-related premiums to ensure coverage is affordable.
- Establishing lower cost-sharing and ceilings on out-of-pocket expenses for low-income families.
- Limiting the range of variation to facilitate choice and discourage risk segmentation. This would also facilitate the publication of useful comparisons.
- Assuring insurance access and renewal and prohibiting premium variations based on health risks. Coupled with risk-adjusted premiums, such insurance market reforms would focus competition on outcomes and added value.
- Structuring insurance choices through a national insurance exchange to help individuals and families choose coverage and stay continually insured.

The design of insurance reforms should also aim to provide a more secure foundation for payment and system reforms. Without a comprehensive approach to improve the quality and cost performance of the U.S. health system, coverage expansions will be difficult to sustain.

A recent report by the Commonwealth Fund Commission on a High Performance Health System illustrates the potential of an integrated set of strategies. The analysis indicates reforms to provide affordable, adequate coverage for all, align incentives with value, and invest in essential information systems and public health measures have the potential to achieve better access for all, improve health outcomes, and reduce projected growth in national spending by $3 trillion through 2020 (11 years) if reforms begin in 2010. National spending would continue to increase but at a much slower rate.

Although politically difficult, there is an urgent need to move in a new direction. Wide public concern and stress on private business and the public sector make it increasingly clear that we cannot afford to maintain the status quo. Each year we wait, the problems grow worse. The nation needs national leadership and public–private sector collaboration to forge consensus to move in positive directions. Insurance coverage reform, coupled with payment and delivery system changes, have the potential to bend the curve of our nation's spending on health and put the nation on a path to high performance. The time has come to act.

Thank you for the opportunity to testify. This hearing could not be more timely.

INSURANCE DESIGN MATTERS: UNDERINSURED TRENDS, HEALTH AND FINANCIAL RISKS, AND PRINCIPLES FOR REFORM

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Thank you, Mr. Chairman, for the invitation to testify on the underinsured and the implications for national health reform. Rapidly rising health care costs and stagnant incomes have fueled steep erosion in insurance coverage across the nation. In addition to steady increases in the number of people uninsured during the year, we are seeing a surge in the number of adults and families who are "underinsured"— these are adults who are poorly protected in the event of illness although insured all year long. Efforts to moderate premium increases have led to higher deductibles, increased cost-sharing, and limits or caps on benefits. Shifting the costs onto individuals and their families and away from pooling risk through premiums is threatening the health and economic security of the nation. In the midst of a severe recession, current trends are saddling vulnerable families with medical debt that can last for years. Although employer coverage remains the mainstay and primary source of insurance for workers and their families, rising costs are stressing private businesses and public employers. The U.S. is already by far the most expensive health system in the world, and the gap is rapidly widening. As a nation, we urgently need health reform, starting with insurance to provide a more secure foundation for the future.

Coverage reform is essential. Yet, the way it is designed matters critically for facilitating access and providing financial protection when sick—the primary goals of health insurance. Insurance reforms are also key for providing a strong base for payment and other system reforms that would enable us to sustain coverage over time by improving the performance and value we get in return for our already high investment in the health system. Moreover, insurance reforms could focus competition on better outcomes and added value.

In my remarks and prepared testimony, I present recent studies on the trends and consequences of the rising number of underinsured and then discuss insurance benefit design principles to move in a new direction with national health reform. In the discussion of trends, it is important to remember that all these studies were conducted during a period of relatively low unemployment. Thus, they vastly understate the current urgent need for reform to secure the nation's health and economic well-being.

Steep Erosion in Coverage: Rising Numbers Uninsured and Underinsured

Well before the current severe recession, coverage has been eroding for the under-65 population. The number uninsured increased by 7 million people from 2000 to 2007, reaching 47 million in a period of relatively low unemployment (Exhibit 1).[1] The increase was concentrated among working-age adults. With a few exceptions, the time-trend map of uninsured adults by state shows a loss in coverage across the country (Exhibit 2). Children's coverage—the only bright spot—improved thanks to expansions to low-income families through the Children's Health Insurance Program (CHIP). Still, 8 million children remain uninsured, and many do not have continuous coverage. Our fractured insurance system and complex eligibility rules result in millions of adults and children moving in and out of coverage from job loss, shifts in employment, or other changes in income or family relationships. Even growing a year older—for instance, when one reaches a 19th birthday—makes a difference.[2] Those at risk of churning in and out of coverage, as well as those remaining uninsured for long periods, are likely to experience considerable access problems and financial stress.

All projections indicate that without national policy action to stem the tide, the number of people who are uninsured at any moment in time will continue to increase rapidly. Assuming we recover from the current recession, projections estimate 61 million will be uninsured by 2020 (Exhibit 1). These uninsured estimates do not count all the people who lose coverage for a period of time during the year: as of 2007, almost 30 percent of adults under age 65 were uninsured for some time during the year.[3]

Millions more are "underinsured"—insured all year yet facing such high cost-sharing relative to income that they lack adequate financial protection when sick or injured. In our recent study of underinsured trends from 2003 to 2007, we defined adults as underinsured if they had insurance all year *and* had out-of-pocket expenses for medical care of 10 percent or more of their annual income or 5 percent if low income (under 200 percent of poverty) or had a deductible that was 5 percent or more of income.[4] Notably, this definition will miss those with inadequate coverage who were healthy during the year—in other words, the estimate is likely to be conservative. [5]

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

[2] J. L. Kriss, S. R. Collins, B. Mahato, E. Gould, and C. Schoen, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update* (New York: The Commonwealth Fund, May 2008).

[3] 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).

[4] 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):w298–w309.

Using this financial definition of the underinsured, as of 2007, 25 million adults ages 19 to 64 were underinsured—a 60 percent increase from 2003 (Exhibit 3). Adding underinsured adults to those uninsured when surveyed or uninsured earlier in the year, more than 75 million—two of five adults—were either underinsured or uninsured during 2007, a sharp increase since 2003. Low-income adults are the most likely to be underinsured or uninsured, yet middle- and higher-income families experienced the most rapid deterioration in protection (Exhibit 4). The percent underinsured nearly tripled for adults in families with incomes of 200 percent of poverty or more (annual family incomes of $40,000 or higher). As of 2007, more than one of four adults (27%) with incomes placing them solidly into the middle class was either underinsured or uninsured. Overall, lower-income adults have been hardest hit: nearly three-fourths (72%) uninsured or underinsured. These low-income adults rarely have health insurance benefits through their jobs yet by working have incomes that make them ineligible for public safety net insurance programs in most states.[6]

Access and Health at Risk: Consequences of Inadequate Insurance and Gaps

The core goals of health insurance are to provide timely and affordable access to care and to protect against the costs of illnesses and injuries. The ongoing deterioration of benefits undermines both goals as benefit designs increasingly shift costs onto the budgets of individuals and families when sick.

According to the same Commonwealth Fund 2007 study, one-fourth of underinsured adults reported deductibles of $1,000 or more, compared with 8 percent of insured adults not classified as underinsured. More than 40 percent of underinsured adults paid 5 percent and one-fifth spent 10 percent or more of their income for their insurance. Premiums are up but people are getting less coverage in return: compared to those with more adequate coverage, underinsured adults were less likely to have prescription benefits and more likely to have limits on the amount a plan would pay or on the number of visits allowed.

Given higher cost-sharing and thinner insurance benefits, the underinsured as well as those uninsured are at very high risk of going without needed care because of costs. Controlling for income, health, and other demographic differences, more than half of underinsured and over two-thirds of uninsured adults went without recommended medications, follow-up care or treatment, or did not see a doctor when sick because of costs during the year (Exhibit 5). Underinsured rates of foregone care were often similar

[5] A financial definition of the underinsured builds on the seminal work of Pamela Farley Short. For early studies, see: P.F. Short and J. Banthin, "New Estimates of the Underinsured Younger than Sixty-five Years," *Journal of the American Medical Association* 1995, 274 (16):1302-1306 and P.J. Farley, "Who Are the Underinsured?" *Milbank Quarterly* 1985, 63 (3): 476-503.

[6] J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007). See page 23.

to rates reported by the uninsured, and cost-related access concerns were typically two to three times higher than those reported by adults with more adequate coverage.

As a whole, the share of non-elderly adults who went without care because of costs increased from 29 percent to 45 percent between 2001 and 2007. Rates increased across all income groups, yet moderate- and middle-income adults experienced more rapid increases (Exhibit 6). While most were insured all year, adults with incomes between $40,000 and $60,000 went without needed care due to costs at rates similar to those reported by low-income adults in 2001. This shift up the income scale further reflects the thinning of benefits.

