TIME FOR CHANGE:
THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM

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TIME FOR CHANGE:
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Executive Summary

We have entered the 21st century encumbered by a health system that is not up to the challenge of ensuring a healthy and productive nation. Set in motion over 50 years ago, the system is costly, complex, and confusing. Most important, it is failing to achieve the twin objectives of health insurance: to ensure that people have access to needed medical care and to protect them from the financial burdens of costly medical bills.

There are five types of costs inflicted by our fragmented health insurance system:

- Costs of a growing number of uninsured
  - 41 million Americans in 2001 fell through the cracks of the American health care system because they were not lucky enough to be covered by employer-based coverage, Medicare, Medicaid, or the Children's Health Insurance Plan
- Health and economic consequences of gaps in health insurance coverage
  - 18,000 deaths of adults ages 25 to 64 occur each year as a result of the absence of health insurance coverage—making it the sixth-leading cause of death in this age group, ahead of HIV/AIDS or diabetes
- Cost-shifting that occurs in a fragmented financing system, especially as health care costs accelerate
  - 70 million American workers are covered by their own employer; 20 million by a family member's or previous employer; 30 million are not covered by an employer
  - Our "pass the buck" system of health insurance perpetually shifts costs from one employer to another, employers to workers, federal government to state governments and back, and to safety-net hospitals serving the uninsured
  - Far more energy goes into shifting costs than enhancing efficiency or quality of health care; insurance companies are profitable by attracting favorable risks, not through innovative incentives to improve quality and efficiency
- Costs of churning in health insurance coverage, as people's economic and personal circumstances change
  - Churning results in frequent gaps in insurance. Sixty-two million—one of four—were uninsured during 2000; 75 million were uninsured in 2000 and 2001. These people were at high risk of not getting care when needed and facing unaffordable medical bills when care could not be postponed.

- The U.S. spent $111 billion in 2002 on private insurance and government administrative costs—not including administrative costs incurred by hospitals and other health care providers or by individuals as they enroll, disenroll, and re-enroll and change insurance coverage and plans.

- Costs of complexity from a pluralistic system of health insurance without an integrating framework and consensus on basic principles
  - Cost of large numbers of individuals eligible for but not enrolled in public programs
  - Cost of lost productivity, health, anxiety, sick days, and valuable time of uninsured patients spent seeking care
  - Cost of resources wasted on administration—jobs underwriting, screening, and verifying eligibility; new administrative apparatuses to cover narrow target groups of eligible individuals; costs of enrolling and disenrolling for public and private insurers and for individuals
  - Costs of inefficient and low-quality care—high costs in emergency rooms for preventable conditions and hospitalizations; costs of differing standards of care depending on insurance status
  - The U.S. spends twice as much per capita on health care as other industrialized OECD nations and is the only one to fail to cover everyone

There has to be a better way:

- Automatic and affordable coverage for all
- Balance between choice, flexibility, and innovation; and between simplicity, efficient administration, and standardization that facilitates informed choice
- Shared responsibility for financing coverage—employers, insured and uninsured, health care providers, federal, state, and local government
- Commitment to quality improvement and greater efficiency in care and insurance administration, using modern information technology
- Setting a goal of high-quality health care for all as a top national policy priority, essential to a strong, healthy, and productive nation

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Karen Davis

Thank you, Mr. Chairman, for this invitation to testify on the state of our nation's health insurance system. We have entered the 21st century encumbered by a health system that is not up to the challenge of ensuring a healthy and productive nation. Set in motion over 50 years ago, it is costly, complex, and confusing. Most important, it is failing to achieve the twin objectives of health insurance: to ensure that people have access to needed medical care and to protect them from the financial burdens of costly medical bills.

Today, I'd like to focus on five types of costs inflicted by our fragmented health insurance system:

- Costs of a growing number of uninsured;
- Health and economic consequences of gaps in health insurance coverage;
- Cost-shifting that occurs in a fragmented financing system, especially as health care costs accelerate;
- Costs of churning in health insurance coverage, as people's economic and personal circumstances change; and
- Costs of complexity from a pluralistic system of health insurance without an integrating framework and consensus on basic principles.

Costs to the Nation from a Growing Number of Uninsured

The primary cost to the nation of having a fragmented health care system is the large and growing number of Americans who do not have health insurance. Forty-one million people fall through the cracks of health insurance coverage. They are not lucky enough to have a job with health benefits. Coverage under Medicaid depends on income, assets, where people happen to live, and whether they have children or are disabled; in addition, people must be aware that they qualify for the program and be able to document their eligibility. Coverage for Medicare requires waiting two years as a disabled person or reaching age 65, plus meeting Social Security work history requirements. Buying coverage through the individual market depends on one's health, age, and income sufficient to afford substantial premiums.

We have made no serious progress in reducing the numbers of uninsured since the mid-1970s (Chart 1).[1] Many factors have either improved or reduced coverage, but on balance, the numbers have risen. The loss of manufacturing jobs in the American economy reduced insurance coverage in the 1980s, but with more women entering the workforce more families had two earners and two chances at a job with health insurance coverage. More low-income children were added to Medicaid in the late 1980s and early 1990s. In the late 1990s, welfare reform—largely unintended—contributed to a loss of coverage for women leaving welfare, their children, and legal immigrants. The enactment of the Children's Health Insurance Program (CHIP) in 1997 picked up many of these children at the turn of the century and, paired with a strong economy, there was a slight rise in coverage rates. But since 2000, the numbers of uninsured have again risen. Most of the increase in the uninsured last year was due to loss of private insurance as rising rates of unemployment led to job and insurance loss. In the coming year, public coverage is likely to erode as states hit by fiscal crises move to restrict coverage.

There are a number of paths to health insurance coverage in the United States (Chart 2). The dominant path to insurance is having a job with an employer who offers such a benefit: 160 million Americans have employer-based coverage. Medicare covers 39 million people ages 65 and over and those who have been disabled for two years or more who meet the work history requirements for Social Security. It is the only universal health plan in the country and, although there are gaps in what it covers, it is still the most popular.[2] Medicaid covers 40 million people, mostly low-income children, their parents, disabled people, and the elderly (some of whom are covered both by Medicare and Medicaid). It is the largest insurer of the very poor and very sick, filling gaps left by the private system. During the recent recession, Medicaid has seen its enrollment climb rapidly, mitigating the increase in the uninsured. About 15 million people under age 65 rely entirely on coverage they buy on their own.[3]

Sources of health insurance coverage vary widely depending on income (Chart 3). Among those living below the federal poverty level, just 19 percent receive coverage through an employer. Forty two percent are publicly insured, and a small group buys individual coverage. Nearly one-third are uninsured. As income increases, employer-sponsored insurance rises, with more than three-fourths (78 percent) of those making more than three times the poverty level getting their coverage through an employer.[4]

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[1] National Health Interview Survey, EBRI, Current Population Survey, and Current Population Report.

[2] K. Davis, et al. "Medicare Versus Private Insurance: Rhetoric and Reality." *Health Affairs* (October 9, 2002).

[3] Analysis done by the Commonwealth Fund Task Force on the Future of Health Insurance and Sherry Glied, Columbia University, using March 2002 Current Population Survey.

[4] Analysis done by the Commonwealth Fund Task Force on the Future of Health Insurance and Sherry Glied, Columbia University, using March 2002 Current Population Survey.

