



THE GROWING PROBLEM OF UNDERINSURANCE IN THE UNITED STATES: WHAT IT MEANS FOR WORKING FAMILIES AND HOW HEALTH REFORM WILL HELP

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Invited Testimony

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Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on the growing number of people in the United States who are underinsured. The soaring costs of health care, along with the economic recession and stagnant wages, are leaving many working families without insurance or with medical expenses that consume a large share of their incomes. In September the Census Bureau reported that 46.3 million people lacked health insurance in 2008, up from 45.7 million in 2007. Among people who do have health insurance, The Commonwealth Fund estimates that in 2007, 25 million working-age adults had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003. Both these trends have had serious financial and health consequences for U.S. families. An estimated 72 million adults under age 65, both with and without health insurance, reported problems paying their medical bills in 2007, and 80 million reported a time that they did not get needed health care because of cost. This Committee and the other key health committees in the House and the Senate are to be commended for pursuing health reforms that will help families secure access to affordable and comprehensive health insurance.

The Growing Problem of Underinsurance

- According to an analysis by Cathy Schoen and colleagues of the Commonwealth Fund Biennial Health Insurance Survey, between 2003 and 2007 the number of underinsured adults in the country climbed from 16 million to 25 million, or from 9 percent to 14 percent of the 19-to-64 population. Underinsured adults were defined as those who spent 10 percent or more of their income on out-of-pocket health costs, excluding premiums; spent 5 percent or more of their income, if their incomes were under 200 percent of poverty; or had deductibles that amounted to 5 percent or more of their income.
- Adults with low incomes are the most likely to be underinsured. Almost one-quarter of adults with incomes under 200 percent of poverty were underinsured in 2007, up from 19 percent in 2003.

- The problem of cost exposure is moving up the income scale. The share of adults with incomes of 200 percent of poverty or more who were underinsured nearly tripled from 2003 to 2007, climbing from 4 percent to 11 percent. The most rapid growth occurred among adults in households earning between \$40,000 and \$60,000 annually.
- Reflecting higher rates of chronic illness and poor health, older adults ages 50 to 64 are the most likely of any age group to be underinsured. Between 2003 and 2007 the share of older adults who were underinsured increased by 60 percent, rising from 11 percent to 18 percent.
- Underinsurance is associated with health plans that cover fewer health care benefits. More than one-quarter (26%) of underinsured adults reported a deductible of \$1,000 or higher, compared with 8 percent of insured adults who were not underinsured; 48 percent reported that their health plan placed limits on the total dollar amount their plan would pay for medical care each year, compared with 36 percent of adults who were not underinsured; and 19 percent reported that their health plans limited the number of times per year that they could see physicians, excluding mental health visits, compared with 11 percent of adults who were not underinsured.
- Underinsurance is also associated with reports of health plan problems. Forty-four percent of underinsured adults reported that they had had expensive medical bills for services that were not covered by insurance, twice the rate reported by adequately covered adults; 38 percent of underinsured adults reported that their doctor had charged them a higher price than their insurance plan would pay and they had to pay the difference, compared with 25 percent of adequately insured adults; and 42 percent said that they had to contact their insurance company because they had failed to pay a bill or were denied payment, compared with 32 percent of adequately insured adults who reported similar problems.
- Adults with plans purchased in the individual insurance market are more likely to be underinsured than those who have health benefits through their employer. In 2007, 30 percent of adults who had a health plan they purchased on the individual insurance market were underinsured, up from 17 percent in 2003. About 17 percent of adults in employer plans were underinsured in 2007, an increase from 10 percent in 2003.

Rising Health Care Costs, Slow Growth in Incomes, and Higher Cost-Sharing Are Contributing to the Growth in Underinsured Adults

- In 2007, national health expenditures grew at a rate of 6.1 percent, faster than the overall rate of growth in the economy, with similar annual rates of growth projected through 2018. Steady annual increases in health care costs have placed upward pressure on the cost of health insurance: premiums grew at a rate of 5.5 percent in 2009, faster than wage growth and consumer price inflation. The average annual cost

of family coverage in employer-based health plans, including employer and employee contributions, topped \$13,375 in 2009. A recent analysis by The Commonwealth Fund found that at current cost trends, average family premiums in employer plans will nearly double by 2020.

- Employers have tried to hold their premiums by increasing employee cost-sharing. In-network deductibles for single coverage in PPO plans have more than tripled since 2000, rising from \$187 to \$634 in 2009. Among companies with fewer than 200 employees, deductibles have risen by nearly a factor of five, climbing to an average \$1,040 in 2009.
- Jon Gabel and Roland McDevitt found that the actuarial value, or the percentage of total health spending paid by insurance, declined in employer plans nationally between 2004 and 2007, falling from an average 81.4 percent to 80.1 percent, a statistically significant drop. Expected out-of-pocket spending for all medical services by adults enrolled in employer plans increased on average by 34 percent, from \$545 to \$729. For the highest-cost 1 percent of adults, expected out-of-pocket spending increased by 42 percent to \$8,703.
- Rising exposure to health care costs over the past decade has occurred at the same time that incomes for working families have grown very little.

Adults with Individual Insurance Market Coverage Face Higher Health Care Costs Than Those with Employer Health Benefits

- The individual insurance market is usually the sole option for people who do not have access to employer coverage and whose incomes are too high to qualify for Medicaid, but it has proven to be a sorely inadequate substitute. People who buy health insurance on their own must pay the full premium, and, in all but a handful of states, insurance carriers can underwrite prospective enrollees on the basis of health status, age, gender, and other characteristics that increase the potential for high claims costs in the future.
- A recent study by The Commonwealth Fund found that of adults who tried to purchase insurance in the individual market in the last three years, nearly three-quarters (73%) said they never bought a plan, either because they could not find a plan they could afford, they could not find a plan that met their needs, or they were turned down, charged a higher price, or had a condition excluded from coverage because of a preexisting health problem.
- People who do purchase health insurance in the individual market pay far more out-of-pocket for their premiums, face much higher deductibles, face more limits on what their plans will pay, and spend larger shares of their income on premiums and out-of-pocket costs than their counterparts with employer-based group coverage.

- Half (51%) of adults with individual market plans spent more than 10 percent of their income on premiums and out-of-pocket expenses in 2007, compared with 29 percent of adults in employer plans.

Underinsured Adults Are Nearly as Likely as Uninsured Adults to Not Get Needed Health Care Because of Cost

- Underinsured adults report not getting needed care because of cost at rates that are nearly as high as those who are uninsured: 60 percent of underinsured adults in The Commonwealth Fund survey reported at least one cost-related problem getting care in 2007, including not going to a doctor or clinic when sick; not filling a prescription; skipping a medical test, treatment, or follow-up visit recommended by a doctor; or not seeing a specialist when a doctor or the respondent thought it was needed.
- Among adults with chronic health problems who regularly took prescription drugs, 46 percent of those who were underinsured reported skipping doses of medications or not filling prescriptions for their chronic conditions because of cost, compared with only 15 percent of adults with chronic conditions who had adequate health insurance. Adults with chronic health problems who were underinsured reported seeking care in an emergency room, staying overnight in the hospital, or both, for their condition at higher rates than did those with adequate health insurance.

Underinsured Adults Report High Rates of Medical Bill Problems

- Based on the Commonwealth Fund Biennial Health Insurance Survey, an estimated 72 million adults under age 65, both with and without health insurance, reported problems paying their medical bills in 2007, up from 58 million in 2005.
- Adults with gaps in health insurance coverage or those who were underinsured were most at risk of having problems with medical bills: in 2007, 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. Nearly half of adults who were underinsured reported that they were paying off medical debt over time.
- Among underinsured adults who reported medical bill problems, 46 percent had used all their savings to pay for their medical bills, 33 percent took on credit card debt because of their bills, and 29 percent were unable to pay for food, heat, or rent.

America's Health Choices Act (H.R. 3200) and the Problem of Underinsurance

- The America's Health Choices Act (H.R. 3200) aims to provide near-universal health insurance coverage by building on the strongest aspects of the insurance system—large-employer insurance and Medicaid and the Children's Health Insurance Program (CHIP)—and regulating and reorganizing the weakest part of the system—the

individual and small-group insurance markets, where so many individuals and small businesses are hurt by high premiums, high administrative costs, underwriting, and a lack of transparency in the content of benefit packages.

- The bill would go a long way toward reducing the problem of uninsurance in the United States. The Congressional Budget Office estimates that by 2019 the number of people without health insurance would fall to 17 million—about 97 percent of legal residents—from an estimated 54 million people.
- Several provisions in the bill would also likely reduce the number of people who are underinsured and the numbers of people who accumulate medical debt each year.
 - The bill replaces the individual insurance market with a regulated insurance exchange operated at the federal level with a choice of both private and public health plans. The new market regulations would extend to all health plans sold in the United States. Guaranteed issue and adjusted community rating with 2:1 age bands would ensure that people in poor health or who are older could not be denied coverage, charged a higher price, or have a condition excluded from coverage because of a preexisting condition. Insurance carriers could not impose annual or lifetime limits on what plans would pay and would be prohibited from the use of rescissions.
 - The bill would establish a new minimum benefit standard with four tiers. Annual out-of-pocket spending in the essential benefits package is limited to \$5,000 for individuals and \$10,000 for families. Such standards will ensure that families do not become bankrupt because of medical costs, encourage the use of timely preventive services, and protect against catastrophic costs and bankruptcy in the event of a serious accident or injury. Standardized benefits will also facilitate the ability of people to compare prices of similar health plans and provide incentives for insurers to compete on price.
 - While keeping the benefit package constant, the bill defines three levels of cost-sharing tiers by actuarial value, or the average share of medical expenses covered by a health plan: 70 percent (basic), 85 percent (enhanced), and 95 percent (premium and premium plus, which also includes oral and vision care). Cost-sharing could include a combination of deductibles, coinsurance, and out-of-pocket limits. The average actuarial value in employer-based plans is an estimated 80 percent and about 84 percent to 87 percent for the Blue Cross Blue Shield Standard Option in the Federal Employees Health Benefits Program.
 - The premium subsidies and cost-sharing credits in H.R. 3200 will substantially improve the affordability and protection of health plans offered through the new exchange. The premium subsidies cap spending on premiums

at no more than 1.5 percent of income for those earning 133 percent of poverty, or \$29,327 for a family of four, and rise to no more than 12 percent of income for those with incomes at 400 percent of poverty, or about \$88,200 for a family of four in 2009. People earning less than 133 percent of poverty are eligible for Medicaid.

- The cost-sharing credits will significantly reduce out-of-pocket expenses for people with incomes under 350 percent of poverty, raising the actuarial value of the basic plan to 97 percent for those with incomes of 133 percent of poverty and sliding down to 72 percent for those with incomes at 350 percent of poverty.
- For people whose incomes exceed the income thresholds for subsidies, premium costs will likely decline from current levels because of a decrease in administrative costs due to restrictions on underwriting and reduced marketing and because of savings achieved through reduced provider payments and profits if a public option is included in the exchange.
- In addition to insurance market regulations, benefit standards, and premium and cost-sharing subsidies, a choice of a public plan in the insurance exchange reducing out-of-pocket expenditures will also require national reforms aimed at improving the overall performance of the health system. The House bill includes key provisions for improving health system performance and lowering the rate of cost growth, including investing in primary care; replacing the current Sustainable Growth Rate (SGR) formula for updating physician fees; adjusting for geographic variations; piloting programs for rapid-cycle testing of innovative payment methods, including medical homes, accountable care organizations, and bundled hospital payments; ensuring choice of private and public plans; containing costs, including reviewing premium increases in the exchange; and fostering quality improvement. These provisions, in combination with provisions of the American Recovery and Reinvestment Act of 2009, would enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the long term.

With working families in crisis from a combination of declining job, income, and health security, the time has never been more urgent for policymakers to find consensus and forge ahead on implementing solutions to the nation's worsening health insurance problem, while placing the health care system on a path to high performance.

Thank you.

THE GROWING PROBLEM OF UNDERINSURANCE IN THE UNITED STATES: WHAT IT MEANS FOR WORKING FAMILIES AND HOW HEALTH REFORM WILL HELP

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Thank you, Mr. Chairman, for this invitation to testify on the growing number of people in the United States who are underinsured. The soaring costs of health care, along with the economic recession and stagnant wages, are leaving many working families without insurance or with medical expenses that consume a large share of their incomes. In September the Census Bureau reported that 46.3 million people lacked health insurance in 2008, up from 45.7 million in 2007 (Figure 1).¹ Among people who do have health insurance, The Commonwealth Fund estimates that in 2007, 25 million working-age adults had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003 (Figure 2).² Both these trends have had serious financial and health consequences for U.S. families. An estimated 72 million adults under age 65, both with and without health insurance, reported problems paying their medical bills in 2007, and 80 million reported a time that they did not get needed health care because of cost.³ The relentless growth in health care costs, combined with the severe downturn in the economy, has almost certainly deepened the health insurance crisis facing families across the country. This Committee and the other key health committees in the House and the Senate are to be commended for pursuing health reforms that will help families secure access to affordable and comprehensive health insurance.

