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

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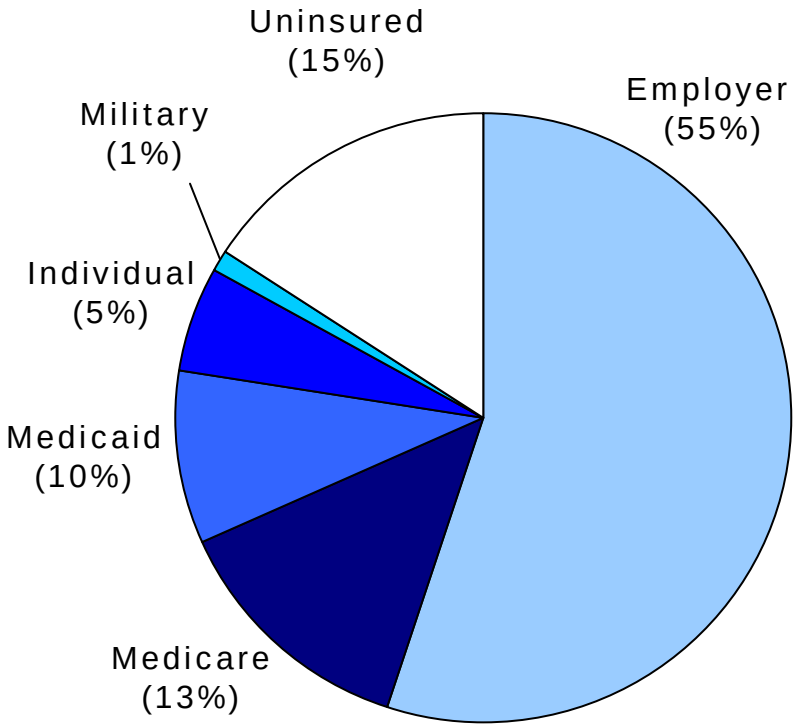
Invited Testimony
U.S. Senate Health, Education, Labor and Pensions Committee
Hearing on “Addressing the Underinsured and National Health Reform”

February 24, 2009

EXHIBIT 1

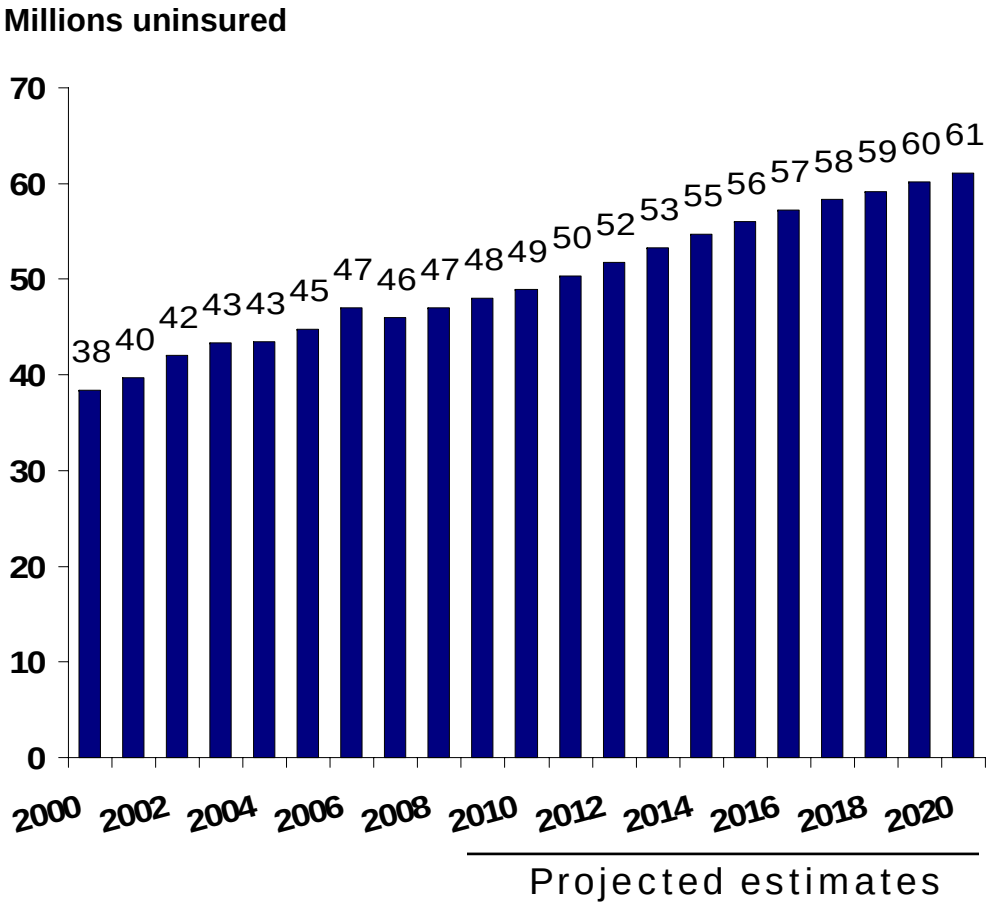
Health Insurance Coverage and Uninsured Trends

45.7 Million Uninsured, 2007



Total population

Uninsured Projected to Rise to 61 million by 2020



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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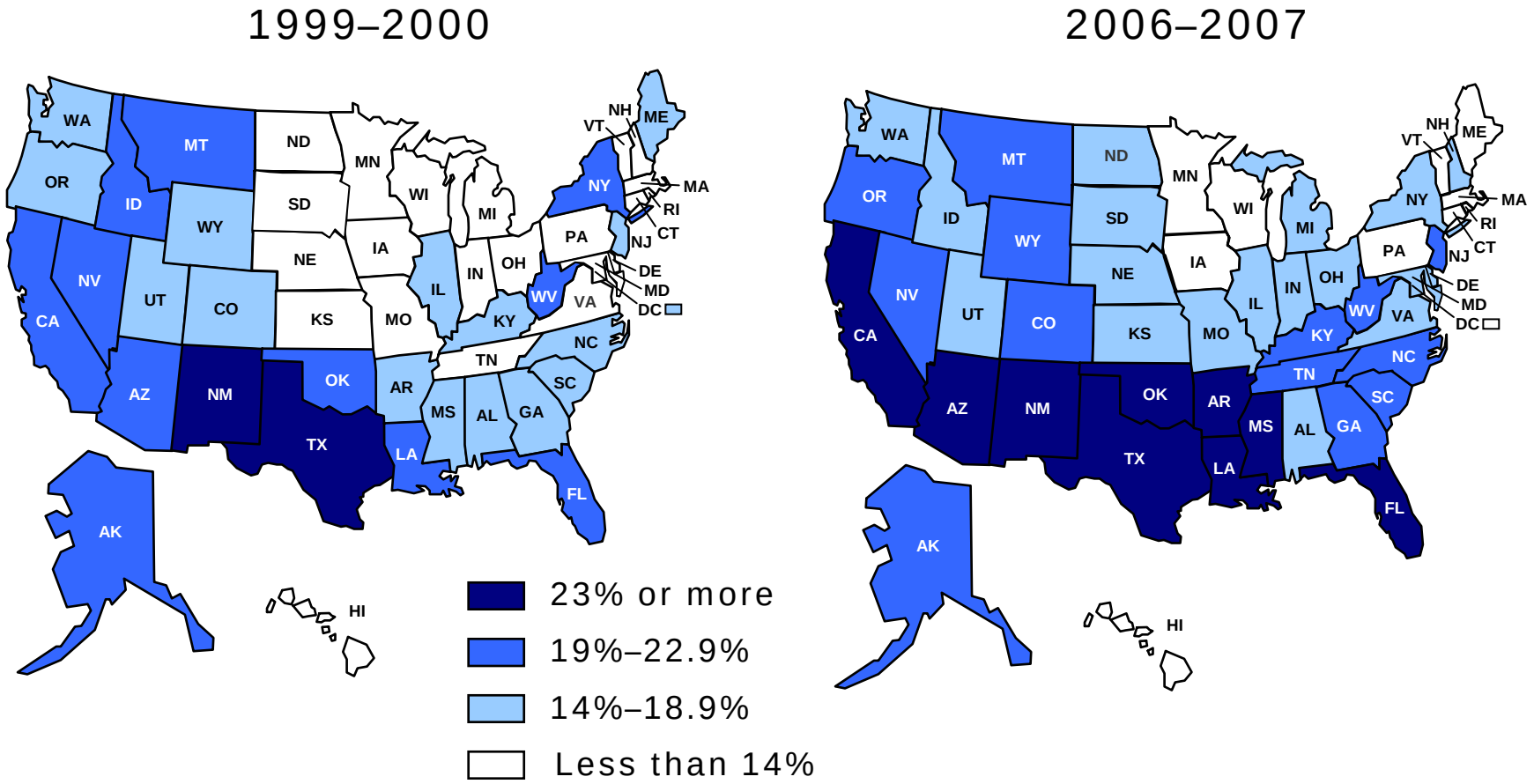
EXHIBIT 2