In addition to the large number of people who report that they are uninsured all year, almost the same number—13 percent of those under age 65—report that there was a time in the past year when they were uninsured (Chart 4).[5] Young adults ages 19 to 29 are especially likely to experience a gap in insurance coverage as they leave their parents' insurance policies or Medicaid, or fail to find a job with benefits or meet categorical eligibility requirements for Medicaid. Among 19- to 23-year-olds, about half were uninsured part or all of the year (Chart 5).[6]

Employer-sponsored health insurance typically allows young adults up to age 21 or 23 to remain on their parents' policies as long as they are full-time students. However, there are more young adults who are part-time students or not in school than there are full-time students, and they are not afforded the same protections. As a result, 36 percent of young adults who are not full-time students are uninsured (Chart 6).[7]

Another group that regularly falls outside the protections of health insurance is Hispanics. Hispanics are more than twice as likely as white, non-Hispanics to be without health insurance (Chart 7). Those who are newer to the United States and working in the lowest-wage jobs, including many Mexican and Central American workers, are among the most likely to be uninsured. Nearly half of people coming to the United States from Mexico lacked health insurance at some time in 2001.[8]

It is a common misperception that many uninsured workers are offered insurance but turn it down, either because they don't need or don't value it relative to other types of compensation. In fact, 60 percent of uninsured workers are not offered insurance by their employer, and another 11 percent are not eligible for their employer's plan because of their part-time status or a waiting period (Chart 8). Twenty-two percent of uninsured workers decline their employer-offered coverage, mainly because of cost.[9]

The rate at which workers take-up coverage varies by how much they earn. People making less than $10 per hour are much less likely to participate in their employer's plan than those making more than $10 per hour (Chart 9). Firm size matters as well. Compared with the smallest firms, medium and large employers tend to offer better coverage at lower or comparable premiums, contributing to the higher take-up rates at larger firms. As a result, the highest uninsured rates are among low-wage workers

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[5] J. Rhoades and J. Cohen, *Statistical Brief #6 – The Uninsured in America, 1996–2001*. (Rockville, MD: Agency for Healthcare Research and Quality, November 2002).

[6] Analysis done by Commonwealth Fund Task Force on the Future of Health Insurance and Sherry Glied, Columbia University, using March 2000 Medical Expenditure Panel Survey.

[7] Analysis done by Commonwealth Fund Task Force on the Future of Health Insurance and Sherry Glied, Columbia University, using March 2002 Current Population Survey.

[8] M. Doty, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English*. (New York: The Commonwealth Fund, February 2003).

[9] Analysis of the Commonwealth Fund 2001 Health Insurance Survey.

employed in small firms. Uninsured rates are almost 10 times higher for these workers than for higher-wage workers in larger firms.[10]

"Nonstandard" employees are also at much higher risk of being uninsured. About one-fourth of part-time workers are uninsured—nearly as many as the unemployed (Chart 10). But even full-time workers who are new on the job can wait two to four months for coverage.[11] Independent contractors or employees who are "leased" through an outside firm are often denied health benefits, even if they effectively work full time for a firm that provides coverage to "standard" employees.

Coverage for retirees has also deteriorated markedly over the past decade (Chart 11). More and more firms are declining to provide health insurance, both for early retirees and supplemental coverage for retirees whose primary source of coverage is Medicare. In 1988, 66 percent of large firms provided retiree health benefits; today, only 34 percent do so.[12]

Supplemental insurance coverage is also problematic, even for Medicare beneficiaries. While almost everyone age 65 and over is covered by Medicare, limits on program benefits mean that Medicare covers only 55 percent of the costs of beneficiaries' care.[13] As a result, most Medicare beneficiaries have some form of supplemental coverage, through retiree plans, enrollment in Medicare+Choice plans, purchase of private Medigap coverage, or coverage under Medicaid (Chart 12). Yet, almost one-fourth of Medicare beneficiaries have no prescription drug coverage and almost half are without prescription drug coverage at some point during the year.[14] Many of the most important sources of prescription drug coverage—retiree coverage and Medicare+Choice—have been eroding in recent years.[15]

Maps reveal a great deal about who experiences the inequities of the health insurance system in the United States (Chart 13). By virtue of where a person lives, he or she may or may not be eligible for public coverage, or may work in an industry in which insurance coverage is commonplace. Uninsured rates vary from a low of 8 percent in five

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[10] S. Collins, C. Schoen, D. Colasanto, and D. Downey, "On the Edge: The Health Insurance Coverage of Low-Wage Workers," Findings from the Commonwealth Fund 2001 Health Insurance Survey (New York: The Commonwealth Fund, March 2003).

[11] J. Gabel, J. Pickreign, H. Whitmore, and C. Schoen. "Embraceable You: How Employers Influence Health Plan Enrollment." *Health Affairs* (July/August 2001): 196–208.

[12] Kaiser Family Foundation/Health Resource and Educational Trust, Employer Health Benefits 2002 Annual Survey. (Menlo Park, CA: Kaiser Family Foundation, 2002).

[13] Kaiser Family Foundation, *Medicare Chart Book*. (Menlo Park, CA: The Kaiser Family Foundation, 2001).

[14] B. Stuart, D. Shea, and B. Briesacher, *The Dynamic of Prescription Drug Coverage for Medicare Beneficiaries* (New York: The Commonwealth Fund, November 2001).

[15] B. Stuart, D. Shea, and B. Briesacher, *The Dynamic of Prescription Drug Coverage for Medicare Beneficiaries* (New York: The Commonwealth Fund, November 2001).

states (Rhode Island, Minnesota, Massachusetts, Iowa, and Wisconsin) to highs of 23 percent in Texas and 22 percent in New Mexico.[16]

Part of the state variation can be understood by looking at Medicaid (and CHIP) eligibility rules and enrollment processes. Since the 1980s, Medicaid programs have been growing to provide health care access for the lowest-income children, elderly, disabled, and, more recently, parents (Chart 14).[17] Medicaid is a major source of coverage for pregnant women and poor children. One-third of all births are covered by Medicaid. However, this coverage varies widely across the states (Chart 15). Furthermore, recent state budget crises portend a flattening out of the programs, or even a retrenchment. Even in the best of times, state programs—with a few exceptions—have fallen well short of providing a uniform base of coverage for those most at risk.

Health and Economic Consequences of Gaps in Health Insurance Coverage

The Institute of Medicine estimates that, each year, 18,000 25- to 64-year-old adults die because they lack health insurance coverage.[18] This would make lack of health insurance the sixth-leading cause of death among people under age 65—after cancer, heart disease, injuries, suicide, and cerebrovascular disease, but before HIV/AIDS or diabetes (Chart 16). Such numbers make a compelling case for addressing this national disgrace.

Failure to act will result in costs to all sectors of society—to the uninsured, who pay in lost years of life; to employers, whose employees miss work or retire early for health reasons; to the health system, which is encumbered by bad debts and inefficient care resulting from inadequate insurance; and to society at large, which forgoes the economic benefits and taxes of a healthier, more productive labor force. We all pay when we fail to invest in health care that would make us a stronger and healthier nation.

Of course, being uninsured exposes individuals to risks in addition to greater probability of death. Lack of health insurance often results in poor-quality care, which can have a multitude of health consequences. The Commonwealth Fund 2001 Health Insurance Survey found that the uninsured are less likely than the insured to see a physician when needed or to get needed specialist care; they are also less likely to fill prescriptions ordered by physicians when they do seek care, and are less likely to get recommended tests or follow-up treatments (Chart 17). More than half (54%) of those uninsured all or part of the year reported one of these problems in terms of access to care, compared with one-fifth (21%) of those who are continuously insured.

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[16] www.statehealthfacts.kff.org, accessed 3/5/03; R. Bovbjerg, et al. "Medicaid Coverage for the Working Uninsured: The Role of State Policy," *Health Affairs* (November/December 2002):231-243.

[17] Centers for Medicare and Medicaid, *An Overview of the U.S. Healthcare System: Two Decades of Change, 1980-2000*. (http://www.cms.gov/charts/healthcaresystem/, accessed 3/5/03)

[18] Institute of Medicine, *Care Without Coverage: Too Little, Too Late.* (Washington, D.C.: The National Academies Press, 2002).