The Growing Problem of Underinsurance

The combination of rising health care costs, greater exposure to health costs in insurance plans, and stagnant income growth has led to an increasing number of adults who are underinsured. As reported in a 2008 *Health Affairs* article by Cathy Schoen and colleagues, between 2003 and 2007 the number of underinsured adults climbed from 16

¹ C. DeNavas-Walt, B.D. Proctor, J.C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008* (Washington, D.C.: U.S. Census Bureau, Current Population Survey, Sept. 2009).

² 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. Underinsured adults are insured all year and report spending 10 percent or more of their income (5 percent if their incomes are under 200 percent of poverty) on out-of-pocket health costs, excluding premiums; or having deductibles that amount to 5 percent or more of their income.

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).

million to 25 million, or from 9 percent to 14 percent of the 19-to-64 population (Figure 3).⁴ The authors based their estimates of underinsured adults on the 2003 and 2007 Commonwealth Fund Biennial Health Insurance Surveys, nationally representative, population-based telephone surveys conducted by Princeton Survey Research Associates International.⁵ The authors defined underinsured adults as those who spent 10 percent or more of their income on out-of-pocket health costs, excluding premiums; spent 5 percent or more of their income, if their incomes were under 200 percent of poverty; or had deductibles that amounted to 5 percent or more of their income. Aside from the deductible component, this measure reflects out-of-pocket costs that were actually incurred over the past year rather than the extent to which a person's health plans leaves them potentially exposed to high out-of-pocket costs. It is thus a conservative estimate of the number of working-age adults who are underinsured.

Adults with low incomes are the most likely to be uninsured or underinsured. Almost one-quarter of adults with incomes under 200 percent of poverty were underinsured in 2007, up from 19 percent in 2003. When combined with the share of people in that income range who were without health insurance for at least part of the year, nearly three-quarters (72%) had inadequate health insurance coverage in 2007.

The problem of cost exposure, however, is not confined to lower-income families, but has moved up the income scale over the last few years. The share of adults with incomes of 200 percent of poverty or more who were underinsured nearly tripled over the four-year period, climbing from 4 percent in 2003 to 11 percent in 2007. The most rapid growth in those underinsured in that income range occurred among adults in households earning between \$40,000 and \$60,000 annually, rising from 5 percent in 2003 to 13 percent in 2007. There was even a doubling of the rate of underinsured among those earning between \$60,000 and \$90,000.

Reflecting higher rates of chronic illness and poor health, older adults ages 50 to 64 are the most likely of any age group to be underinsured. Between 2003 and 2007, the share of older adults who were underinsured increased by 60 percent, rising from 11 percent to 18 percent.⁶ Similarly, about 18 percent of all adults under age 65 who are in

⁴ Schoen, Collins, Kriss et al., “[How Many are Underinsured?](#)” 2008.

⁵ The Commonwealth Fund Biennial Health Insurance Survey (2007), is a national telephone survey conducted June 6, 2007 through October 24, 2007, among a nationally representative sample of 3,501 adults ages 19 and older and living in the continental United States. The underinsured measure is based on the 2,616 respondents ages 19 to 64. The survey achieved a 45 percent response rate (calculated according to the standards of the American Association for Public Opinion Research) and has an overall margin of sampling error of ±2 percent at the 95 percent confidence level. In 2003, the survey was conducted Sept. 2003–Jan. 2004 and included 3,293 adults ages 19 to 64 with a 50 percent response rate and an overall margin of sampling error of +/– 2 percent at the 95 percent confidence level. Both surveys were conducted by Princeton Survey Research Associates International using the same methodology.

⁶ Schoen, Collins, Kriss et al., “[How Many are Underinsured?](#)” 2008.

fair or poor health or who have at least one of five chronic conditions were underinsured in 2007.

Underinsurance is associated with health plans that cover fewer health care costs. More than one-quarter (26%) of underinsured adults reported a deductible of \$1,000 or higher, compared with 8 percent of insured adults who were not underinsured (Figure 4).⁷ Nearly 50 percent of underinsured adults reported that their health plan placed limits on the total dollar amount their plan would pay for medical care each year, compared with 36 percent of adults who were not underinsured. Underinsured adults also were more likely to report that their health plans limited the number of times per year that they could see physicians, excluding mental health visits: 19 percent of underinsured adults compared with 11 percent of adults who were not underinsured. And underinsured adults were slightly but significantly less likely to have prescription drug coverage (91% vs. 94%) and substantially and significantly less likely to have dental coverage (59% vs. 78%) than those who were not underinsured.

Underinsurance is also associated with reports of health plan problems. In the Commonwealth Fund Biennial Health Insurance Survey, 44 percent of underinsured adults reported that they had had expensive medical bills for services that were not covered by insurance, twice the rate reported by adequately covered adults (Figure 5). Nearly two of five (38%) underinsured adults reported that their doctor had charged them a higher price than their insurance plan would pay and they had to pay the difference, compared with 25 percent of adequately insured adults, and 42 percent said that they had to contact their insurance company because they had failed to pay a bill or were denied payment, compared with 32 percent of adequately insured adults who reported similar problems.

While rates of underinsurance are climbing among all adults with private insurance, those with plans purchased in the individual insurance market are more likely to be underinsured than those who have health benefits through their employer. In 2007, 30 percent of adults who had a health plan they purchased on the individual insurance market were underinsured, up from 17 percent in 2003 (Figure 6). About 17 percent of adults in employer plans were underinsured in 2007, an increase from 10 percent in 2003.

Rising Health Care Costs, Slow Growth in Incomes, and Higher Cost-Sharing Are Contributing to the Growth in Underinsured Adults

The growing number of people who are underinsured in the United States is the likely consequence of three factors: rapid annual growth in health care costs and premiums, little or no growth in real incomes, and increased cost-sharing in health plans. In 2007, national health expenditures grew at a rate of 6.1 percent, faster than the overall

⁷ Ibid.

rate of growth in the economy.⁸ Similar annual rates of growth are projected through 2018.⁹ Steady annual increases in health care costs have placed upward pressure on the cost of health insurance: premiums grew at a rate of 5.5 percent in 2009, compared with average wage growth of 3.1 percent and a decline in consumer price inflation of 0.7 percent (Figure 7). The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped \$13,375 in 2009.¹⁰ A recent analysis by The Commonwealth Fund found that at current cost trends, average family premiums in employer plans will nearly double by 2020 (Figure 8).¹¹

Employers have tried to hold their premiums by increasing employee cost-sharing. In-network deductibles for single coverage in PPO plans have more than tripled since 2000, rising from \$187 to \$634 in 2009 (Figure 9). Among small companies with fewer than 200 employees, deductibles have risen by nearly a factor of five, climbing to an average \$1,040 in 2009.¹² Indeed, the share of workers in all companies who had a deductible of \$1,000 or more climbed from 18 percent in 2008 to 22 percent in 2009. Copayments, which are paid by 77 percent of covered workers, rose by a small but statistically significant margin in 2009, increasing from \$19 to \$20 for a primary care physician visit and from \$26 to \$28 for a specialist visit. About 14 percent of covered workers pay coinsurance, with the average for physician visits about 18 percent.

Adults who have health plans with deductibles of more than \$1,000 spend substantial amounts on out-of-pocket costs compared with those with lower deductible plans. In the 2007 Commonwealth Fund Biennial Health Insurance Survey, among adults who had a deductible of \$1,000 or more, 46 percent spent between \$1,000 and \$5,000 on health care costs, not including premiums, and 24 percent spent \$5,000 or more (Figure 10). In contrast, among adults with deductibles of less than \$500, one-third (34%) spent between \$1,000 and \$5,000 out-of-pocket, and only 9 percent spent \$5,000 or more.

In a simulation analysis of employer-based health plans, Jon Gabel and Roland McDevitt found that the actuarial value, or the percentage of total health spending paid by insurance, declined in employer plans nationally between 2004 and 2007, falling from

⁸ M. Hartman, A. Martin, P. McDonnell et al., “National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998,” *Health Affairs*, Jan./Feb. 2009 28(1):246–61.

⁹ A. Sisko, C. Truffer, S. Smith et al., “Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook,” *Health Affairs* Web Exclusive, Feb. 24, 2009, w346–w357.

¹⁰ G. Claxton, B. DiJulio, H. Whitmore et al., “Job-Based Health Insurance: Costs Climb at a Moderate Pace,” *Health Affairs* Web Exclusive, Sept. 15, 2009, w1002–w1012.

¹¹ C. Schoen, J. L. Nicholson, and S. D. Rustgi, [Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes—State Health Insurance Premium Trends and the Potential of National Reform](#) (New York: The Commonwealth Fund, Aug. 2009).

¹² The Kaiser Family Foundation/Health Research and Educational Trust, Employer Health Benefits, 2000 and 2009 Annual Surveys; and Claxton, DiJulio, Whitmore et al., “Job-Based Health Insurance,” 2009.

an average 81.4 percent to 80.1 percent, a statistically significant drop.¹³ Over that period, expected out-of-pocket spending for all medical services by adults enrolled in employer plans increased on average by 34 percent, from \$545 to \$729. For the highest-cost 1 percent of adults, expected out-of-pocket spending increased by 42 percent to \$8,703. Actuarial values are higher among people with chronic health problems or who become severely ill and have greater health expenses since they exceed their deductibles and out-of-pocket maximums.¹⁴ Still, people in the worst health often pay the most out-of-pocket for their health care. For example, Gabel and McDevitt found that while insurance paid 90.6 percent of an average \$66,000 bill for breast cancer treatment among patients in the study, those patients were still left with out-of-pocket expenses of \$6,250, the highest in the study. The study illustrates that, despite the fact that actuarial values have not changed significantly over time, rapid growth in underlying health care costs have dramatically increased cost exposure among Americans with employer coverage.

Rising exposure to health care costs over the past decade has occurred at the same time that incomes for working families have grown very little. Despite the fact that the economy expanded between 2001 and 2007, real median incomes rose from \$51,356 in 2001 to \$52,163 in 2007, an increase of just 1.6 percent.¹⁵ And according to the most recent Census data, those meager gains were completely wiped out last year: real median incomes declined by 3.6 percent in 2008 to \$50,303, lower than the level 10 years ago.

The combined effect of more expensive health care, greater cost-sharing, and stagnant incomes has led to increasing numbers of privately insured Americans who are spending large shares of their income on health care. According to the Commonwealth Fund Biennial Health Insurance Surveys, between 2001 and 2007 the share of privately insured adults under age 65 who spent 10 percent or more of their income on health care costs, including premiums and out-of-pocket costs, climbed from 20 percent to 31 percent (Figure 11).¹⁶ By 2007, three of five (60%) privately insured adults with incomes under 200 percent of poverty were spending 10 percent or more of their incomes on health care costs and premiums, up from two of five (40%) in 2001. Among privately insured adults with incomes of 200 percent of poverty or more, one-quarter (25%) were spending 10 percent or more of their income on health care, an increase from 13 percent in 2001.

¹³ J. R. Gabel, R. McDevitt, R. Lore et al., “[Trends in Underinsurance and the Affordability of Employer Coverage, 2004–2007](#),” *Health Affairs* Web Exclusive, June 2, 2009, w595–w606.

¹⁴ Among adults in the study with five chronic health conditions including asthma, breast cancer, diabetes, and chronic obstructive pulmonary disease, employer-based plans paid on average 84 percent of their claims cost.

¹⁵ A. Sherman, R. Greenstein, D. Trisi, et al., *Poverty Rose, Median Income Declined, and Job-Based Health Insurance Continued to Weaken in 2008*, Center on Budget and Policy Priorities, Sept. 10, 2009, <http://www.cbpp.org/cms/index.cfm?fa=view&id=2914>.

¹⁶ Collins, Kriss, Doty et al., [Losing Ground](#), 2008.

