

**ADDRESSING UNDERINSURANCE IN NATIONAL  
HEALTH REFORM**

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**HEARING**  
OF THE  
**COMMITTEE ON HEALTH, EDUCATION,  
LABOR, AND PENSIONS**  
**UNITED STATES SENATE**  
**ONE HUNDRED ELEVENTH CONGRESS**

FIRST SESSION

ON

EXAMINING ADDRESSING UNDERINSURANCE IN NATIONAL  
HEALTH REFORM

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FEBRUARY 24, 2009  
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## ADDRESSING UNDERINSURANCE IN NATIONAL HEALTH REFORM

TUESDAY, FEBRUARY 24, 2009

U.S. SENATE,  
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,  
*Washington, DC.*

The committee met, pursuant to notice, at 10:00 a.m. in Room SD-430, Dirksen Senate Office Building, Hon. Jeff Bingaman, presiding.

Present: Senator Bingaman, Casey, Hagan, Enzi, Alexander, Burr, Hatch, and Coburn.

### OPENING STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. OK. Why don't we go ahead and get started. Senator Hatch is here and I'm told that Senator Enzi may be able to be here. But it's not clear at this point.

I thank everyone for coming. As everyone knows there's a great desire on the part of the Obama administration and the Congress to develop comprehensive health reform legislation this year. The legislation is intended to focus on expanding health insurance coverage to all Americans and improving the quality of our health care system and controlling the costs of health care.

As part of developing this legislation, Senator Kennedy has asked me to lead efforts here on our committee to develop some of the coverage proposals. And I'm very glad to do that. As we all know there are 45 to 47 million Americans currently uninsured.

This number is expected to grow as the economic difficulties continue. The case for expansion of health care coverage is highlighted by the report that was released yesterday by the Institute of Medicine entitled, "America's Uninsured Crisis—The Consequences of Health and Health Care." The report notes that there is a compelling case for action, that health insurance matters and that expanding health care coverage for all Americans is essential.

Today's hearing, however, is focused on an even more complex problem. And that is the problem of underinsurance. Underinsurance is the term used to describe the problems that many Americans with health insurance may face in meeting their health care expenses. Some experts define underinsurance as an insured individual whose family medical expenditures total 10 percent or more of their income or whose health plan includes deductibles greater than 5 percent of their income.

This first coverage hearing is on the issue of underinsurance because it's a subject that's often ignored in health coverage discus-

sions. But it does impact a very large segment of the American population. These are hard working Americans who pay every month for health insurance benefits. However, when they or their children become ill and rely on those benefits they discover that the coverage either is not comprehensive or they end up having a very significant out-of-pocket cost that they did not anticipate.

Underinsurance occurs because health insurance plans may have significant cost sharing requirements. It occurs because certain conditions or treatments may be excluded from coverage often as pre-existing conditions. This is particularly problematic in the individual insurance market.

And finally plans may have overall limits on benefits that fall far short of an enrollee's needs such as a cap on the total number of days an enrollee may stay in a hospital or aggregate lifetime limits on the total payments that may be made for a particular service. In the end these insured individuals may be left with thousands upon thousands of dollars in health care expenses. Of course extending a very rich benefit package to everyone may lead to over utilization of unnecessary health care which could then, of course, further drive up cost. The question of the right balance between underinsurance which can lead to individual financial risk or avoidance of needed health care and the resulting poor health outcomes that come from that and over insurance which can drive up health care costs is a difficult one, but one that obviously needs to be addressed if we're going to enact comprehensive health care.

Let me stop with that. I see Senator Enzi is here. Let me call on him for any comments that he's got. Then of course we'll hear from the witnesses and hopefully have some questions for them.

Senator Enzi, thank you for being here.

#### OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman, for holding this hearing today on health insurance and the issue of the underinsured. I look forward to working with members of the HELP Committee and all members of the Senate to exact meaningful health care reform legislation this year. That was a challenge we were given at the White House Economic Summit yesterday.

All of the speakers mentioned that health care is one of the main economic factors that we have to deal with and should be a priority. We do have a task force that's working on that which is a couple of people from each of the committees that are affected. And you'd be surprised how many committees are affected by it.

This, of course, is the committee of jurisdiction for the health care. I appreciate all the hearings that we've been having in this committee. I have been assured that whatever product any task force comes up with will come through regular process which means through this committee. And that always results in a better product.

This committee has gone from being one of the most contentious committees to being one of the most productive committees. I think it's because of the work that we do in committees. I do miss the days of roundtables, however. And hope that we'll go back to roundtables.

Hearings have a different meaning in the Senate. Because of the way that they're set up, we bring in people to make specific points. Whereas in the roundtables we bring in people that have—15 or 20 people—that have actually been involved in solving the issue and they have an interchange between themselves as well as stating what they've done. That's helped us a number of times in bills that we've drafted. I hope that we'll add some of those to the repertoire.

We all emphasize and empathize with the stories that we'll hear in today's testimony about patients who could not afford their health care. We all support protecting individuals and families from catastrophic health care costs. At the same time we need to be careful that in trying to solve this problem we don't make matters worse.

We know that while having the best of intentions many past health care reform efforts to protect consumers have actually increased costs and caused many of these same consumers to lose their health insurance. The single greatest challenge in reforming our health care system is rapidly escalating costs. Last Friday USA Today reported that many individuals who purchased their own health insurance faced double digit premium increases in 2008 with some plan premiums increasing by 20, 30 and in one case 56 percent.

These increases aren't sustainable. And we don't address the problem that is driving this cost growth more and more. Americans will lose their health insurance if we continue that.

We also know that when consumers bear some of the costs of their health care, total spending is reduced. It's common sense that we're more vigilant with our own money than if someone else is paying the bill. And this is especially true in health policy.

Going all the way back to the Rand Study in the 1970s, we know that reasonable cost sharing reduces spending without adversely impacting the quality of care. Anyone needing further proof of this, look no further than our recent experience with health savings accounts. Health savings accounts require consumers to pay for more routine services. And as a result health savings accounts have seen premium increases that have been dramatically lower than other types of insurance.

There are many factors that impact an individual's decision to purchase health insurance. Certainly cost plays an important role. But plan design and personal preference play a role too.

A 25-year-old male and a 55-year-old female have different health needs. And would probably have very different ideas of what they're willing to pay for health insurance. We need a private health insurance market that can deliver choices of high quality products to all types of people. Not a one-size-that-fits-all federally determined solution.

While we all agree that patients should be protected against catastrophic costs, we should not adopt reforms that limit consumer's choices or try to develop the Federal one-size-fits-all approach to cost sharing. I believe the most important thing Congress can do to increase access to affordable, high quality health insurance is to create an environment that forces private health insurance companies to innovate on ways to better control costs and compete for our business.

I think that's one of the messages that the President delivered yesterday as well—that we do have to work with public and private companies and get the costs under control. It's the costs that are driving us crazy and that are forcing, particularly small businesses, out of the market.

Mr. Chairman, I thank you again for bringing us together today. I look forward to hearing the testimony of our witnesses and the question and answer period.

The CHAIRMAN. Alright. Why don't we go ahead? We have four excellent witnesses today. Let me introduce them, if they'll just come forward.

Cathy Schoen is the Senior Vice President with the Commonwealth Fund in New York.

Gail Shearer is the Director of Health Policy Analysis with the Consumers Union.

Diane Rowland is the Executive Vice President with the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

And Grace-Marie Turner is the President of Galen Institute in Alexandria.

So thank you all very much for being here. Why don't we start with you, Ms. Schoen if you would go ahead and give us the main points we need to understand that you'd like to make. We'll hear from all witnesses and then have some questions.

**STATEMENT OF CATHY SCHOEN, MS, SENIOR VICE  
PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NY**

Ms. SCHOEN. Thank you, Mr. Chairman and committee members for the invitation to testify on the underinsured and implications for national reform. Rising health care costs and stagnating cuts have fueled steep erosion in insurance coverage across the Nation. In addition to steady increases in the number of uninsured we're seeing a surge in the number of adults who are underinsured, poorly protected in the event of illness although they're insured all year long.

Current trends are saddling individuals and their families with medical debt that can last for years and putting their health at risk. Insurance reforms are central to improving health system performance. But the way we design these reforms is critical both for assuring access, addressing cost concerns and addressing quality concerns.

In my remarks and prepared testimony I will briefly summarize trends, discuss consequences and then discuss some design principles as you look toward insurance reform.

First on trends. As we know the number of uninsured are up dramatically from 2000 to 2007. They're projected to increase to 61 million people by the end of the next decade. This doesn't count the people who churn in and out of coverage and our uninsured for part of the year.

We've seen a surge in the number underinsured. Our study published last year in Health Affairs estimates 25 million adults were underinsured as of 2007. This is a 60-percent increase since 2003.

We define the underinsured as adults who spent a high share of their income, 10 percent of their income, or more on medical care

expenses not counting premiums or 5 percent if they are low income. We also use deductibles alone of 5 percent of annual income for one person in the definition. This erosion is moving up the income scale.

There was a tripling in the percent of underinsured among adults in the middle-income range. In total an estimated 42 percent of all adults under 65 are now uninsured or underinsured. This was before the current, severe recession.

Compared to those with more adequate coverage we find underinsured and uninsured adults are much more likely to go without needed care because of costs, not following up on recommended care, not filling prescriptions for medication, not seeing doctors when sick. About half the underinsured and two-thirds of the uninsured reported this going without care because of cost. Half of both groups also confront financial stress including long-term medical debt.

Indeed the experiences of these two groups are increasingly similar. It's getting hard to tell an insured, underinsured, and an uninsured person from each other. The share of adults under 65 going without care because of cost is affecting the chronically ill as well.

In our 2007 study we found those with chronic illnesses were not filling medications for their chronic diseases. With both the uninsured and underinsured highly likely to go to the hospital and go to the emergency room as a consequence.

In our 2008 international study of eight countries, the United States stands out with half of all chronically ill adults. This is all, not just the under 65 going without care because of costs. We stand alone. And this rate was high for the insured as well as the underinsured.

As was mentioned in your opening remarks this is because of an ongoing erosion in the content of insurance limits on benefits, higher deductibles. We know from the Rand Study that part of this is an incentive to reduce unnecessary care. But Rand as well as more recent studies found people are just about as likely to cut back on essential and effective care as discretionary care, particularly those with low incomes and chronically ill.

More recently, studies who have focused on medications have found that people cut back on essential medications unless the benefit package is designed around value benefits. And this has led to higher hospitalizations, emergency room and even spikes in death. We're following behind other countries on preventing preventable deaths amenable to health care before age 75. We are now 19 out of 19 countries. Our rates of death came down slightly while other countries moved more rapidly. Our health is at risk.

I won't cite you the statistics on financial stress other than to say we are seeing as of 2007, 72 million adults facing bad debt, long-term debt, bill collectors, going without basic necessities to pay for bills. This is up dramatically from 2005. The rates among the middle income group now look like the low-income group did in 2001. This stress has all occurred before the current severe recession.