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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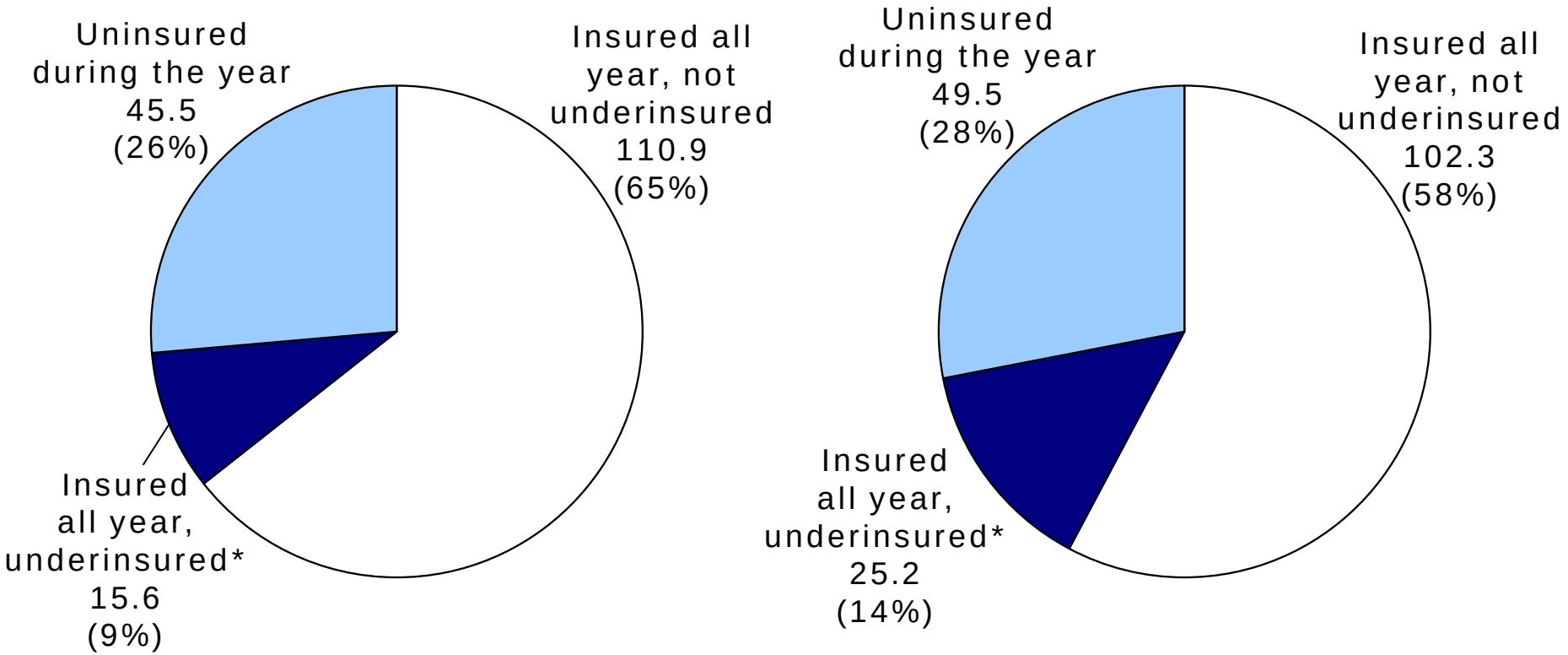
EXHIBIT 3

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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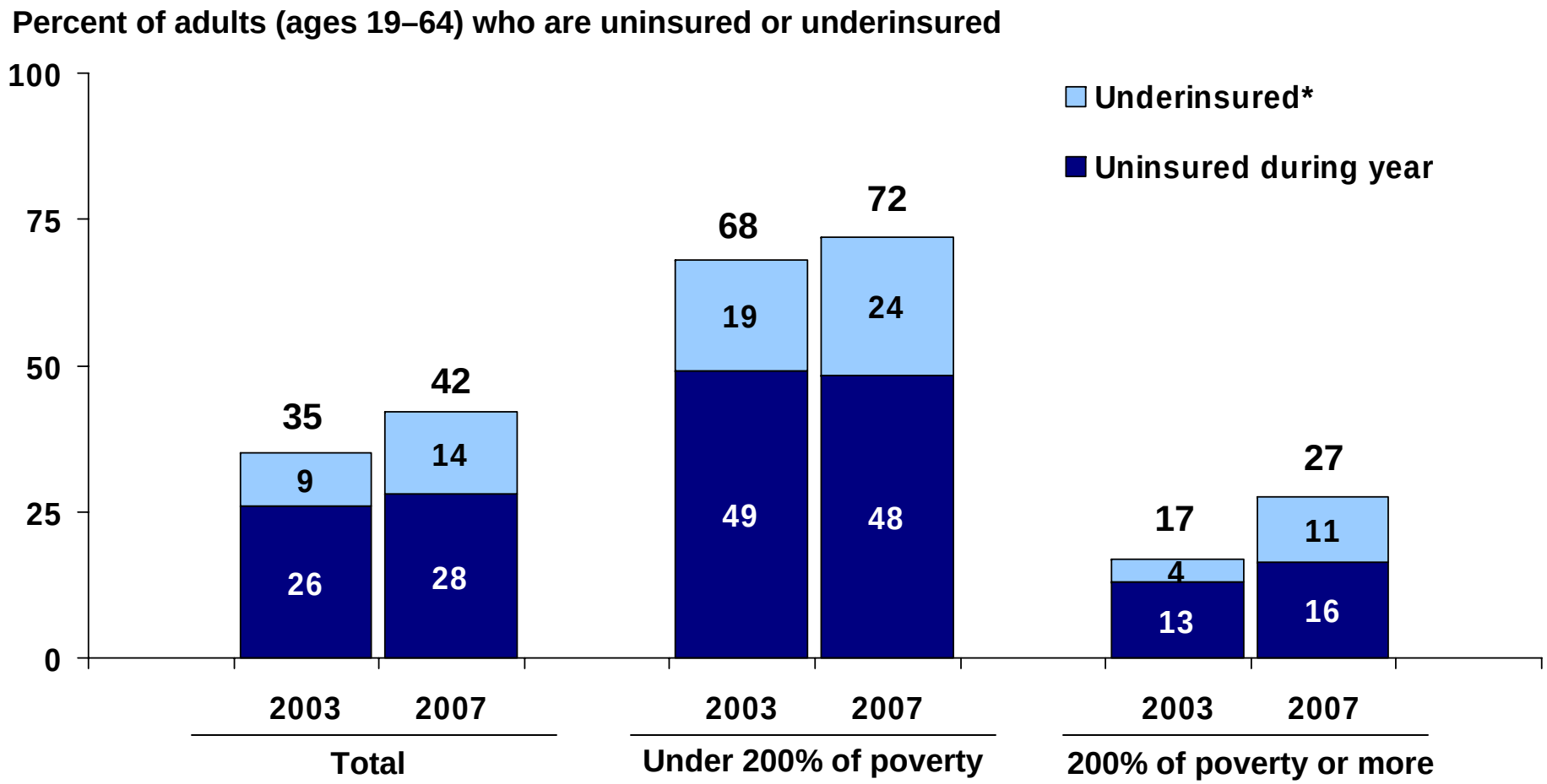
EXHIBIT 4

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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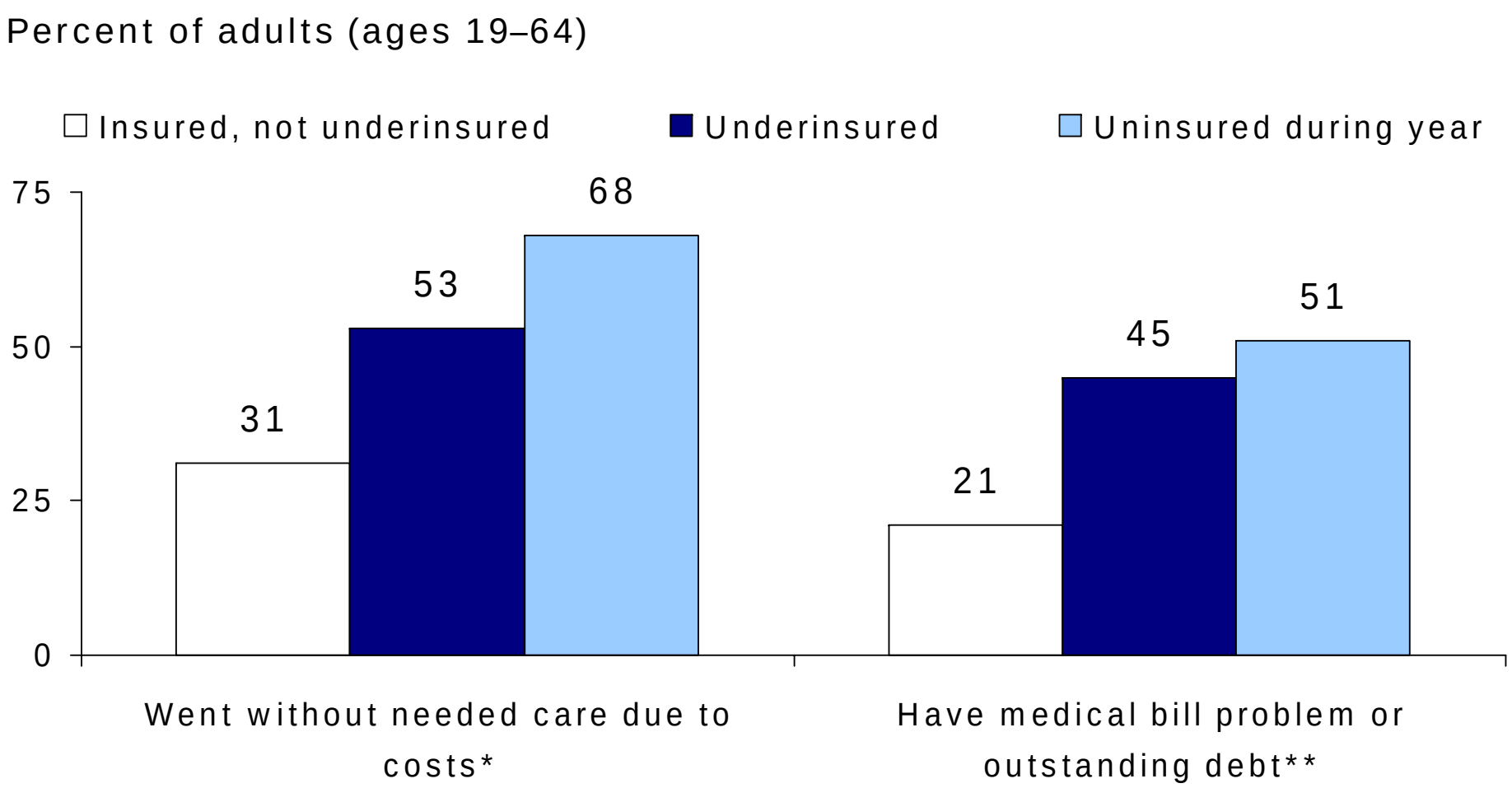
EXHIBIT 5