Adults with Individual Insurance Market Coverage Face Higher Health Care Costs Than Those with Employer Health Benefits

Employer-based health benefits are the prevailing source of health insurance in the United States. More than 160 million people, or more than 60 percent of the under-65 population, have health benefits through an employer. Nearly all employers with more than 200 employees offer their employees coverage.¹⁷ Employers contribute on average 73 percent of family premiums and 84 percent of single policies. According to Gabel and McDevitt, employer plans cover an average 80 percent of medical expenses.¹⁸

The individual insurance market is usually the sole option for people who do not have access to employer coverage and whose incomes are too high to qualify for Medicaid, but that market has proven to be a sorely inadequate substitute. This is because people who buy health insurance on their own must pay the full premium, and, in all but a handful of states, insurance carriers can underwrite prospective enrollees on the basis of health status, age, gender, and other characteristics that increase the potential for high claims costs in the future. A recent study by The Commonwealth Fund found that of adults who tried to purchase insurance in the individual market in the last three years, nearly three-quarters (73%) said they never bought a plan, either because they could not find a plan they could afford, they could not find a plan that met their needs, or they were turned down, charged a higher price, or had a condition excluded from coverage because of preexisting health problems (Figure 12).¹⁹

People who do purchase health insurance in the individual market pay far more out-of-pocket for their premiums, face much higher deductibles, face more limits on what their plans will pay, and spend larger shares of their income on premiums and out-of-pocket costs than their counterparts with employer-based group coverage. The Commonwealth Fund Biennial Health Insurance Survey found that in 2007, of adults with coverage through the individual market, nearly two-thirds spent 5 percent or more of their income on premiums, more than two times the share of adults in employer plans who spent that much (Figure 13). Nearly one-third of adults in individual market plans spent \$6,000 or more on premiums, compared with just 6 percent of people in employer plans (Figure 14). Despite spending more on premiums, nearly 40 percent of adults with individual market plans had per-person deductibles of \$1,000 or more, compared with just 11 percent of adults in employer plans. In addition, people with individual market plans were much more likely than people in employer plans to report that their health plan limited the total amount of medical expenses it would cover (49% vs. 38%), that a

¹⁷ Claxton, DiJulio, Whitmore et al., “Job-Based Health Insurance,” 2009.

¹⁸ Gabel, McDevitt, Lore et al., “[Trends in Underinsurance, 2004–2007](#),” 2009.

¹⁹ M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, [Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families](#) (New York: The Commonwealth Fund, July 2009).

doctor had charged them more than their health plans would pay and they had to pay the difference (39% vs. 28%), or that they had expensive medical bills that were not covered by their health plans (36% vs. 27%) (Figure 15). Adults with individual market plans also were less likely than those in employer plans to have prescription drug or dental coverage. Consequently, half (51%) of adults with individual market plans spent more than 10 percent of their income on premiums and out-of-pocket expenses in 2007, compared with 29 percent of adults in employer plans (Figure 16).

Underinsured Adults Are Nearly as Likely as Uninsured Adults to Not Get Needed Health Care Because of Cost

The purpose of health insurance is to provide timely and affordable access to care and to protect against the costs of catastrophic illnesses and injuries. However, the rising costs of health insurance and inadequate health insurance are straining limited family budgets and leaving people less protected. The Commonwealth Fund Biennial Health Insurance Survey asked respondents if in the last year, because of cost, they did not go to a doctor or clinic when sick; had not filled a prescription; skipped a medical test, treatment, or follow-up visit recommended by a doctor; or did not see a specialist when a doctor or the respondent thought it was needed. In 2007, more than 70 percent of adults who were uninsured at the time of the survey or spent some time uninsured in the past year cited cost-related problems accessing needed health care (Figure 17).²⁰ Underinsured adults reported not getting needed care at rates that were nearly as high as those who were uninsured: three of five underinsured adults reported at least one cost-related problem getting care in 2007.

There is considerable evidence that exposure to costs can have a negative effect on the ability of adults with chronic conditions to effectively manage their diseases. The Commonwealth Fund Biennial Health Insurance Survey asked respondents whether a doctor had told them they had any one of four chronic conditions: high blood pressure; heart disease; diabetes; or asthma, emphysema, or other lung disease.²¹ In 2007, among adults with chronic health problems who regularly took prescription drugs, 64 percent who lacked insurance and 46 percent of those who were underinsured reported skipping doses of medications or not filling prescriptions for their chronic conditions because of cost (Figure 18). In contrast, only 15 percent of adults with chronic conditions who were insured all year with adequate health insurance reported skimping on their medications. The survey also found that adults with chronic health problems who were uninsured or underinsured reported seeking care in an emergency room, staying overnight in the

²⁰ Collins, Kriss, Doty et al., *Losing Ground*, 2008.

²¹ About 34 percent, or an estimated 59.7 million adults in the 2007 Commonwealth Fund Biennial Health Insurance Survey reported at least one chronic health problem.

hospital, or both, for their condition at higher rates than did those with adequate health insurance.

Other studies highlight the risks of greater cost-sharing in health plans. A study by John Hsu and colleagues of Medicare beneficiaries found that people whose drug benefits were capped had lower drug utilization than those whose benefits were not capped; the consequences were poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels.²² Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use. Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs among elderly and poor patients, and it increased the risk of adverse health events like hospitalizations and admissions to the emergency room.²³ A review by Thomas Rice and K. Y. Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people age 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.²⁴

Underinsured Adults Report High Rates of Medical Bill Problems

The growing problem of uninsurance and underinsurance has not only exacted a heavy toll on the health of U.S. families, it has also exacted a similarly heavy toll on their finances. The Commonwealth Fund Biennial Health Insurance Survey found more than two of five (41%) adults under age 65, or 72 million people, reported problems paying medical bills in 2007, an increase from 34 percent, or 58 million people, in 2005.²⁵ Problems with medical bills included experiencing difficulty or inability to pay bills, being contacted by a collection agency concerning outstanding medical bills, changing your life significantly in order to pay bills, or paying off medical debt over time. Adults with gaps in health insurance coverage or those who were underinsured were most at risk of having problems with medical bills: in 2007 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 (26%) (Figure 19). Indeed, adults who were underinsured had the highest rates of medical debt: nearly half reported that they were paying off medical debt over time.

²² 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.

²³ 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.

²⁴ T. Rice and K. Y. Matsuoka, “The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors,” *Medical Care Research and Review*, Dec. 2004 61(4):415–52.

²⁵ Collins, Kriss, Doty et al., *Losing Ground*, 2008; and M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by Families* (New York: The Commonwealth Fund, Aug. 2008).

In the face of mounting medical bills and debt, many adults make stark trade-offs in their spending and saving priorities. Among adults who reported any problems with medical bills or accumulated debt in 2007, nearly one of three (29%) said they had been unable to pay for basic necessities like food, heat, or rent because of medical bills; nearly two of five (39%) had used all their savings; nearly one of three (30%) had taken on credit card debt; and one-tenth (10%) had taken out a mortgage against their home (Figure 20). Rates of reported trade-offs were especially high among people who had spent any time uninsured or those 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.

America's Health Choices Act (H.R. 3200) and the Problem of Underinsurance

The America's Health Choices Act (H.R. 3200) aims to provide near-universal health insurance coverage by building on the strongest aspects of the insurance system—large-employer insurance and Medicaid and the Children's Health Insurance Program (CHIP)—and regulating and reorganizing the weakest part of the system—the individual and small-group insurance markets, where so many small businesses and individuals are hurt by high premiums, high administrative costs, underwriting, and a lack of transparency in the content of benefit packages (Figure 21). The bill would establish new federal rules that require all insurance carriers selling policies in all markets to accept every individual and employer that applied for coverage (guaranteed issue) and prevent carriers from setting premiums based on health status (adjusted community rating). The bill would create a new health insurance exchange, which is an organized marketplace managed and regulated by government in which eligible individuals and businesses can choose among health plans (private, public, or nonprofit cooperative plans) that meet the requirements of participation set by the exchange.²⁶ Premium subsidies would be available on a sliding scale to offset the cost of plans purchased through the exchange. A minimum standard benefit package with cost-sharing tiers would set a floor for plans offered through the exchange. Income eligibility for Medicaid and CHIP would be expanded up to 133 percent of poverty. Individuals would be required to have coverage, and large employers would be required to either offer coverage or contribute to the cost of their employees' insurance.

²⁶ P. B. Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," *Health Affairs*, May/June 2008 27(3):675–85.

Reducing Uninsurance and Underinsurance

The bill would go a long way toward reducing the problem of uninsurance in the United States. The Congressional Budget Office estimates that by 2019 the number of people without health insurance would fall to 17 million—about 97 percent of legal residents—from an estimated 54 million people (the bill does not cover illegal immigrants) (Figure 22).

Several provisions in the bill also would likely reduce the number of people who are underinsured and the numbers of people who accumulate medical debt each year. The bill replaces the individual insurance market with a regulated insurance exchange operated at the federal level with a choice of both private and public health plans. The new market regulations would extend to all health plans sold in the United States. Guaranteed issue and adjusted community rating with 2:1 age bands would insure that people in poor health or who are older could not be denied coverage, charged a higher price, or have a condition excluded from coverage because of a preexisting condition. Insurance carriers could not impose annual or lifetime limits on what plans would pay and would be prohibited from the use of rescissions except in cases where there is “clear and convincing evidence of fraud.” This set of consumer protections alone would be a vast improvement over the current situation in most states for people seeking coverage in the individual market.

In addition to new market regulations, the bill would establish a new minimum benefit standard with four tiers (Figure 23). Annual out-of-pocket spending in the essential benefits package is limited to \$5,000 for individuals and \$10,000 for families. Such standards will ensure that consumers have comprehensive health plans that both encourage the use of timely preventive services and protect against catastrophic costs in the event of a serious accident or injury. Standardized benefits also will facilitate the ability of consumers to compare prices of similar health plans and provide incentives for insurers to compete on price.²⁷ Uniform standards across markets also will prevent adverse selection into the exchange by people who are sicker, provide transparency of information for people purchasing coverage through the exchange, and ensure that the cost of premium subsidies to the federal government doesn’t vary by the type of benefit package offered. The requirement that employers provide at least the basic benefit package ensures equity and provides a benchmark for the enforcement of the employer requirement to offer coverage.

While keeping the benefit package constant, the bill defines four tiers by actuarial value, or the average share of medical expenses covered by a health plan: 70 percent (basic), 85 percent (enhanced), and 95 percent (premium and premium plus, which also

²⁷ L. J. Blumberg and K. Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Washington, D.C.: The Urban Institute, April 2009).

includes oral and vision care). Cost-sharing could include a combination of deductibles, coinsurance, and out-of-pocket limits. For comparison, the average actuarial value in employer-based plans is an estimated 80 percent and about 84 percent to 87 percent for the Blue Cross Blue Shield Standard Option in the Federal Employees Health Benefits Program.²⁸ In Medicare, a forthcoming Commonwealth Fund analysis by Gabel and McDevitt finds that actuarial value ranges from an estimated 64 percent for Medicare Parts A and B to 90 percent for Medicare Parts A, B, D, and a supplemental (Medigap) policy.²⁹

The bill importantly specifies a minimum standard benefit package even though cost-sharing is allowed to vary. Allowing tiering by actuarial equivalence (i.e., defining benefit levels by the share of expenses covered by an insurance policy) can lead to substantial product differentiation with very different implications for enrollees of different health status and thus confusion during the enrollment process.³⁰ But variation just by cost-sharing also can lead to a proliferation of plan options and different levels of protection from out-of-pocket costs even within the same cost-sharing category, while presenting the possibility of selection into plans that would offer greater cost protection for people with health problems.³¹

It is important to note that actuarial values are averages. Actuarial value, as well as out-of-pocket spending, will vary by the medical expenses incurred by the policy holder and by the combination of deductibles, out-of-pocket maximums, and coinsurance in the policy. While actuarial values of health plans will generally rise among people with chronic health problems as they exceed their deductibles and out-of-pocket maximums, the Gabel and McDevitt analysis shows that people in poor health often pay more out-of-pocket for their health care.³² The authors estimated the number of people in employer-based plans with incomes under 200 percent of poverty who could expect to spend 5 percent or more of their income on out-of-pocket expenses, excluding premiums. They found that about 20 percent would exceed the 5 percent threshold. But nearly all those with the highest medical claims costs (top 1% of the spending distribution) would spend more than 5 percent of their income on out-of-pocket costs, while no one in the bottom

²⁸ Gabel, McDevitt, Lore et al., “[Trends in Underinsurance, 2004–2007](#),” 2009; and J. Gabel, R. McDevitt, R. Lore et al., *Comparing Medicare’s Benefit Package with the Blue Cross Blue Shield Standard Option Federal Employees’ Plan* (New York: The Commonwealth Fund, forthcoming Nov. 2009).

²⁹ Gabel, McDevitt, Lore et al., *Comparing Medicare’s Benefit Package*, forthcoming 2009.

³⁰ American Academy of Actuaries, *Critical Issues in Health Reform: Actuarial Equivalence* (May 2009); N. Turnbull, “Health Insurance Connectors: Lessons from Massachusetts,” Presentation at the Alliance for Health Reform and Commonwealth Fund Briefing on Health Insurance Exchanges: See How They Run, May 11, 2009; and Alliance for Health Reform and Commonwealth Fund Briefing on Health Insurance Exchanges: See How They Run, Transcript, May 11, 2009.

³¹ American Academy of Actuaries, *Critical Issues in Health Reform*, 2009.

³² Gabel, McDevitt, Lore et al., “[Trends in Underinsurance, 2004–2007](#),” 2009.

50 percent of the spending distribution would exceed the threshold.³³ Similarly, more than 80 percent of people with incomes at 400 percent of the poverty level who were in the top 1 percent of the spending distribution would spend more than 10 percent of their income on out-of-pocket expenses, excluding premiums.