Multiple studies provide evidence that exposure to costs have negative effects on access to care for those with chronic conditions, undermining efforts to manage conditions and prevent complications.[7] In the Commonwealth Fund 2007 survey, we focused on adults with any of four chronic conditions: high blood pressure, heart disease, diabetes, or asthma/other chronic lung conditions. Among these chronically ill adults, nearly half of underinsured adults and over 60 percent of those uninsured skipped doses or did not fill prescriptions for their chronic conditions (Exhibit 7). Lack of access to preventive services, primary care, and ongoing care for chronic conditions contributes to increased reliance on hospital emergency room (ER) care or hospitalization. One-third of underinsured chronically ills adults in the study went to the ER or were admitted to a hospital. Rates were similar to those reported by uninsured adults. Recent studies indicate overcrowding of ERs is a result of more insured as well as uninsured people turning to this safety net.[8]

Patient-reported experiences are consistent with and confirm a rich array of studies that find that cost-sharing, unless designed with a focus on value, can result in the insured foregoing essential and effective care, especially when costs are high relative to incomes. Those with low or modest incomes are particularly at risk. Early on, the RAND health insurance experiment pointed to the need to design benefits carefully to encourage

[7] M. E. Chernew, A. B. Rosen, and A. M. Fendrick, "Value-Based Insurance Design," *Health Affairs,* March/April 2007 26(2):w195–w203; M. E. Chernew, T. B. Gibson, K. Yu-Isenberg et al., "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care," *Journal of General Internal Medicine*, Aug. 2008 (8):1131–1136; D.P. Goldman, G. F. Joyce, J. J. Escarce et al., "Pharmacy Benefits and Use of Drugs by the Chronically Ill," *Journal of the American Medical Association* 291, no. 19 (2004): 2344–2350; M.D. Wong, R. Andersen, C. D. Sherbourne et al., "Effects of Cost Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study," *American Journal of Public Health* 91, no. 11 (2001): 1889–1894; Jonathan Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond* (Washington D.C.:Kaiser Family Foundation, Oct. 2006.

[8] M. F. Newton, C. C. Keirns, R. Cunningham et al., "Uninsured Adults Presenting to US Emergency Departments: Assumptions vs. Data," *Journal of the American Medical Association*, Oct. 2008 300(16):1914–24.

effective care.[9] This seminal study found that cost-sharing reduced the likelihood of receiving highly effective care as well as more discretionary care (Exhibit 8). Access for low-income children and adults was particularly sensitive despite the fact that the RAND design capped financial exposure relative to income. Among those with chronic disease and low incomes, RAND found delayed or foregone care had adverse health effects.[10]

Recent studies reach the same conclusion, pointing to the importance of benefit designs that encourage effective and preventive care, including essential medications. A Canadian study assessing the impact of increased cost-shares for medications among the elderly and low-income, found a steep reduction in use of essential medications and a sharp increase in adverse events (i.e., complications and deaths) as well as increased use of the emergency department (Exhibit 9).[11] In the U.S., Hsu and colleagues at Kaiser Permanente found that placing a limit on pharmacy benefits led to patients skipping their blood pressure and other essential medications (Exhibit 10). Consequences included poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels.[12] The study also found a spike in mortality. Moreover, cost savings from capping benefits were offset by increases in the costs of hospitalization and ER use.[13]

Preventive measures can avoid or delay the onset of many conditions. Nationally, we see broad evidence of failure to intervene early or provide preventive care, with gaps in coverage contributing to poor quality care. Adults in the U.S. receive the recommended screenings and preventive care for their age groups only half the time.[14] Those uninsured for any time during the year are the least likely to receive preventive care but rates are also low among the insured (Exhibit 11). The underinsured and uninsured often delay or postpone care or go without essential medications and preventive care that could help prevent complications of chronic conditions. Only 63 percent of uninsured adults with diabetes had their illness under control compared with 81 percent of insured adults with diabetes. In addition, uninsured adults reported their high blood pressure was under control at half the rates reported by insured adults.

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[9] K. N. Lohr, R. H. Brook, C. J. Kamberg et al., "Use of medical care in the Rand Health Insurance Experiment. Diagnosis- and service-specific analyses in a randomized controlled trial," *Medical Care*, Sept. 1986 24 (9 Suppl):S1–87; K. Davis, *Will Consumer-Directed Health Care Improve System Performance?* (New York: The Commonwealth Fund) August 2004.

[10] J. Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health insurance Experiment and Beyond* (Washington D.C.: Kaiser Family Foundation) October 2006.

[11] R. Tamblyn, R. Laprise, J. A. Hanley et al., "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," *Journal of the American Medical Association*, Jan. 2001 285(4):421–29.

[12] J. Hsu, M. Price, J. Huang et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine*, June 1, 2006 354(22):2349–59.

[13] See also, S.R. Collins, et al, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2008).

[14] 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* (New York: The Commonwealth Fund, July 2008).

Gaps in coverage increase risks of complications over the longer-term as well. McWilliams and colleagues found that among adults with chronic conditions, previously uninsured adults who acquired Medicare coverage at age 65 reported significantly greater increases in the number of doctor visits and hospitalizations and in total medical expenditures than did previously insured adults, with the difference persisting through age 70.[15]

The leading chronic diseases—diabetes, asthma, congestive heart failure, coronary artery disease, and depression—account for a disproportionate share of potentially preventable complications, severe acute conditions, and related co-morbidities. With early interventions to prevent the onset of disease or deterioration in health, the U.S. could substantially lower health risks and help people lead healthier, longer, and productive lives. Yet, current health insurance design incentives often run counter to goals of chronic care management, preventive care, and incentives for physicians to improve.[16]

Compared to other countries, we are losing ground. In a 2008 eight-country survey that focused on chronically ill adults with recent care experiences, U.S. chronically ill adults were far more likely to go without needed care because of costs than were their counterparts in other countries.[17] More than half of chronically ill U.S. adults did not see a doctor when they were sick or did not adhere to and follow up on recommended care (Exhibit 12). The U.S. rate is double to five times higher than rates of foregone care in seven other countries. U.S. rates were high for both insured and uninsured adults. In contrast to the U.S., the other seven countries have a minimum benefit floor that is comprehensive. Two countries—Germany and France—have special provisions that cap total out-of-pocket spending relative to income for those with chronic conditions. Germany has a general provision that caps expenses at 2 percent of income and lower rate of 1 percent for the chronically ill or disabled. France lowers prescription costs for essential medications and covers care in full for those with serious and chronic diseases.[18]

Those with chronic disease or acute conditions often end up admitted or readmitted to hospitals, with surgery or expensive procedures for preventable complications, such as amputations or kidney dialysis for diabetics. Too often, instead of

[15] J. M. McWilliams, E. Meara, A. M. Zaslavsky, and J. Z. Ayanian, "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine*, July 2007 357(2):143–53.
[16] M. E. Chernew, A. B. Rosen, and A. M. Fendrick, "Value-Based Insurance Design," *Health Affairs* March/April 2007 26(2):w195–w203.
[17] C. Schoen, R. Osborn, S. K. H. How, M. M. Doty, and J. Peugh, "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008," *Health Affairs* Web Exclusive (Nov. 13, 2008):w1–w16.
[18] I. Durand-Zaleski, "The Health System in France," *Eurohealth* 14, no. 1 (2008): 3–4; R. Busse, "The Health System in Germany," *Eurohealth* 14, no. 1 (2008): 5–6.N.

acting early to stop the onset of or complications associated with diabetes, we build dialysis centers and, for Medicare patients, cover the costs of treating end-stage renal disease.[19]

Complications of chronic disease often result in potentially preventable hospitalizations, particularly in low-income communities with reduced access to primary care. As illustrated in the Commonwealth Fund's *National Scorecard on U.S. Health System Performance, 2008*, hospital admissions for ambulatory care-sensitive conditions such as diabetes, asthma and heart failure, are three to five times higher in low-income communities than in higher-income areas (Exhibit 13).[20]

A recent study by Bindman and colleagues underscores the importance of continuous as well as adequate coverage. The study found that interruptions in Medicaid coverage were associated with sharply higher rates of hospitalization for conditions that could have been treated in a much less expensive setting or prevented (Exhibit 14).[21] The probability of hospitalization for ambulatory-care sensitive conditions (e.g. asthma, diabetes, hypertension, pneumonia, ruptured appendix) was eight times higher for those with interrupted coverage—and four times higher after controlling for demographics. In this study of California Medicaid beneficiaries, 62 percent experienced an interruption in coverage during the study period between 1998 and 2002; the average duration of interruption was 25 months. Most became uninsured when they lost Medicaid.

Our failure to provide adequate coverage and ensure access, as well as a lack of emphasis and value for primary and preventive care, undermines the health of the nation. Despite spending far more of our national resources on our the health system, the U.S. is failing to keep pace with other countries in reducing deaths from conditions that are potentially preventable with early access to timely and effective care. From 1997–1998 to 2002–2003, the U.S. fell to last place behind 18 other high-income countries on mortality amenable to health care before age 75 (Exhibit 15). This provides a sensitive measure of potentially preventable deaths, including children dying from infections and respiratory diseases before age 14, diabetic deaths before age 50, appendicitis, and screenable cancers. Although the U.S. rates declined by 4 percent, other country rates improved much faster, with an average decline in mortality of 16 percent. The difference between the U.S. rate and the lowest-rate countries amounts to 100,000 potentially preventable deaths per year.

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[19] D. Tuller, "Overshadowed, Kidney Disease Takes a Growing Toll," *New York Times*, Nov. 18, 2008.
[20] The Commonwealth Fund Commission, *Why Not the Best?*, 2008.
[21] A. Bindman, A. Chattopadhyay and G. Auerback, "Interruptions in Medicaid Coverage and Risks for Hospitalization for Ambulatory Sensitive Conditions," *Annals of Internal Medicine*, Dec. 2008 149(12):854-60.

Financial Stress and Economic Insecurity

The financial and economic consequences of having inadequate insurance or being uninsured are immediate and often long-lived as medical debt accumulates. In our 2007 survey, 72 million adults ages 19–64 (41%) faced problems paying their medical bills or were paying medical debt over time—an increase from 58 million (34%) in 2005 (Exhibit 16). The majority of adults (60%) with bill problems or debt had insurance at the time the health care expenses were incurred.[22] This increase occurred across all income groups, but especially among families with low and moderate incomes: more than half of adults with incomes under $40,000 reported problems with medical bills in 2007 (Exhibit 17). Adults with gaps in health insurance coverage or those underinsured were most at risk of having problems with medical bills: three of five reported any one medical bill problem or accrued medical debt, more than double the rate of those who had adequate insurance all year.