The uninsured who do obtain care are more likely to experience financial burdens from medical bills. Those without insurance are twice as likely as those continuously insured to be required to pay cash in advance to get care. More than half of the uninsured reported that they were not able to pay medical bills and more than a third said that they had been contacted by a collection agency about unpaid medical bills. Overall, twice as many uninsured as insured said that they experienced cost-related problems in accessing care or paying for medical bills (70% vs. 34%).[19]

The uninsured are also less likely to have a regular source of care, and are thus less likely to receive preventive care or benefit from early detection of medical problems (Chart 18).[20] For example, among adults ages 45 to 64, the uninsured are less likely than the insured to have had a cholesterol screening in the past five years. Early detection of abnormalities is critical to the successful treatment of breast cancer, yet among women ages 50 to 64, 32 percent of the uninsured compared with 11 percent of the insured had not received a mammogram in the past two years.[21] Moreover, the uninsured say they are less satisfied with the quality of care they receive and are less likely to follow their physician's advice because of costs. In terms of the quality framework set forth by the Institute of Medicine, the uninsured are systematically less likely than the insured to receive effective, safe, and timely care.

A recent study estimates that an individual's earnings are 15 to 20 percent lower as a result of being uninsured, largely because of reduced workforce participation and productivity.[22] Employers, too, may incur costs when employees miss work, leave jobs, or retire early for health reasons. The Fund's 2001 Health Insurance Survey found that 16 percent of the uninsured were absent from work during the year because of a problem with their teeth, compared with 8 percent of those with health insurance. Almost half (45%) of the uninsured said that they went without needed dental care over the course of a year.

Caregiving responsibilities for a sick or disabled child, spouse, or parent may also keep employees from the workplace. Women in particular may miss work to care for sick family members, especially children, and uninsured children are more likely than insured

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[19] L. Duchon, et al., *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk, Findings from the Commonwealth Fund 2001 Health Insurance Survey* (New York: The Commonwealth Fund, December 2001).

[20] K. Collins, et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans, Findings from the Commonwealth Fund 2001 Health Care Quality Survey* (New York: The Commonwealth Fund, March 2002).

[21] J. Ayanian, et al., "Unmet Health Needs of Uninsured Adults in the United States," *Journal of the American Medical Association* 284 no 16 (2000): pp 2061–2069.

[22] J. Hadley, *Sicker and Poorer: The Consequences of Being Uninsured* (Menlo Park, CA: Kaiser Family Foundation, 2002).

children to miss school.[23] In an analysis of women previously on welfare, one study found that having a health limitation and having a child with a health limitation were associated with significantly increased risk of job loss—even after accounting for differences in social and demographic characteristics.[24] In a 1999 study, about 37 percent of women on welfare were caring for a child with a chronic condition.[25]

Cost Shifting that Occurs in a Fragmented System

Health care costs have accelerated markedly in recent years. In 1988, we were spending $600 billion on health care in the United States. Estimates are that we spent $1.5 trillion last year, and that number will double to more than $3 trillion by 2012 (Chart 19).[26] After years of relatively stable growth in the mid-1990s, health spending as a percent of gross domestic product increased to 14.1 percent in 2001, up from 13.3 in 2000.[27] Health spending is projected to reach 17.7 percent of GDP in 2012 (Chart 20).

Health insurance premiums are growing rapidly too, at about 13 percent in 2002. By contrast, workers' earnings are growing at just 4 percent a year (Chart 21).[28] Even this increase in premiums understates the rising cost for the same benefits, since there has also been about a 2-percent reduction in the actuarial value of covered benefits through increased cost-sharing or other restrictions on covered services.

The fragmentation in the U.S. health care system leads to an uneven distribution of the costs of coverage. About 70 million American workers get coverage from their own employer. Another 20 million American workers get coverage from another employer, typically that of their spouse.[29] Employers who cover their own workers often pay in multiple ways—for the cost of coverage for their workers and their workers' dependents, and for higher premiums that reflect the costs of uncompensated care that are passed on by hospitals and other health care providers. By contrast, employers who do not offer coverage effectively shift this cost and responsibility onto other employers or public programs. Many of their uninsured employees are minimum-wage workers who—

[23] B. Wolfe and S. Hill, "The Effect of Health on the Work Effort of Single Mothers." *Journal of Human Resources* 30(1) 1994.

[24] A. Earle and J. Heymann. "What Causes Job Loss Among Former Welfare Recipients: The Role of Family Health Problems." *Journal of the American Medical Women's Association* 57(1) 2002: 5–10.

[25] J. Heymann and A. Earle. "The Impact of Welfare Reform on Parents' Ability to Care for Their Children's Health." *American Journal of Public Health* 89(4) 1999:502–505.

[26] Heffler et al., "Health Spending Projections for 2002–2012," *Health Affairs* (February 7, 2003).

[27] Stephen Heffler et al., "Health Spending Projections for 2002–2012," *Health Affairs* Web exclusive, February 7, 2003.

[28] Gabel et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs* (Sept/Oct 2002):143–151.

[29] S. Collins, et al., "On the Edge: The Health Insurance Coverage of Low-Wage Workers Findings from the 2001Commonwealth Fund Health Insurance Survey." (New York: The Commonwealth Fund, forthcoming).

despite an economic theory that assumes backward shifting of health insurance costs—are unlikely to be paid higher wages in lieu of health insurance coverage.

Similarly, some states do a good job of covering low-income children and adults who fall through the cracks of employer-based coverage. But others have quite restrictive income and asset limits, thereby shifting the cost of care to safety net institutions, which in turn try to shift the costs to those with private coverage.

As a result of its fragmentation, we have a "pass the buck" health care system in which cost-shifting among payers is commonplace. This problem only intensifies as health care costs grow, and more payers attempt to hold the line on their own spending. Most recently, employers who cover their workers have been shifting a greater proportion of that cost directly onto employees in the form of higher premiums and cost-sharing.[30]

While the problem of rising health care costs is troubling to those who are insured, it can be devastating to those who are not. When the uninsured absolutely cannot skip needed health care, they seek care at safety net institutions and from charitable providers. The cost to the system of caring for the uninsured was estimated at $40.6 billion in 2001. The biggest portion of this—more than $24 billion—was the amount providers report as uncompensated care. The uninsured paid an additional $14 billion out of pocket, and worker's compensation covered about $2 billion.[31]

Public programs also indirectly fund care for the uninsured (Chart 22). Medicaid and Medicare contributed $17 billion in 2001 through disproportionate share payments to hospitals and support for medical education. The Veterans Administration spent $7.4 billion on health care, many for uninsured men who could not afford care through other health care providers, or for elderly without prescription drug coverage. Community health centers, Ryan White centers for people with HIV/AIDS, the Indian Health Service, and other public programs also provide funding for care of the uninsured. Together, these public sources of care spent $30.6 billion in 2001 for the health needs of the uninsured.

Government is not immune to the temptation to shift costs as well. For years, states have complained that the Medicare program fails to pick up the costs of Medicare beneficiaries, instead shifting that cost in part to states through the federal-state Medicaid program. Prescription drug coverage, which most agree is a glaring omission in the Medicare program, winds up being covered by the states for the poorest of the elderly. In 2002, states spent approximately $6.8 billion on prescription drugs for Medicare beneficiaries with full Medicaid benefits; there was wide variability among states in

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[30] J. Edwards, M. Doty, and C. Schoen, *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Surve*y (New York: The Commonwealth Fund, August 2002).

[31] J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for it?" *Health Affairs* Web Exclusive, February 12, 2003.

terms of spending for this group (Chart 23).[32] Similarly, by setting an arbitrary two-year waiting period for coverage of the disabled, Medicare shifts to states the cost of covering low-income disabled individuals during that period, even after they have qualified for Social Security Disability Insurance.

The federal government provides higher matching rates for low-income children under CHIP than under Medicaid. States thus have an incentive to restrict eligibility under Medicaid and instead cover children under CHIP. Groups without federal matching assistance, particularly low-income single individuals and childless couples, are the least likely to be covered by state programs.