The premium subsidies and cost-sharing credits in H.R. 3200 will substantially improve the affordability and protection of health plans offered through the new exchange. The premium subsidies cap spending on premiums at no more than 1.5 percent of income for those earning 133 percent of poverty, or \$29,327 for a family of four, and rise to no more than 12 percent of income for those with incomes at 400 percent of poverty, or about \$88,200 for a family of four in 2009. People earning less than 133 percent of poverty are eligible for Medicaid. Using the Kaiser Health Reform Subsidy Calculator, annual premiums for single adults earning less than 400 percent of poverty would range from \$487 per year for those earning 150 percent of poverty, to \$1,191 for people earning 200 percent of poverty, to a high of about \$3,200 for those earning 300 percent of poverty (Figure 24).³⁴ People earning between 300 percent and 400 percent of poverty who are living in areas of the country with high medical costs and who are older, given the 2:1 age bands, would particularly benefit from the premium subsidies in that income range. For people exceeding the subsidy thresholds, premiums would be higher for older people and those living high-cost areas.³⁵ For example, annual premiums for 60-year-olds with incomes exceeding the subsidy thresholds could range from \$5,000 to about \$7,600, compared with \$2,500 to \$3,800 for 20-year-olds who exceed the subsidy thresholds.

The cost-sharing credits will significantly reduce out-of-pocket expenses for people with incomes under 350 percent of poverty. Costs covered by the basic plan (or its actuarial value) would rise from 70 percent to 97 percent for those earning 133 percent to 150 percent of poverty, 93 percent for those earning 150 percent to 200 percent of poverty, 85 percent for those earning 200 percent to 250 percent of poverty, 78 percent for those earning 250 percent to 300 percent of poverty, and 72 percent for those earning 300 percent to 350 percent of poverty.

Reducing Health Care Costs and Premiums and the Importance of a Public Option

For people whose incomes exceed the income thresholds for subsidies, premium costs will likely decline from current levels because of a decrease in administrative costs due to restrictions on underwriting and reduced marketing, and because of savings

³³ Ibid.

³⁴ Kaiser Health Reform Subsidy Calculator—Premium Assistance for Coverage in Exchanges/Gateways, Kaiser Family Foundation, available at: <http://healthreform.kff.org/Subsidycalculator.aspx>.

³⁵ L. J. Blumberg, M. Buettgens, and B. Garrett, *Age Rating Under Comprehensive Health Reform: Implications for Coverage Costs, and Household Financial Burdens* (Washington, D.C.: The Urban Institute, Oct. 2009).

achieved through reduced provider payments and profits if a public option is included in the exchange. In addition, the House bill calls for a review of any health plan participating in the exchange whose premium increases exceed 150 percent of the medical inflation rate. Private insurance premiums more than doubled over the last decade, and they are projected to double again by 2020. If premiums had increased annually at even 150 percent of medical inflation from 1999 to 2008, family premiums would have been \$2,600 lower in 2008.³⁶ A Commonwealth Fund analysis finds that slowing premium growth by 1.0 percentage points annually would save \$2,571 in 2020 family premiums; slowing it by 1.5 percentage points, as pledged by an industry coalition, would save \$3,759 for the average family in 2020.³⁷

The insurance exchange should allow consumers a choice of both private and public health plans for at least three reasons. First, public insurance plans operate with significantly lower administrative overhead than private plans and do not have profit margins imbedded in their premiums as private for-profit plans do. Administrative costs in the Medicare program, for example, are estimated to account for 2 percent to 5 percent of premiums, compared with 25 percent to 40 percent of premiums in the individual insurance market.³⁸ This means that public plan premiums may be lower relative to private plans, providing an incentive for competing private plans to minimize costs. This would reduce the cost of premiums for people who do not qualify for premium subsidies and the cost of subsidies to the federal government, and would potentially help to lower the rate of overall cost growth in the health system.³⁹ Second, extensive consolidation in both insurance markets and hospital markets across the country has substantially reduced price competition in both markets.⁴⁰ There are only three states in the U.S. where the two largest health plans dominate less than 50 percent of the market (Figure 25). If insurance companies are unable to negotiate lower rates with providers, the lack of competition in insurance markets means that carriers can pass on costs to employers and consumers in the form of higher premiums.

A public plan would enable the federal government to lower premium costs by setting provider rates for the public plan between Medicare and commercial rates. This ability of the public plan to set rates would stimulate competition in both provider and

³⁶ K. Davis, S. R. Collins, R. Nuzum, and C. Schoen, “[On the Road to a High Performance Health System: Changing Course and Making History](#),” Invited Presentation, Forum on the Urgent Need for Health Care Reform, U.S. House of Representatives Steering and Policy Committee, Sept. 15, 2009.

³⁷ Schoen, Nicholson, and Rustgi, [Paying the Price](#), 2009.

³⁸ McKinsey Global Institute, [Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More](#), Dec. 2008.

³⁹ C. Schoen, K. Davis, S. Guterman, and K. Stremikis, [Fork in the Road: Alternative Paths to a High Performance U.S. Health System](#) (New York: The Commonwealth Fund, June 2009); and S. R. Collins, R. Nuzum, S. D. Rustgi, S. Mika, C. Schoen, and K. Davis, [How Health Care Reform Can Lower the Costs of Insurance Administration](#) (New York: The Commonwealth Fund, July 2009).

⁴⁰ J. Holahan and L. Blumberg, [Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?](#) (Washington, D.C.: The Urban Institute, 2008).

insurance markets. This would lower premiums and thus federal premium subsidies, and has the potential to lower overall health care cost inflation. Third, the public plan option within the exchange would enable the development and proliferation of innovative provider payment reforms that reward quality and efficiency beyond those efforts currently under way in the Medicare program. This dynamic could encourage similar innovations among carriers, and provide a competitive edge to integrated delivery systems that are already pursuing new models of patient-centered care coordination, disease management, and payment reform. CBO estimates that a public plan along the lines of that described in the House Ways and Means Committee bill would lower premiums by 10 percent, enrolling about 10 million people (Figure 26).

Health System Reforms

One of the major factors driving the increase in the number of people who are underinsured is the nation's rapid rate of growth in health care costs. In addition to insurance market regulations, benefit standards, premium and cost-sharing subsidies, a choice of a public plan in the exchange reducing out-of-pocket costs will also require national reforms aimed at improving the overall performance of the health system.

The House bill includes key provisions for improving health system performance and lowering the rate of cost growth, including investing in primary care; replacing the current Sustainable Growth Rate (SGR) formula for updating physician fees; adjusting for geographic variations; piloting programs for rapid-cycle testing of innovative payment methods, including medical homes, accountable care organizations, and bundled hospital payments; ensuring choice of private and public plans; containing costs, including limiting premium increases in the exchange; and fostering quality improvement (Figure 27). The provisions would affect both the way we pay for care by giving providers an incentive to deliver high-value care, and the rate of increase in cost over time by requiring ongoing productivity improvements. These provisions, in combination with provisions of the American Recovery and Reinvestment Act of 2009, would enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the long term.⁴¹ Specifically:

- Investments in primary care, pilot programs to test new payment methods, and using the purchasing leverage of Medicare and a new public health insurance plan to slow health care spending growth would all help bend the health system cost curve over the long run. Annual productivity improvements of one percentage point a year are assumed to be possible for providers to achieve, given the reductions in bad debt and charity care and given the opportunity to share in the savings gained from preventing

⁴¹ Davis, Collins, Nuzum et al., “[On the Road to a High Performance Health System](#),” 2009.

avoidable hospitalizations and hospital readmissions, controlling chronic conditions, and eliminating ineffective and duplicative care.

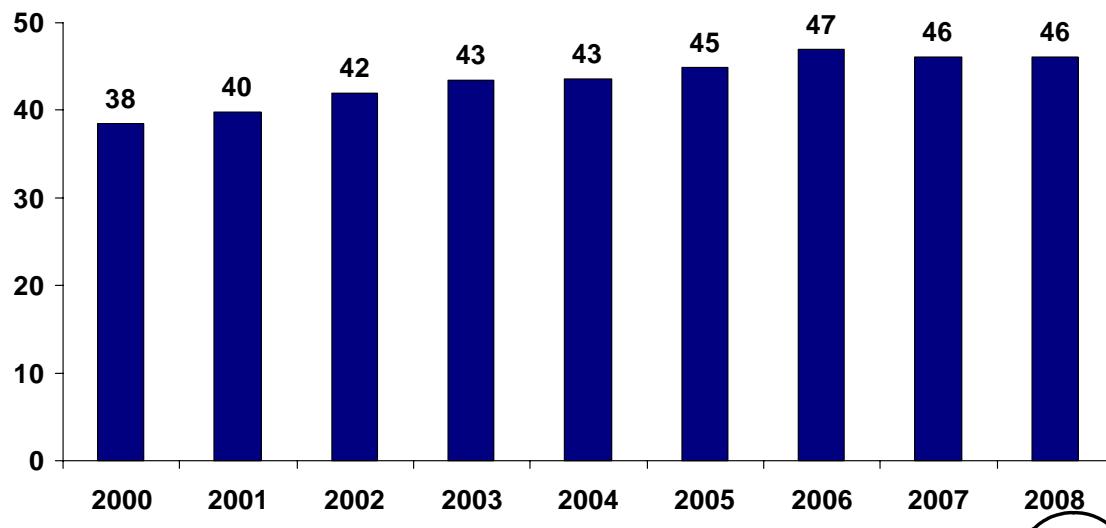
- The House bill emphasizes the importance of prevention and wellness by eliminating any cost-sharing for preventive services in Medicare and increasing Medicare payments for key preventive services.
- Additional Medicare spending would come from resetting the SGR formula for updating physician fees—\$245 billion over the period 2010 to 2019 (including interactions with other provisions). Major new savings come from the productivity improvement requirement and other changes in provider payment updates (\$200 billion) and correcting Medicare Advantage payment rates (\$172 billion).
- The net effect would be \$448 billion of savings before the revision of the SGR formula, and \$219 billion after making this adjustment (Figure 28). Including the SGR payments in the baseline projection yields an 8.0 percent annual growth rate in federal health expenditures over the 2010–2019 period, up from 7.6 percent under current law. Applying the other net savings would bend the Medicare spending cost curve and reduce the annual growth rate to 7.3 percent.

With working families in crisis from a combination of declining job, income, and health security, the time has never been more urgent for policymakers to find consensus and forge ahead on implementing solutions to the nation’s worsening health insurance problem, while placing the health care system on a path to high performance.

Thank you.

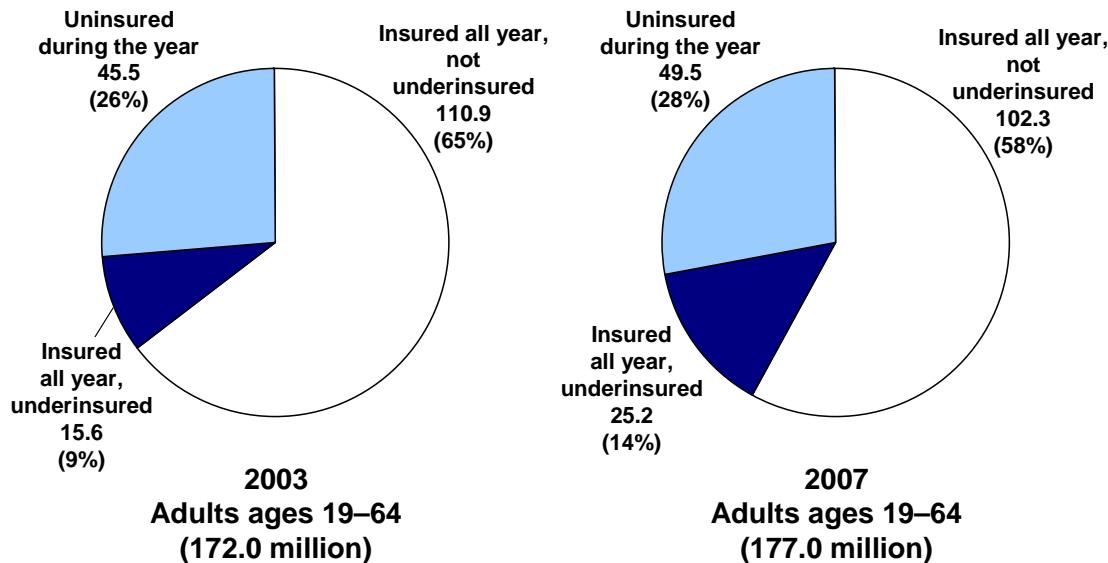
**Figure 1. 46 Million Uninsured in 2008;
Increase of 7.9 Million Since 2000**

Number of uninsured, in millions



Source: U.S. Census Bureau, March Current Population Survey, 2001–2009.