Of the estimated 50 million adults who were paying off medical debt in 2007, many were carrying substantial debt loads that had accrued over time. One-quarter of adults with medical debt were carrying $4,000 or more in debt and 12 percent had $8,000 or more. More than one-third (37%) of adults with medical debt were carrying overdue bills from care received more than one year ago.

In the face of mounting medical bills and debt, many adults are making stark trade-offs in their spending and saving priorities. Among adults who reported financial stress or accumulated debt in 2007, nearly one third (29%) said they had been unable to pay for basic necessities like food, heat, or rent because of medical bills; 39 percent had used all their savings; 30 percent had taken on credit card debt; and 10 percent had taken out a mortgage against their home. Such actions were especially high among people who had spent any time uninsured or among the underinsured. Nearly half of adults who had spent any time uninsured and reported medical bill problems had used all their savings to pay for their medical bills and two of five were unable to pay for food, heat, or rent. Underinsured adults made similar trade-offs: 46 percent said they had used all their savings, 33 percent took on credit card debt, and 29 percent were unable to pay for basic life necessities. In short, underinsured and uninsured adults are going without care *and* living with the financial stress of medical bills. The U.S. is unique among industrialized countries: it is possible to be insured all year yet face bankruptcy or exhaust savings for retirement or college if you get sick.

To date, much of the erosion in more comprehensive coverage, including benefit limits has occurred in the small-group and individual market. Although there has been a broad trend toward higher cost-sharing, including higher deductibles and copayments for medications and other care, employees of small businesses have been particularly hard

[22] S.R. Collins, J.L.Kriss, M.M. Doty et al., *Losing Ground,* 2008.

hit. Without the leverage and risk pool of large firms, small businesses tend to pay the same premiums or more for less comprehensive coverage.[23] As employers try to "buy down" the cost of premiums to hold onto coverage, average deductibles for single coverage in PPO plans for small firms have quadrupled since 2000 (Exhibit 18). [24] Similarly, those insured through the individual market tend to pay more and get less due to much higher administrative costs (including underwriting and marketing) and restrictions in benefits. Coverage equivalent to employer plans in the individual market—if available—is estimated to cost at least an additional $2,000.[25] Plans in the individual market and small firm market are also more likely to place restrictions on benefits, including caps on the amounts plans will pay.

Moving in New Directions: Insurance and System Reforms

Extending affordable insurance to all and doing so in a way that ensures access and provides financial protection is critical to moving in a more positive direction. The U.S. leads the world in health care spending. At an expected 17 percent of gross domestic product (GDP) in 2009, we are an outlier and spending per person is double or more what other countries spend. With current trends, the share of GDP spent on health care is projected to increase to 21 percent by 2020. At the same time, millions more individuals will lose basic access to care.[26]

Insurance reform is essential to address rising costs, as well as growing concerns about wide variations in quality and health care delivery system performance. In addition to access concerns, the fractured insurance makes it difficult to develop coherent payment policies that could align incentives with better outcomes and more prudent use of resources. Further, insurance markets do not align incentives to reward added value—better outcomes as well as efficient use of resources.

Discontinuous coverage increases administrative costs and erodes incentives to invest in population health and disease prevention for the long term. Further, competing private insurance plans can often gain at the margin by using benefit designs that segment patients by health risk or deny or limit coverage and care to the sickest. For instance, by limiting benefits for chemotherapy without regard to effective care or cost-sharing,

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[23] J. R. Gabel and J. D. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees* (New York: The Commonwealth Fund, April 2004).

[24] G. Claxton, J. Gabel, B. DiJulio et al., "Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises In Small Firms," *Health Affairs* Web Exclusive (Sept. 24, 2008):w492–w502.

[25] T. Buchmueller, S.A. Glied, A. Royalty, and K. Swartz, "Cost and Coverage Implications of the McCain Plan to Restructure Health Insurance," *Health Affairs* Web Exclusive (Sept. 16, 2008):w472–w481.

[26] The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund) February 2009. 2020 estimates from the Lewin Group. International comparisons from OECD.

insurance companies can lower premiums. Ten percent of the sickest share of the population account for 64 percent of total national spending each year—the healthiest half account for only 3 percent (Exhibit 19).[27] With such highly concentrated expenditures, there is a strong financial incentive to appeal to the healthier half of the population—even a small increase or decrease in the share of the sickest 10 percent enrolled with an insurer makes a difference. It is in no health plan's interest to advertise the best outcomes for chronic conditions and in all plans' interests to appeal to young, healthier adults. Currently, we have no mechanism to counteract this market incentive.

The complexity and fragmentation of the current insurance system adds cost without value. Net costs of private insurance administration, including underwriting, marketing, claims payment, and profit margins, have grown faster than total health spending for the past decade—more than doubling from 2000 to 2008 (Exhibit 20).[28] The U.S. leads the world in the proportion of national health expenditures spent on insurance administration. The nation could save $102 billion annually if it did as well as the best countries.[29]

Moreover, these costs do not include the internal costs to providers of multiple reporting forms, formularies, prices or payment methods for the same care, and benefit designs. Insurance complexity requires additional staff and consumes physician time that could otherwise be devoted to patient care. In Commonwealth Fund international and national surveys, U.S. patients stand out for reports of time spent on insurance-related paper work or disputes [30]

Multiple variations in benefits, underwriting, and marketing costs all drive up costs of insurance administration. These costs are particularly high as a share of premiums in the small group and individual market, consuming 22 percent to as much as 40 percent of premiums.[31]

Complex variations in benefits also undermine meaningful choice and open the door to potential market segmentation based on health risks. Even within the current Medicare Advantage program, the wide variation in benefit designs makes it difficult to make an informed choice on anything but premium rates and whether your current doctor

[27] 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.
[28] The Commonwealth Fund Commission, *The Path to a High Performance U.S. Health System*, 2009.
[29] The Commonwealth Fund Commission, *Why Not the Best?*, 2008.
[30] C. Schoen, R. Osborn, M. M. Doty et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive (October 31, 2007):w717–w734; S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions* (New York: The Commonwealth Fund) August 2008.
[31] The Lewin Group technical report, The Path to a High Performance U.S. Health System: Technical Documentation, February 2009. See page 14.

is in the network (Exhibit 21). Plans vary on multiple dimensions and the extent of the variation is often not evident until one enrolls or experiences a serious illness.[32]

As evidence of the potential to reduce overhead costs with reforms, private insurers in other countries with multi-payer systems, including the Netherlands and Switzerland, are able to provide coverage with only 5 percent of premiums allocated to plan overhead and the rest for benefits.[33] In these countries, relatively little is spent on marketing, benefits are more standardized and comparable, and underwriting health risks (i.e., premium variations based on health) is prohibited. Similarly, the standard option offered to federal employees through the Federal Employee Health Benefits Program (FEHBP) operates for about 5 percent of claims.[34]

Among states, Massachusetts efforts to achieve coverage for all have succeeded in insuring all but 2 percent of the population.[35] Underinsured rates have also declined.[36] Massachusetts has also shown that consolidating risk, changing market competitive rules, and organizing an insurance connector with an easy Web-based choice of plans, with review of premiums for reasonableness, can improve benefits and lower premiums. Benefits have improved and premiums costs have come down following reforms. For example, a typical uninsured 37-year-old male faced a monthly premium of $335 before the reform, compared with $184 afterwards, with a $2,000 deductible instead of a $5,000 pre-reform deductible. To provide choices but simplify decision-making, Massachusetts has offered three tiers of benefits—gold, silver, and bronze—with actuarially equivalent policies within each tier. The Web site fully discloses the plan features and variations, as well as premiums.

Insurance Design Principles

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 across the U.S. Organizing a national insurance exchange that builds on the experience of Massachusetts and other countries could enhance choice and continuity, focus competition on better outcomes, and provide a mechanism to broadly pool risk. All these elements provide a foundation for broader health system reforms.

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[32] E. O'Brien and J. Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice*, (New York: The Commonwealth Fund, April 2008).
[33] R. E. Leu, F. F. H. Rutten, W. Brouwer et al., *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*, (New York: The Commonwealth Fund, Jan. 2009).
[34] Jon Gabel e-mail and memo to Commonwealth Fund, Jan. 30, 2009.
[35] Jon Kingsdale, Executive Director, Commonwealth Health Insurance Connector Authority, presentation at AcademyHealth National Health Policy Conference, "Massachusetts Health Care Reform Results So Far and Looking Ahead," Feb. 2, 2009.
[36] S. K. Long, *The Impact of Health Reform on Underinsurance in Massachusetts: Do the Insured Have Adequate Protection?* (Wash. D.C.: The Urban Institute, Oct. 2008).

There are several key principles to insurance and benefit design if reforms seek to expand coverage and aim to improve access, provide financial protection, and focus insurance market competition on better outcomes (Exhibit 22).

- Establish a minimum benefit level. The goals of access and financial protection should guide this minimum. A minimum is necessary to avoid driving coverage even lower and will be necessary for any reform requiring everyone to have insurance. It sets the standard for minimum "creditable" coverage.