As you turn to implications for insurance reform it's important to remember that design matters. It matters for the twin goals of health insurance, timely access to essential care and financial protection. But it also matters for providing a foundation for payment

and system reforms to address the current cost dilemmas and value dilemmas we face in this country.

The fractured insurance system we have makes it very difficult to design coherent payment policies. We all go in different directions. It erodes incentives to invest for the long-term. The multiple benefit designs churning in and out of coverage drive up insurance administrative costs as well as driving down and eroding incentives for the long-term.

I've provided a list of design principles in my testimony. And I'll only list them briefly here, but would be happy to discuss them as you turn to how to design insurance for the twin goals of access and financial protection. We urgently need these reforms.

We need to start discussing a minimum benefit floor. This was a discussion in Massachusetts about putting a floor under insurance so that we don't have insurance surprises where insurance fails us with an emphasis on value benefits covering essential care as well as catastrophic cost.

We need to provide income-related premium assistance to make sure that that coverage is affordable. Pay particular attention to low-income individuals both for cost sharing and financial protection. Design of benefits should restrict the number of benefit variations both to make choice possible and to avoid risk selection. We need to have new mechanisms that allow people to keep their insurance as well as have choices as situations change.

I'll end my testimony just to urge you that this is an urgent problem. If we do insurance reform, payment reform and system reforms, we have an opportunity to put the Nation on a much different track. A report released last week by the Commonwealth Fund's Commission on a high performance health system shows that we would be able to improve access, outcomes and costs, but we need to act soon. Thank you.

[The prepared statement of Ms. Schoen follows:]

PREPARED STATEMENT OF CATHY SCHOEN, MS

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

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

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

ies regarding the consequences of inadequate coverage and gaps, and discuss design principles with the potential to move our system in new, more positive directions.

#### EROSION IN COVERAGE: RISING NUMBER UNDERINSURED AND UNINSURED

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

#### ACCESS, QUALITY, AND HEALTH AT RISK: CONSEQUENCES OF INADEQUATE INSURANCE

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

#### FINANCIAL STRESS AND ECONOMIC INSECURITY

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

- In 2007, 41 percent of adults—72 million people—said they had problems paying their medical bills, faced bill collectors, or were in debt for medical care, up from

34 percent or 58 million in 2005. The majority reported having insurance at the time these bills were incurred.

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

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

#### MOVING IN NEW DIRECTIONS: INSURANCE AND HEALTH SYSTEM REFORM

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

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

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

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

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

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

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

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Thank you, Mr. Chairman, for the invitation to testify on the underinsured and the implications for national health reform. Rapidly rising health care costs and stagnant incomes have fueled steep erosion in insurance coverage across the Nation. In addition to steady increases in the number of people uninsured during the year, we are seeing a surge in the number of adults and families who are "underinsured"—these are adults who are poorly protected in the event of illness although insured all year long. Efforts to moderate premium increases have led to higher

deductibles, increased cost-sharing, and limits or caps on benefits. Shifting the costs onto individuals and their families away from pooling risk through premiums is threatening the health and economic security of the Nation. In the midst of a severe recession, current trends are saddling vulnerable families with medical debt that can last for years. Although employer coverage remains the mainstay and primary source of insurance for workers and their families, rising costs are stressing private businesses and public employers. The United States is already by far the most expensive health system in the world, and we are rapidly widening the gap. As a nation, we urgently need health reform, starting with insurance to provide a more secure foundation for the future.

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

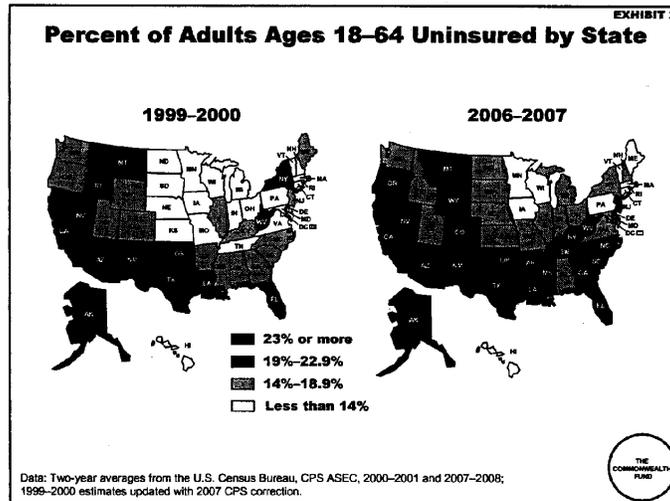
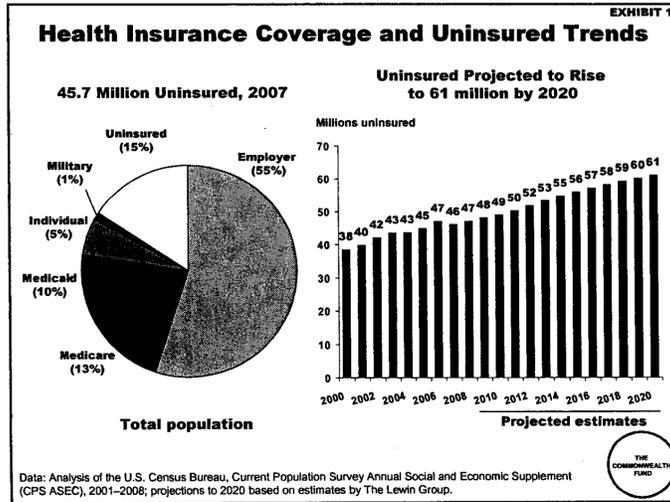
In my remarks and prepared testimony, I present recent studies on the trends and consequences of the rising number of underinsured and then discuss insurance benefit design principles to move in a new direction with national health reform. In the discussion of trends, it is important to remember that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

#### STEEP EROSION IN COVERAGE: RISING NUMBERS UNINSURED AND UNDERINSURED

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

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

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



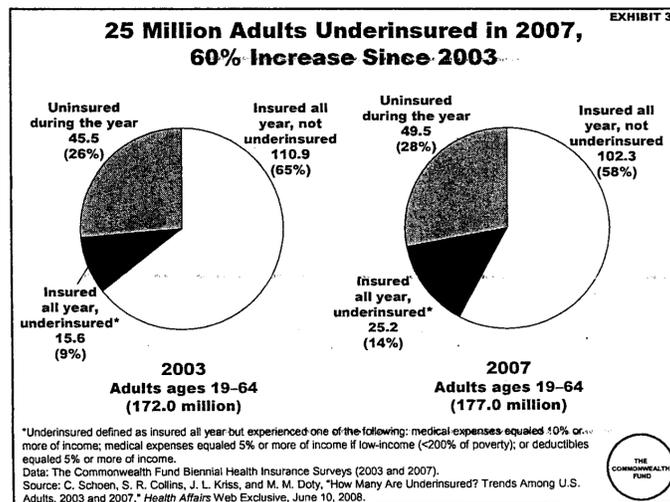
All projections indicate that without national policy action to stem the tide, the number of people who are uninsured at any moment in time will continue to increase rapidly. Assuming we recover from the current recession, projections estimate 61 million will be uninsured by 2020 (Exhibit 1). These uninsured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

Millions more are “underinsured”—insured all year yet facing such high cost-sharing relative to income that they lack adequate financial protection when sick or injured. In our recent study of underinsured trends from 2003 to 2007, we defined adults as underinsured if they had insurance all year *and* had out-of-pocket ex-

<sup>3</sup>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) August 2008.

penses for medical care of 10 percent or more of their annual income or 5 percent if low income (under 200 percent of poverty) or whose deductible alone was 5 percent or more of income.<sup>4</sup> Notably, this definition will miss those with inadequate coverage who were healthy during the year—in other words, the estimate is likely to be conservative.<sup>5</sup>

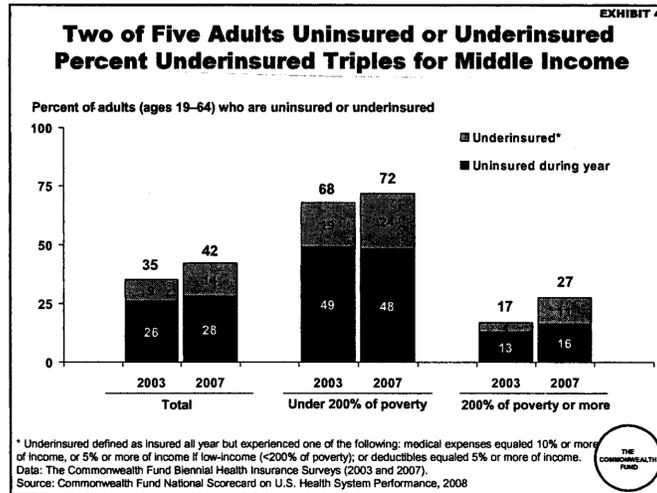
Using this financial definition of the underinsured, as of 2007, 25 million adults ages 19 to 64 were underinsured—a 60 percent increase from 2003 (Exhibit 3). Adding underinsured adults to those uninsured when surveyed or uninsured earlier in the year, more than 75 million—two of five adults—were either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



<sup>4</sup> 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.

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

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

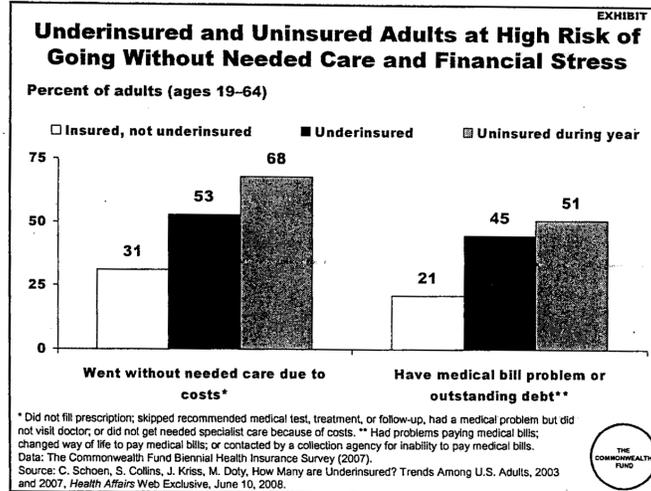


#### ACCESS AND HEALTH AT RISK: CONSEQUENCES OF INADEQUATE INSURANCE AND GAPS

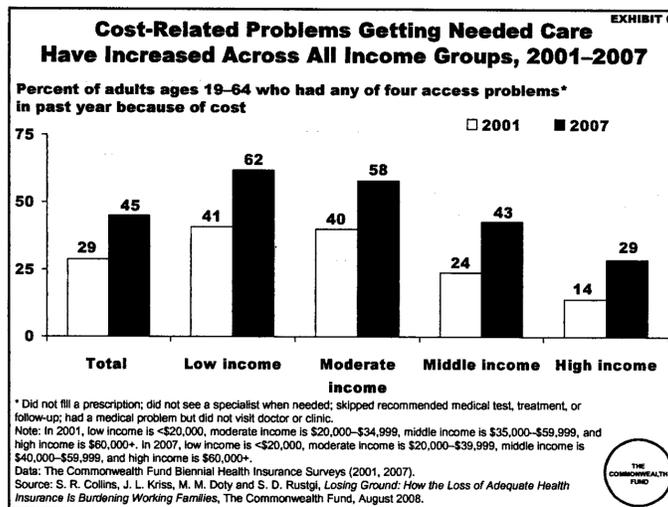
The core goals of health insurance are to provide timely and affordable access to care and to protect against the costs of illnesses and injuries. The ongoing deterioration of benefits undermines both goals as benefit designs increasingly shift costs onto the budgets of individuals and families when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