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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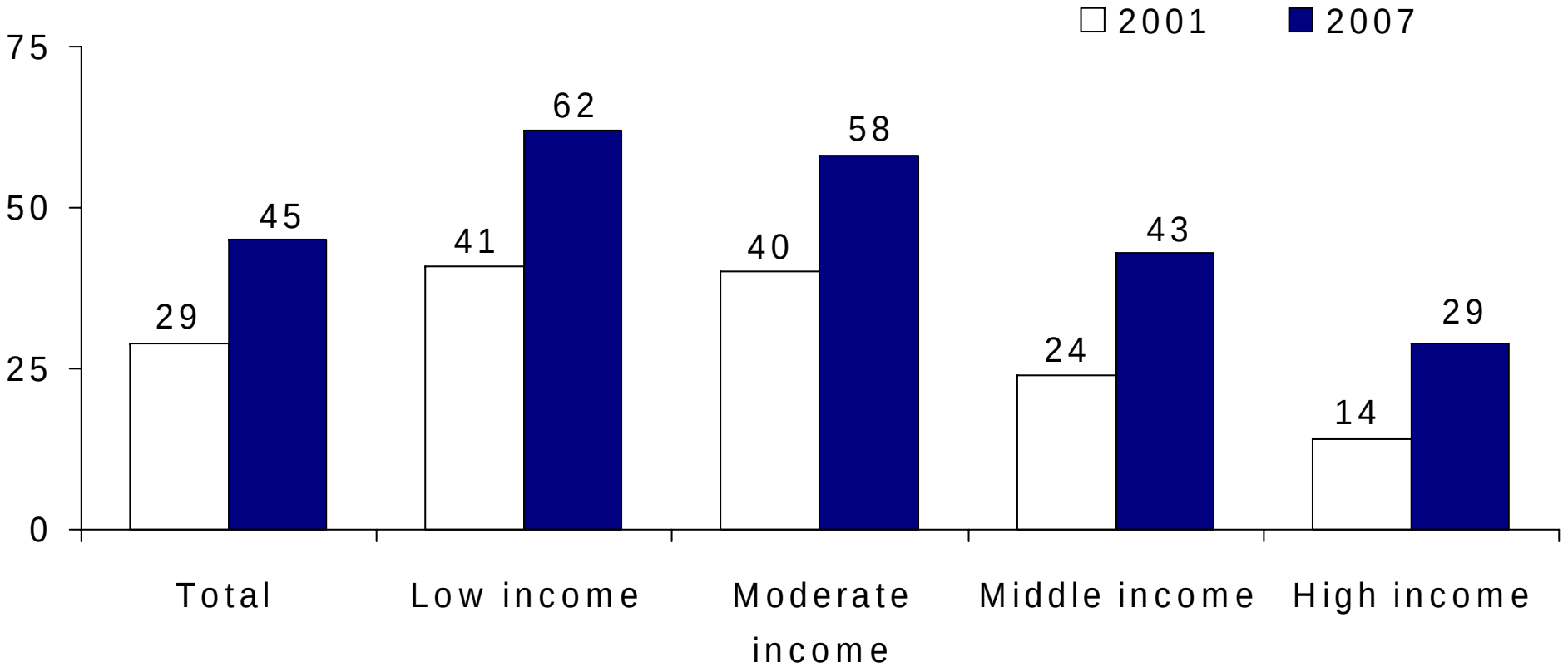
EXHIBIT 6

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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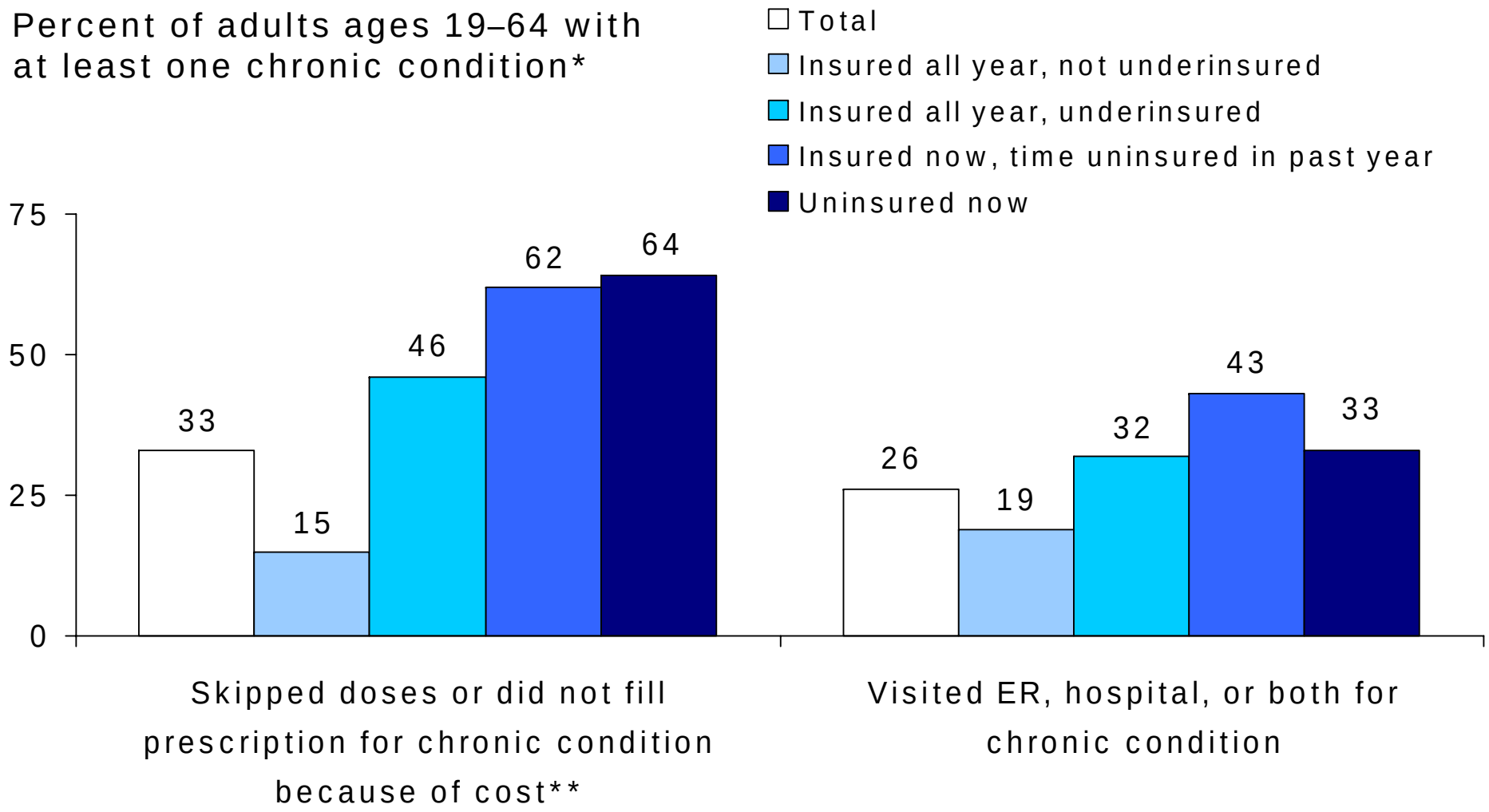
EXHIBIT 7

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



* 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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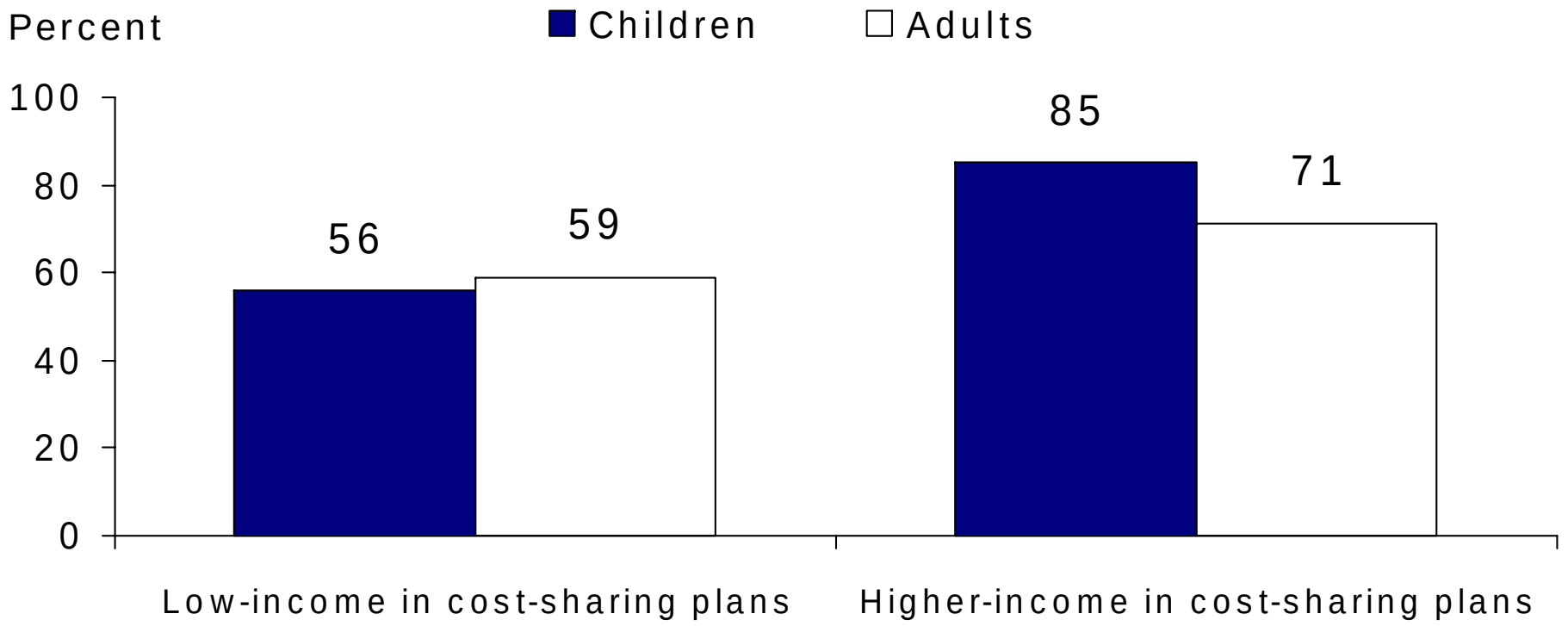
EXHIBIT 8