There can also be shifting among state and local governments. If states limit eligibility under Medicaid, costs are shifted to public hospitals supported by localities. In some states, localities share in the cost of Medicaid but not CHIP, changing the calculus of who wins and who loses when coverage is expanded or restricted. The uninsured are often forced to use costly emergency room care that could have been provided in lower-cost primary care settings.[33] As their beds fill with uninsured patients, hospital emergency rooms routinely have to turn away patients who have insurance, and overcrowding adversely affects the quality of care for all patients.[34]

"Passing the buck" also occurs among health care providers. Some hospitals treat patients without health insurance coverage, others do not. As fiscal pressures have tightened with managed care, and greater restrictions have been placed on Medicare and Medicaid payments to hospitals, certain hospitals—particularly public hospitals, teaching hospitals, and other safety net institutions—have provided an increased share of care of the uninsured (Chart 24). This has threatened the hospitals' fiscal stability, leading many to restrict admission for people who can not pay.

Some have viewed the expansion of community health centers as an alternative to providing health insurance coverage. These primary care centers are often models of care, serving low-income and minority communities with a commitment to providing quality care. But they are not funded to provide specialized services, and it is often difficult for them to find providers to perform mammograms, colonoscopy exams, MRIs, ultrasound

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[32] S. Dale and J. Verdier, *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles.* (New York: The Commonwealth Fund, forthcoming.)

[33] Schur, C., P. Mohr, and L. Zhao, *Emergency Department Use in Maryland: A Profile of Use, Visits, and Ambulance Diversion*, Report to the Maryland Health Care Commission, Project HOPE: Bethesda, Md., February 2003.

[34] The Institute of Medicine, A Shared Destiny: Community Effects of Uninsurance. (Washington, DC: National Academies Press, 2003)

tests, cardiology consultation, orthopedics, infectious disease consultation, or inpatient hospital care for their uninsured patients (Chart 25).[35]

"Passing the buck" is a way of life in certain segments of the health insurance market. The individual insurance market, except in a few states, can exclude those with serious health problems, or charge such high premiums that individuals cannot afford to purchase coverage. Individual health insurance premiums typically vary by age, and are often unaffordable for uninsured individuals with limited incomes (Chart 26). The Commonwealth Fund 2001 Health Insurance Survey found that 53 percent of individuals who explored obtaining health insurance on the individual market reported that it was very difficult or impossible to find a plan they could afford.[36]

Medicare's experience with Medicare+Choice also illustrates how risk selection can take place. Plans can withdraw from market areas where they are losing money, and focus their marketing on geographic areas where they attract healthier or more profitable patients.

When we use large groups to gain economies of scale and spread risk, the cost of administering benefits is low. Medicare and Medicaid have administrative costs in the range of 2 to 4 percent (Chart 27). Private plans, on the other hand, have the costs of marketing, advertising, sales commissions, claims administration, reserves, and profits, and so have a higher overhead rate. This is most apparent in the small group and individual market, where small firms pay administrative costs of 30 percent.[37] By comparison, Canada, which has a uniform national benefit plan that is administered by the government and delivered by private hospitals and physicians, spends just one percent a year on administration.[38]

Costs of Churning

While a great deal of attention is focused on the 41 million people who are uninsured at a point in time, there is much less awareness of the high rate of turnover in health insurance coverage. Sixty-two million people were uninsured at some point during 2000. About 13 percent of people under age 65 are uninsured all year, and a nearly equal percentage are

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[35] M. Gusmano, G. Fairbrother, and H. Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured." *Health Affairs* (November/December 2003): 188–194.

[36] L. Duchon and C. Schoen, *Experiences of Working-Age Adults in the Individual Insurance Market* (New York, The Commonwealth Fund, December 2001).

[37] U.S. House of Representatives, *Health Care Resource Book* (Washington, D.C.: Government Printing Office, 1993).

[38] U.S. House of Representatives, *Health Care Resource Book* (Washington, D.C.: Government Printing Office, 1993).

uninsured at some point during the year. A recent study estimates that 75 million people were uninsured at some time over the two-year period 2000–2001.[39]

In a recent analysis of the reasons people move on and off coverage, Leighton Ku and Donna Cohen Ross estimated that if people were able to stay on the insurance they had at the beginning of the year for the entire year, there would be 40 percent fewer uninsured low-income children and 28 percent fewer uninsured low-income adults (Chart 28).[40] Just helping people keep their coverage would make an enormous difference in the numbers of uninsured.

People can lose their insurance coverage when they lose or change jobs, are widowed or divorced, become sick or disabled and leave the workforce, move from one state to another, experience a change in income or wages, or fail to complete recertification processes in public programs. Young adults can lose coverage just by celebrating their 19th birthday—what a birthday surprise that is! Workers lose employer coverage when they become unemployed, and many either do not quality for COBRA extension of coverage or cannot afford the high premiums.[41]

This churning in health insurance coverage also imposes a hidden cost on the U.S. health system. Every time an individual or family signs up for insurance coverage, whether public or private, there is a cost of enrollment. There are other costs when disenrollment or reenrollment occurs. Low-income families, particularly, have unstable incomes and changing employment status. This can lead a low-income family to have multiple episodes of public program coverage over time, with frequent changes in insurance status. Public programs also require reenrollment administrative processes, even when circumstances do not change, and families burdened with other issues of daily living may not have the time or resources to provide a second round of documentation to qualify for coverage. Health plans participating in public programs also incur the expense of starting a new beneficiary in their networks only to lose them again—one New York HMO estimates that they spend a full two months' worth of the initial premium to set up a new family.[42] This is wasted if the enrollment is short term.

Employer coverage can also be very unstable, not just because people change jobs but because employers change plans that are offered to employees. Particularly in the managed care era of the 1990s, plan changes were frequent. Consolidation in the

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[39] FamiliesUSA, *Going Without Coverage: Nearly One in Three Non-Elderly Americans* (Robert Wood Johnson Foundation: Princeton, NJ 2003).

[40] L. Ku and D. Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families* (New York: The Commonwealth Fund, 2002).

[41] M. Doty and C. Schoen, *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (New York: The Commonwealth Fund, December 2001).

[42] Personal communication with Benjamin K. Chu, M.D., President and Chief Executive, New York City Health and Hospitals Corporation, February 27, 2003.

managed care industry, with mergers and conversions, added to this instability. Plan withdrawals from selected geographic areas also required many Medicare, Medicaid, federal employees, and privately insured individuals to change coverage.

Not surprisingly, both U.S. spending on health insurance program administration and the net cost of private health insurance have soared over the last three decades (Chart 29). In 1970, the U.S. spent $2.8 billion on administrative costs. In 1980, it was $12.1 billion. By 1990 it was $40 billion. In 2002, it was $110.9 billion. By 2012 it is expected to reach a staggering $222.6 billion—8 percent of all personal health care expenditures.

These costs do not include the administrative costs borne by health care providers. When patients change insurance status or their doctor, insurance eligibility needs to be verified, administrative records changed, and medical records forwarded to a new doctor.

Perhaps most troubling of all, this turbulence in coverage undermines the continuity of care for patients. The Commonwealth Fund 2001 Health Care Quality Survey found that only 20 percent of the uninsured have been with their physician for five years or more. But it is also troubling that only 35 percent of adults under age 65 who are currently insured have been with their physician for five years (Chart 30). When patients do not have a regular doctor or have a limited choice of where to go for care, they are likely to be less satisfied with their care and have less confidence in their physicians.[43] In addition, discontinuity in care may contribute to higher costs. One study found that Medicare patients who had been with the same physician for 10 years or longer had fewer hospitalizations and incurred lower Medicare payments.[44]

Costs of Complexity

Professor Uwe Reinhardt of Princeton University has a famous chart that illustrates the way in which Americans get health insurance coverage, depending on their age and income (Chart 31). It's an amusing and confusing chart. But when he explains Qualified Medicare Beneficiary coverage, Specified Low-Income Beneficiary, and Qualified Individuals I and II coverage to an international audience he leaves his audience bewildered. How could Americans design a Medicaid program with federal/state funding to cover Medicare beneficiaries with incomes below 100 percent of poverty to pick up their Medicare premiums and cost-sharing, another program to pick up premiums between 100 and 125 percent of poverty, another program to pick up their premiums between 125 and 135 percent of poverty, and another program to pick up the "home health" portion of their Medicare premium between 135 and 175 percent of poverty. But

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[43] Analysis of the Commonwealth Fund 2001 Health Care Quality Survey.