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

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



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

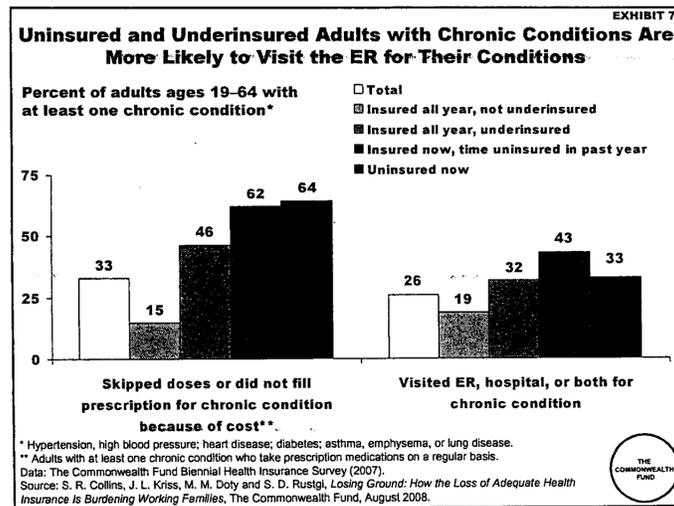


Multiple studies provide evidence that exposure to costs have negative effects on access to care for those with chronic conditions, undermining efforts to manage conditions and prevent complications.<sup>7</sup> In the Commonwealth Fund 2007 survey, we fo-

<sup>7</sup> M.E. Chernew, A.B. Rosen, and A.M. Fendrick, "Value-Based Insurance Design," *Health Affairs*, March/April 2007 26(2):w195-w203; M.E. Chernew, T. B. Gibson, K. Yu-Isenberg, et al., "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care," *Journal of General Internal Medicine*, Aug. 2008 (8):1131-1136; D.P. Goldman, G.F. Joyce, J.J.

Continued

cused on adults with any of four chronic conditions: high blood pressure, heart disease, diabetes, or asthma/other chronic lung conditions. Among these chronically ill adults, nearly half of underinsured adults and over 60 percent of those uninsured skipped doses or did not fill prescriptions for their chronic conditions (Exhibit 7). Lack of access to preventive, primary care, and ongoing care contributes to increased reliance on hospital emergency care (ER) or hospitalization. One third of underinsured chronically ill adults in the study went to the ER or were admitted to a hospital. Rates were similar to those reported by uninsured adults. Recent studies indicate over-crowding of ERs is a result of more insured as well as uninsured people turning to this safety net.<sup>8</sup>



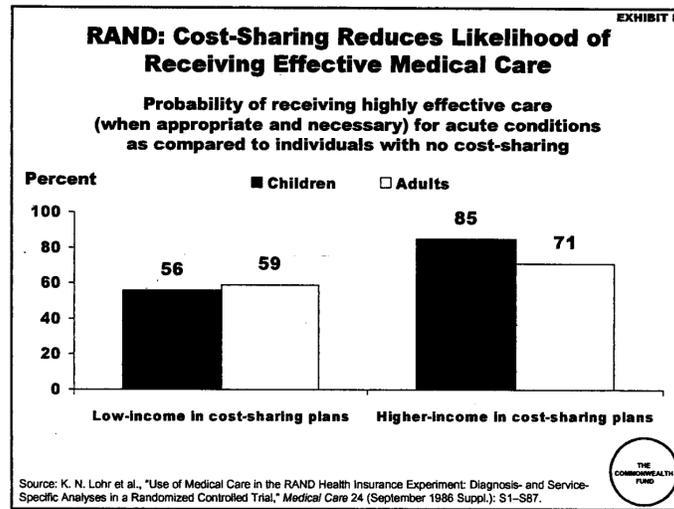
Patient-reported experiences are consistent with and confirm a rich array of studies that find that cost-sharing, unless designed with a focus on value, can result in the insured foregoing essential and effective care, especially when costs are high relative to incomes. Those with low or modest incomes are particularly at risk. Early on the RAND health insurance experiment pointed to the need to design benefits carefully to encourage effective care.<sup>9</sup> This seminal study found that cost-sharing reduced the likelihood of receiving highly effective care as well as more discretionary care (Exhibit 8). Access for low-income children and adults was particularly sensitive despite the fact that the RAND design capped financial exposure relative to income. Among those with chronic disease and low incomes, RAND found delayed or foregone care had adverse health effects.<sup>10</sup>

Escarce, et al., "Pharmacy Benefits and Use of Drugs by the Chronically Ill," *Journal of the American Medical Association* 291, no. 19 (2004): 2344-2350; M.D. Wong, R. Andersen, C.D. Sherbourne, et al., "Effects of Cost Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study," *American Journal of Public Health* 91, no. 11 (2001): 1889-1894; Jonathan Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond* (Washington, DC:Kaiser Family Foundation) October 2006.

<sup>8</sup>M.F. Newton, C.C. Keirns, R. Cunningham, et al., "Uninsured Adults Presenting to U.S. Emergency Departments: Assumptions vs. Data," *Journal of the American Medical Association*, Oct. 2008 300(16):1914-24.

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

<sup>10</sup>J. Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond* (Washington, DC: Kaiser Family Foundation) October 2006.

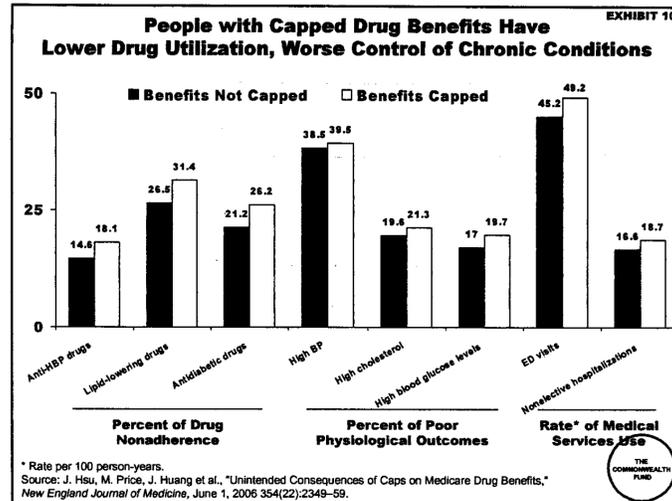
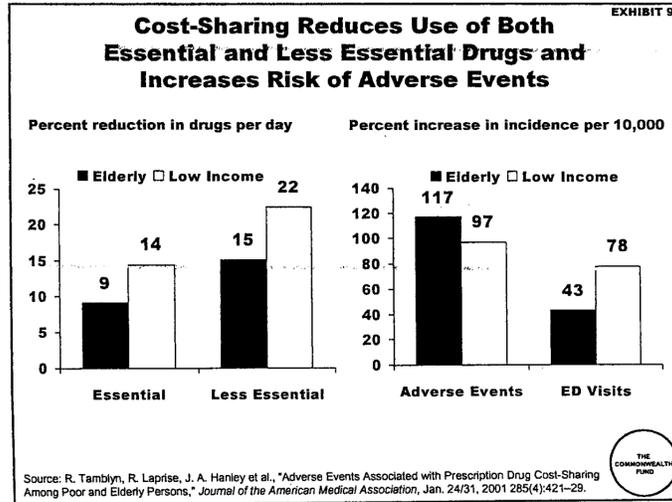


Recent studies reach the same conclusion, pointing to the importance of benefit designs that encourage effective and preventive care, including essential medications. A Canadian study assessing the impact of increased cost-shares for medications among the elderly and low-income, found a steep reduction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

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

<sup>12</sup>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.

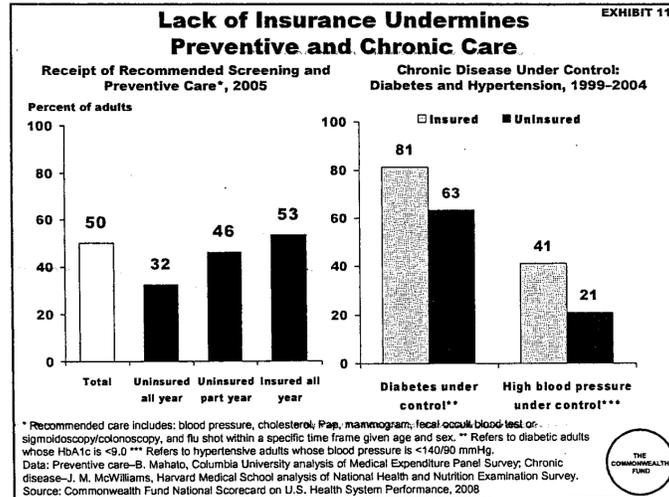
<sup>13</sup>See also, S.R. Collins, et al., *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund) October 2008.



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

<sup>14</sup>The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund) July 2008.

uninsured adults reported their high blood pressure was under control at half the rates reported by insured adults.



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

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

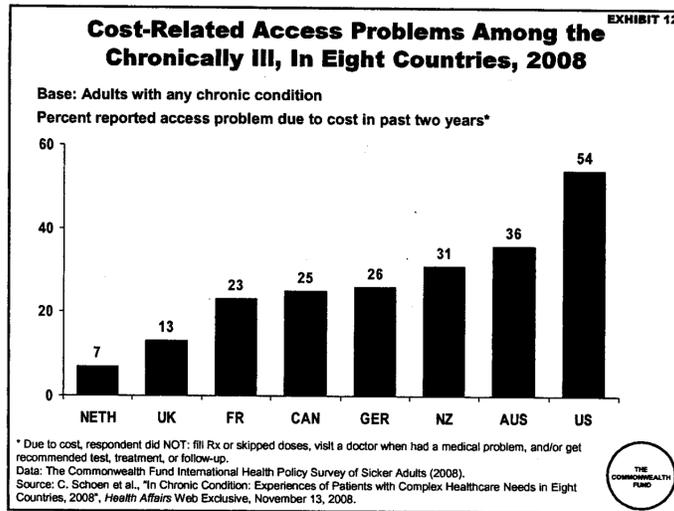
Compared to other countries, we are losing ground. In a 2008 eight-country survey that focused on chronically ill adults with recent care experiences, U.S. chronically ill adults are far more likely to go without needed care because of costs than do their counterparts in other countries.<sup>17</sup>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

<sup>15</sup> J.M. McWilliams, E. Meara, A.M. Zaslavsky, and J.Z. Ayanian, "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine*, July 2007 357(2):143-53.