**Figure 2. 25 Million Adults Underinsured in 2007,
Up from 16 Million in 2003**

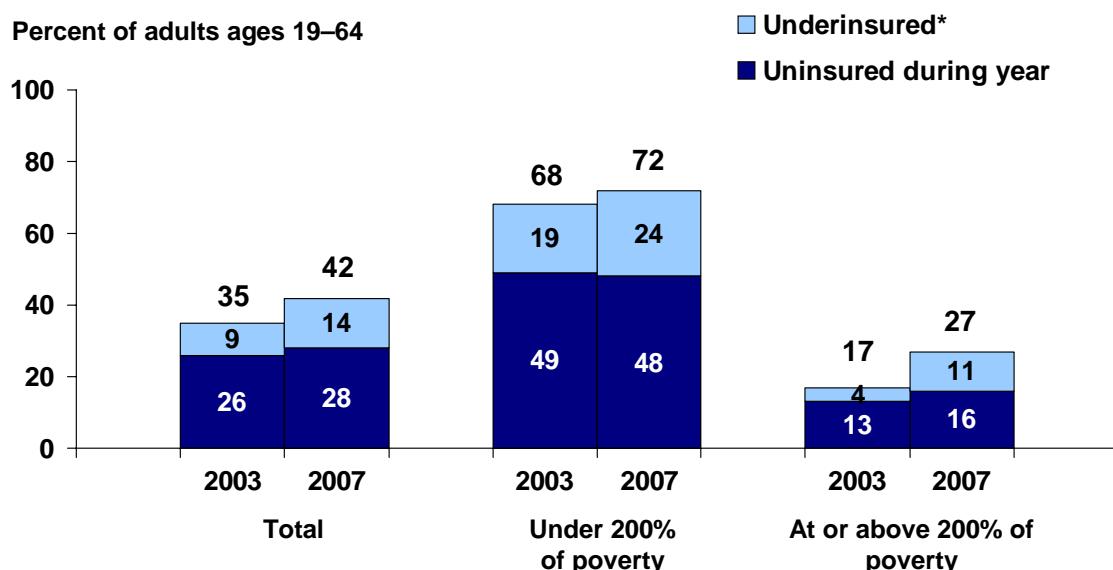


*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).



Figure 3. Half of Adults with Low Incomes Lack Coverage During the Year; Another Quarter Are Underinsured

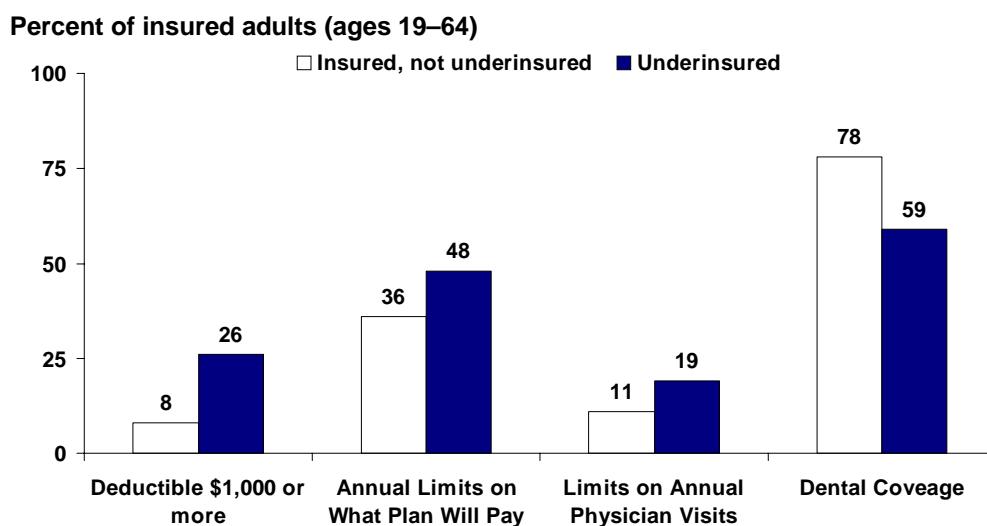


*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).



Figure 4. Underinsured Adults are More Likely to Have Health Plans With Coverage Limits; Less Likely to Have Dental Coverage



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. Data: 2007 Commonwealth Fund Biennial Health Insurance Survey

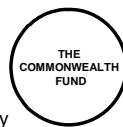
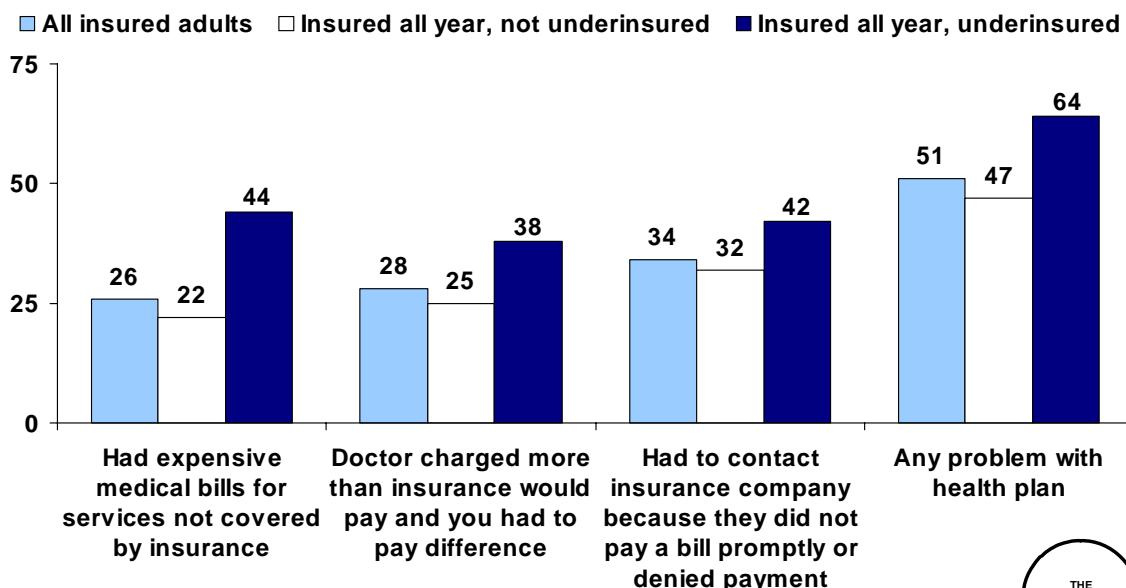


Figure 5. Underinsured Adults Report Higher Rates of Health Insurance Plan Problems than Adults with Adequate Insurance

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

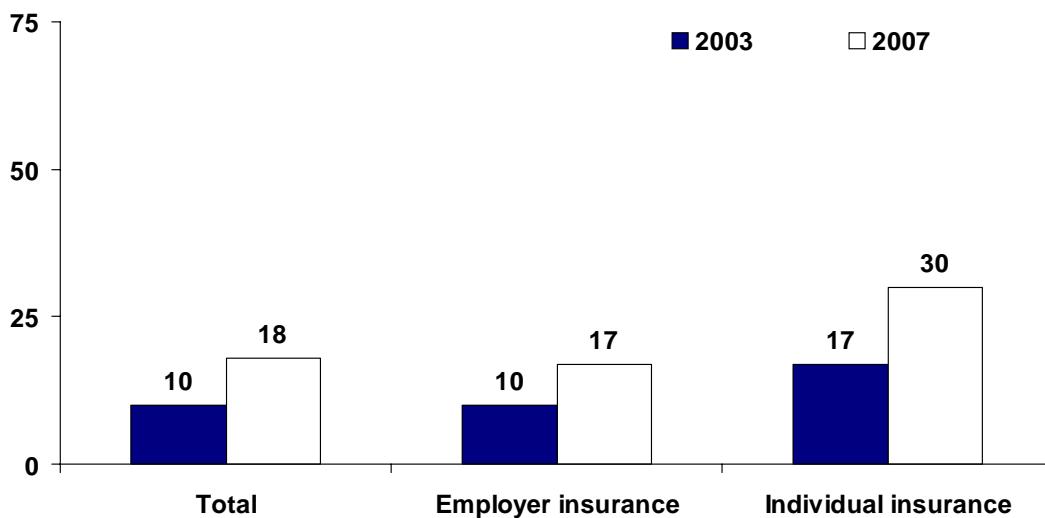


Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*, The Commonwealth Fund, August 2008.



Figure 6. Adults with Plans Purchased on the Individual Insurance Market Are More Likely to Underinsured Than Those with Employer Coverage

Percent of privately insured adults ages 19–64 who are underinsured



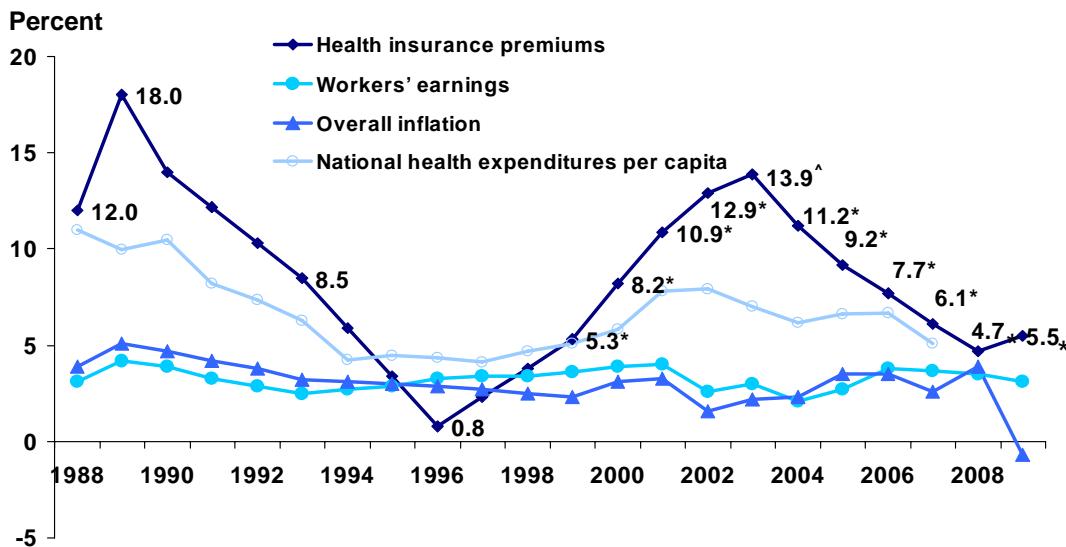
Notes: Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Adults continuously insured all year with employer-sponsored insurance or individual insurance.

Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund, July 2009.



Figure 7. Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2009



* Estimate is statistically different from the previous year shown at p<0.05.

^ Estimate is statistically different from the previous year shown at p<0.1.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).

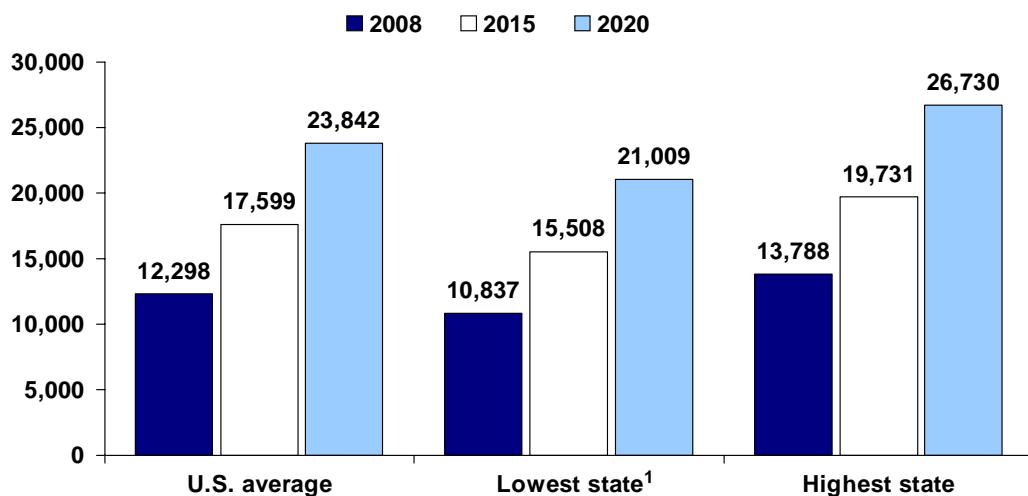
Source: Premiums: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 1999–2007, and KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996. Inflation: Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation, April to April), 1993–2009. Earnings: Bureau of Labor Statistics, seasonally adjusted data from the Current Employment Statistics Survey (April to April), 1993–2009. NHE: A.

Cisko, C. Truffer, S. Smith, et al, "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook," *Health Affairs*, 28, no. 2 (2009): w346-w357.



Figure 8. Projected Premiums for Family Coverage, 2008, 2015, 2020

Health insurance premiums for family coverage



¹The lowest state is Idaho; highest state is Massachusetts.