[44] Blustein, J. and Weiss, L.J., 1996. "Faithful Patients: The Effect of Long-Term Physician–Patient Relationships on the Costs and Use of Healthcare by Older Americans," *American Journal of Public Health* 86 (December):1742–47.

if it's confusing to an international audience, it's equally confusing to frail elderly Americans with limited incomes. Not surprisingly, many people who qualify for these "Medicare Savings Programs" fail to enroll simply because they do not know they are eligible.[45] Add to that the asset limits that vary from state to state for Medicaid supplemental coverage, and it is no wonder that many elderly fail to receive the help they need in affording care.[46] More than half of children who are uninsured qualify for either Medicaid or CHIP but are not enrolled, in large part because their families do not know about the programs or think they are ineligible.[47]

By narrowing coverage to a given "current object of concern," in Professor Reinhardt's terminology, (e.g., workers displaced from their jobs by international trade who qualify for a 65-percent tax credit toward their employer COBRA coverage), we often create costly new administrative apparatuses, designed as much to keep the ineligible off as to ensure that the eligible qualify.

This also leads to different standards of care, with some covered under Medicaid, some under CHIP, and some not at all. Different managed care plans, hospitals, and physicians participate in Medicaid and CHIP. The quality of health care delivered in Medicaid, Medicare, and commercial managed care plans differs not only across plans and geographic regions, but also across sources of coverage.[48] Different providers are covered in different employer managed care plan networks. When your doctor thinks you need to see a specialist, the specialist he thinks is best and with whom he has had the best experience may not be a member of your managed care plan network.

A given hospital may serve patients covered by more than 100 different managed care contracts. Each contract has a different method and rate of payment, and varying requirements on prior authorization of hospitalization and approved length of stay. The administrative cost to the hospital of our complex system of care is not inconsequential.

We have moved away from insurance plans that allow patients to go to any doctor or hospital to more restricted networks. But giving consumers a choice among health plans may allow individuals to find physicians and networks that meet their health care needs, including those who practice in their communities. However, complex benefit designs that vary from plan to plan make informed choice impossible. An analysis of Medicare+Choice plans in Tampa found so much variation among copayments for such services as radiation therapy and inpatient hospital care, as well in the design of drug

[45] M. Moon, C. Kuntz, and L. Pounder, *Protecting Low-Income Medicare Beneficiaries* (New York: The Commonwealth Fund, December 1996).

[46] L. Summer and R. Friedland, *The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs* (New York: The Commonwealth Fund, October 2002).

[47] Center on Budget and Policy Priorities analysis of March 2000 Current Population Survey

[48] National Committee for Quality Assurance, *The State of Health Care Quality 2002.* (Washington, D.C: NCQA, 2002).

benefits, that no beneficiary—with or without the assistance of family members or consumer advocates—could hope to make an informed choice (Chart 32).[49] Many individuals will be penalized for making choices not in their best interest, or that do not serve them well when an unanticipated event such as cancer occurs. The purpose of insurance to provide financial protection and greater certainty is undermined by widely various benefits, hidden out-of-pocket costs, and networks that fail to provide stable access to physicians or specialized services.

Conclusion

The United States is the only major industrialized nation that fails to provide health insurance coverage to its people. Yet, it spends far more than any other country—devoting more than $110 billion just to health insurance administrative costs in 2002. There has to be a better way.

Most important, we need a system that provides health coverage for all. The cost of not covering the uninsured—including 18,000 preventable deaths a year—is one we should not accept. This is not only a human tragedy but an economic loss as well, as we are deprived as a society of their productive contributions.

We have built an incredibly complex, costly, and confusing health insurance system. We need a single guiding framework for coverage. It can include multiple sources of financing, multiple choices of public and private coverage, and multiple benefit packages, but it needs to be integrated within a single framework. Certainly, we should have a system that preserves innovation, flexibility, and choice, but some standardization will be required to cut through the maze of complexity in our current system. Reaching consensus on the parameters of choice versus standardization is an important part of public debate on this issue.

We also need to reach agreement on the shared responsibility for financing health insurance coverage. In my view, covering everyone will only be possible if everyone contributes—employers, those currently uninsured as well as insured, health care providers, federal, state, and local government. But we need to begin to have public discussion about what constitutes a fair share of financial responsibility.

We need a health care system that promotes quality improvement and much greater efficiency. Investment in modern information technology to reduce administrative costs, provide information for consumer choice, and serve as a tool for quality improvement must also be a component of what we do.

[49] Geraldine Dallek and Clair Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages*, New York: The Commonwealth Fund, October 2001.

We need to build on efficient administrative mechanisms, whether that is group coverage or using the tax system to identify people without coverage and ensure that they are automatically enrolled and provided with the financial assistance required to make coverage affordable. Making coverage easy to obtain, automatic, and affordable—rather than difficult, confusing, and expensive—must be at the heart of comprehensive reform.

But most fundamentally we need to commit to high-quality health care for all as a national policy priority. If we continue to put cutting taxes over ensuring a strong and healthy nation, we will pay a heavy price. Our health care system will not be there when we need it. Investment in better health care can have a significant return—in terms of healthier, more productive workers who are able to continue longer in the workforce, children who grow up to be healthy, productive adults, and healthy immigrants, who can help fuel our economic growth and bring vitality and diversity to our cultural life. The returns also include prevention of serious illness, better management of chronic conditions, and better functioning and quality of life in old age. We have a shared stake in working together to find common ground. It is a challenge worthy of the 21st century.

Thank you.

Growth in the Number of Uninsured, 1953–2001

Number of uninsured, in millions

Year	Uninsured (millions)
1953	71
1958	64
1963	63
1970	49
1976	23
1980	30
1990	34
1995	41
2000	39
2001	41

Source: 1953–1976, National Health Interview Survey; 1980, EBRI; 1990–2001 Current Population Survey

Primary Source of Health Insurance, 2001

Employers Paid $335 Billion in Premiums

Uninsured
15%

Medicaid
8%

Medicare
13%

Military
1%

Individual
coverage
5%

Employer-based
coverage
57%

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2002 Current Population Survey

Sources Health Insurance by Poverty Level, 2001

	Total	Less than 100% poverty	100–199% of poverty	200–299% of poverty	Greater than 300% of poverty
Uninsured	15	32	22	14	6
Medicaid	8	27	13	11	1
Medicare	13	15	21	15	8
Military	1	1	2	2	1
Individual coverage	5	7	6	5	5
Employer-based coverage	57	19	38	59	78

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2002 Current Population Survey

One of Four People Under 65 With Time Uninsured During 2000
62 Million People

Uninsured all year 13.3%

Uninsured part year 12.6%

Insured all year 74.1%

Total Population Under 65 = 241 Million

Source: MEPS Statistical Brief #6 - The Uninsured in America, 1996–2001. Civilian Noninstitutionalized Population Under Age 65, Nov. 2002

Percent Uninsured by Age Group and Length of Time Uninsured

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Medical Expenditure Panel Survey

Insurance Sources for Young Adults, Ages 19–23

Not full-time students
12.5 million

Full-time students
7.1 million

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2002 Current Population Survey

Nearly One-Half of Hispanics Uninsured During the Year

Source: Michelle M. Doty, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English.* The Commonwealth Fund, February 2003.