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



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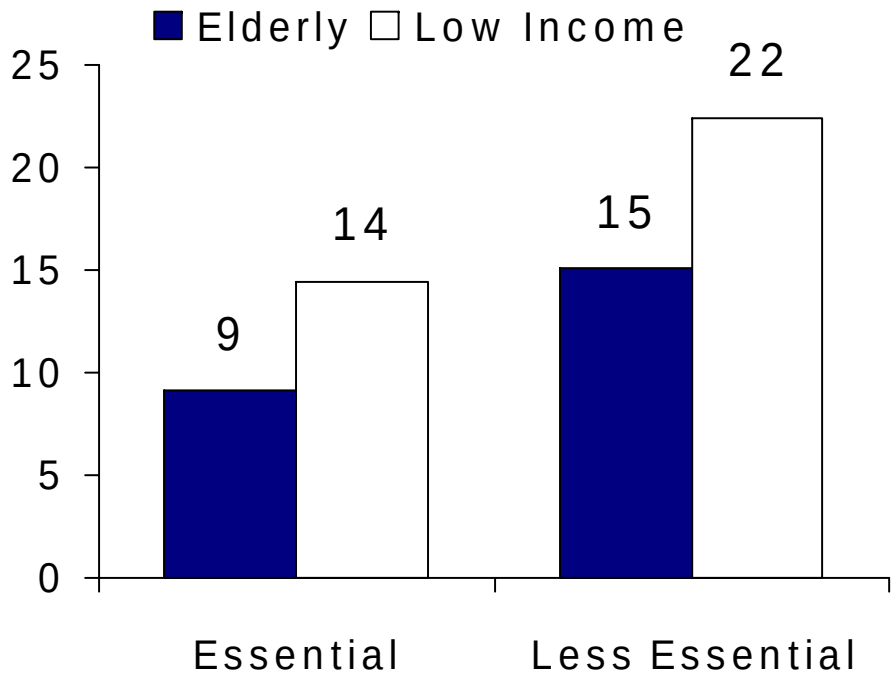
Source: K. N. Lohr et al., "Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial," *Medical Care* 24 (Sept. 1986 Suppl.):S1–S87.

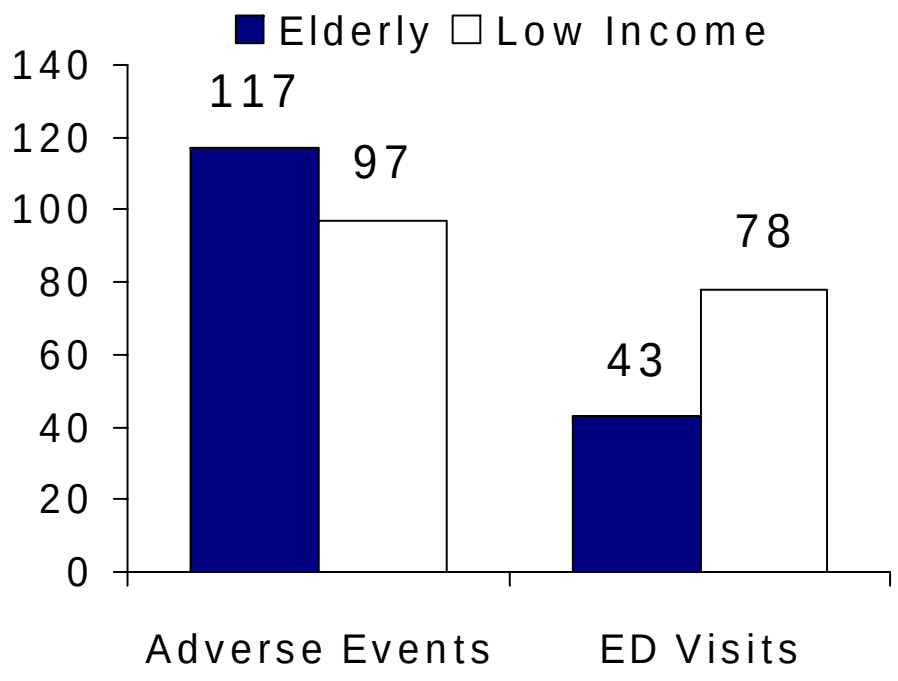
EXHIBIT 9

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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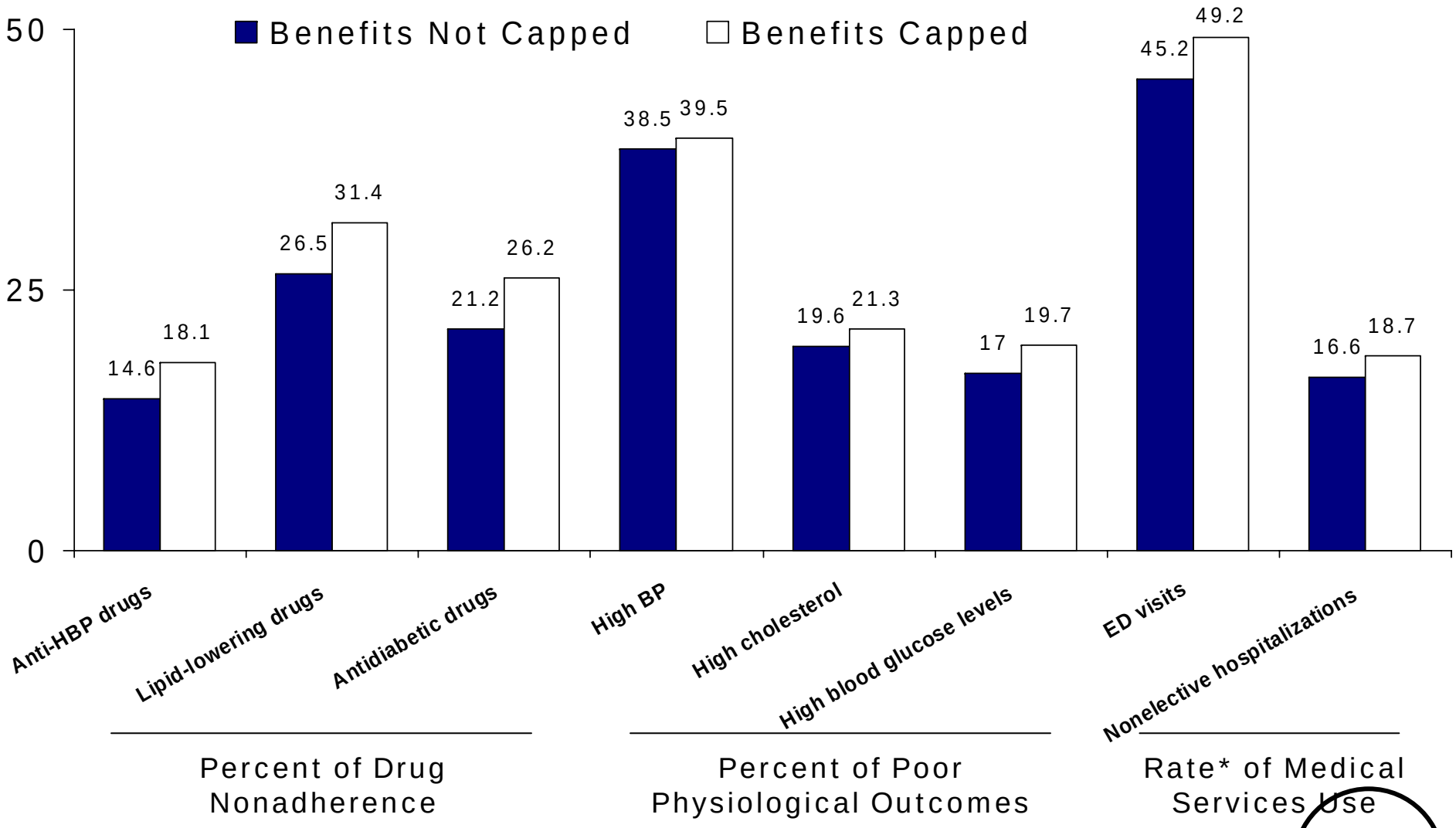
EXHIBIT 10