- Minimum design. To assure access and provide protection, a minimum should:
    - Be broad in scope, including essential acute care.
    - Prohibit disease-specific or service-specific limits: otherwise, patients can "run out" of critical care (such as effective medication or cancer treatment) and opportunities for risk segmentation remain.
    - If deductibles are included, exempt preventive care and essential care for chronic conditions. Primary and preventive care should either be covered in full or with minimal copayment to encourage and support providing the right care and to align incentives with efforts to hold clinicians accountable for care outcomes
    - Set lifetime limits high or eliminate altogether and standardize to facilitate comparisons.
    - Establish annual out-of-pocket maximums, including deductibles and copayments or coinsurance.
- Low-income protection. Reduce cost-sharing and limit total out-of-pocket exposure for low-income individuals and families. At or near poverty, families are already spending most or all of their income on basic essentials such as food and housing. Therefore, they are particularly sensitive to costs, including costs for preventive and chronic care.[37] Expansion of the Medicaid/CHIP program to adults and higher-income individuals, with sliding-scale premiums and modest cost-sharing (as in Massachusetts), is one potential approach. Given advances in electronic claims, it would also be possible to limit total out-of-pocket exposure as a share of income.
- Limit the range of variation in benefit designs. More standardized benefits, including actuarial bands within limit ranges (e.g., same scope of benefits and total out-of-pocket protection but variations in deductible or cost-sharing) help facilitate choice

[37] M. E. Chernew, T. B. Gibson, K. Yu-Isenberg et al., "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care," *Journal of General Internal Medicine*, Aug. 2008 (8):1131–1136.

and encourage risk pooling. Review should limit designs without clear rationale based on effectiveness and appropriateness of care.

- Premiums for the standard plan should be affordable. Income-related premium assistance for costs in excess of a given threshold of income should be available. Such provisions could include sliding-scale premiums or tax credits that vary with income.
- Public comparisons of choices. Standardization plus Web-based posting should make it easy to compare information on benefits, expected out-of-pocket costs, physician and other provider networks, and premiums.
- Insurance market reforms. Reforms should ensure access, avoid premium variations based on health risks, and focus competition on outcomes. In the context of coverage for all, ground rules should require that insurers cover everyone (guaranteed issue and renewal) and charge the same premium regardless of health status of enrollee (community rating or age bands). If there is an insurance exchange, these provisions should apply to plans sold through the connector and those sold outside the connector. Such provisions would lower underwriting and marketing costs.
- Risk adjustment of premiums. Premiums should be risk adjusted to reduce incentives to avoid risk and to provide incentives to promote positive outcomes, including better outcomes for those with complex or chronic conditions.
- Competition based on value added. The goal of the various insurance market reforms, including an exchange, should be a market where plans and care systems that achieve better health outcomes with more prudent use of resources do well and those that do not lose money and market share. Insurers should compete on the basis of the added value they bring by fostering quality and efficiency in the delivery of health care, and efficiency in administrative costs.
- Structure insurance choices and make it easy to enroll and stay insured. This can be accomplished through a national insurance exchange or "connector."

Insurance reforms that extend coverage to all, set a minimum benefit floor, limit the range of variation, and eliminate underwriting would reduce complexity, ensure access, improve continuity, and lower administrative costs. Such reforms will require a significant increase in the role of the public sector to provide a framework and oversight for market competition and to provide financing to make coverage affordable relative to incomes.

Improving Access, Quality, *and* Slowing Cost Growth

Although insurance reforms are essential, health reforms will need to combine insurance with payment and system reforms to achieve the triple goals of improving access for all,

achieving better quality (health outcomes), and slowing the growth of health spending. Indeed, unless reforms also seek to improve the value of care and the performance of the care system, efforts to expand coverage will be difficult to sustain. At the same time, efforts to provide affordable insurance to all and reform the insurance market could provide a stronger foundation for payment and system reforms.

In its 2007 call for more comprehensive reform, the Commonwealth Fund Commission on a High Performance Health System identified five core strategies for improving on all three dimensions of system performance and fostering care system innovations.[38] These include:

- Ensuring affordable coverage for all.
- Aligning incentives with value and effective cost control.
- Fostering accountable, accessible, patient-centered and coordinated care.
- Aiming high to improve quality, health outcomes: investing in information systems and efforts to promote health and disease prevention.
- Providing accountable leadership and collaboration to set and achieve national goals.

To examine what could be possible with an integrated set of insurance, payment, and system reforms, the Commission recently issued a report entitled *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way.* [39] The *Path* report provides a set of recommendations in each strategic area and assesses the potential impact from 2010 to 2020 using policies that illustrate recommended actions.

Central to the Commission's strategic recommendations is the creation of a national insurance exchange that offers a choice of private plans and a new public plan, with associated insurance market reforms and provisions to make coverage affordable. Insurance recommendations include:

- Establish a health insurance exchange that offers an enhanced choice of private plans and a new public plan. This new public plan would offer comprehensive benefits with incentives for disease prevention and payment methods that reward results. It would build on Medicare's claims administrative structure and national

[38] The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund) November 2007.
[39] The Commonwealth Fund Commission, *The Path to a High Performance U.S. Health System*, 2009.

provider networks. The exchange and new public plan would be open to all, including large employers.

- Require individuals to have coverage and employers to offer coverage or contribute to a trust fund for insurance, sharing responsibility to pay for insurance for all.
- Provide income-related premium assistance to make coverage affordable.
- Expand eligibility for and improve payment under Medicaid and CHIP to improve affordability and access. Eliminate Medicare's two-year waiting period for the disabled.
- Set a minimum benefit standard to ensure access and adequate protection from the financial burden of obtaining needed health care.
- Reform health insurance markets to improve insurance efficiency, access, and affordability by prohibiting premium variation based on health and guaranteeing offer and renewal of coverage to all regardless of health status.

Building on this foundation, an integrated set of polices would change the way the nation pays for care and would invest in system reforms and health initiatives. Payment reforms include: enhanced value for primary care and new payment methods to support better care coordination and management of chronic disease (often called "patient-centered medical home"); moving away from fee-for-service to more "bundled" payment for care; and correcting price signals to align payment levels with more efficient care. Together, the set of payment reforms aims to reward efficiency (high quality and prudent use of resources) and penalize waste and ineffective care by stimulating and supporting a more effective and efficient delivery system. System reforms include investing in and expanding effective use of health information technology (HIT) and networks (HIT with information exchanges), providing better information on comparativeness effectiveness and using this information to guide benefit and pricing policies, and all-population data with benchmarks of top performance.

The analysis of the potential impact indicates that it would be possible to extend affordable insurance to everyone, improve quality, *and* substantially slow the rate of growth of national spending by a cumulative $3 trillion by 2020, assuming reforms begin in 2010. Although spending would slow compared with projected trends, it would still go up each year (Exhibits 23 and 24).

Many of the Commission's recommendations would be politically difficult to achieve. They depend on building the political will and reaching consensus that the nation can no longer afford to continue on the current path. Changes will require new leadership roles and collaboration across public and private sectors. Effective payment reforms will require time to develop and implement and flexibility to innovate as the

nation learns. Information systems require investment and time to yield maximum returns through adoption and use.

With the current severe recession, there is broad public support for fundamental reform. The United State's continued failure to protect its population when sick is undermining national health and economic security. Wide public concern and stress on businesses and public sectors make it increasingly clear that we cannot afford to maintain the status quo. Each year we wait, the problems grow worse. There is an urgent need for leadership and policy action to forge consensus to move in a positive direction.

Thank you for the opportunity to testify on these critical issues.

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Insurance Design Matters: Underinsured Trends, Health and Financial Risks, and Principles for Reform

Cathy Schoen
Senior Vice President
The Commonwealth Fund
cs@cmwf.org

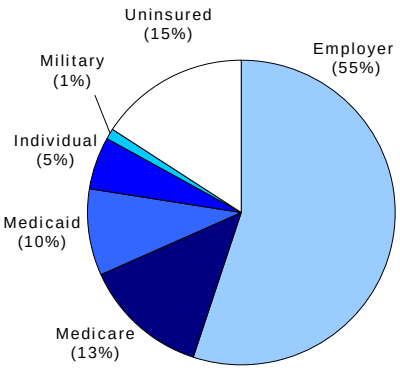
Invited Testimony
U.S. Senate Health, Education, Labor and Pensions Committee
Hearing on "Addressing the Underinsured and National Health Reform"

February 24, 2009

EXHIBIT 1

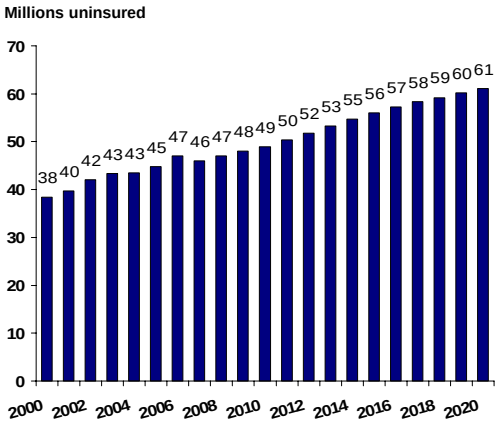
Health Insurance Coverage and Uninsured Trends

45.7 Million Uninsured, 2007



Total population

Uninsured Projected to Rise to 61 million by 2020



Projected estimates

Data: Analysis of the U.S. Census Bureau, Current Population Survey Annual Social and Economic Supplement (CPS ASEC), 2001–2008; projections to 2020 based on estimates by The Lewin Group.