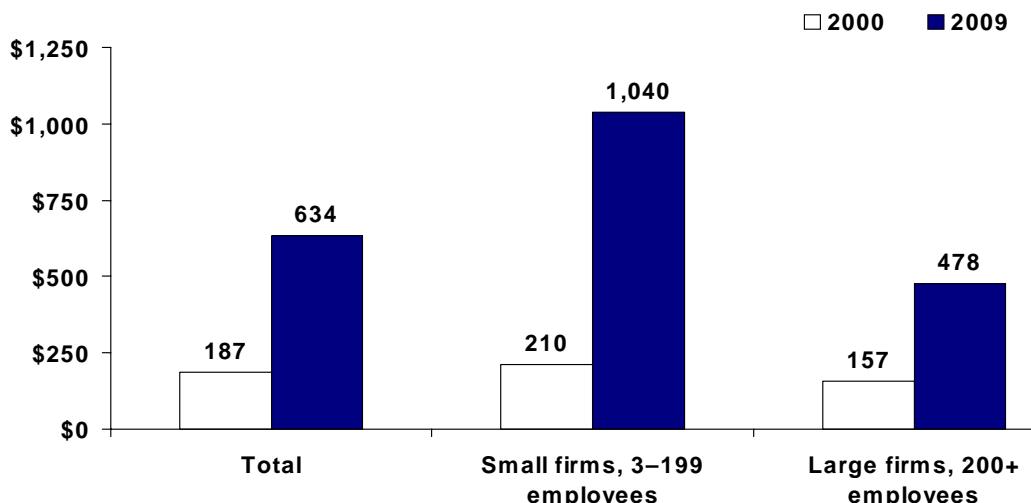
Data: 2008 premium data from Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2008 Medical Expenditure Panel Survey-Insurance Component; Premium estimates for 2015 and 2020 based on CMS, Office of the Actuary, National Statistics Group, national health expenditures per capita annual growth rate.



Source: C. Schoen, J.L. Nicholson, S.D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes, State-by-State Health Insurance Premium Projections With and Without National Reform* (New York: The Commonwealth Fund) August 2009.

**Figure 9. Deductibles Rise Sharply,
Especially in Small Firms, 2000–2009**

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.

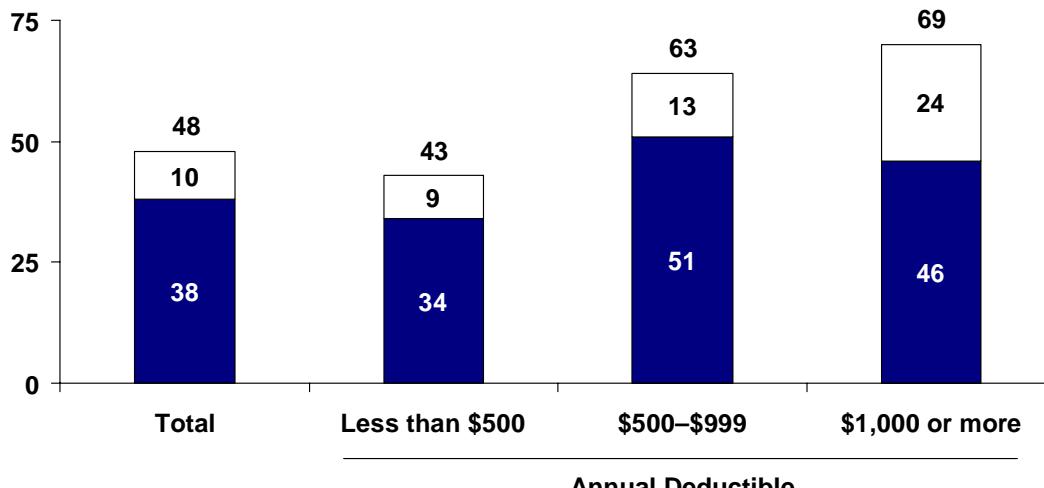
Source: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2009 Annual Surveys.



**Figure 10. Adults with Higher Deductibles Are More Likely to Spend
\$1,000 or More on Family Out-of-Pocket Expenses, 2007**

Percent of privately insured adults ages 19–64

- Annual out-of-pocket costs \$5,000 or more
- Annual out-of-pocket costs \$1,000–\$4,999



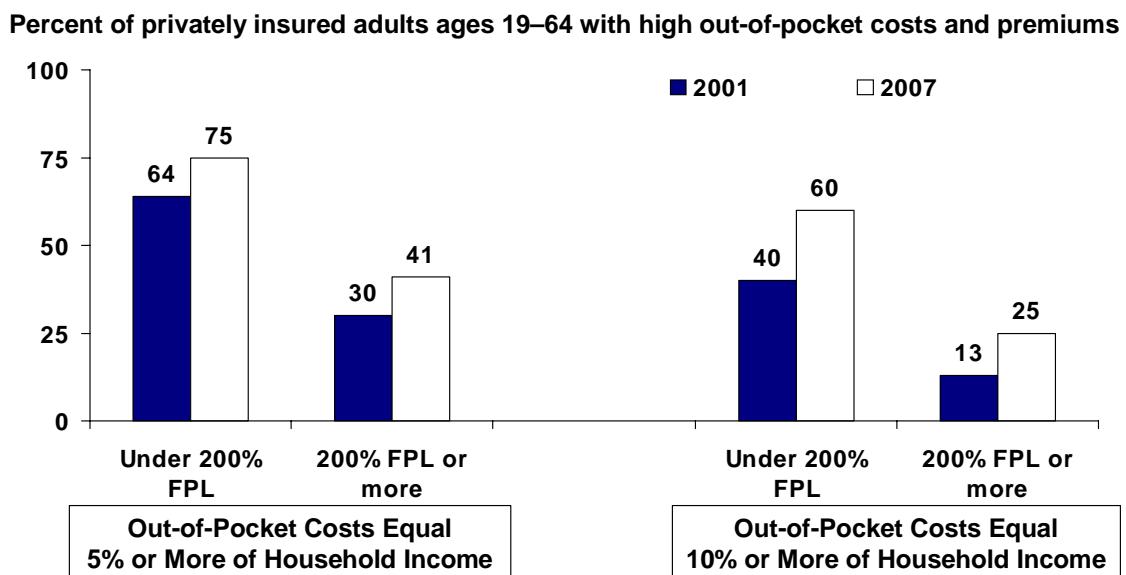
Notes: Family out-of-pocket expenses include out-of-pocket spending on medical care, prescription drugs, and dental and vision care. Does not include premium costs. Numbers may not sum because of rounding.

Adults continuously insured all year with employer-sponsored insurance or individual insurance.

Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund, July 2009.



Figure 11. Increasing Shares of Adults Across the Income Scale Are Spending Large Amounts of Income on Out-of-Pocket Costs and Premiums, 2001–2007



Notes: Family out-of-pocket costs include all medical expenses, premiums, and prescription drug spending.
Adults continuously insured all year with employer-sponsored insurance or individual insurance.

FPL = Federal Poverty Level.

Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund, July 2009.



Figure 12. The Individual Insurance Market Is Not an Affordable Option for Many People

| Adults ages 19–64 with individual coverage or who tried to buy it in past three years who: | Total | Health problem | No health problem | <200% FPL* | 200%+ FPL* |
|--|-------|----------------|-------------------|------------|------------|
| Found it very difficult or impossible to find coverage they needed | 47% | 60% | 35% | 52% | 40% |
| Found it very difficult or impossible to find affordable coverage | 57 | 70 | 45 | 63 | 53 |
| Were turned down, charged a higher price, or excluded because of a preexisting condition | 36 | 47 | 26 | 39 | 34 |
| Never bought a plan | 73 | 79 | 66 | 85 | 62 |

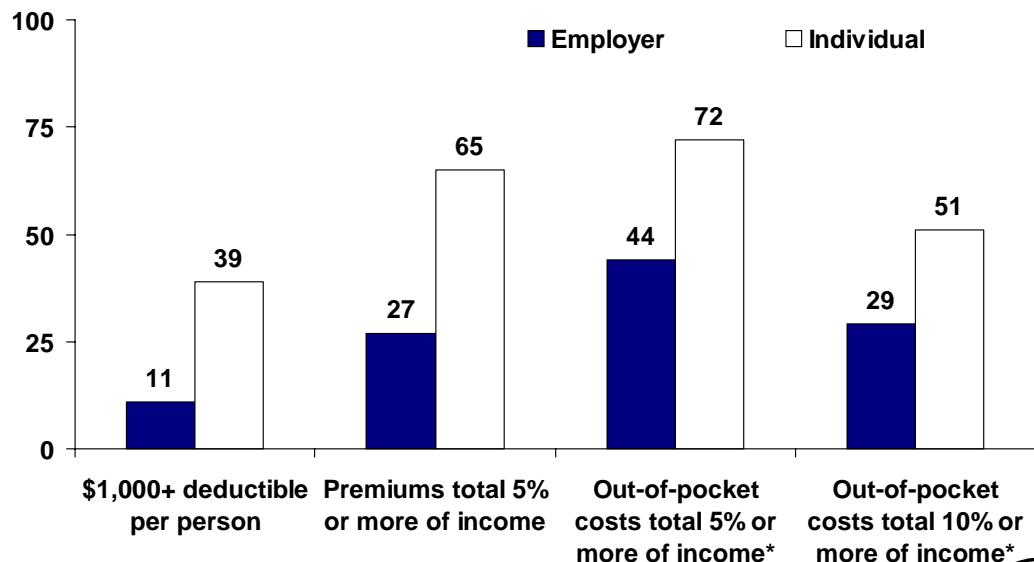
* FPL = federal poverty level.

Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund, July 2009.



Figure 13. Deductibles, Premium Costs, and Out-of-Pocket Spending Are Higher for Adults with Individual Insurance, 2007

Percent of privately insured adults ages 19–64



* Out-of-pocket costs include all medical expenses, premiums, and prescription drug spending.

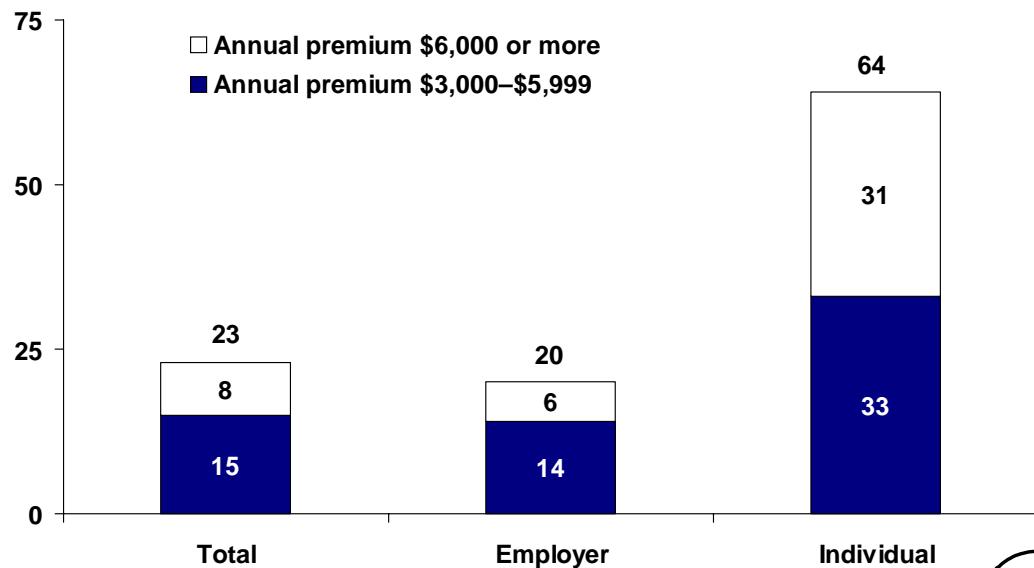
Note: Adults continuously insured all year with employer-sponsored insurance or individual insurance.

Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.