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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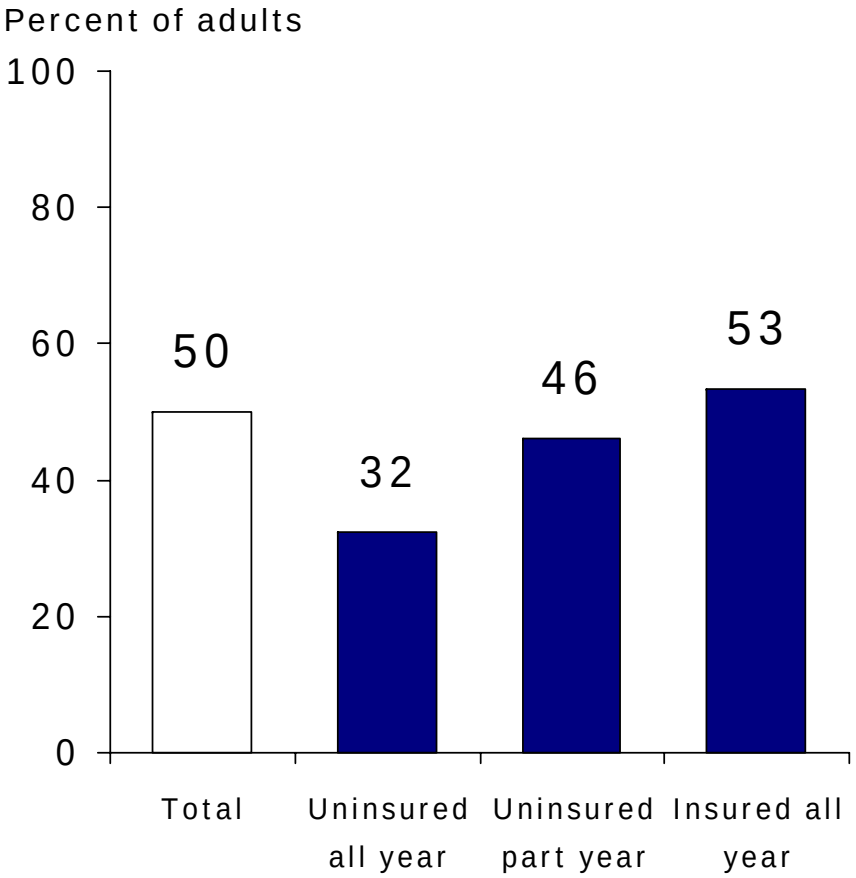
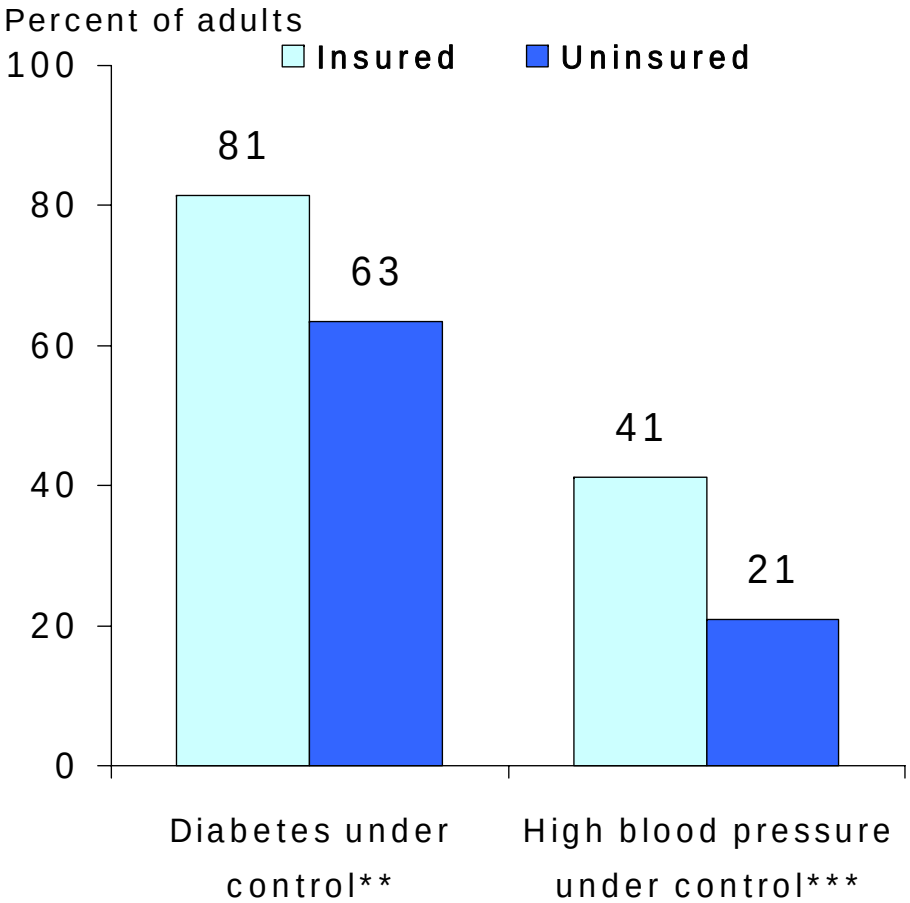
EXHIBIT 11

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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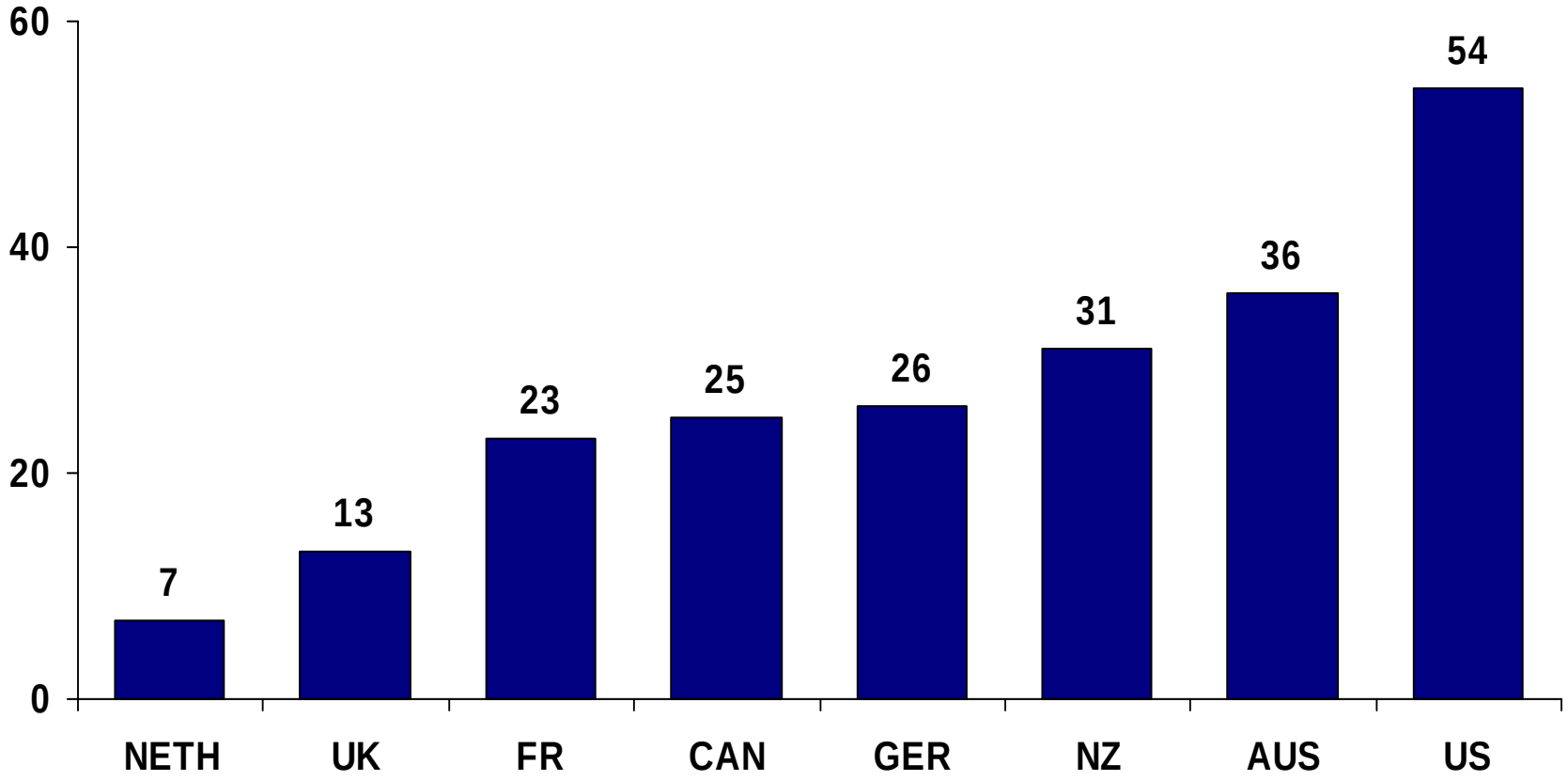
EXHIBIT 12

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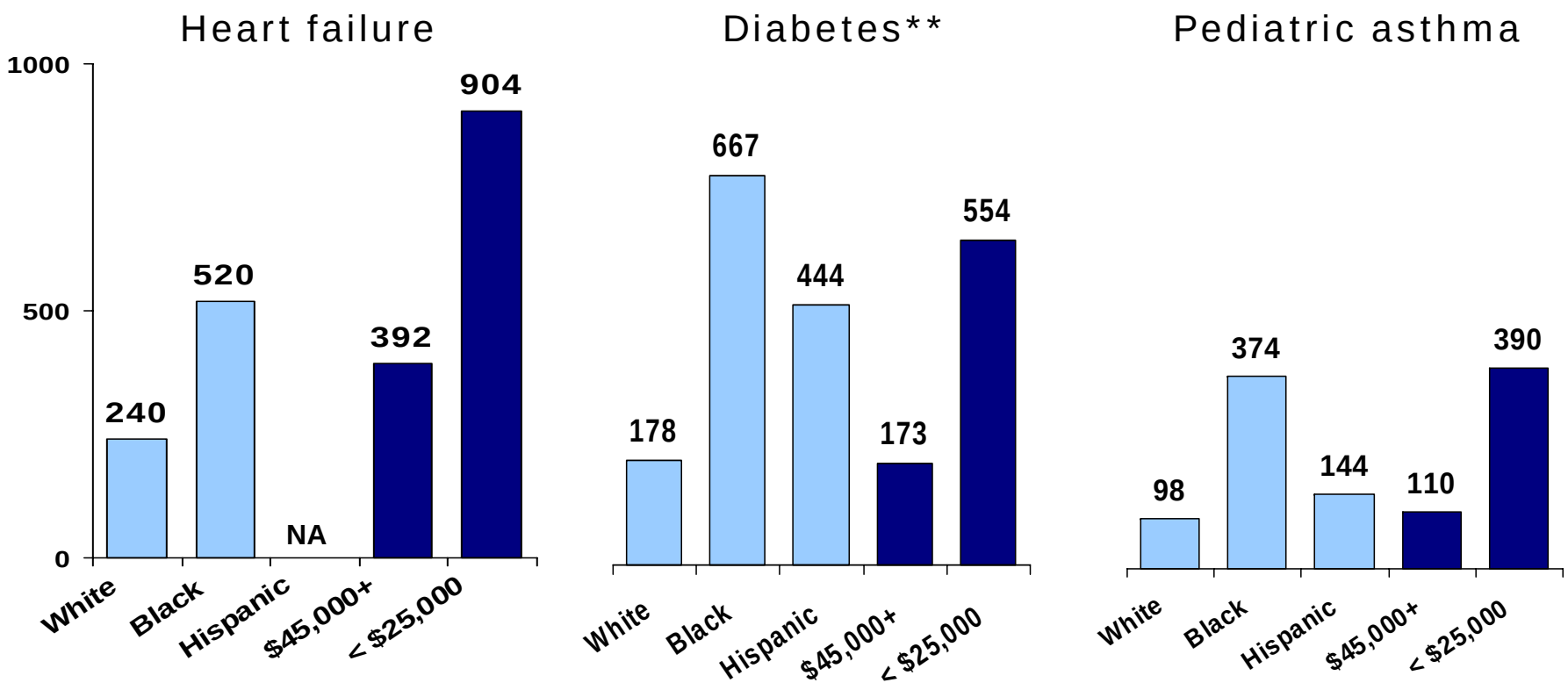
Ambulatory Care–Sensitive (Potentially Preventable) Hospital Admissions, by Race/Ethnicity and Patient Income Area, 2004/2005*