Uninsured Workers: Reasons for Lack of Insurance Coverage, Ages 19–64

Worker doesn't know if offered, eligible 7%

Employer Offers, Worker Ineligible 11%

Employer Offers, Worker Eligible, Does Not Participate 22%

Employer Doesn't Offer Coverage 60%

Source: S. Collins, et al., *On the Edge: The Health Insurance Coverage of Low-Wage Workers Findings from the 2001Commonwealth Fund Health Insurance Survey* . The Commonwealth Fund, forthcoming.

Workers who are Offered, Eligible, and Participate in own Employer Health Plan, by Firm Size and Wage, All Workers, 19–64

*Difference by wage significant at p<.0001

Source: S. Collins, et al., *On the Edge: The Health Insurance Coverage of Low-Wage Workers Findings from the 2001Commonwealth Fund Health Insurance Survey* . The Commonwealth Fund, forthcoming.

Percent Uninsured Now or During Past Year, by Work Status

Percent of adults 19–64

Work status	Percent
Full-time	21
Part-time	26
Not currently employed	30

Source: L. Duchon, et al. *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk.* The Commonwealth Fund, December 2001.

Percentage of Firms Offering Retiree Health Benefits, 1988–2001

Source: The 2003 CMS Chart Series (Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000, 2001; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1991, 1993, 1995)

Medicare Beneficiaries With Drug Coverage by Primary Source of Supplemental Coverage, 1995 and 1999

Note: Data are based on the non-institutionalized beneficiaries.
Percentages shown in bars are Medicare beneficiaries with drug coverage as a percent of total Medicare beneficiaries. Beneficiaries do not necessarily get drug coverage from their primary sources of supplemental insurance.

Source: The 2003 CMS Chart Series (CMS/Office of Research, Development and Information. Data are from the Medicare Current Beneficiary Survey).

Percent of Non-Elderly Population Uninsured by State, 1999-2000

Population without health insurance

- 17% or more
- 14 – 16%
- 11 – 13%
- 10% or less

Source: R. Mills, U.S. Census Bureau, Current Population Reports, P60-220, *Health Insurance Coverage: 2001,* 2002. Uninsured rates are three-year averages, 1999-2001.

Medicaid Beneficiaries by Eligibility Group, 1975–2001

Other**
Adults
Children Under 21
Blind & Disabled
Age 65 & Older

Persons Served (in millions)

50
40
30
20
10
0

1975 1980 1985 1990 1995 1999 2000 2001

Fiscal Year

2001 Total = 46.1 million

Adults 10.4 million

Children Under 21 23.1 million

Blind & Disabled 7.9 million

Age 65 & Older 4.8 million

*Note: (1) In 1998, a large increase occurred in the number of persons served, mainly the result of a new reporting methodology of classifying payments to managed care organizations; FY 1998 was the first year capitation payments were counted as a service for purposes of the HCFA 2082 reporting, and thus all managed care enrollees were counted as individuals receiving services. This new methodology probably has the greatest effect on the reported number of children; (2) the term "adults" as used above refers to nonelderly, nondisabled adults; (3) disabled children are included in the blind & disabled category shown above. **The Other category was dropped in 1999.

Source: The 2003 CMS Chart Series (CMS, CMSO, Medicaid Statistical Information System.)

Births Financed by Medicaid as a Percent of Total Births by State, 1998

Less than 28.8%
28.8% to 33.9%
34.0% to 41.3%
More than 41.3%
No data

Note: CO, GA 1997 data; KY, NJ, VT 1996 data.
Source: The 2003 CMS Chart Series (Maternal and Child Health (MCH) Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children, National Governors Association, February, 2001, Table 23, at http://www.nga.org.)

Deaths of Adults Ages 25 – 64, 1999

1. Cancer – 156,485
2. Heart disease – 115, 827
3. Injuries – 46,045
4. Suicide – 19,549
5. Cerebrovascular disease – 18,369
6. Uninsured – 18,000
7. Diabetes – 16,156
8. Respiratory disease – 15,809
9. Chronic liver disease and cirrhosis – 15,714
10. HIV/AIDS – 14,017

Sources: U.S. Department of Health and Human Services, National Center for Health Statistics, Health, United States, 2002, Table 33, p. 132 – deaths for causes other than uninsured; Institute of Medicine, Care Without Coverage, Appendix D, p. 162, deaths attributable to higher risks of uninsured adults 25–54.

Uninsured at Risk for Access and Medical Bill Problems

Percent of adults 19–64

*Adult said he or she did not go to the doctor when needed, did not fill a prescription, did not follow up on recommended tests or treatment, or did not see a specialist due to costs

** Adult said he or she not able to pay medical bills, has been contacted by collection agency, or had to change way of life to pay bills

Source: The Commonwealth Fund 2001 Health Insurance Survey

Uninsured at Risk for Low-Quality Medical Care

*Among women 50–64.
**Among adults 45–64.
Source: J. Ayanian, et al. “Unmet Health Needs of Uninsured Adults in the United States,” JAMA 284 no 16 (2000): pp 2061–2069.

National Health Expenditures, 1988–2012

Trillions

Year	Expenditures
1988	$0.6
1993	$0.9
2000	$1.3
2002*	$1.5
2008*	$2.4
2012*	$3.1

*Projected
Source: Heffler et al., “Health Spending Projections for 2002–2012,” *Health Affairs* (February 7, 2003).

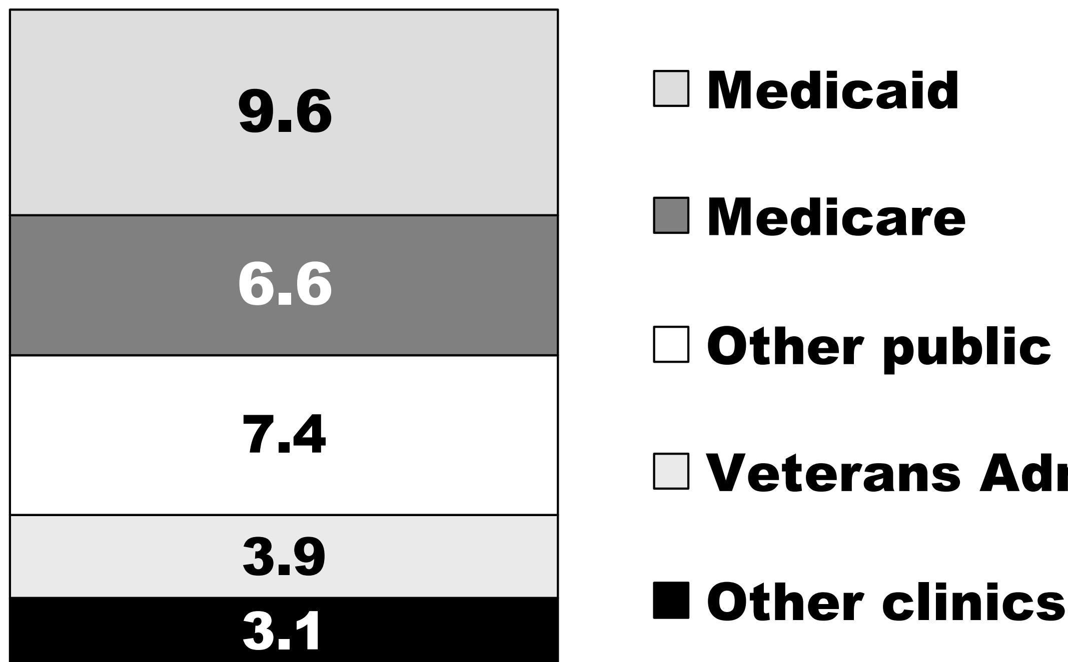
National Health Expenditures as Percent of GDP, 1988–2012

*Projected
Source: Heffler et al., “Health Spending Projections for 2002–2012,” *Health Affairs* (February 7, 2003).

Percent Change in Health Insurance Premiums and Workers' Earnings from Previous Year, 1988–2002

Source: Gabel et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs* (Sept/Oct 2002): 143–151.