Figure 14. More than Three of Five Adults with Individual Market Coverage Have Annual Premium Costs of \$3,000 or More, 2007

Percent of privately insured adults ages 19–64



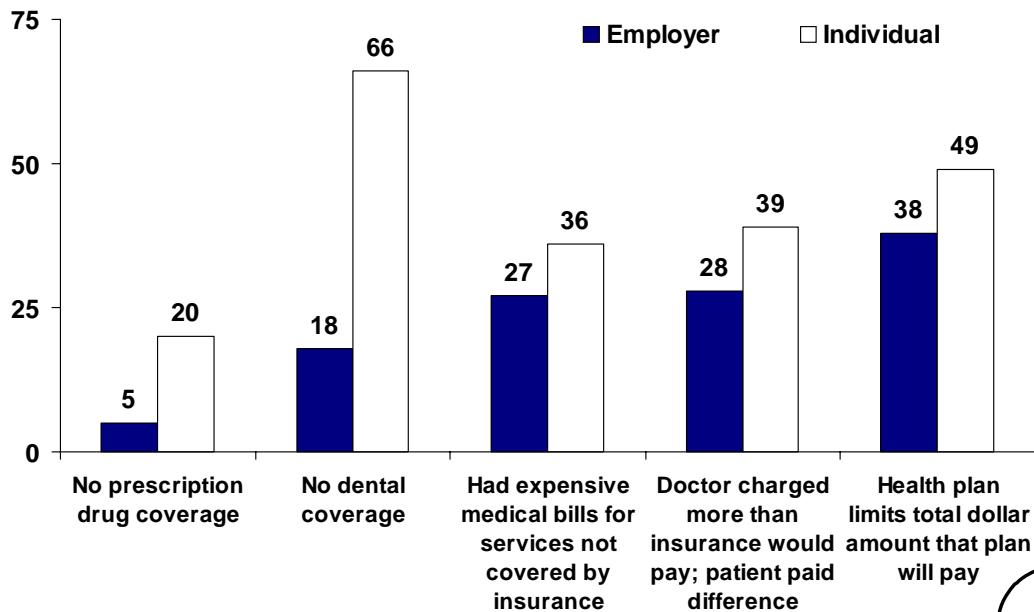
Note: Adults continuously insured all year with employer-sponsored insurance or individual insurance.

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



Figure 15. Individual Insurance Plans Are More Likely to Limit Benefits and Require Greater Cost-Sharing in 2007

Percent of privately insured adults ages 19–64



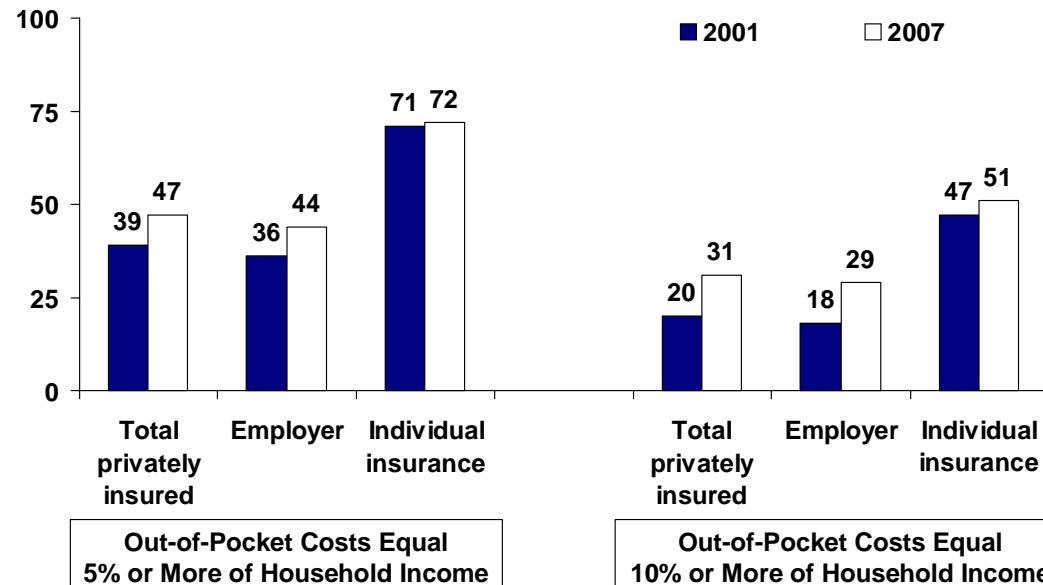
Note: Adults continuously insured all year with employer-sponsored insurance or individual insurance.

Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.



Figure 16. More Privately Insured Adults Are Spending Large Amounts of Income on Out-of-Pocket Costs and Premiums, 2001–2007

Percent of privately insured adults ages 19–64 with high out-of-pocket costs and premiums



Notes: Family out-of-pocket costs include all medical expenses, premiums, and prescription drug spending.

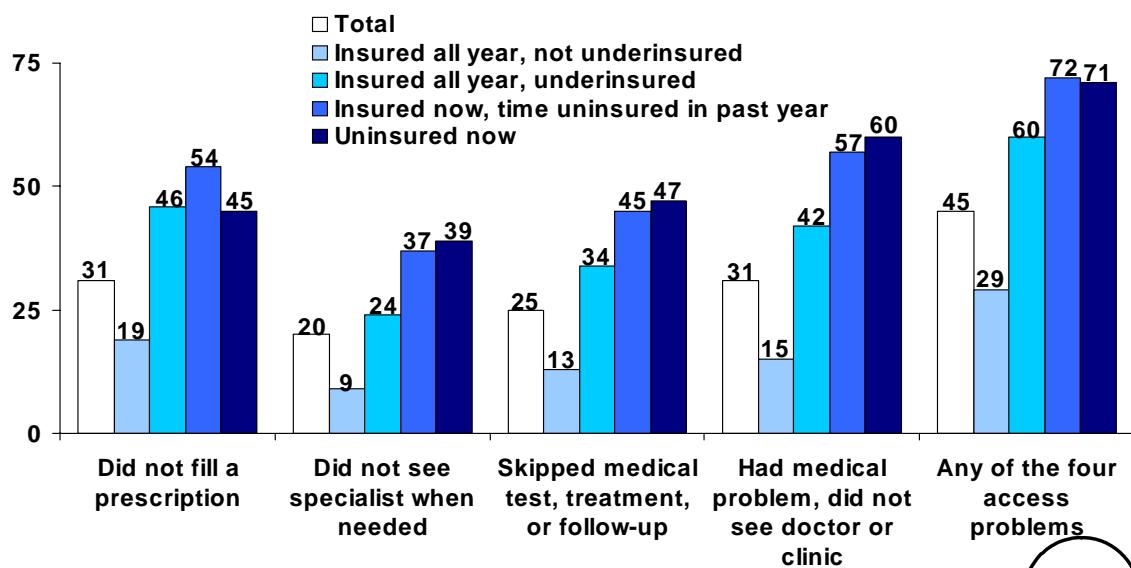
Adults continuously insured all year with employer-sponsored insurance or individual insurance.

Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.



Figure 17. Uninsured and Underinsured Adults Report High Rates of Cost-Related Access Problems

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

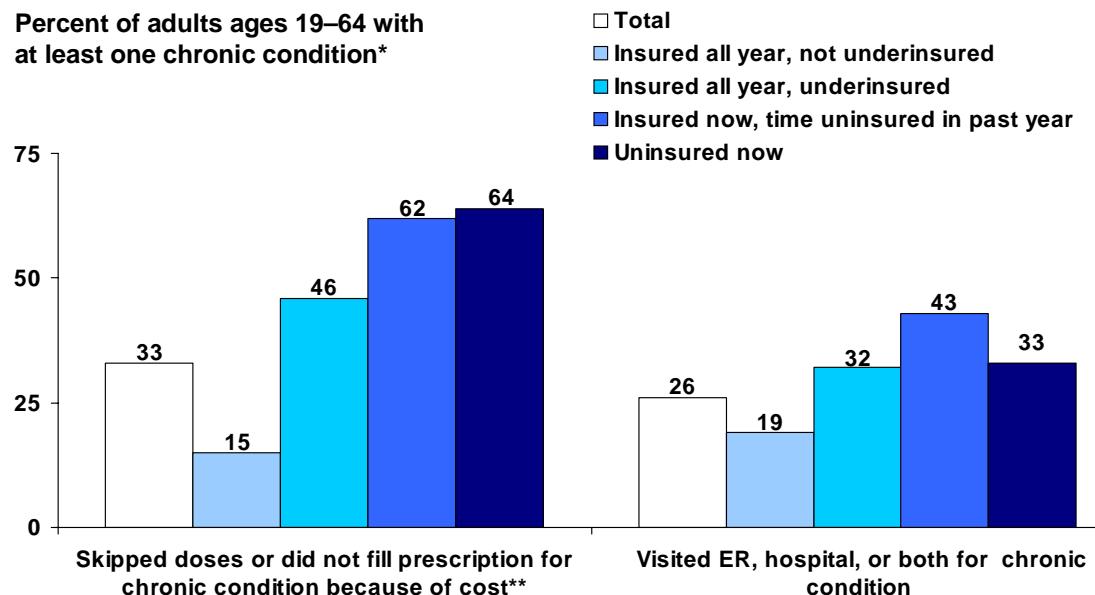


Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*, The Commonwealth Fund, August 2008.



Figure 18. 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.

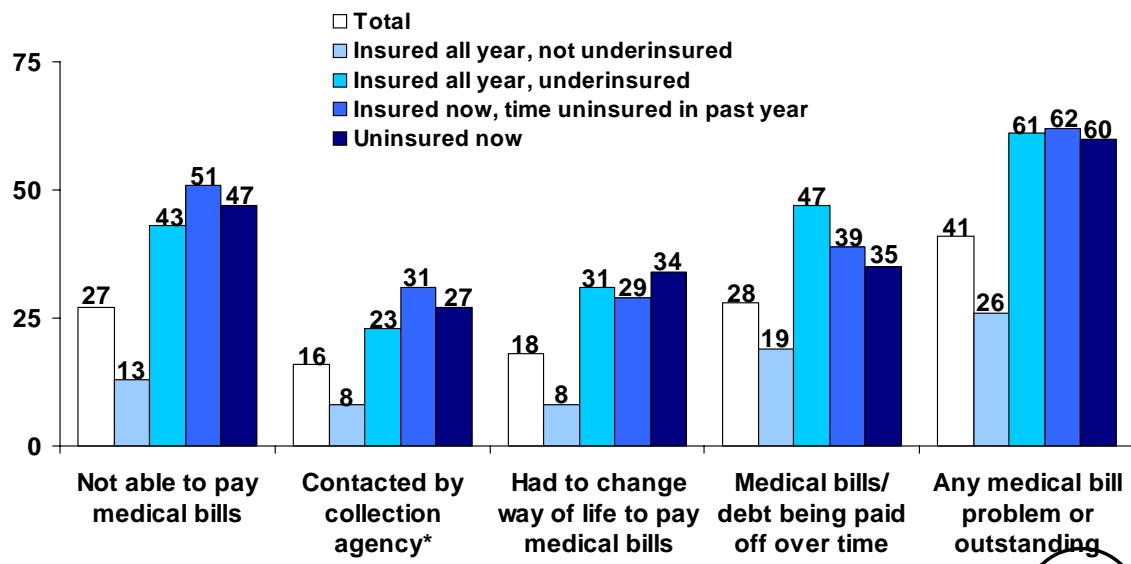
**Adults with at least one chronic condition who take prescription medications on a regular basis.

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: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*, The Commonwealth Fund, August 2008.



Figure 19. Sixty Percent of Underinsured or Uninsured Adults Reported Medical Bill Problems or Debt

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



*Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.

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: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*, The Commonwealth Fund, August 2008.



Figure 20. More Than One-Quarter of Adults Under Age 65 with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

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

| Percent of adults reporting: | Insured All Year | | | Uninsured Anytime During Year | |
|--|------------------|----------------------------|--------------|--|---------------|
| | Total | No underinsured indicators | Underinsured | Insured now, time uninsured in past year | Uninsured now |
| | | | | | |
| Unable to pay for basic necessities (food, heat, or rent) because of medical bills | 29% | 16% | 29% | 42% | 40% |
| Used up all of savings | 39 | 26 | 46 | 46 | 47 |
| Took out a mortgage against your home or took out a loan | 10 | 9 | 12 | 11 | 11 |
| Took on credit card debt | 30 | 28 | 33 | 34 | 26 |
| Insured at time care was provided | 61 | 80 | 82 | 46 | 24 |

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: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*, The Commonwealth Fund, August 2008.