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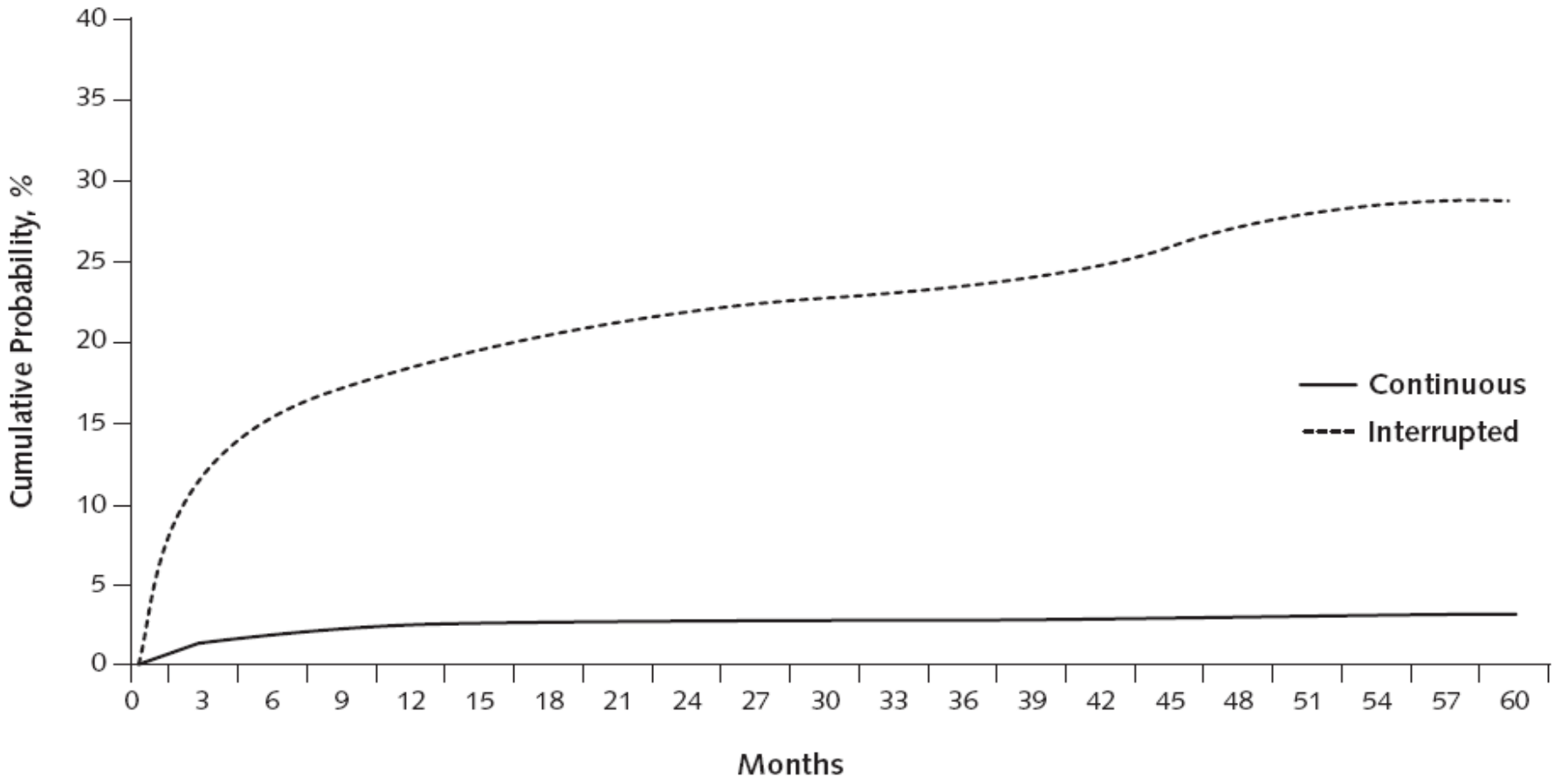
Probability of ACS Hospitalizations Increases with Medicaid Coverage Gaps, 1998–2002



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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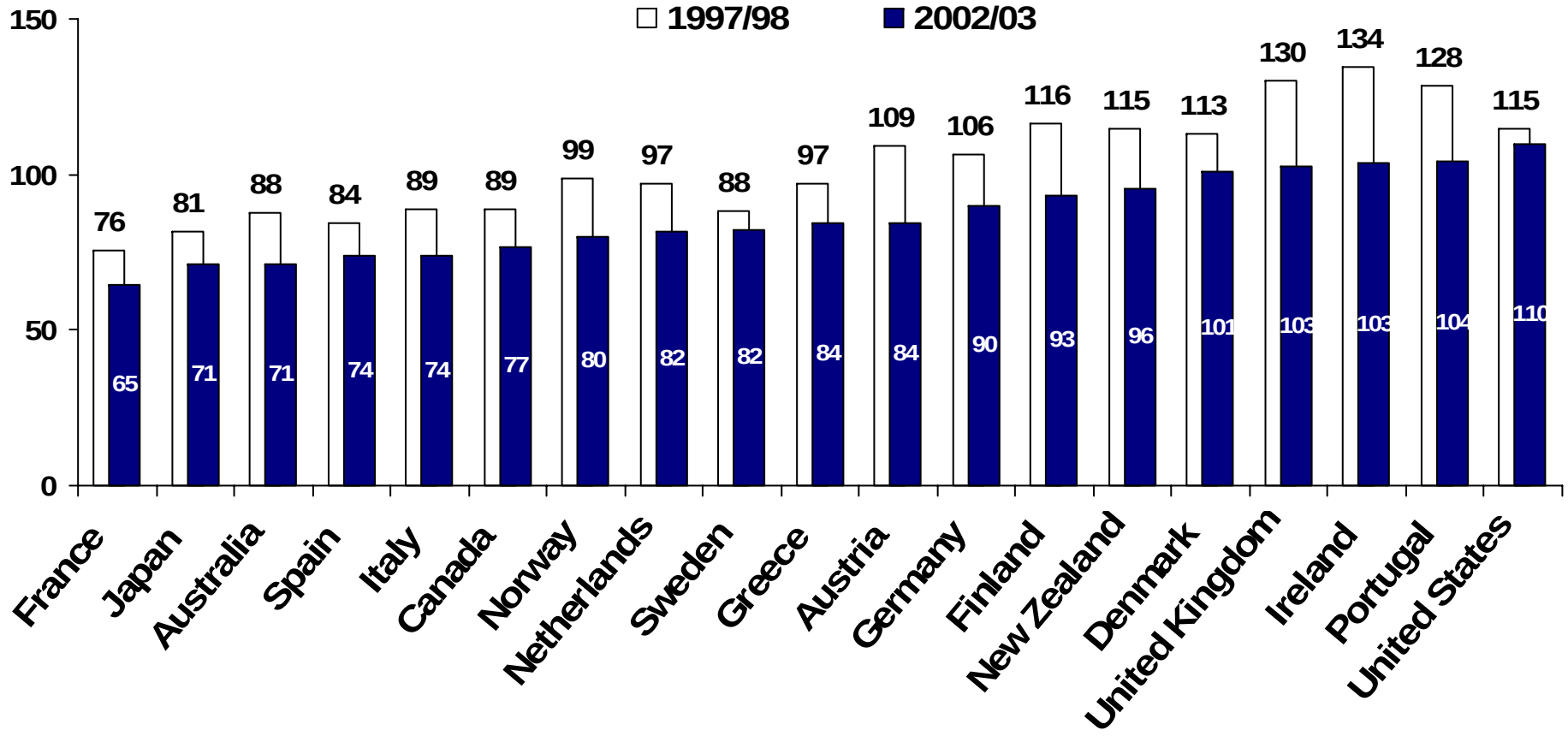
Mortality Amenable to Health Care

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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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.

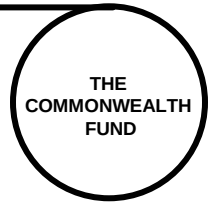
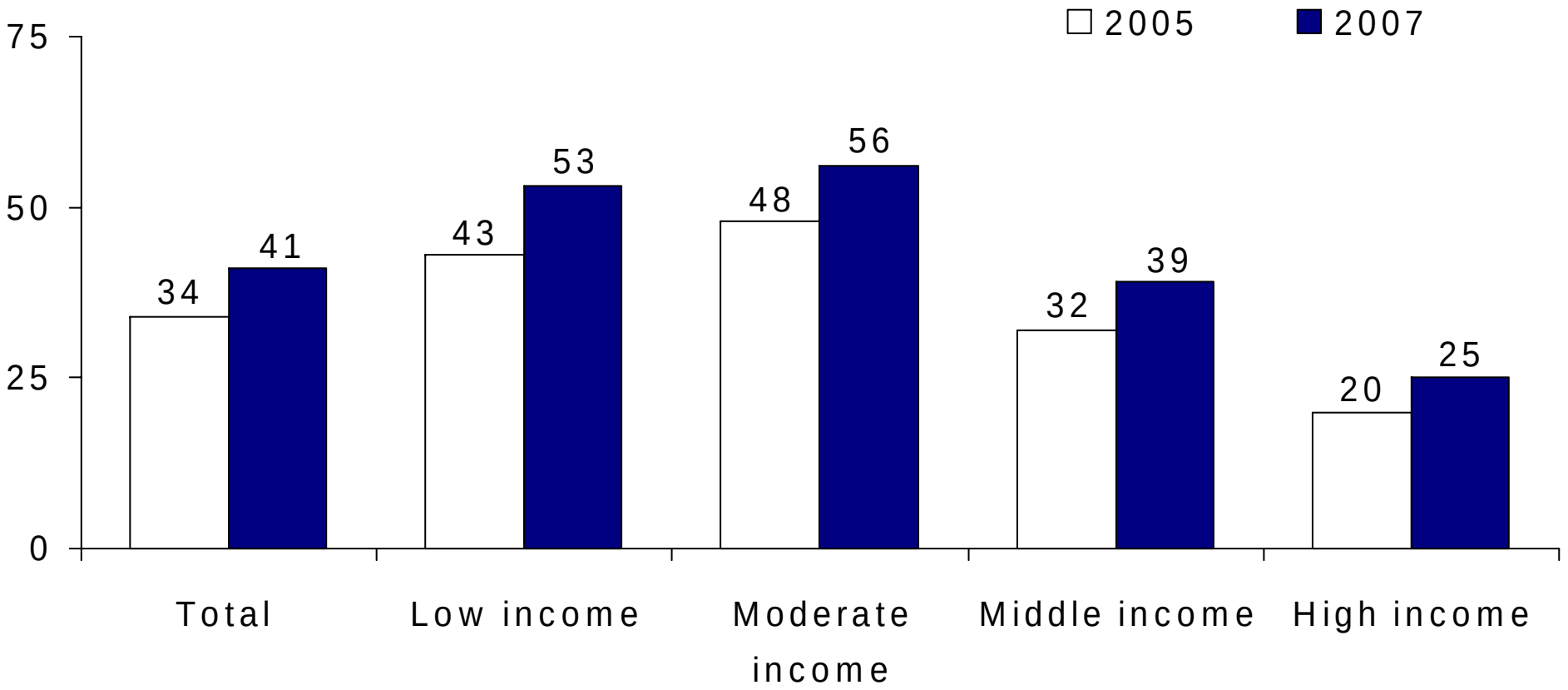