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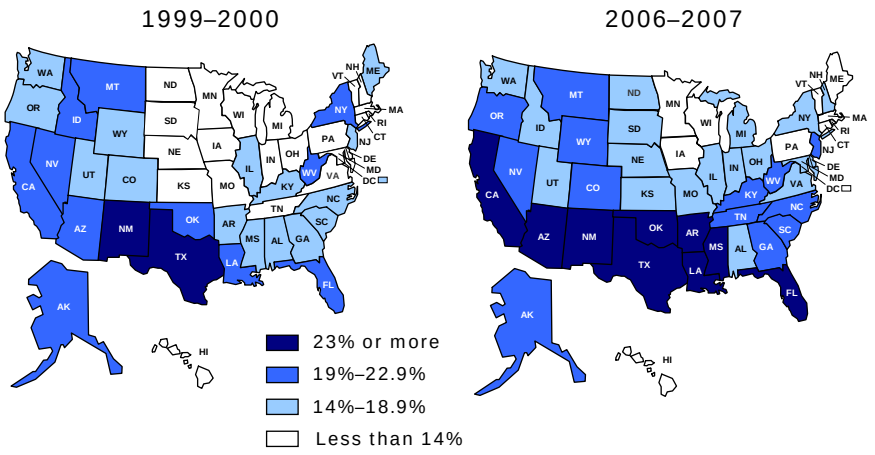
EXHIBIT 2

Percent of Adults Ages 18–64 Uninsured by State



Data: Two-year averages from the U.S. Census Bureau, CPS ASEC, 2000–2001 and 2007–2008; 1999–2000 estimates updated with 2007 CPS correction.

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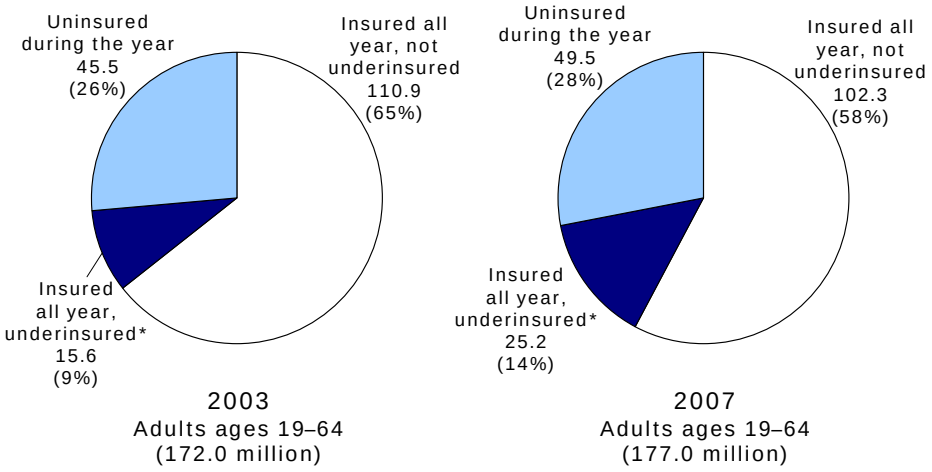
EXHIBIT 3

25 Million Adults Underinsured in 2007, 60% Increase Since 2003



*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.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).
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.

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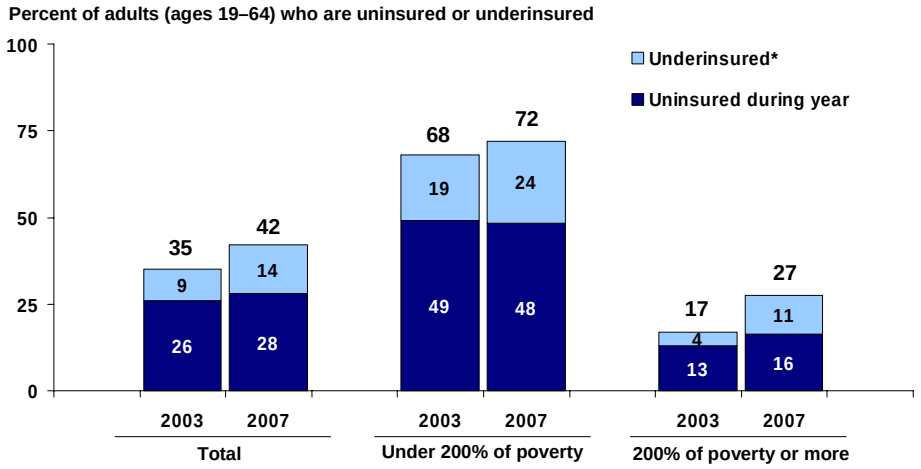
EXHIBIT 4

Two of Five Adults Uninsured or Underinsured
Percent Underinsured Triples for Middle Income



* Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income, or 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

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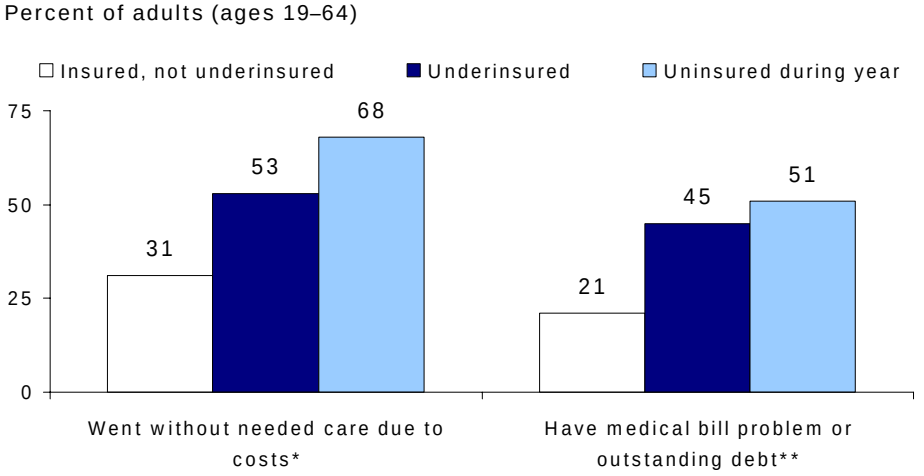
EXHIBIT 5

Underinsured and Uninsured Adults at High Risk of Going Without Needed Care and Financial Stress



* Did not fill prescription; skipped recommended medical test, treatment, or follow-up, had a medical problem but did not visit doctor; or did not get needed specialist care because of costs. ** Had problems paying medical bills; changed way of life to pay medical bills; or contacted by a collection agency for inability to pay medical bills.
Data: The Commonwealth Fund Biennial Health Insurance Survey (2007).
Source: C. Schoen, S. Collins, J. Kriss, M. Doty, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008.

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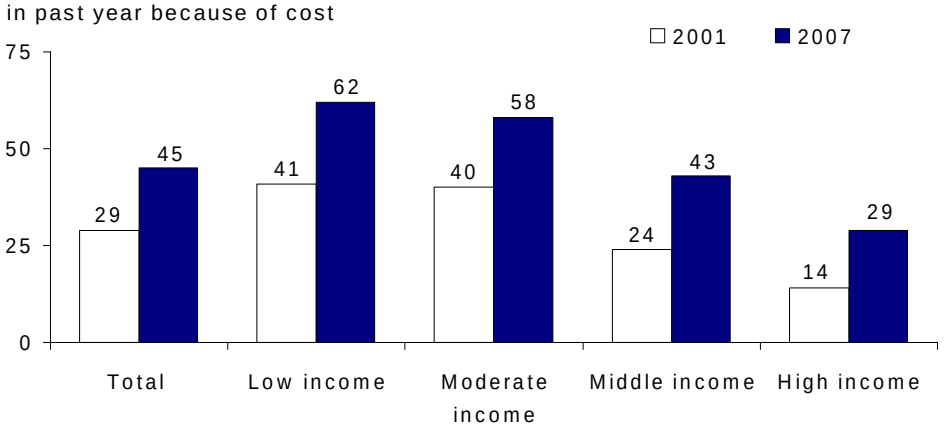
EXHIBIT 6

Cost-Related Problems Getting Needed Care Have Increased Across All Income Groups, 2001–2007

Percent of adults ages 19–64 who had any of four access problems* in past year because of cost



* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.
Note: In 2001, low income is <$20,000, moderate income is $20,000–$34,999, middle income is $35,000–$59,999, and high income is $60,000+. In 2007, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000+.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2007).
Source: 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*, The Commonwealth Fund, August 2008.

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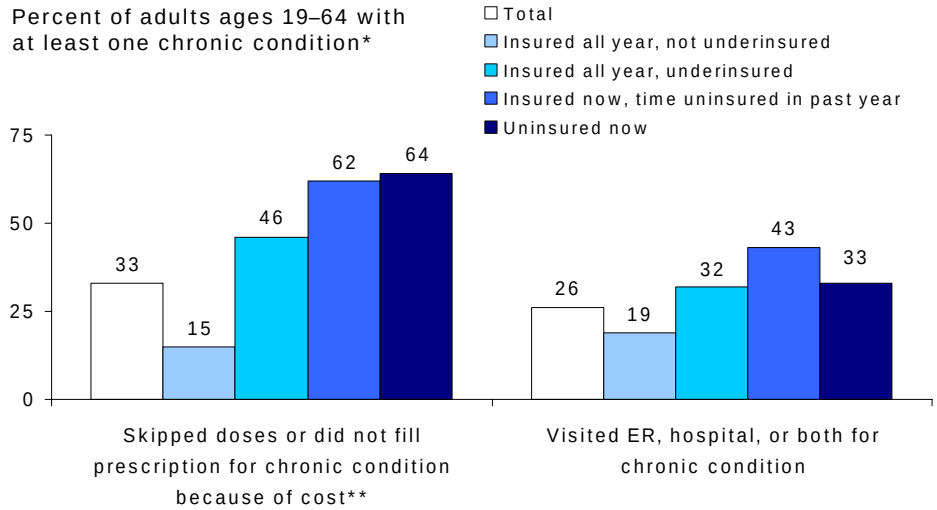
EXHIBIT 7

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

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



* 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.
Data: The Commonwealth Fund Biennial Health Insurance Survey (2007).
Source: 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*, The Commonwealth Fund, August 2008.