Sources of Government Funding Available for Uncompensated Care of the Uninsured, in Billions of 2001 Dollars



Source: J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs* Web Exclusive February 12, 2003.

Projected Annual Medicaid Prescription Drug Expenditures Per Dual Eligible With Full Medicaid Benefits, 2002 (In Dollars)

States spend $6.8 billion on prescription drugs for dual-eligible beneficiaries

State	Expenditure
New Mexico	1,896
Alabama	1,958
Arkansas	1,985
Georgia	2,058
District of	2,137
Mississippi	2,196
Michigan	2,379
Oregon	2,435
California	2,563
Massachusetts	2,571
Maryland	2,677
Iowa	2,702
South Carolina	2,707
Illinois	2,724
South Dakota	2,729
Colorado	2,735
Wisconsin	2,756
Tennessee	2,814
Oklahoma	2,814
New York	2,814
Arizona	2,814
U.S. Average	**2,815**
Alaska	2,823
North Carolina	2,839
Hawaii	2,841
Vermont	2,862
Wyoming	2,866
Kentucky	2,916
Nevada	2,929
Rhode Island	2,943
Montana	2,948
West Virginia	2,961
Florida	3,003
Nebraska	3,012
Kansas	3,024
New Jersey	3,037
Virginia	3,054
Louisiana	3,054
Maine	3,082
North Dakota	3,087
Utah	3,094
Minnesota	3,116
Texas	3,119
Delaware	3,267
Pennsylvania	3,280
Idaho	3,321
New	3,327
Ohio	3,338
Missouri	3,393
Washington	3,556
Indiana	3,558
Connecticut	3,851

Axis: 0, 500, 1,000, 1,500, 2,000, 2,500, 3,000, 3,500, 4,000, 4,500

Source: J. Verdier and S. Dale, *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles* (New York: The Commonwealth Fund, forthcoming.

Uncompensated Care* as a Percentage of Gross Patient Revenues, by Ownership and Type of Hospital, 1996

*Bad debt plus charity care

**Includes minor teaching and non-teaching hospitals

Source: Commonwealth Fund Task Force on Academic Health Centers. *A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured,* The Commonwealth Fund, April 2001.

Percentage of Community Health Center Medical Directors Who Report That Additional Care Can Be Provided For Their Patients Very Frequently or Frequently

Source: M. Gusmano, G. Fairbrother, and H. Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured." *Health Affairs* (November/December 2002) 188–193.

Comparing Annual Premiums for Single Coverage: Employer-Sponsored PPOs vs. Individual Insurance, by Market Area

Metro Area	Average Group Premium	Individual Insurance Premium for Males Age 55	Individual Insurance Premium for Females Age 55	Individual Insurance Premium for Males Age 27	Individual Insurance Premium for Females Age 27
Providence-Fall River-Warwick, RI/MA	$2940	$6480	$6456	$2256	$2880
Los Angeles-Long Beach, CA	2736	9528	9504	3324	4788
Rural Texas	2436	6660	6648	2328	3348
Chicago, IL	2688	3336	3384	1020	1284
Greensboro, NC*	2712	3900	3888	1368	1716
Median	2736	6120	6108	2136	2880

* Group insurance data presented for Greensboro were based on averages for the state of North Carolina

Source: J. Gabel, K. Dhont, and J. Pickreign, *Are Tax Credits Alone the Solution to Affordable Health Insurance?* The Commonwealth Fund, May 2002.

Administrative Cost as Percent of Benefits, Various Programs, 1991

%
20
10
0

	U.S. Total	All Private Insurance	Medicare	Medicaid	Canada (1987)
%	6.6	16.8	2.1	4.2	1.2

Source: Committee on Ways and Means, U.S. House of Representatives. *Health Care Resource Book*. U.S. Government Printing Office, Washington:1993

Reduction in the Number of Uninsured Over the Course of a Year

Percent reduction in uninsurance if everyone with coverage retained it during the year

Source: Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families.* The Commonwealth Fund, December 2002.

Government Program Administration and Net Cost of Private Health Insurance, in billions 1970–2012

Billions

250

125

0

$2.8

$12.1

$53.3

$110.9

$222.6

1970

1980

1993

2002*

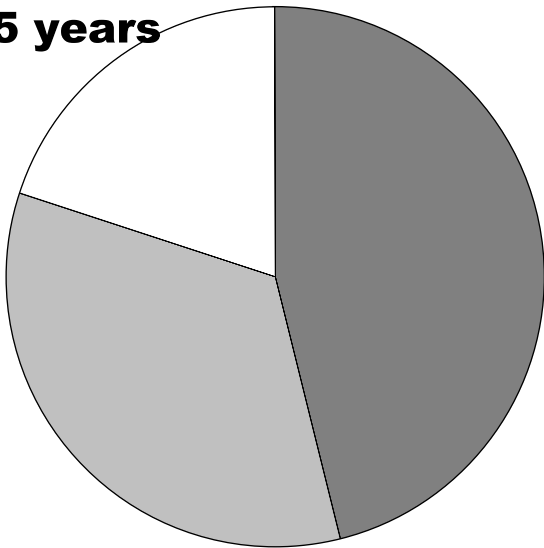
2012*

*Projected

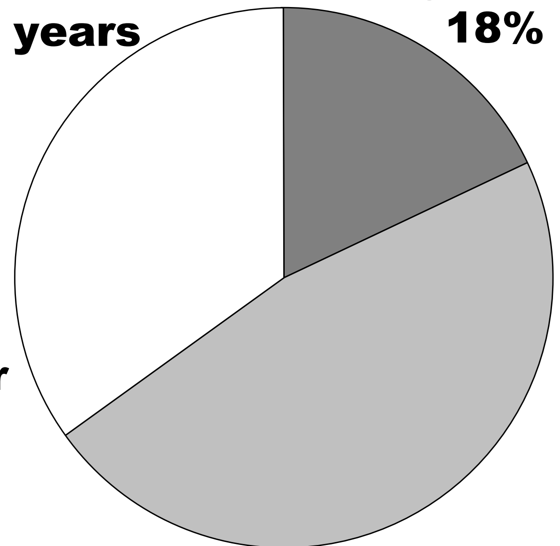
Source: Levit et al., “Trends in U.S. Health Care Spending, 2001,” *Health Affairs* (January/February 2003): 154–164 and Heffler et al., “Health Spending Projections for 2002–2012,” Health Affairs (February 7, 2003).