EXHIBIT 17

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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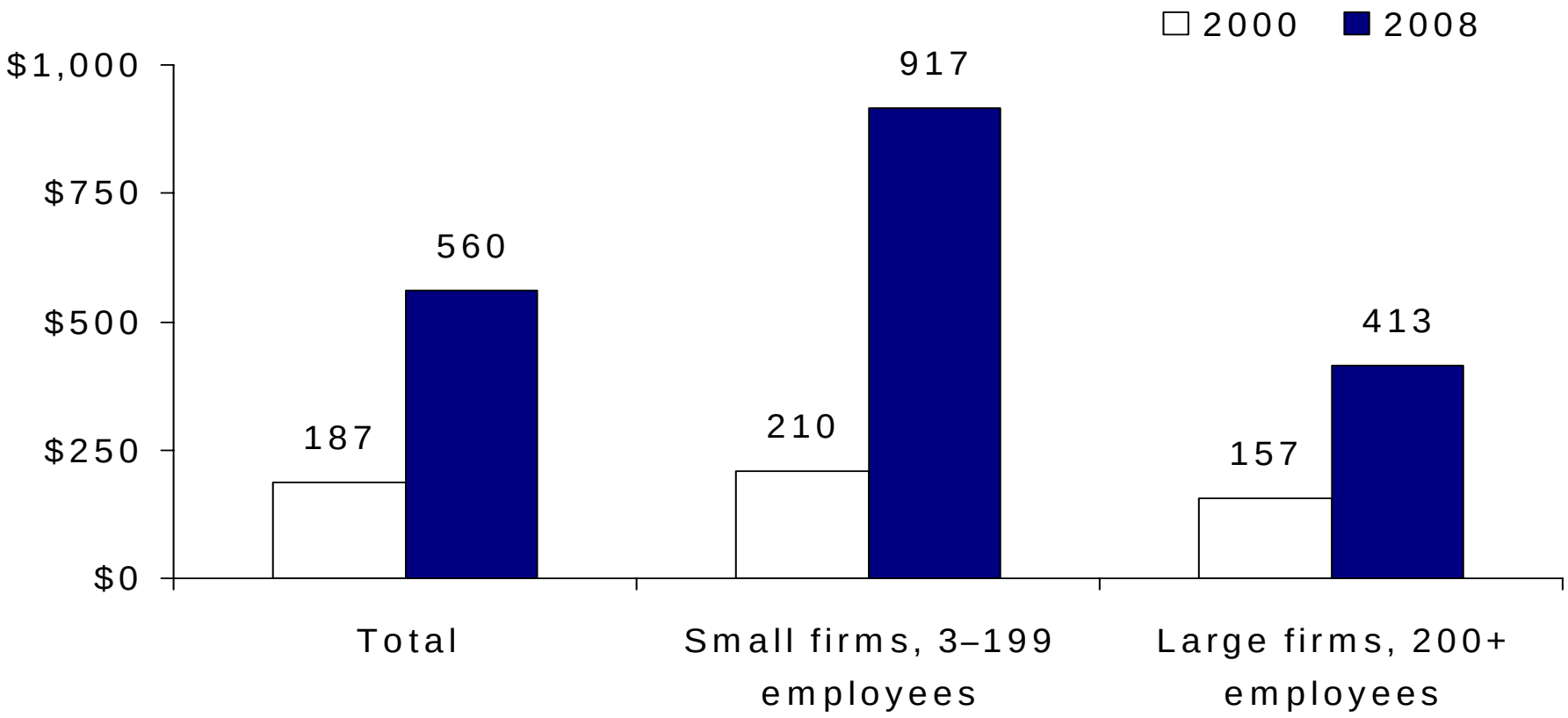
EXHIBIT 18

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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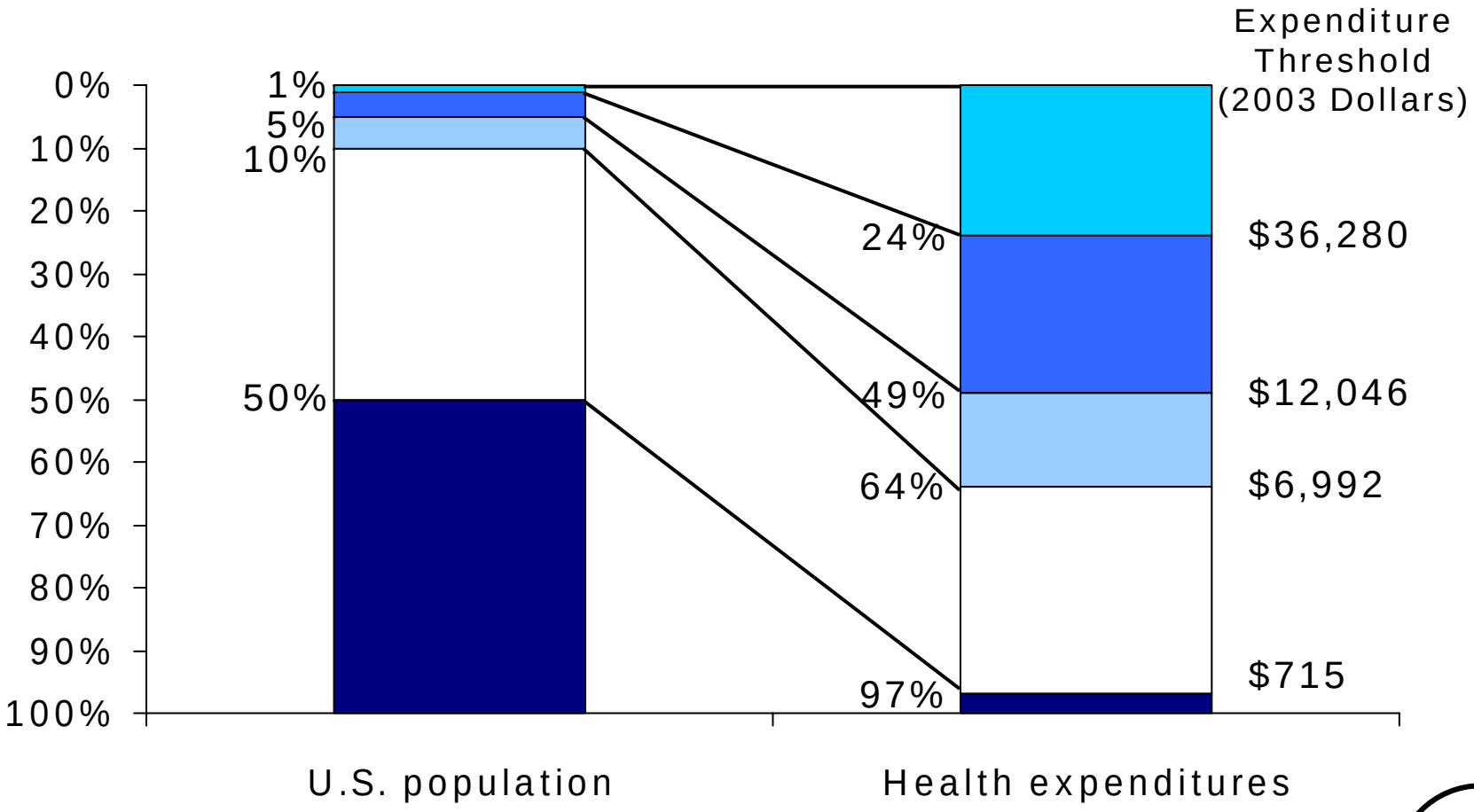
EXHIBIT 19