<sup>16</sup> M.E. Chernew, A.B. Rosen, and A.M. Fendrick, "Value-Based Insurance Design," *Health Affairs* March/April 2007 26(2):w195-w203.

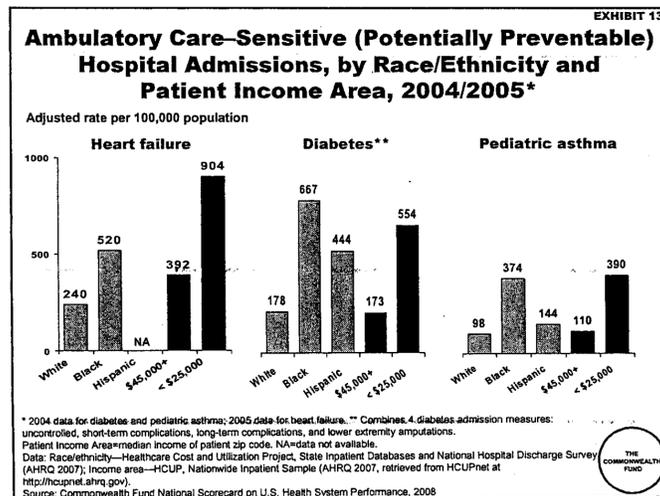
<sup>17</sup> C. Schoen, R. Osborn, S.K.H. How, M.M. Doty, and J. Peugh, "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008," *Health Affairs* Web Exclusive (Nov. 13, 2008):w1-w16.

<sup>18</sup> I. Durand-Zaleski, "The Health System in France," *Eurohealth* 14, no. 1 (2008): 3-4; R. Busse, "The Health System in Germany," *Eurohealth* 14, no. 1 (2008): 5-6.N.



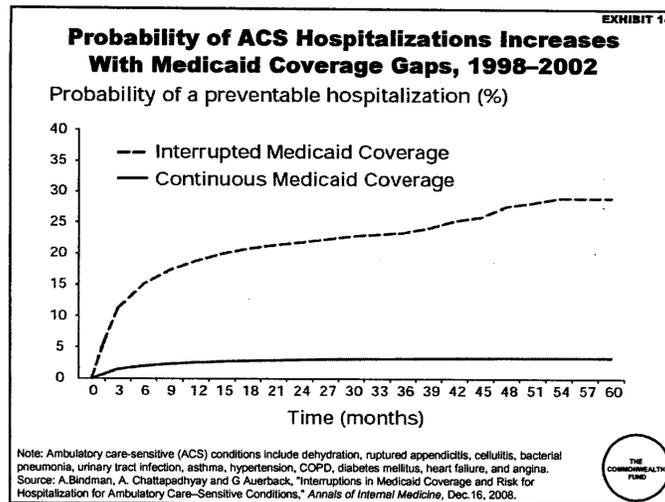
Those with chronic disease or acute conditions often end up admitted or re-admitted to hospitals, with surgery or expensive procedures for preventable complications, such as amputations or kidney dialysis for diabetics. Too often instead of acting early to stop the onset of or complications associated with diabetes, we build dialysis centers and, for Medicare patients, cover the costs of treating end-stage renal disease.<sup>19</sup>

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



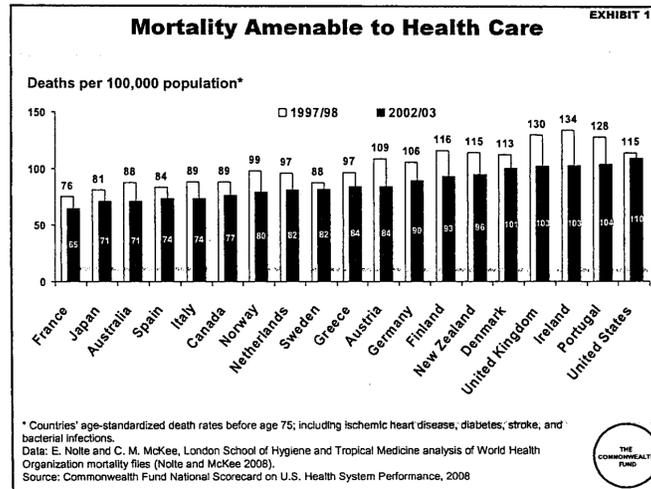
<sup>19</sup>David Tuller, "Overshadowed, Kidney Disease Takes a Growing Toll," *New York Times*, Nov. 18, 2008.

A recent study by Bindman and colleagues underscores the importance of continuous as well as adequate coverage. The study found that interruptions in Medicaid coverage were associated with sharply higher rates of hospitalization for conditions that could have been treated in a much less expensive setting or prevented (Exhibit 14).<sup>20</sup> The probability of hospitalization for ambulatory-care sensitive conditions (e.g. asthma, diabetes, hypertension, pneumonia, ruptured appendix) was eight times higher for those with interrupted coverage—and four times higher after controlling for demographics. In this study of California Medicaid beneficiaries, 62 percent experienced an interruption in coverage during the study period between 1998 and 2002—the average duration of interruption was 25 months. Most became uninsured when they lost Medicaid.



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

<sup>20</sup> A. Bindman, A. Chattopadhyay and G. Auerback, "Interruptions in Medicaid Coverage and Risks for Hospitalization for Ambulatory Sensitive Conditions," *Annals of Internal Medicine*, Dec. 2008 149(12):854–60.



#### FINANCIAL STRESS AND ECONOMIC INSECURITY

The financial and economic consequences of having inadequate insurance or being uninsured are immediate and often long-lived as medical debt accumulates. In our 2007 survey, 72 million adults ages 19–64 (41 percent) faced problems paying their medical bills or were paying medical debt over time—an increase from 58 million (34 percent) in 2005 (Exhibit 16). The majority of adults (60 percent) with bill problems or debt had insurance at the time the healthcare expenses were incurred.<sup>21</sup> This increase occurred across all income groups but especially among families with low and moderate incomes: more than half of adults with incomes under \$40,000 reported problems with medical bills in 2007 (Exhibit 17). Adults with gaps in health insurance coverage or those underinsured were most at risk of having problems with medical bills: three of five reported any one medical bill problem or accrued medical debt, more than double the rate of those who had adequate insurance all year.

<sup>21</sup> 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) August 2008.

EXHIBIT 16

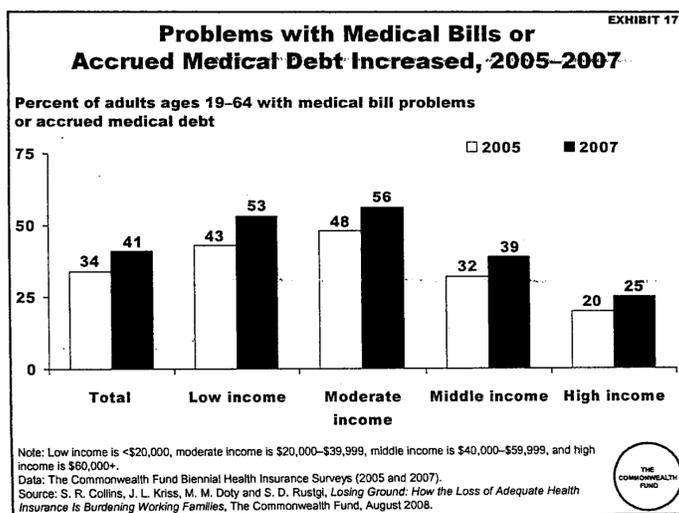
### Medical Bill Problems and Accrued Medical Debt, 2005-2007

Percent of adults ages 19-64

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

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

THE COMMONWEALTH FUND

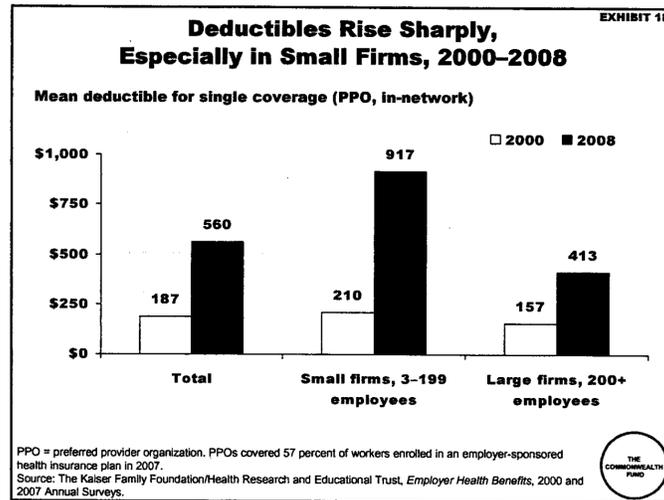


Of the estimated 50 million adults who were paying off medical debt in 2007, many were carrying substantial debt loads that had accrued over time. One-quarter of adults with medical debt were carrying \$4,000 or more in debt and 12 percent had \$8,000 or more. More than one-third (37 percent) of adults with medical debt were carrying overdue bills from care received more than 1 year ago.

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

To date, much of the erosion in more comprehensive coverage, including benefit limits has occurred in the small group and individual market. Although there has been a broad trend toward higher cost-sharing, including higher deductibles and co-payments for medications and other care, employees of small businesses have been particularly hard hit. Without the leverage and risk pool of large firms, small businesses tend to pay the same premiums or more for less comprehensive coverage.<sup>22</sup> As employers try to “buy down” the cost of premiums to hold onto coverage, average deductibles for single coverage in PPO plans for small firms have quadrupled since 2000 (Exhibit 18).<sup>23</sup> Similarly, those insured through the individual market tend to pay more and get less due to much higher administrative costs (including underwriting and marketing) and restrictions in benefits. Coverage equivalent to employer plans in the individual market—if available—is estimated to cost at least an additional \$2,000.<sup>24</sup> Plans in the individual market and small firm market are also more likely to place restrictions on benefits, including caps on the amounts plans will pay.



#### MOVING IN NEW DIRECTIONS: INSURANCE AND SYSTEM REFORMS

Extending affordable insurance to all and doing so in a way that ensures access and provides financial protection is critical to moving in a more positive direction. The United States leads the world on health care spending: at an expected 17 percent of gross domestic product (GDP) in 2009, we are an outlier and spending per person is double or more what other countries spend. With current trends, the share of GDP spent on health care is projected to increase to 21 percent by 2020, at the same time millions more will lose basic access to care.<sup>25</sup>

<sup>22</sup> J.R. Gabel and J.D. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees* (New York: The Commonwealth Fund) April 2004.