Regular Doctor, by Insurance Status

adults 18–64



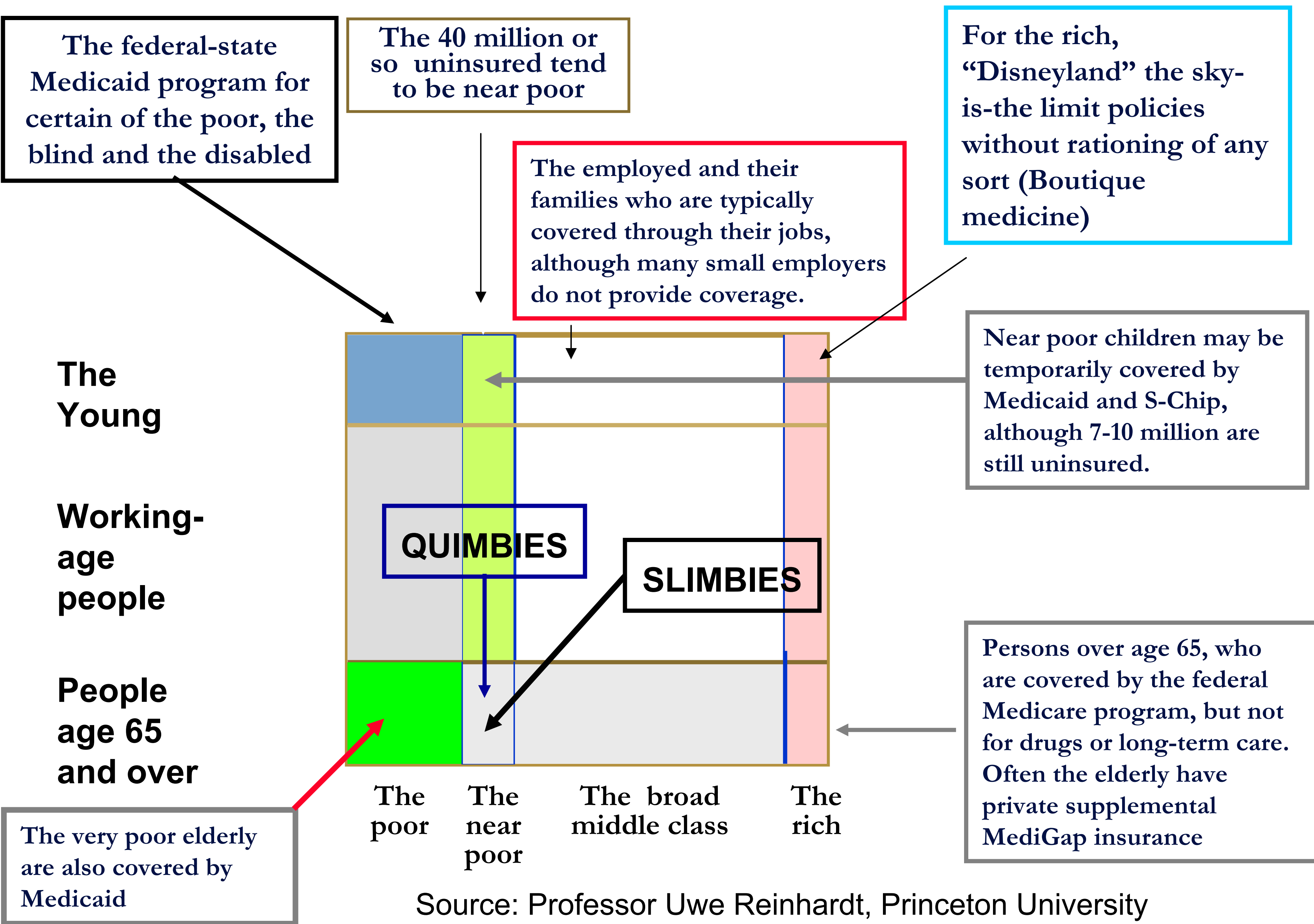
Uninsured (full or part-year)*



Insured

*p<.001 (differs significantly from insured population)

Source: The Commonwealth Fund 2001 Health Care Quality Survey


CATEGORIES OF PEOPLE IN THE U.S. HEALTH INSURANCE SYSTEM
31
The federal-state Medicaid program for certain of the poor, the blind and the disabled
The 40 million or so uninsured tend to be near poor
The employed and their families who are typically covered through their jobs, although many small employers do not provide coverage.
For the rich, “Disneyland” the sky-is-the limit policies without rationing of any sort (Boutique medicine)
Near poor children may be temporarily covered by Medicaid and S-Chip, although 7-10 million are still uninsured.
The Young
Working-age people
People age 65 and over
QUIMBIES
SLIMBIES
Persons over age 65, who are covered by the federal Medicare program, but not for drugs or long-term care. Often the elderly have private supplemental MediGap insurance
The very poor elderly are also covered by Medicaid
The poor
The near poor
The broad middle class
The rich
Source: Professor Uwe Reinhardt, Princeton University

2001 Premium and Selected Benefit Copayments: Tampa Medicare+Choice Plans

Chart 32

	Plan V_1	Plan V_2	Plan W	Plan X_1	Plan X_2	Plan Y	Plan Z_1	Plan Z_2
Enrollment limit	No	No	Yes	No	No	No	No	Yes
Premium	$63	$0	$63	$179	$0	$0	$0	$19
Doctor visits: Primary care	$10	$15	$10	$10	$10	$15	$10	$5
Specialist	$5–$200	$15–$400	$25	$15	$15	$20	$15	$10
Outpatient visits: Ambulatory surgery	$200	$500	$0	$35	$50	$100	$25	$25
Hospital visit	$200	$500	$50	$35	$50	$50	$25	$25
Durable medical equipment	$0	$0	$0	$0	$0	20%	$0	$0
Diagnostic tests: Clinical lab	$0	$0	$0	$0	$0	$5	$0	$0
X-rays/diagnostic lab	$40–$200	$40–$350	$0	$0	$0	$5 X-ray; $50 other radiation services	$0	$0
Radiation therapy	$40/visit	$40/visit	$0	$0	$0	$5–$50	$15/service	$10/service
Outpatient rehabilitation services	$40/visit	$40/visit	$25/visit	$10–$15/visit	$10–$15/visit	$25/visit	$15/visit	$10/visit
Inpatient hospital care	$500 per admiss.; $200/day for days 7–30 at network hospital	$500 per admiss.; $200/day for days 7–30 at network hospital	$150/day	$100/stay	$300/stay	$150/day	$200/stay	$0
Skilled nursing facility: Days 1–20	$0/day	$0/day	$0	$0	$0	$75	$0	$0
Days 21–100	$85/day	$90/day	$97	$0		$75	$0	$0
Home health care	$0	$0	$0	$0	$0	$0	$0	$0
Bone mass measurement	$10/physician's office, $40 non-physician clinic	$15/physician's office, $40/non-physician clinic	$0	$0	$0	$0	$0	$0
Prescription drugs								
Formulary drugs								
30–31-day supply							(31-day)	(31-day)
Generic copay	$10	No prescription drug coverage	$5	$5	$10	$8	$7	$5
Brand copay	$20 preferred		$20	$15	Not covered	$40	$20	$15
90-day mail order								
Generic copay	$20		$15	$15	$30	$24	Not available	Not available
Brand copay	$40 preferred		$60	$45	Not covered	$120		
Cap								
Generic	$150/3 months generic and preferred & non-preferred brand		Unlimited	Unlimited	Unlimited	$500/year	Unlimited	Unlimited
Brand			$250/6 month formulary & non-formulary brand	$50/month formulary & non-formulary brand	Not covered		$125/3 months non-formulary generic & all brand drugs	$125/3 months non-formulary generic & all brand drugs
Non-formulary								
30–31-day supply			$35	$30	Not covered	Plan has no formulary		
Generic copay	$10		$35	$30			$30	$30
Brand copay	$40						$30	$30
90-day mail order			$105	$90				
Generic copay	$10		$105	$90			Not available	Not available
Brand copay	$80		See above	See above				
Cap	See above						See above	See above

[a] Plan Y has a $3,500 out-of-pocket limit protection for combined inpatient and outpatient services, not including certain office visit copays, prescription drugs, medical supplies, and selected other benefits.
[b] $40 specialist per visit copay, except $10/visit to Allergy physicians, $5/specimen to hospital pathologists, $5/interpretation to hospital radiologists, $50/visit to ER physician, $200 for cataract surgery, $50/each allergy skin testing, and 40% of charges for non-plan second medical opinion.
[c] $50 specialist per visit copay, except $15/visit to Allergy physicians, $15/specimen to all hospital pathologists, $15/interpretation to hospital radiologists, $50/ visit to ER physicians, $400 for cataract surgery, and 50% of charges for non-plan second medical opinion.
[d] $200 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copay for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.
[e] $350 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copayment for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.
[f] $1,000 per admission and $200/day for days 7-30 at non-participating hospitals.
[g] $1,000 per admission and $300/day for days 7-30 at non-participating hospitals.
[h] Glucose monitors, test strips, lancets, and self-management training.

Source: G. Dallek and C. Edwards, *Restoring Choice to Medicare + Choice: The Importance of Standardizing Health Plan Benefit Packages.* (New York: The Commonwealth Fund, October 2001.)