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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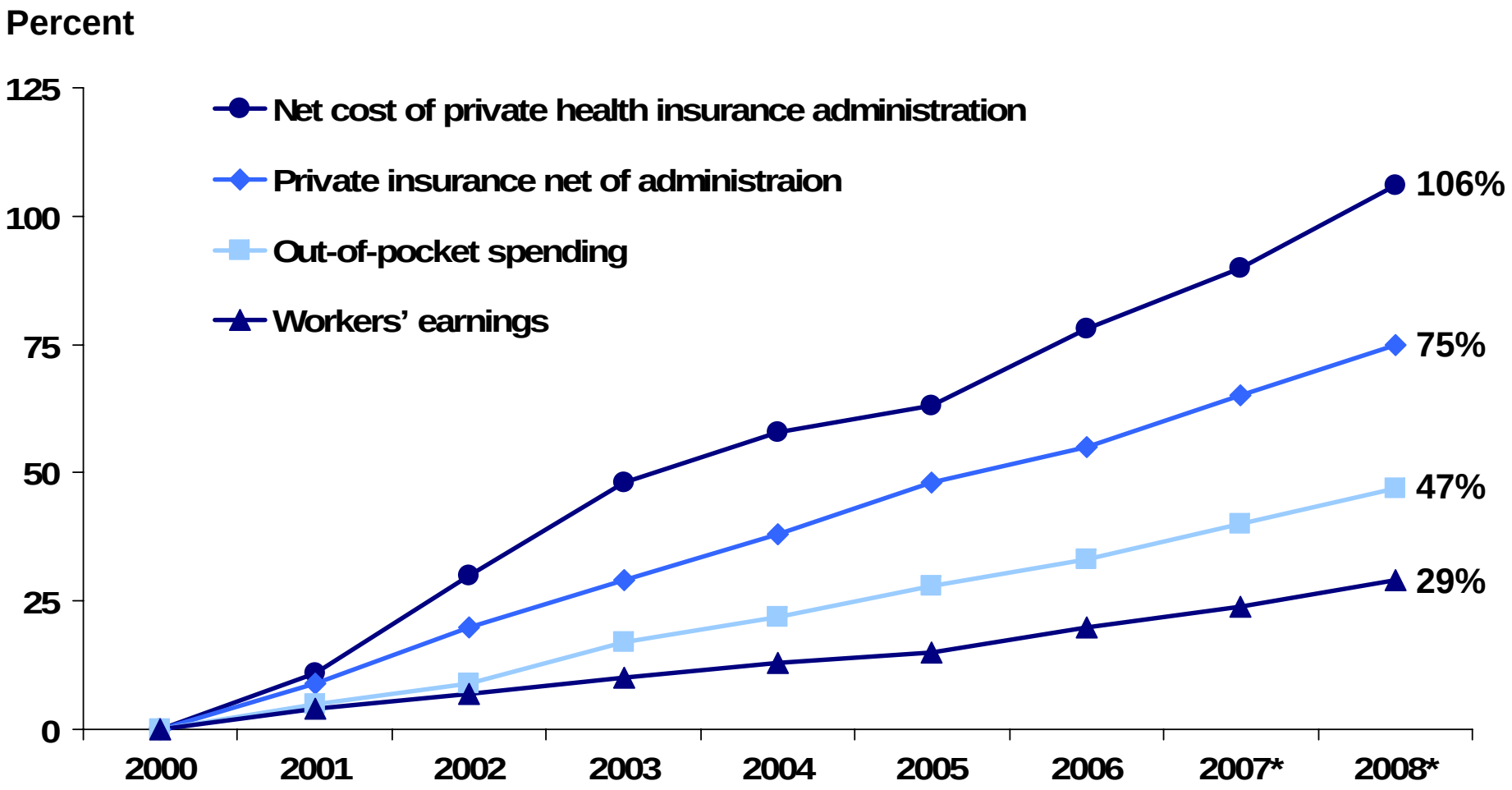
EXHIBIT 20

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.

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

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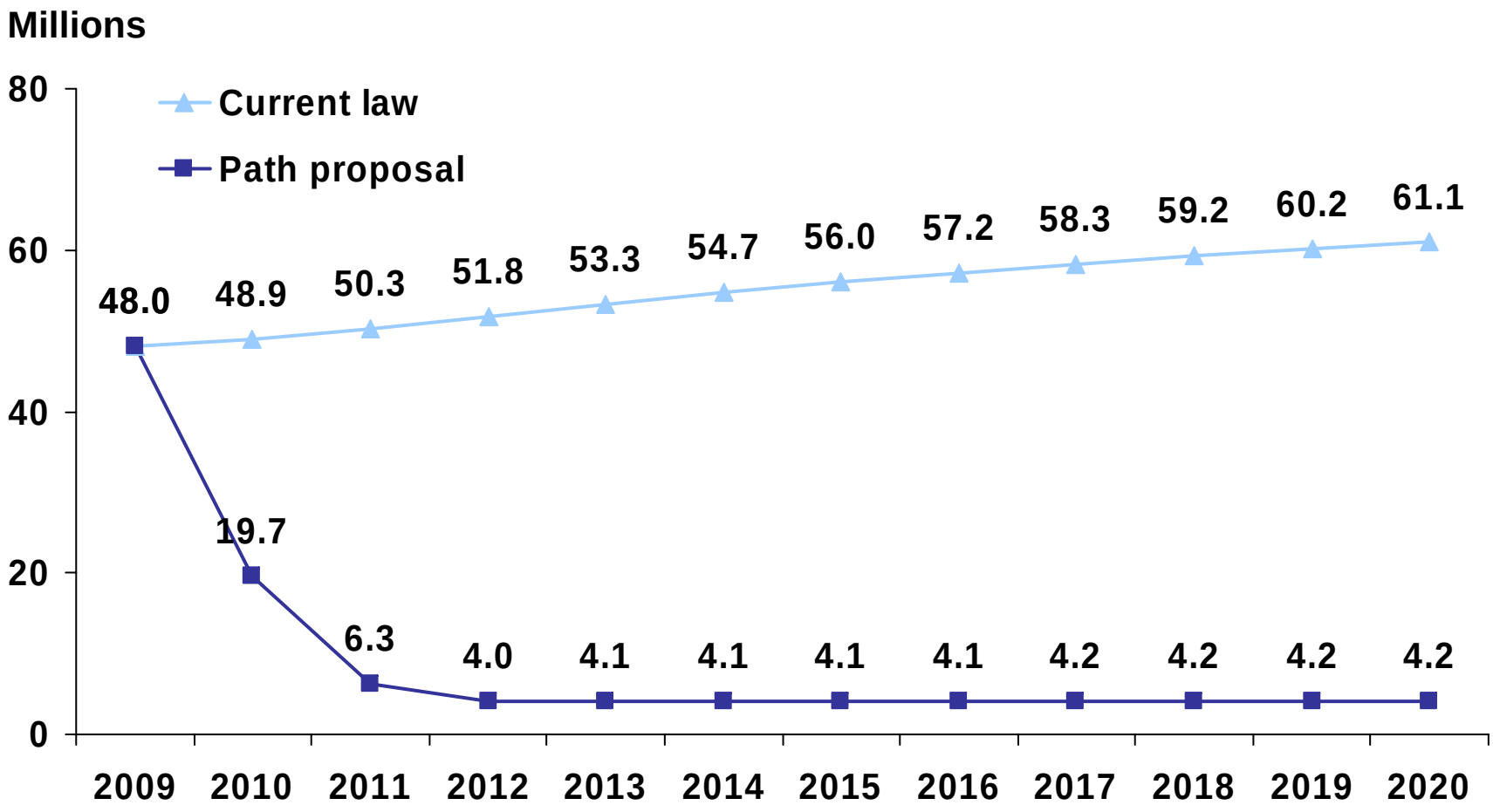
Insurance Reforms: Goals and Design Principles

- 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

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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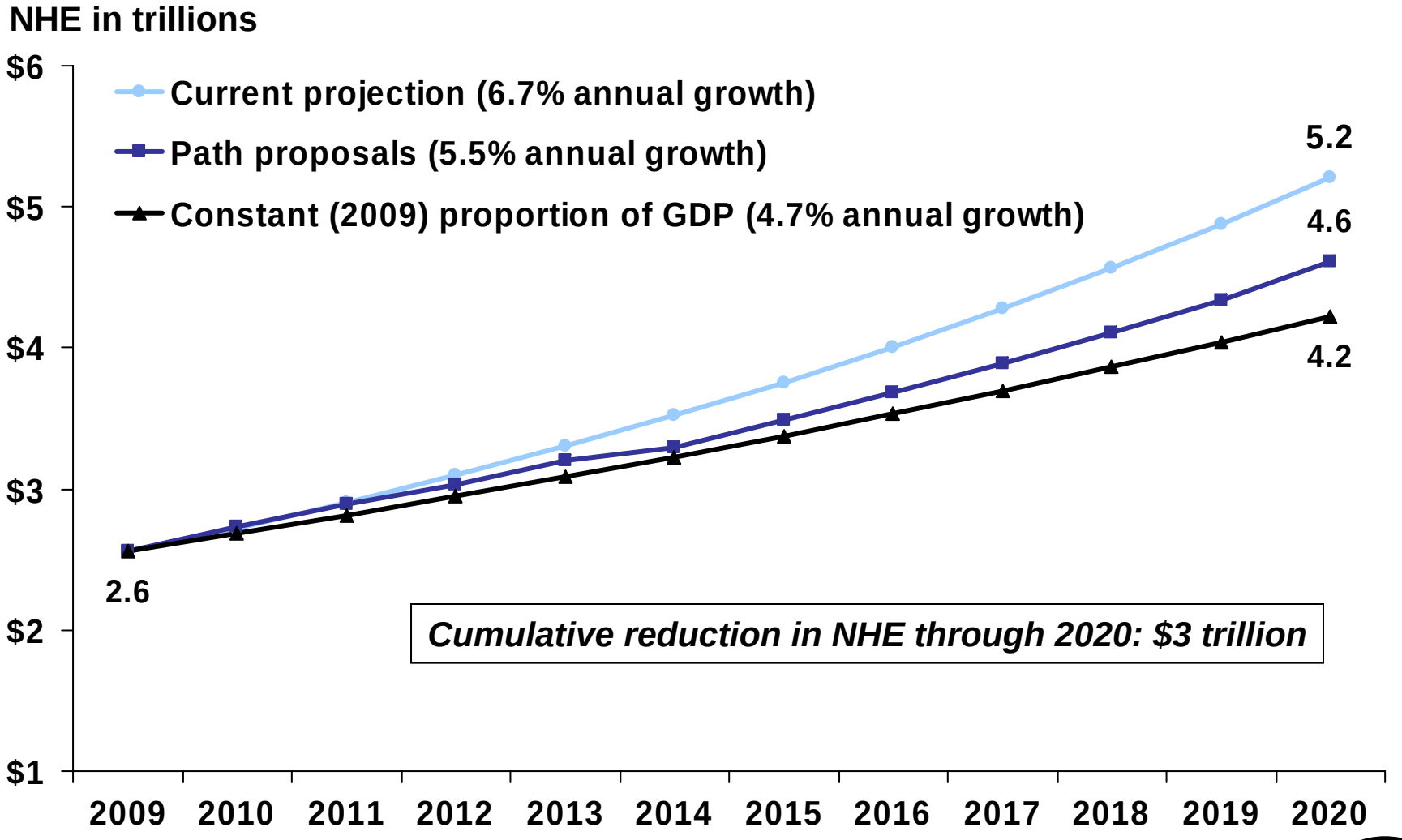
EXHIBIT 24

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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