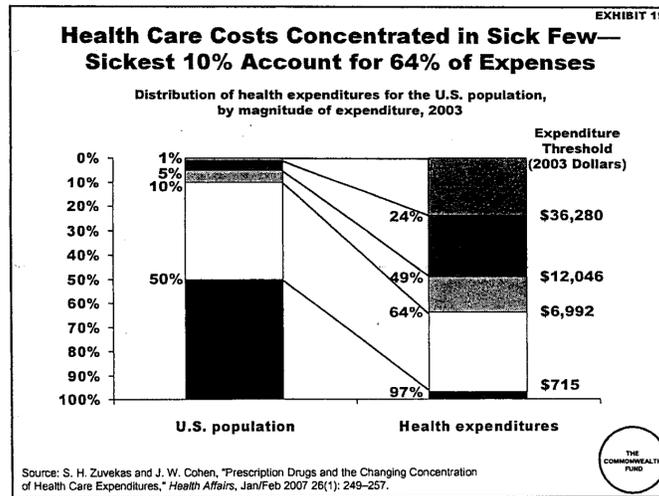
<sup>23</sup> G. Claxton, J. Gabel, B. DiJulio, et al., “Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises in Small Firms,” *Health Affairs* Web Exclusive (Sept. 24, 2008):w492–w502.

<sup>24</sup> T. Buchmueller, S.A. Glied, A. Royalty, K. Swartz, “Cost and Coverage Implications of the McCain Plan to Restructure Health Insurance,” *Health Affairs* Web Exclusive (Sept. 16, 2008):w472–w481.

<sup>25</sup> The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund) February 2009. 2020 estimates from the Lewin Group. International comparisons from OECD.

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

Discontinuous coverage increases administrative costs and erodes incentives to invest in population health and disease prevention for the long term. Further, competing private insurance plans can often gain at the margin by using benefit designs that segment patients by health risk or deny or limit coverage and care to the sickest. For instance, by limiting benefits for chemotherapy without regard to effective care or cost-sharing, insurance companies can lower premiums. Ten percent of the sickest share of the population account for 64 percent of total national spending each year—the healthiest half account for only 3 percent (Exhibit 19).<sup>26</sup> With such highly concentrated expenditures, there is a strong financial incentive to appeal to the healthier half of the population—even a small increase or decrease in the share of the sickest 10 percent enrolled with an insurer makes a difference. It is in no health plan's interest to advertise for the best outcomes for chronic conditions and in all plans' interests to appeal to young, healthier adults. Currently, we have no mechanism to counteract this market incentive.

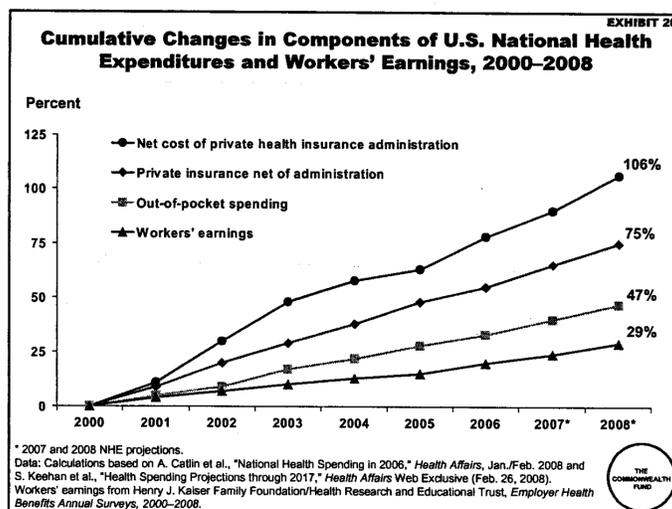


The complexity and fragmentation of the current insurance system adds cost without value. Net costs of private insurance administration, including underwriting, marketing, claims payment, and profit margins have grown faster than total health spending for the past decade—more than doubling from 2000 to 2008 (Exhibit 20).<sup>27</sup> The United States leads the world in the proportion of national health expenditures spent on insurance administration, and the Nation could save \$102 billion annually if it did as well as the best countries.<sup>28</sup>

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

<sup>27</sup> The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund) February 2009.

<sup>28</sup> The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund) July 2008.



Moreover, these costs do not include the internal costs to providers of multiple reporting forms, formularies, prices or payment methods for the same care, and benefit designs. Insurance complexity requires additional staff and consumes physician time that could otherwise be devoted to patient care. In Commonwealth Fund international and national surveys, U.S. patients stand out for reports of time spent on insurance-related paper work or disputes.<sup>29</sup>

Multiple variations in benefits, underwriting, and marketing costs all drive up costs of insurance administration. These costs are particularly high as a share of premiums in the small group and individual market, consuming 22 to as much as 40 percent of premiums.<sup>30</sup>

Complex variations in benefits also undermine meaningful choice and open the door to potential market segmentation based on health risks. Even within the current Medicare Advantage program, the wide variation in benefit designs makes it difficult to make an informed choice on anything but premium rates and whether your current doctor is in the network (Exhibit 21). Plans vary on multiple dimensions and the extent of the variation is often not evident until one enrolls or experiences a serious illness.<sup>31</sup>

<sup>29</sup>C. Schoen, R. Osborn, M.M. Doty, et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive (October 31, 2007):w717–w734; S.K.H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions* (New York: The Commonwealth Fund) August 2008.

<sup>30</sup>The Lewin Group technical report, *The Path to a High Performance U.S. Health System: Technical Documentation*, February 2009. See page 14.

<sup>31</sup>E. O'Brien and J. Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice* (New York: The Commonwealth Fund) April 2008.

**EXHIBIT 21**

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

	Plans								
	1 Local PPO H2616-1 Humana	2 HMO-POS H2623-4 UNC WI	3 Local/HMO H2625-6 UNC WI	4 Local/HMO H2627 UNC WI	5 HMO-POS H2621 UNC WI	6 PFFB H2623 Humana	7 Reg PPO R2624 Humana	8 Reg PPO R2622-23 Humana	9 Reg PPO R2626-27 Humana
Premium	\$37	\$0	\$58	\$26.15	\$26.15	\$25	\$37	\$0	\$36
In-Network OOP Max	—	\$4,800	\$4,200	\$778	\$4,800	\$5,000	\$5,000	\$5,000	\$5,000
Primary Care Office Visit	\$10	\$20	\$15	\$0	\$20	\$15	\$10	\$10	\$10
Specialist Office Visit	\$28	\$35	\$25	20%	\$25	\$20	\$28	\$28	\$28
Mammography Services	\$35-\$50	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
X-ray Services	\$10-\$50	\$0-\$10	0%-20%	0%-15%	0%-15%	\$10-\$30 or 20%	\$10-\$75	\$10-\$75	\$10-\$75
Chiropractic Services	\$5-\$50	\$0-\$10	0%	0%	0%	\$10-\$30	\$5-\$75	\$5-\$75	\$5-\$75
Radiation Therapy	\$26-\$50	\$0-\$10	20%	15%	15%	\$10-\$30	\$10-\$30	\$10-\$30	\$10-\$30
Outpatient Hospital Services	\$80-\$100	20%	20%	20%	20%	\$70-\$120	\$70-\$120	\$70-\$120	\$70-\$120
Ambulatory Surgical Center Services	\$100	20%	20%	20%	20%	\$100	\$100	\$100	\$100
Home Health Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Emergency Department Services	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Inpatient Hospital OOP Max	—	—	—	—	—	(to \$50)	—	—	—
Inpatient Hospital Copay per Day	—	—	—	—	—	—	—	—	—
Inpatient Hospital Daily Copay	\$17-\$60; days 1-6	\$20-\$60; days 1-17	\$20-\$60; days 1-17	\$7-\$60; days 1-11	\$20-\$60; days 1-18	\$10-\$60; days 1-6	\$10-\$60; days 1-6	\$10-\$60; days 1-6	\$10-\$60; days 1-6
Skilled Nursing Facility Services OOP Max	—	—	—	—	—	—	—	—	—
SNF Daily Copay	—	—	—	—	—	—	—	—	—
SNF Daily Copay	\$0-\$60; days 1-13; \$75-\$60; days 14-100	\$150-\$60; days 1-32	\$150-\$60; days 1-34	—	\$150-\$60; days 1-31	\$0-\$60; days 1-3; \$90-\$60; days 4-100	\$0-\$60; days 1-10; \$75-\$60; days 11-100	\$0-\$60; days 1-10; \$75-\$60; days 11-100	\$0-\$60; days 1-10; \$75-\$60; days 11-100
Rx Drugs	Enhanced	Enhanced	None	Enhanced	None	Enhanced	Enhanced	None	Standard

Notes: Two special-needs plans are excluded from this list; premiums shown are the full premiums (including any premium for Part D benefits). OOP is out-of-pocket. "—" means the plan has no parameter for that category. Source: Medicare Preferred Plan Finder data, downloaded March 8, 2006.

THE COMMONWEALTH FUND

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

As evidence of the potential to reduce overhead costs with reforms, private insurers in other countries with multi-payer systems, including the Netherlands and Switzerland, for example, are able to provide coverage with only 5 percent of premiums allocated to plan overhead and the rest for benefits.<sup>32</sup> In these countries, relatively little is spent on marketing, benefits are more standardized and comparable, and underwriting health risks (i.e., premium variations based on health) is prohibited. Similarly, the standard option offered to Federal employees through the Federal Employee Health Benefits Program (FEHBP) operates for about 5 percent of claims.<sup>33</sup>

Among States, Massachusetts efforts to achieve coverage for all have succeeded in insuring all but 2 percent of the population.<sup>34</sup> Rates for underinsured have also declined.<sup>35</sup>

Massachusetts has also shown that consolidating risk, changing market competitive rules, and organizing an insurance connector with an easy web-based choice of plans, with review of premiums for reasonableness, can improve benefits and lower premiums. Benefits have improved and premiums costs have come down following reforms. For example, a typical uninsured 37-year-old male faced a monthly premium of \$335 pre-reform, compared with \$184 post-reform, with a \$2,000 deductible instead of a \$5,000 deductible pre-reform. To provide choices but simplify decision-making, Massachusetts has offered three tiers of benefits—labeled gold, silver, and bronze—with actuarially equivalent policies within each tier. The Web site fully discloses the plan features and variations as well as premiums.

INSURANCE DESIGN PRINCIPLES

Insurance market reforms—including minimum requirements on insurers to cover everyone, the sick and healthy alike, at the same premium—could ensure the availability of coverage across the United States. Organizing a national insurance exchange that builds on the experience of Massachusetts and other countries could enhance choice and continuity, focus competition on better outcomes, and provide a mechanism to broadly pool risk. All these elements provide a foundation for broader health system reforms.

<sup>32</sup>R.E. Leu, F.F.H. Rutten, W. Brouwer, et al., *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*, The Commonwealth Fund, January 2009.

<sup>33</sup>Jon Gabel e-mail and memo to Commonwealth Fund, January 30, 2009.