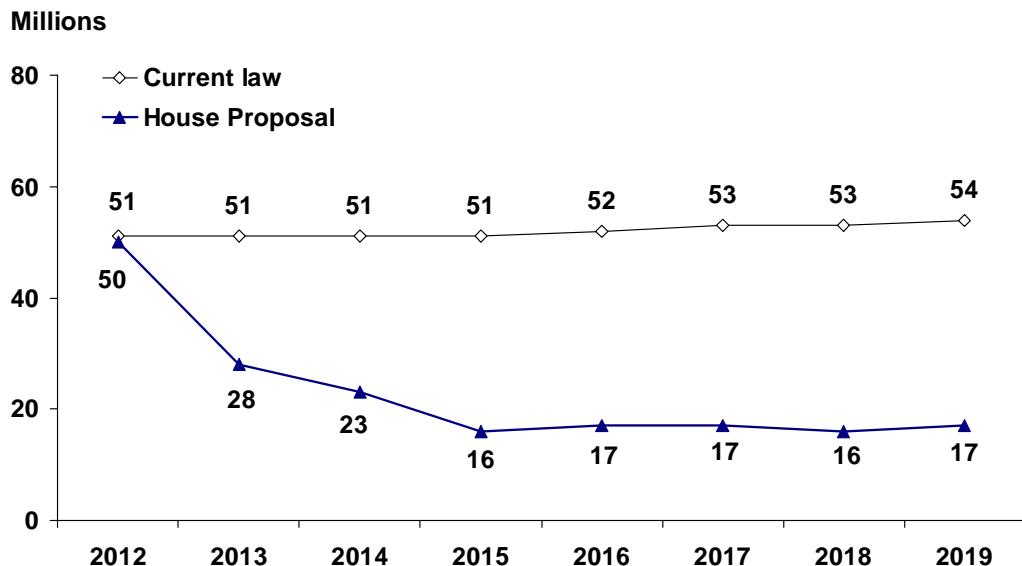
Figure 21. America's Health Choices Act (H.R. 3200) As Amended

| | |
|--|---|
| Insurance Market Regulations | Guaranteed issue, adjusted community rating with 2:1 age bands; no annual or lifetime limits on benefits; prohibits rescissions; carriers meet medical loss standards |
| Individual mandate | Penalty 2.5% of difference between MAGI and GI up to average national premium; |
| Exchange | National or state |
| Plans offered | Private, public and co-op |
| Eligibility for exchange | Individuals and small businesses phase in <10-20+ |
| Minimum benefit standard | Essential Health Benefits 70%-95% actuarial value, Four cost sharing tiers |
| Premium / cost-sharing assistance | Sliding scale 1.5%-12% of income 133%-400% FPL; cost-sharing credits 133%-350%FPL |
| Medicaid / CHIP expansion | Up to 133% FPL |
| Shared Responsibility / Employer Pay-or-play | Play or pay; amended firms >\$500,000 payroll, contribute 7.5%+ prem. contribution for ind/65%+ for families; sliding scale phased-in from 2% to 8% of payroll \$500k-\$750K; Small employer tax credit |

Source: Commonwealth Fund analysis of H.R. 3200.



**Figure 22. Trend in the Number of Uninsured, 2012–2020
Under Current Law and H.R. 3200**



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, 97% of legal nonelderly residents are projected to have insurance under H.R. 3200.
Data: Estimates by The Congressional Budget Office.

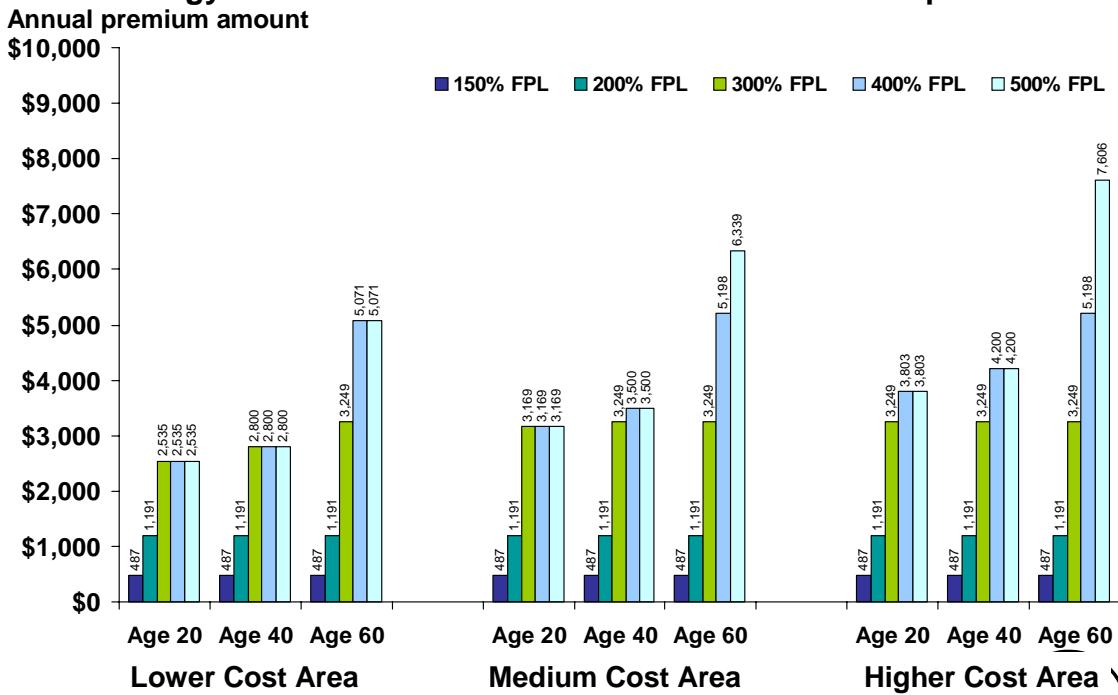


Figure 23. America's Health Choices Act (H.R. 3200) As Amended

| | |
|--------------------------------|--|
| Minimum Benefit Package | <p>An essential health benefits package, as specified by new Health Benefits Advisory Council, must provide comprehensive set of services, cover at least 70% of actuarial value, limit annual cost-sharing and not impose limits on benefits; All plans, including employers, must provide at least the basic package inside and outside the exchange</p> |
| Cost Sharing Tiers | <p>Essential health benefits package at four cost-sharing tiers 1st tier (Basic) actuarial value: 70% 2nd tier (Enhanced) actuarial value: 85% 3rd tier (Premium) actuarial value: 95% 4th tier (Premium-Plus) actuarial value: 95% plus oral health and vision care Annual out-of-pocket maximum \$5,000 for individuals, \$10,000 for families</p> |
| Premium subsidy | <p>Premium subsidy for purchase through exchange so contribution is limited to: 133-150% FPL: 1.5%-3.0% of income 150-200% FPL: 3.0-5.5% of income 200-250% FPL: 5.5-8.0% of income 250-300% FPL: 8.0-10.0% of income 300-350% FPL: 10.0-11.0% of income 350-400% FPL: 11.0-12.0% of income (based on average premium of 3 lowest cost plans) If ESI coverage contribution is <12% of income, not eligible for subsidies</p> |
| Cost-sharing credits | <p>Cost sharing credits reduce limits on cost-sharing, thus increasing actuarial value of basic plan to: 133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72%</p> |

Source: Commonwealth Fund analysis of health reform proposals.

Figure 24. Annual Premium Amount Paid by Individuals Under House Energy and Commerce Committee Health Reform Proposal



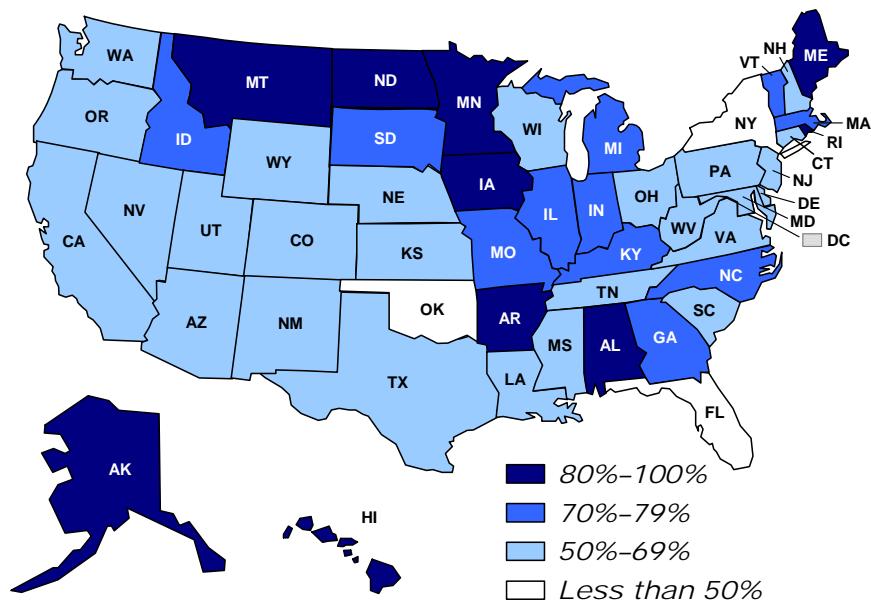
FPL = Federal Poverty Level

Note: Estimates are for single adults with no access to employer coverage.

Source: Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, Kaiser Family Foundation, <http://healthreform.kff.org/Subsidycalculator.aspx>, accessed 10/9/09.

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Figure 25. Concentrated Insurance Markets: Market Share of Two Largest Health Plans, by State, 2006

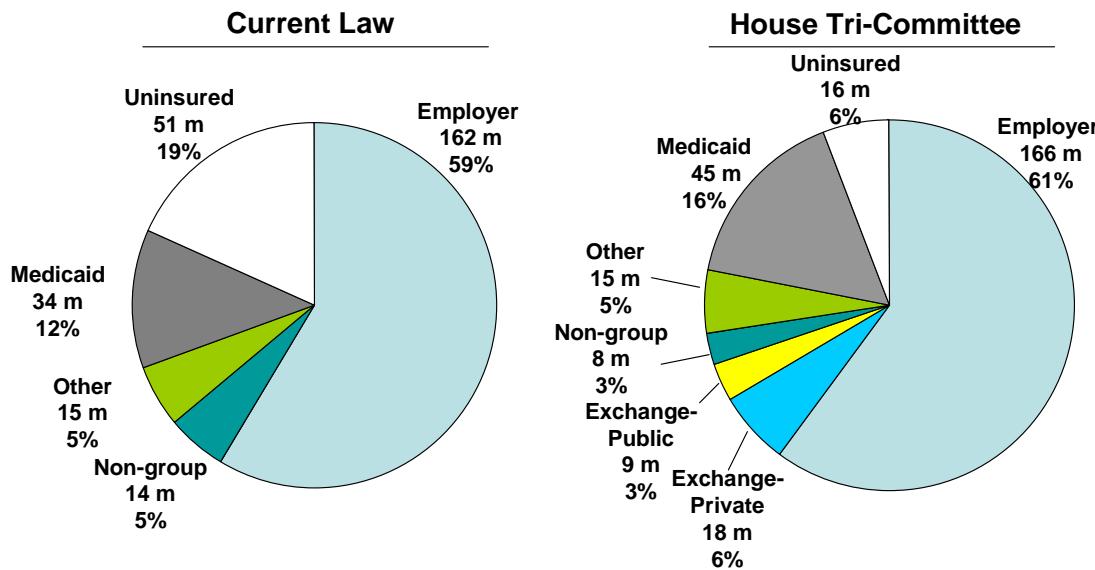


Note: Market shares include combined HMO+PPO products. For MS and PA share = top 3 insurers 2002-2003.

Source: American Medical Association, *Competition in health insurance: A comprehensive study of U.S. markets, 2008 update*; MS and PA from J. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Nov/Dec 2004; ND from D. McCarthy et al., "The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation," The Commonwealth Fund, May 2008.



**Figure 26. Effect of HR 3200 on Insurance Coverage of People Under Age 65, 2015
(in millions)**



Source: Congressional Budget Office, Letters to Honorable Charles Rangel and Honorable Henry Waxman, July 17, 2009.



Figure 27. System Improvement Provisions of National Health Reform Proposals, 2009

| H.R. 3200 as amended | |
|---|--|
| Exchange Standards and Plans | National or state exchanges; private, public or co-op plans offered; Essential health benefits 70%-95% actuarial value, four tiers; insurers must meet specified medical loss ratio |
| Primary Care | Increase Medicare payments for PCPs by 5%; bring Medicaid PCPs up to Medicare level |
| Prevention and Wellness | Develop a national prevention and wellness strategy; remove cost-sharing for proven preventive services in Medicare; grants to support employer wellness programs |
| Innovative payment pilots: medical homes, accountable care organizations, bundled hospital and post-acute care | Adopt medical homes, ACOs, and bundled payments on large scale if pilot programs prove successful; Center for Payment Innovation |
| Productivity Improvements | Modify market basket updates to account for productivity improvements |
| Comparative Effectiveness | Establish Comparative Effectiveness Research within AHRQ |
| Quality Improvement | Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices; develop national priorities for performance improvement and quality measures |

Source: Commonwealth Fund analysis of health reform proposals.



Figure 28. Major Sources of Savings And Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019 Dollars in billions

| CBO estimate of H.R. 3200, as of 7.31.09 | |
|---|----------------|
| Total Net Impact on Federal Deficit, 2010-2019 | \$239 |
| Total Federal Cost of Coverage Expansion and Improvement | \$1,042 |
| • Medicaid/CHIP outlays | 438 |
| • Exchange subsidies | 773 |
| • Payments by employers to exchanges | -45 |
| • Small employer subsidies | 53 |
| • Payments by uninsured individuals | -29 |
| • Play-or-pay payments by employers | -163 |
| • Associated effects on taxes and outlays | 15 |
| Total Savings from Payment and System Reforms | -\$219 |
| • Physician payment SGR reform | 229 |
| • Net improvements and savings | -448 |
| Total Revenues | -\$583 |
| • Excise tax on high premium insurance plans | 0 |
| • Surtax on wealthy individuals and families | -544 |
| • Other revenues | -39 |

Source: The Congressional Budget Office Analysis of HR 3200, The Affordable Health Choices Act, July 17, 2009, <http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf>.