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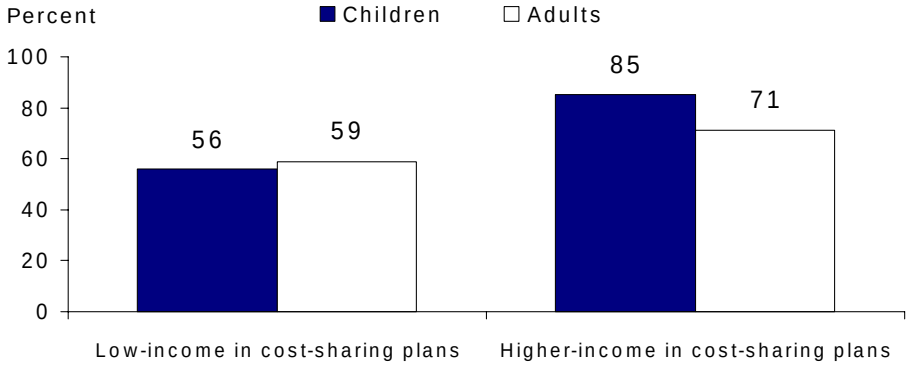
EXHIBIT 8

RAND: Cost-Sharing Reduces Likelihood of Receiving Effective Medical Care

Probability of receiving highly effective care (when appropriate and necessary) for acute conditions as compared to individuals with no cost-sharing



Source: K. N. Lohr et al., "Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial," *Medical Care* 24 (Sept. 1986 Suppl.):S1–S87.

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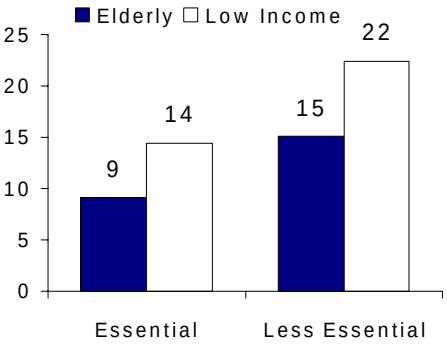
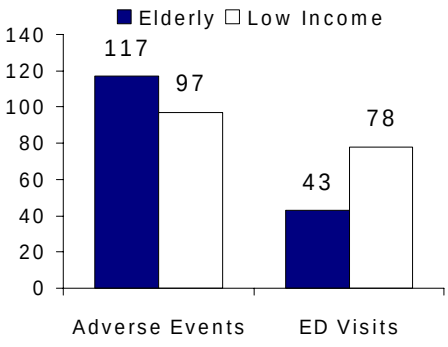
EXHIBIT 9

Cost-Sharing Reduces Use of Both Essential and Less Essential Drugs and Increases Risk of Adverse Events

Percent reduction in drugs per day



Percent increase in incidence per 10,000



Source: R. Tamblyn, R. Laprise, J. A. Hanley et al., "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," *Journal of the American Medical Association,* Jan. 24/31, 2001 285(4):421–29.

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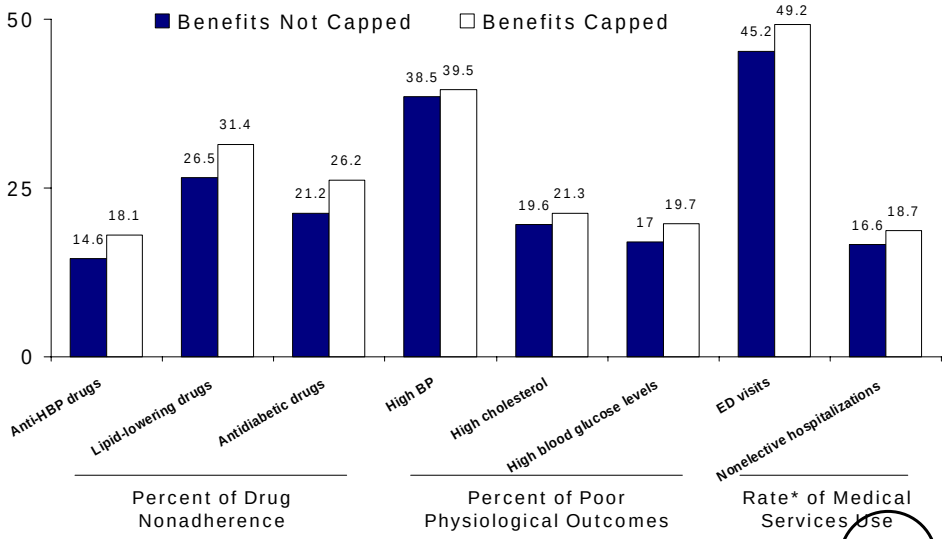
EXHIBIT 10

People with Capped Drug Benefits Have Lower Drug Utilization, Worse Control of Chronic Conditions



* Rate per 100 person-years.
Source: J. Hsu, M. Price, J. Huang et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine,* June 1, 2006 354(22):2349–59.

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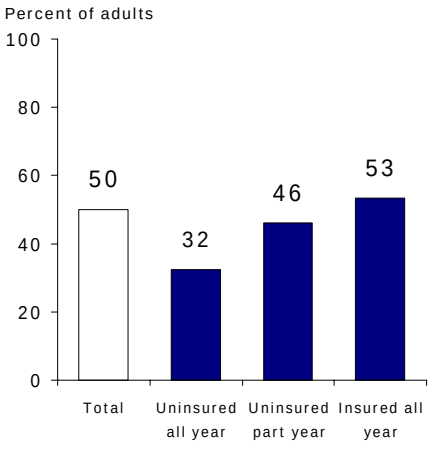
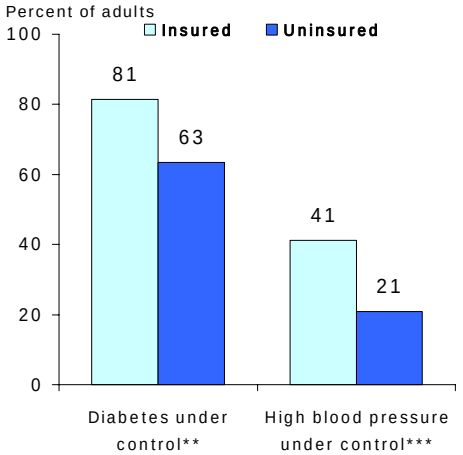
EXHIBIT 11

Lack of Insurance Undermines Preventive and Chronic Care

Receipt of Recommended Screening and Preventive Care,* 2005



Chronic Disease Under Control: Diabetes and Hypertension, 1999–2004



* Recommended care includes: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot within a specific time frame given age and sex. ** Refers to diabetic adults whose HbA1c is <9.0 *** Refers to hypertensive adults whose blood pressure is <140/90 mmHg.
Data: Preventive care–B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey; Chronic disease–J. M. McWilliams, Harvard Medical School analysis of National Health and Nutrition Examination Survey.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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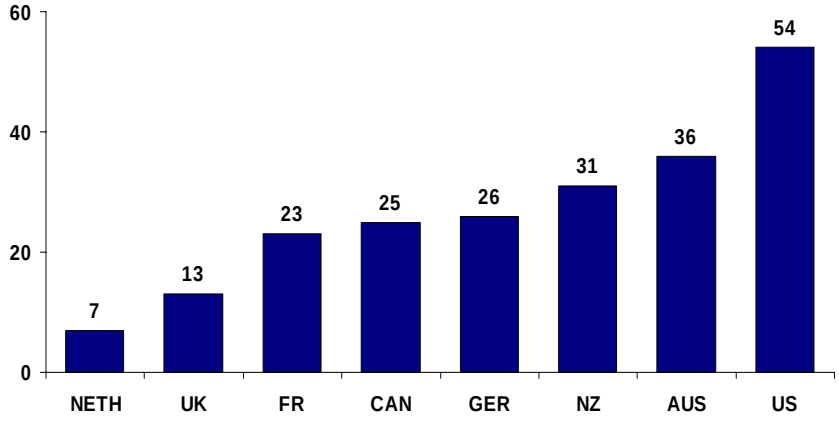
EXHIBIT 12

Cost-Related Access Problems Among the Chronically Ill, in Eight Countries, 2008

Base: Adults with any chronic condition

Percent reported access problem due to cost in past two years*



* Due to cost, respondent did NOT: fill Rx or skipped doses, visit a doctor when had a medical problem, and/or get recommended test, treatment, or follow-up.
Data: The Commonwealth Fund International Health Policy Survey of Sicker Adults (2008).
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008," *Health Affairs* Web Exclusive, Nov. 13, 2008.