<sup>34</sup>Jon Kingsdale, Executive Director, Commonwealth Health Insurance Connector Authority, presentation at AcademyHealth National Health Policy Conference, "Massachusetts Health Care Reform Results So Far and Looking Ahead," February 2, 2009.

<sup>35</sup>S.K. Long, *The Impact of Health Reform on Underinsurance in Massachusetts: Do the Insured Have Adequate Protection?* (Washington, DC: The Urban Institute) October 2008.

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

EXHIBIT 22

**Insurance Reforms: Goals and Design Principles**

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



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

- *Minimum design.* To assure access and provide protection a minimum should:

- Be broad in scope, including essential acute care.
- Prohibit disease-specific or service-specific limits: otherwise, patients can “run out” of critical care (such as effective medication or cancer treatment) and opportunities for risk segmentation remain.
- If deductibles are included, exempt preventive care and essential care for chronic conditions. Primary and preventive care should either be covered in full or with minimal copayment to encourage and support providing the right care and to align incentives with efforts to hold clinicians accountable for care outcomes.
- Set lifetime limits high or eliminate altogether and standardize to facilitate comparisons.
- Establish annual out-of-pocket maximums, including deductibles and copayments or coinsurance.

- *Low-income protection.* Reduce cost-sharing and limit total out-of-pocket exposure for low-income individuals and families. At or near poverty, families are already spending most or all of their income on basic essentials such as food and housing. Therefore, they are particularly sensitive to costs, including costs for preventive and chronic care.<sup>36</sup> Expansion of the Medicaid/SCHIP program to adults and higher incomes, with sliding scale premiums and modest cost-sharing (as in Massachusetts), is one potential approach. Given advances in electronic claims, it would also be possible to limit total out-of-pocket exposure as a share of income.

- *Limit the range of variation in benefit designs.* More standardized benefits, including actuarial bands within limit ranges (e.g., same scope of benefits and total out-of-pocket protection but variations in deductible or cost-sharing) help facilitate choice and encourage risk pooling. Review should limit designs without clear rationale based on effectiveness and appropriateness of care.

- *Premiums for the standard plan should be affordable,* with income-related premium assistance for premium costs in excess of a given threshold of income. Such

<sup>36</sup>M.E. Chernew, T.B. Gibson, K. Yu-Isenberg, et al., “Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care,” *Journal of General Internal Medicine*, Aug. 2008 (8):1131–1136.

provisions could include sliding-scale premiums or tax credits that vary with income.

- *Public comparisons of choices.* Standardization plus web-based posting should make it easy to compare information on benefits, expected out-of-pocket costs, physician and other provider networks, and premiums.

- *Insurance market reforms* to ensure access, avoid premium variations based on health risks, and focus competition on outcomes. In the context of coverage for all, ground rules should require that insurers cover everyone (guaranteed issue and renewal) and charge the same premium regardless of health status of enrollee (community rating or age bands). If there is an insurance exchange, these provisions should apply to plans sold through the connector and those sold outside the connector. Such provisions would lower underwriting and marketing costs.

- *Risk adjustment of premiums.* Premiums should be risk-adjusted to reduce incentives to avoid risk and to provide incentives to promote positive outcomes, including better outcomes for those with complex or chronic conditions.

- *Competition based on value added.* The goal of the various insurance market reforms, including an exchange, should be a market where plans and care systems that achieve better health outcomes with more prudent use of resources do well and those that do not lose money and market share. Insurers should compete on the basis of the added value they bring by fostering quality and efficiency in the delivery of health care, and efficiency in administrative costs.

- *Structure insurance choices and make it easy to enroll and stay insured* through a national insurance exchange or “connector.”

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

#### IMPROVING ACCESS, QUALITY, AND SLOWING COST GROWTH

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

In its 2007 call for more comprehensive reform, the Commonwealth Fund Commission on a High Performance Health System identified five core strategies for improving on all three dimensions of system performance and fostering care system innovations.<sup>37</sup> These include:

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

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

Central to the Commission strategic recommendations is the creation of a national insurance exchange that offers a choice of private plans and a new public plan, with associated insurance market reforms and provisions to make coverage affordable.<sup>38</sup> Insurance recommendations include:

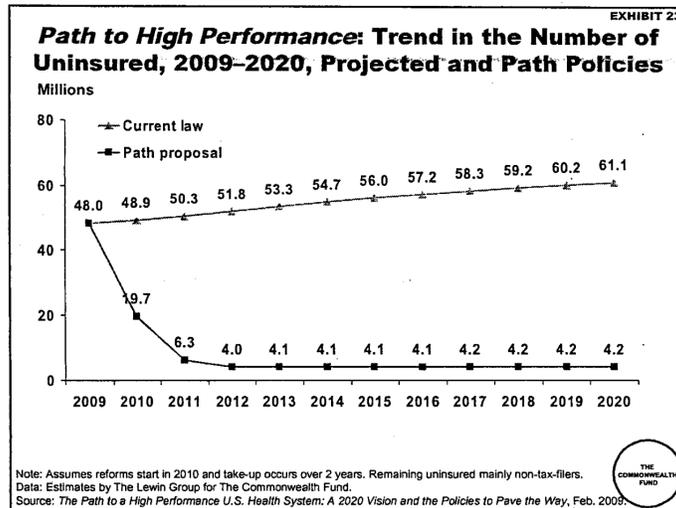
<sup>37</sup>The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund) November 2007.

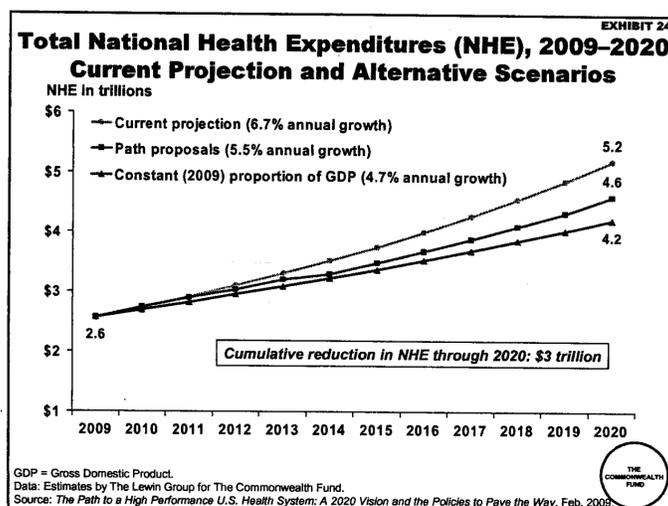
<sup>38</sup>The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund) February 2009.

- Establish a health insurance exchange that offers an enhanced choice of private plans and a new public plan. This new public plan would offer comprehensive benefits with incentives for disease prevention and payment methods that reward results. It would build on Medicare's claims administrative structure and national provider networks. The exchange and new public plan would be open to all, including large employers.
- Require individuals to have coverage and employers to offer coverage or contribute to a trust fund for insurance, sharing responsibility to pay for insurance for all.
- Provide income-related premium assistance to make coverage affordable.
- Expand eligibility for and improve payment under Medicaid and the Children's Health Insurance Program to improve affordability and access. Eliminate Medicare's 2-year waiting period for the disabled.
- Set a minimum benefit standard to ensure access and adequate protection from the financial burden of obtaining needed health care.
- Reform health insurance markets to improve insurance efficiency, access, and affordability by prohibiting premium variation based on health and guaranteeing offer and renewal of coverage to all, regardless of health status.

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

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





Many of the Commission recommendations would be politically difficult to achieve. They depend on building the political will and consensus that the Nation can no longer afford to continue on the current path. Changes will require new leadership roles and collaboration across public and private sectors. Effective payment reforms will require time to develop and implement and flexibility to innovate as the Nation learns. Information systems require investment and time to yield maximum returns through adoption and use.

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

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

Senator BINGAMAN. Thank you very much.

Ms. Shearer, please go right ahead.

**STATEMENT OF GAIL SHEARER, MS, DIRECTOR OF HEALTH  
 POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC**

Ms. SHEARER. Thank you, Mr. Chairman, members of the committee. Thank you very much for the invitation to testify on this important issue of the underinsured. The key break downs of the health coverage marketplace that have fueled the growth in the underinsured include the increase in high deductible coverage, annual caps in coverage, lifetime benefit limits, limited benefits, pre-existing condition exclusions, higher co-pays, out of network charges, bare bones policies and a flawed individual health insurance market.

During 2008, Consumers Union sent a bus around the country to find out what was happening to real people and their healthcare. More than 4,000 people told us their healthcare stories. In my written statement I have presented profiles of several of these people that we encountered. Each tells in its own way that we are all at risk of being underinsured.

Kim, in Minneapolis came to the end of her 18 months of Cobra coverage and then found that her individual policy had a glaring loop hole. A condition that she not file any claims for counseling for 2 years. She had been in grief counseling following her husband's suicide.

Charles, in Georgia discovered that the doctor's office on one floor of the insurance company's network was covered, but on the second floor where biopsies are done, was not part of the network. Finding an in network surgeon for his prostate cancer proves so challenging that he said, "It's not the cancer that's going to kill me, it's the insurance company."

Bea from North Carolina was laid off from her county social worker job and could only afford catastrophic coverage which did not cover her preexisting condition including her arthritis. She told us, "I quickly realized that the American dream of owning your own business is only for the young and the healthy."

Solving the problems faced by the underinsured will require fundamental reforms of our health care system. It's relatively easy to review the situation of the individual's plights and conclude that deductibles should be lower, benefits should be more comprehensive, networks should provide appropriate services and caps and annual or lifetime benefits should be prohibited, for example. But the underlying problem is that health care costs are high as a percentage of GDP and continue to grow at a rate faster than the rate of other goods and services.

This differential growth rate translates to higher premiums, higher co-payments and higher burdens on individuals and families. As long as the growth in health care costs continues unabated, we will struggle as a nation to address the very difficult challenge of coming up with how to best pay for health care and relieve the burden on the underinsured.

Consumers Union believes that the problems faced by the underinsured can best be addressed by health reforms that provide for broad-risk pooling with comprehensive quality coverage for all. A health care system that allows pre-existing condition exclusions, caps and benefits and underwriting can not address the underlying problems. A key building block that will make this kind of affordable coverage is increased comparative effectiveness research. Congress took an important step by including funding for expanded comparative effectiveness research in the Stimulus bill.

Consumers Union has developed a program, Consumer Reports Best Buy Drugs, that demonstrates why this type of research is so important. Our reports show that individuals can often save between \$1,000 and \$2,000 a year simply by switching from a high priced drug to a best buy drug that is equally safe and effective. The reality is that in this country and in this economy, just about all of us are at risk of being underinsured.

The cause might be a pink slip, a major accident, a birth defect, a serious illness such as cancer, pregnancy or being eligible only for a limited, loop hole laden, individual policy. The real issue is the growth of health care costs at a rate much higher than GDP growth and the responses of payers who increase deductibles and decrease coverage. The problem of the underinsured must be addressed in the context of overall system reform that helps moves

to a system that rewards prevention, bases decision on evidence and is committed to getting better value for our health care dollar whether the dollar comes from taxpayers, consumers or employers.

Mr. Chairman and members of the committee, the growing problem of the uninsured and underinsured cries out for your prompt attention. Thank you very much for considering our views.

[The prepared statement of Ms. Shearer follows:]

PREPARED STATEMENT OF GAIL SHEARER, MS

EXECUTIVE SUMMARY

The reality is that in this country—and in this economy—just about all of us are at risk of being underinsured. The cause might be a pink slip, a major accident, a birth defect, serious illness such as cancer, pregnancy, or being eligible only for a limited, loophole-laden individual policy.

While the definition of the “underinsured” varies, quantitative definitions used by the government tend to focus on the percent of adults between 19 and 64 whose out-of-pocket health care expenses (excluding premiums) are 10 percent or more of family income. The ranks of the underinsured have grown. The Commonwealth Fund estimates that 42 percent of U.S. adults were uninsured or underinsured in 2007. You can be sure that with the recent loss of millions of jobs, and unaffordability of COBRA premiums, these numbers will rise dramatically in 2008 and 2009.

Research by the *Consumer Reports National Research Center* used a series of questions to determine the percent who were underinsured based on answers to questions such as whether they considered their deductible too high, and whether they felt adequately covered for costs of surgery, doctors visits, and catastrophic medical conditions. We found that 41 percent of the adult population sampled lacked adequate health coverage. Nine percent of the underinsured (by our survey) took extraordinary measures to pay medical bills, including dipping into IRAs, 401(k)s or pension funds, selling cars, trucks or boats, or taking on home equity or second mortgage loans.

Underinsurance is a problem for two key reasons: Inadequate coverage results in the financial burden of uncovered health care. In our survey, for example, 30 percent of the underinsured had out-of-pocket costs of \$3,000 or more for the previous 12 months. Underinsurance can lead to medical debt and even bankruptcy. The second problem posed by underinsurance is delayed or denied health care and poorer health outcomes, caused by the financial barrier to care.

The key breakdowns of the health coverage marketplace that have fueled the growth in the underinsured included the increase in high deductible coverage, annual caps in coverage, lifetime benefit limits, limited benefits, pre-existing condition exclusions, higher co-pays, out-of-network charges, barebones policies, and a flawed individual health insurance market.

Fundamental reforms of our health care system are needed to solve the problem of the underinsured. A necessary building block will be expanded research of comparative effectiveness so that we increase the knowledge base for making treatment and coverage decisions. It will be necessary to cut the growth of health care costs and get better value for our health care dollar in order to be able to afford the coverage improvements and expansions necessary to eliminate the risk of being underinsured. Moving from the ranks of the uninsured to the insured does not guarantee protection against the financial hardship that illness can bring, as demonstrated by the plight of the underinsured. We look forward to working with you to address this problem that threatens families with financial crises just when they are battling health care challenges.

Mr. Chairman, members of the committee, thank you for the invitation to testify on the issue of the underinsured. This growing problem creates financial hardship and results in barriers to getting needed health care. Being underinsured in America means both pocketbook and healthcare hardship. Fortunately, there is increased awareness that we can't assume that a simple measure of the uninsured neatly sums up the health care status of our Nation. The growing population of underinsured demonstrates clearly that moving from the ranks of the uninsured to the insured alone does not guarantee protection against the financial hardship that illness can bring. We commend you for holding this hearing to help keep attention focused on this crucial element of the health care problem.

Consumers Union<sup>1</sup> is the independent, non-profit publisher of *Consumer Reports*, with circulation of about 7 million (*Consumer Reports* plus ConsumerReports.org subscribers). We regularly poll our readership and the public about key consumer issues, and the high cost of health care consistently ranks among their top concerns. My statement includes information about a survey that we conducted about the problem of the underinsured.

After reviewing the latest numbers that show a recent growth in the ranks of the underinsured, my testimony will show how being inadequately insured can place tremendous health and financial burdens on families. I will provide an overview of the basic causes of becoming underinsured, present some profiles of the faces of the underinsured, and will provide some comments about finding a solution to this problem.

#### THE UNDERINSURED: THE NUMBERS

Estimates of the underinsured vary based on the underlying data source, the methodology, and the definition. Early estimates of the underinsured used focused on *risk* of incurring out-of-pocket costs (not including premiums) exceeding 10 percent of income.<sup>2</sup> Government estimates are based on the percent of adults between 19 and 64 whose out-of-pocket expenses are 10 percent or more of family income, sometimes adjusting to a lower percent for low-income individuals.<sup>3</sup> A recent Commonwealth Fund estimate shows a 60 percent growth in underinsured between 2003 and 2007, with an estimated 25.2 million individuals underinsured in 2007. The Commonwealth Fund estimates that 42 percent of U.S. adults were uninsured or underinsured in 2007.<sup>4</sup>

#### CONSUMER REPORTS NATIONAL RESEARCH CENTER SURVEY RESEARCH REPORT<sup>5</sup>

The Consumer Reports National Research Center conducted a nationally representative survey of 2,905 respondents between the ages of 18 and 64 in May 2007. The findings were reported in the September 2007 issue of *Consumer Reports*.<sup>6</sup> We found that 16 percent of the adult population under 65 was uninsured. We also found that 29 percent of those surveyed who had health insurance at the time of our survey were underinsured. Combined with the uninsured, the CR survey found that 41 percent of the population sampled lacked adequate health coverage.

Nine percent of underinsured in our survey took extraordinary measures to pay medical bills—including dipping into IRAs, 401(k)s, or pension funds, selling cars, trucks or boats, selling off stocks and bonds, taking on home equity or second mortgage loans, selling homes, or declaring bankruptcy. Three percent reported taking on home equity or second mortgage loans, selling homes, or declaring bankruptcy. While 65 percent of the adequately-insured felt well prepared for unexpected future medical expenses, only 37 percent of the underinsured expressed such confidence.

The underinsured were defined by *Consumer Reports* based on responses to individual survey items. Respondents were categorized as underinsured if they were insured and complained in our survey about two or more of the following aspects of their plans:

- It does not adequately cover prescription drug costs;
- It does not adequately cover the costs of doctors' visits;
- It does not adequately cover the costs of medical tests;
- It does not adequately cover the costs of surgery or other medical procedures;
- It does not provide enough coverage for catastrophic medical conditions;

<sup>1</sup> Consumers Union, the nonprofit publisher of *Consumer Reports*, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

<sup>2</sup> Pamela Farley Short and Jessica S. Banthin. 1995. *New Estimates of the Underinsured Younger than 65 Years*. JAMA. 274: 1302–1306.

<sup>3</sup> Jessica Banthin. AHRQ. Out-of-Pocket Burdens for Health Care, Insured, Uninsured and Underinsured. September 23, 2008.

<sup>4</sup> Cathy Schoen, et al., *How Many are Underinsured? Trends Among U.S. Adults, 2003 And 2007*, Health Tracking, Health Affairs—Web Exclusive, June 10, 2008. See also: Jessica S. Banthin and Didem Bernard, *Changes in Financial Burdens for Health Care—National Estimates for the Population Younger than 65 Years, 1996 to 2003*, JAMA, December 13, 2006.

<sup>5</sup> Health Care Experiences of the American Public: May 2007 Survey, Consumer Reports National Research Center Survey Research Report.

<sup>6</sup> *Are You Really Covered? Why 4 in 10 Americans can't depend on their health insurance*, *Consumer Reports*, September 2007.

- The deductible is too high.

Table 1 shows the percent of underinsured reporting various types of dissatisfaction. Table 2 shows the relative financial impact on the underinsured compared with the insured.

Table 1.—Dissatisfaction with Insurance: Consumer Reports National Research Center Survey

Percent of respondents who are underinsured expressing dissatisfaction with these aspects of their insurance:	In Percent
Deductible is too high .....	70
Does not adequately cover the costs of medical tests .....	67
Does not adequately cover prescription drug costs .....	63
Does not adequately cover the costs of surgery or other medical procedures .....	58
Does not adequately cover the costs of doctors' visits .....	53
Does not provide enough coverage for catastrophic medical conditions .....	51

Table 2.—Financial Impact of Being Underinsured Consumer Reports National Research Center Survey

	Under-insured (In percent)	Adequately insured (In percent)
Compared with adequately insured, the underinsured in our survey were:		
Twice as likely to spend \$3,000 out-of-pocket for medical expenses in the past 12 months	30	16
Four times as likely to have dug deep into their savings to pay for medical expenses .....	33	9
Twice as likely to have charged at least some of their medical bills to credit cards .....	29	11
Three times as likely as adequately-insured to have outstanding unpaid bills owed to doctors or hospitals .....	27	8

WHY IS UNDERINSURANCE A PROBLEM?

There are two serious health system problems that result from the growing numbers of the underinsured—the financial burden resulting from uncovered health costs and the health care burden caused by delayed or denied care.

**Financial burden of uncovered health care.** Health care is expensive. When needed health care must be paid out-of-pocket, the burden on those who are sick can add tremendously to the burden of fighting illness. The burden falls hardest on those with the least resources to weather the extra burden of illness—those with low and moderate income. Our survey found the underinsured were much more likely to face out-of-pocket costs of \$3,000 for the previous 12 months (30 percent vs. 16 percent of the adequately insured).

Medical debt has increased recently, even before the financial crisis of 2008. Forty-nine million adults (28 percent of the adult population) reported carrying medical debt in 2007, an increase from 21 percent in 2005.<sup>7</sup> Not surprisingly, underinsured adults, who have less comprehensive health care coverage, are more likely than the insured to face medical bill and medical debt problems. Some of the key factors were inadequate drug and dental coverage, high premiums as percent of income, out-of-network charges, and benefit gaps.<sup>8</sup>

The Commonwealth Fund study<sup>9</sup> found that the underinsured, 82 percent of which were insured at the time they were provided medical care, face other burdens from high medical bills.

- 29 percent are unable to pay for basic necessities such as food, heat or rent;
- 46 percent used up all of their savings;
- 12 percent took out a mortgage against their home or took out a loan;
- 33 percent took on credit card debt.

As a nation, the current financial crisis has been a cogent reminder of the downside of carrying too much debt. Medical costs contribute substantially to debt. Sixty percent of underinsured or uninsured adults reported medical bill problems or debt in the Commonwealth Fund Biennial Health Insurance Survey (2007). This study

<sup>7</sup>Sara Collins, et al., *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families*, The Commonwealth Fund, August 2008, p. 10.

<sup>8</sup>Michelle M. Doty, et al., *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families*, Issue Brief, the Commonwealth fund, August 2008.

<sup>9</sup>The Commonwealth Fund Biennial Health Insurance Survey (2007), Chart pack, Figure 15.

showed that 62 percent of those with medical debt had insurance at the time of their medical incident.<sup>10</sup> Clearly, health insurance is not providing the financial protection that it is meant to.