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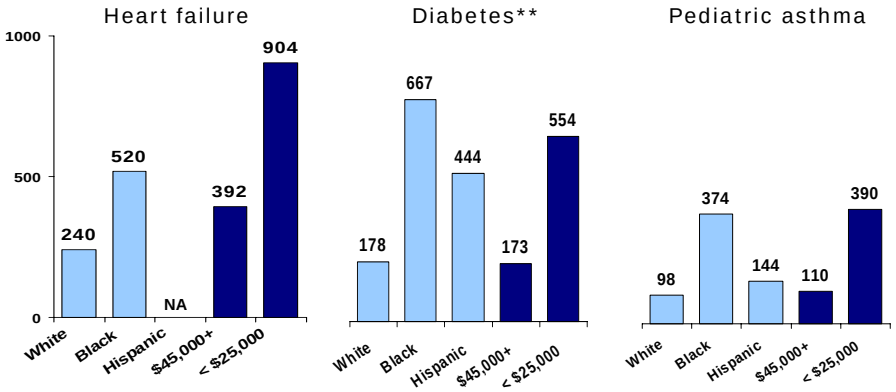
EXHIBIT 13

Ambulatory Care–Sensitive (Potentially Preventable) Hospital Admissions, by Race/Ethnicity and Patient Income Area, 2004/2005*

Adjusted rate per 100,000 population



* 2004 data for diabetes and pediatric asthma; 2005 data for heart failure. ** Combines 4 diabetes admission measures: uncontrolled, short-term complications, long-term complications, and lower extremity amputations.
Patient Income Area=median income of patient zip code. NA=data not available.
Data: Race/ethnicity—Healthcare Cost and Utilization Project, State Inpatient Databases and National Hospital Discharge Survey (AHRQ 2007); Income area—HCUP, Nationwide Inpatient Sample (AHRQ 2007, retrieved from HCUPnet at http://hcupnet.ahrq.gov).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

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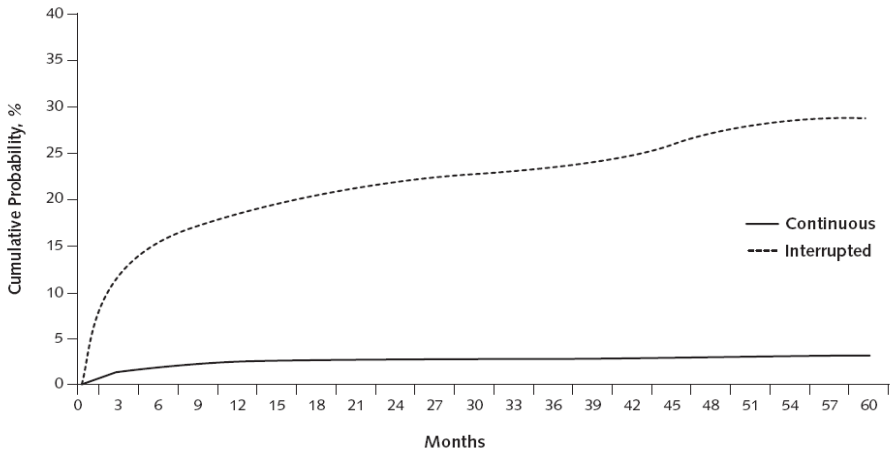
EXHIBIT 14

Probability of ACS Hospitalizations Increases with Medicaid Coverage Gaps, 1998–2002



Note: Ambulatory care-sensitive (ACS) conditions include dehydration, ruptured appendicitis, cellulitis, bacterial pneumonia, urinary tract infection, asthma, hypertension, COPD, diabetes mellitus, heart failure, and angina.
Source: A. Bindman, A. Chattapadhyay, and G. Auerback, "Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care–Sensitive Conditions," *Annals of Internal Medicine,* Dec.16, 2008.

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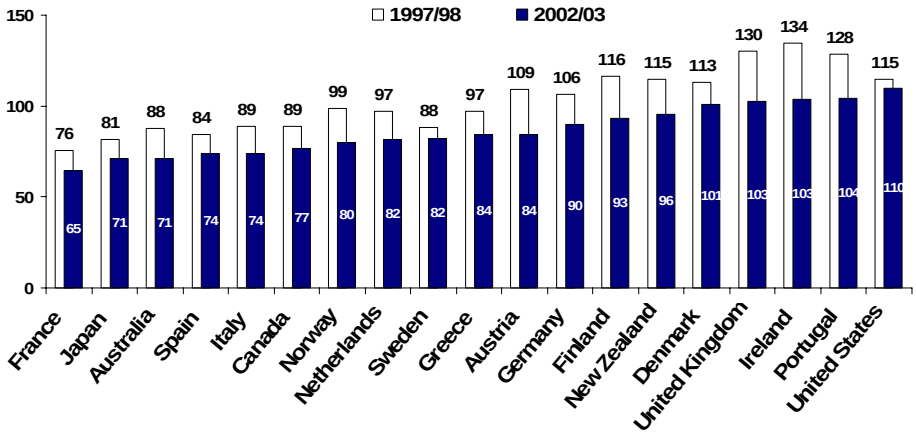
EXHIBIT 15

Mortality Amenable to Health Care

Deaths per 100,000 population*



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.
Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee 2008).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

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EXHIBIT 16

Medical Bill Problems and Accrued Medical Debt, 2005–2007

Percent of adults ages 19–64

	2005	2007
In the past 12 months:		
Had problems paying or unable to pay medical bills	23% 39 million	27% 48 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 28 million
Had to change way of life to pay bills	14% 24 million	18% 32 million
Any of the above bill problems	28% 48 million	33% 59 million
Medical bills being paid off over time	21% 37 million	28% 49 million
Any bill problems or medical debt	34% 58 million	41% 72 million

Source: 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,* The Commonwealth Fund, August 2008.

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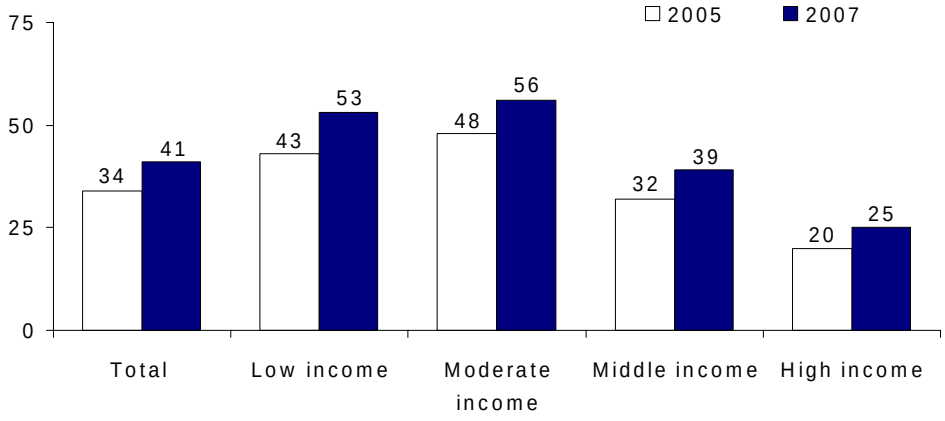
EXHIBIT 17

Problems with Medical Bills or Accrued Medical Debt Increased, 2005–2007

Percent of adults ages 19–64 with medical bill problems or accrued medical debt



Note: Low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000+.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2007).
Source: 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*, The Commonwealth Fund, August 2008.

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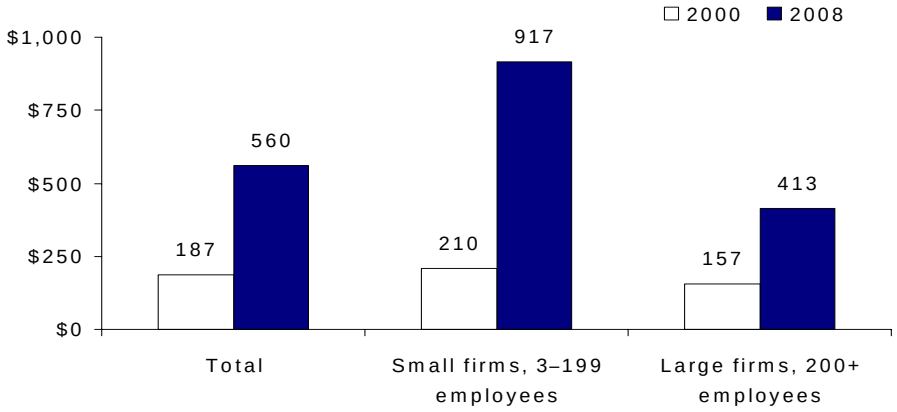
EXHIBIT 18

Deductibles Rise Sharply, Especially in Small Firms, 2000–2008

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.

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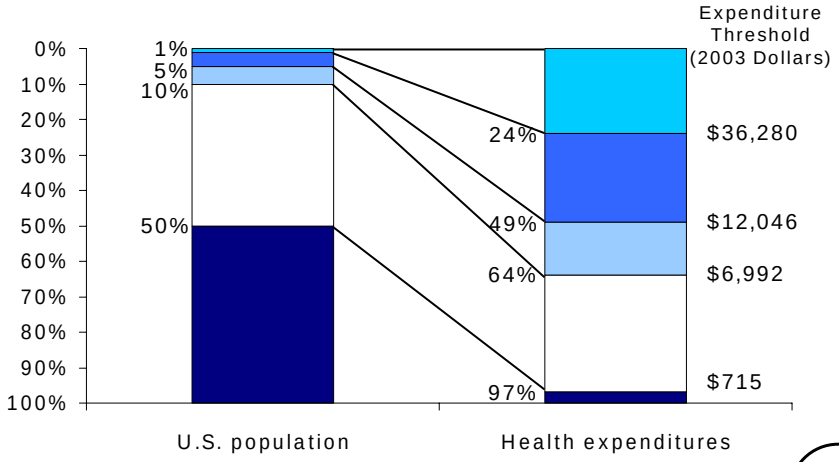
EXHIBIT 19

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):249–57.

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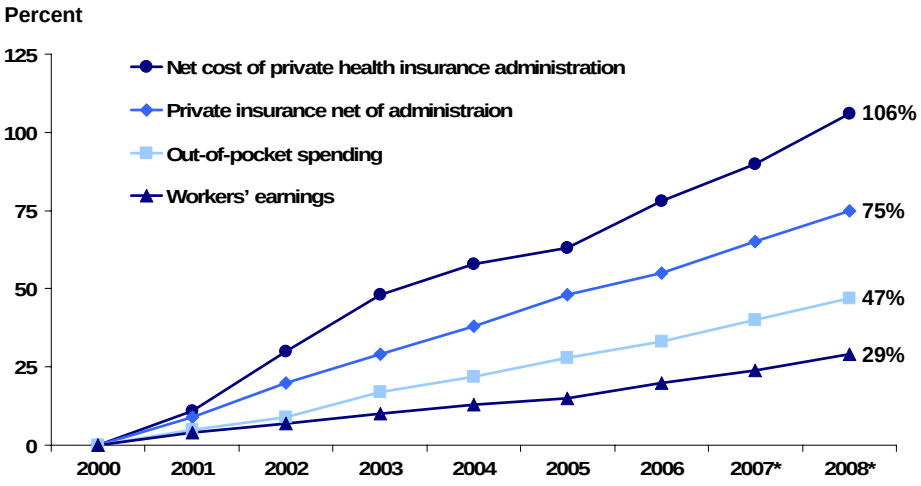
EXHIBIT 20

Cumulative Changes in Components of U.S. National Health Expenditures and Workers' Earnings, 2000–2008



* 2007 and 2008 NHE projections.
Data: Calculations based on A. Catlin et al., "National Health Spending in 2006" *Health Affairs*, Jan./Feb. 2008; and S. Keehan et al. Health Spending Projections through 2017" *Health Affairs* Web Exclusive (Feb. 26, 2008). Workers earnings from Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000–2008*.

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EXHIBIT 21

Table 1. Medicare Advantage Plan Choices in Milwaukee County, Wisconsin, 2006

	Plans								
	1 Local PPO H5216-1 Humana	2 HMO-POS H5253-4 UHC WI	3 Local HMO H5253-6 UHC WI	4 Local HMO H5253-7 UHC WI	5 HMO-POS H5253-21 UHC WI	6 PFFS H1804-23 Humana	7 Reg PPO R5826-4 Humana	8 Reg PPO R5826-23 Humana	9 Reg PPO R5826-37 Humana
Premium	$37	$0	$58	$28.15	$28.15	$35	$97	$0	$35
In-Network OOP Max	—	$4,800	$4,200	$775	$4,600	$5,000	$5,000	$5,000	$5,000
Primary Care Office Visit	$10	$20	$15	$0	$20	$15	$10	$10	$10
Specialist Office Visit	$35	$35	$25	20%	$25	$30	$35	$35	$35
Mammography Services	$35–$50	$0	$0	$0	$0	$0	$0	$0	$0
X-ray Services	$10–$50	$0–$10	0%–20%	0%–15%	0%–15%	$15–$30 or 20%	$10–$75	$10–$75	$10–$75
Clinical Lab Services	$0–$50	$0–$10	0%	0%	0%	$15–$30	$0–$75	$0–$75	$0–$75
Radiation Therapy	$35–$50	$0–$10	20%	15%	15%	$15–$30	$15–$30	$15–$30	$15–$30
Outpatient Hospital Services	$50–$100	20%	20%	20%	20%	20%	$75–$125	$75–$125	$75–$125
Ambulatory Surgical Center Services	$100	20%	20%	20%	20%	20%	$100	$100	$100
Home Health Services	$0	$0	$0	$0	$0	$0	$0	$0	$0
Emergency Department Services	$50	$50	$50	$50	$250	20% (to $50)	$50	$50	$50
Inpatient Hospital OOP Max	—	—	—	—	—	—	—	—	—
Inpatient Hospital Copay per Stay	—	—	—	—	—	—	—	—	—
Inpatient Hospital Daily Copays	$175/day, days 1–5	$295/day, days 1–17	$250/day, days 1–17	$75/day, days 1–11	$265/day, days 1–18	$180/day, days 1–5	$165/day, days 1–5	$165/day, days 1–5	$165/day, days 1–5
Skilled Nursing Facility Services OOP Max	—	—	—	—	—	—	—	—	—
SNF Copay per Stay	—	—	—	$0	—	—	—	—	—
SNF Daily Copays	$0/day, days 1–13; $75/day, days 14–100	$150/day days 1–32	$125/day days 1–34	—	$150/day days 1–31	$0/day, days 1–3; $90/day, days 4–100	$0/day, days 1–10; $75/day, days 11–100	$0/day, days 1–10; $75/day, days 11–100	$0/day, days 1–10; $75/day days 11–100
Rx Drugs	Enhanced	Enhanced	None	Enhanced	None	Enhanced	Enhanced	None	Standard

Notes: Two special-needs plans are excluded from this list; premiums cited are the full premiums (including any premium for Part D benefit); OOP = out-of-pocket; "—" means the plan has no parameter in that category.
Source: Medicare Personal Plan Finder data, downloaded March 9, 2006.

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Source: E. O'Brien and J. Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice*, The Commonwealth Fund, April 2008.

EXHIBIT 22

Insurance Reforms: Goals and Design Principles

- Goals:
  - Access, financial protection and risk pooling
  - Focus competition on value: better health & effective care
- Benefit floor: a standard benefit available to all
  - Broad scope of benefits
  - Prohibit limits by disease or spending by specific benefits
  - If deductible, exempt preventive care and essential medications
  - Annual out-of-pocket maximums
  - High life-time maximum (or no ceiling)
- Limit range of variation and standardize (actuarial equivalent?)
  - Enable informed comparison
  - Provide consumer protection
  - Limit risk-segmentation
  - Lower administrative costs
- Income-related premium assistance to assure affordability
- Low-income: low-cost sharing and limit total cost exposure
- Insurance market reforms – guarantee offer and renewal; premiums same for same benefits, not vary with health (no underwriting)
- Mechanism to risk-adjust premiums: align incentives with value

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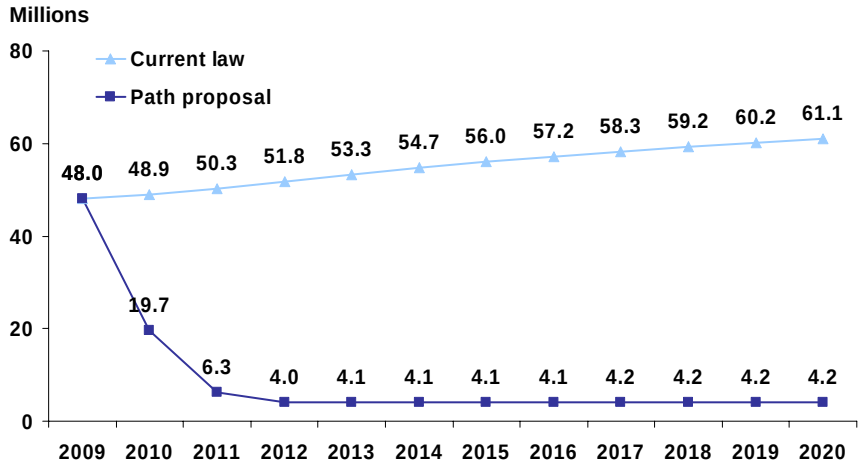
EXHIBIT 23

Path to High Performance: Trend in the Number of Uninsured, 2009–2020, Projected and Path Policies



Note: Assumes reforms start in 2010 and take-up occurs over 2 years. Remaining uninsured mainly non-tax-filers.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, Feb. 2009.

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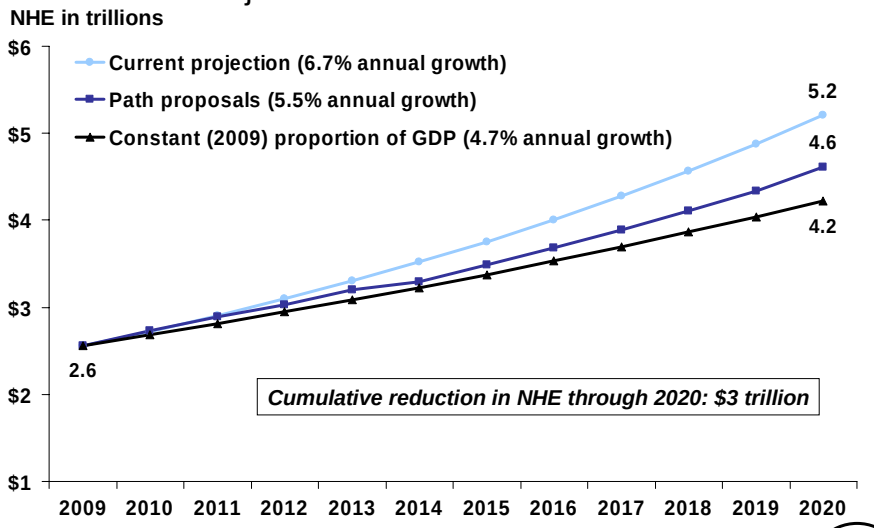
EXHIBIT 24

Total National Health Expenditures (NHE), 2009–2020
Current Projection and Alternative Scenarios



GDP = Gross Domestic Product.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, Feb. 2009.

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