Medical expenses of the underinsured are a major contributing factor toward bankruptcy. Researchers at Harvard Medical School and Harvard Law School conducted interviews with families who filed for bankruptcy in 2001. About half said that medical costs contributed to the bankruptcy. Three quarters of those whose bankruptcies were related to health care expenses had insurance when the illness began.<sup>11</sup>

**Barrier to getting needed health care.** Being underinsured translates into delayed or foregone medical care, and this can result in people getting sicker and even death. Commonwealth Fund research found that the underinsured are more likely not to fill a prescription, to skip a test or treatment, to not visit the doctor for a medical problem and to forego needed specialist care.<sup>12</sup>

High deductibles and co-pays can result in delayed care or foregone care. The recent Kaiser Family Foundation/American Cancer Society report tells the story of a prostate cancer survivor whose health insurance has a \$3,750 deductible. He cuts back on screening to every other year, instead of every year, because of the burden of the \$250 test.<sup>13</sup>

#### DIFFERENT ROUTES TO BEING UNDERINSURED

High out-of-pocket health care costs can lead to financial burden and to consumers being underinsured in a number of ways. Some of the most common causes of being underinsured are high deductibles, caps on annual or lifetime benefits, limited benefits, pre-existing condition exclusions, co-pays, network restrictions, barebones policies, and limited individual health insurance policies.

**Increase in high deductible coverage.** One route to being underinsured is high deductible health insurance. Many consumers who lack employer-based coverage can not afford comprehensive coverage and resort to a high deductible policy in the individual market. Tax policy that favors health savings accounts has fueled the growth of high deductible coverage. Many employers are offering high deductible coverage. If a family earning \$50,000 faces a \$5,000 deductible, even a minor illness can cause them to fall into the ranks of the underinsured.

Average deductibles are on the rise. In the individual market, 67 percent of coverage has deductibles of \$1,000 or above.<sup>14</sup> The Kaiser Family Foundation/Health Research & Education Trust annual Employer Health Benefits report showed an increase in high deductible health plans offered by employers from 7 percent in 2006 to 13 percent in 2008.<sup>15</sup>

**Annual caps in coverage.** Many policies have annual caps in coverage. A serious illness—such as a brain injury or cancer—can lead to reaching the cap in coverage. High costs of cancer treatment, for example, can quickly lead to using up a \$100,000 benefit. The Kaiser/ACS report tells the story of a breast cancer patient with employer-sponsored coverage with a \$100,000 annual limit. Having to face a medical debt of \$30,000 while battling cancer created major stress.<sup>16</sup>

**Lifetime caps in benefits.** Many policies also have lifetime caps in benefits. Again, with a serious illness, these caps can be reached.

**Limited benefits.** Policies limit benefits in other ways, such as excluding emergency room coverage and excluding prescription drugs. Individual insurance plans are more likely to have limited benefits, in part to keep premiums low and in part because of the concern about adverse selection in this market. Even employer plans often limit benefits. For example, 55 percent of covered workers in small firms (3 to 199 workers) have limited mental health benefits, e.g., limits of 20 or fewer outpatient mental health visits per year.<sup>17</sup>

**Pre-existing condition exclusions.** Many people have gaps in coverage that result in pre-existing condition exclusions when they join a new employer and new

<sup>10</sup> Michelle M. Doty, et al., *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families*, Issue Brief, The Commonwealth Fund, August 2008.

<sup>11</sup> David U. Himmelstein, Elizabeth Warren, Deborah Thorne and Steffie Woolhandler, *Illness and Injury as Contributors to Bankruptcy*, Health Affairs, February 2, 2005.

<sup>12</sup> Cathy Schoen, et al., *Insured but not Protected: How Many Adults are Underinsured?*, Health Affairs Web Exclusive, June 14, 2005, p. 295.

<sup>13</sup> Kaiser/Cancer, p. 8.

<sup>14</sup> Kaiser/Cancer, p. 9.

<sup>15</sup> P. 5, Employer Health Benefits, 2008 Summary of Findings, The Kaiser Family Foundation and Health Research & Education Trust.

<sup>16</sup> Kaiser p. 11.

<sup>17</sup> Employer Health Benefits 2008, Kaiser Family Foundation and Health Research and Educational Trust, p. 141.

health plan. Individual health insurance policies often have such exclusions. For someone with a pre-existing condition such as cancer or pregnancy, the resulting out-of-pocket costs can be very large.

**Copays.** A recent report by the Kaiser Family Foundation and the American Cancer Society told the story of cancer patients whose deductibles, combined with copays for doctor visits, outpatient visits and prescription drugs led to high medical bills, in some cases exceeding \$100,000 despite having health insurance coverage.<sup>18</sup> The Medicare Part D doughnut hole is an example of a “copay” that is designed into the benefit. New research shows that the doughnut hole results in Medicare beneficiaries not getting the drugs that they need in order to treat chronic conditions.<sup>19</sup>

**Out-of-network charges.** When serious or chronic illness strikes, or when emergencies occur, consumers may find that they need to seek care from an out-of-network provider. In some cases, they may discover after their own careful planning that while their surgeon is in network, other doctors (e.g., radiologists or anesthesiologists) are out-of-network. This can result in large uncovered costs. This can be a problem also if a job change leads to a different network, if physicians switch out of a network, or if an insurer drops a provider.

**Bare-bones policies.** All payers of health care are struggling with the high cost and rate of increase of health care costs. Unfortunately, States are allowing “bare-bones” policies which technically move people from the ranks of the uninsured—but leave them being underinsured. For example, the “Cover Florida” plan (which became law in May 2008) allows policies that do not cover hospital or emergency room care. While the premium may be low, the absence of this basic coverage exposes any purchasers to the risk of facing high out-of-pocket costs.<sup>20</sup> Other exclusions in bare-bones policies can be mental health, maternity services, cancer care, substance abuse treatment, and prescription drugs.<sup>21</sup> Bare-bones policies with limited benefits impose special risks on low-wage consumers who are most likely to have out-of-pocket costs that exceed 10 percent of income.<sup>22</sup>

**Individual health insurance market.** While even employer-sponsored health insurance plans often have limits that result in underinsurance, the individual insurance market, a residual market that covers just 9 percent of the population, has far more problems that can result in being underinsured.<sup>23</sup> Unlike employer policies, in most States companies that sell individual coverage can pick and choose who they cover. Through underwriting, in many cases insurers can deny coverage. They can attach riders, for example covering all body systems *except* the system where there might be a pre-existing condition. Benefits can be skimpy, excluding for example pregnancy or prescription drugs.

#### FACES OF THE UNDERINSURED

During 2008, Consumers Union sent a bus around the country to find out what is happening to real people. More than 4,000 people told us their stories.<sup>24</sup> Below are some examples of our stories about real people who are underinsured.

##### *Pre-Existing Condition Exclusion in Individual Policy*

*Kim—Minneapolis, MN.* Kim’s husband was having a difficult time sleeping so he saw his doctor who sent him home with a 3-week sample pack of anti-depressants. Her husband had no previous history of depression, but 5 weeks later he took his own life. After her husband’s death, Kim saw a therapist for grief counseling. Kim ended up leaving her job in advertising to devote her time to drug safety advocacy and do freelance work. She paid for 18 months of COBRA coverage and then shopped around for an individual health plan. Since she had no serious health issues in her past, she expected her coverage would be affordable. But the insurer she had received coverage through previously refused to issue her an individual pol-

<sup>18</sup> Karyn Schwartz and Gary Claxton, Kaiser Family Foundation and Kristi Martin and Christy Schmidt, American Cancer Society, *Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System*, February 5, 2009, 1.

<sup>19</sup> Sebastian Schneeweiss et al., *The Effect of Medicare Part D Coverage On Drug Use and Cost Sharing Among Seniors Without Prior Drug Benefits*, Health Affairs—Web Exclusive, February 1, 2009.

<sup>20</sup> Judith Solomon, *New Georgia and Florida Health Plans Unlikely to Reduce Ranks of Uninsured*, Center on Budget and Policy Priorities, July 1, 2008.

<sup>21</sup> *Bare-Bones Health Plans: Is Something Better than Nothing?* Reform Matters, National Women’s Law Center.

<sup>22</sup> Sherry Glied, et al., *Bare-Bones Health Plans: “Are They Worth the Money,”* Issue Brief, The Commonwealth Fund, May 2002.

<sup>23</sup> *Income, Poverty and Health Insurance Coverage in the United States*, U.S. Census Bureau, 2007, p. 61.

<sup>24</sup> More stories are available at [prescriptionforchange.org](http://prescriptionforchange.org).

icy because they said that her participation in grief counseling was an indication of possible mental illness. Kim was able to get coverage through a second insurer but only on the condition that she would not file any claims for counseling for 2 years.<sup>25</sup>

*Limited Benefits That Exclude Emergency Room Visit*

*Phuonglon—Denver, CO.* While Phuonglon was traveling out-of-state, she had a small seizure and was brought to a hospital emergency room for treatment. When she returned home, she reviewed her health insurance policy and it appeared that she was covered for the ER visit. But then she started to receive bills for care that was not covered by her policy. At times, it was really difficult for her because she had not budgeted for these expenses. The experience opened her eyes to how easily people can go bankrupt by unforeseen medical expenses.<sup>26</sup>

*High-Deductible Health Insurance That Creates Financial Barrier to Care*

*Gina—St. Joseph, MO.* Gina and her husband own their own delivery company and have purchased an individual health insurance policy for their family. Gina recently had a miscarriage and decided not to seek medical treatment because they have a high \$3,500 deductible and she couldn't afford to see the doctor. When Gina gave birth to her son a few years ago, the insurance company refused to pay for her C-section because they maintained it was elective (even though her son was born breeched). She had to fight with the insurance company to get them to pay for these medical costs. In the meantime, the insurance company sent their bill to collections. The insurance company eventually paid 6 months after Gina had paid her full deductible.<sup>27</sup>

*Out-of-Network Provider for Emergency Transportation*

*John—Pelham, AL.* This 23-year-old young father had an accident on a four wheel vehicle in a rural area. When the ambulance arrived, the EMT decided he needed to be taken to the hospital by helicopter. John spent 3 days in the hospital recovering from his injuries and left with a \$9,000 bill because his insurance company said the ambulance and helicopter were not preferred providers.<sup>28</sup>

*Cancer Patient Faced Delayed Care Because of "Out-of-Network" Issues*

*Charles—Alma, GA.* Charles ("Buddy") was diagnosed with prostate cancer but his insurance company denied payment for the services from the doctor who diagnosed him. While the doctor's office on the first floor is part of his insurance company's network, the second floor where biopsies are done is not part of the network. When Charles needed surgery he had a very difficult time finding doctors that belonged to his insurer's network who could perform the surgery in hospitals that were also part of the network. It was only after his State legislator intervened on his behalf that Charles was able to resolve his issues with his insurance company. "It's not the cancer that is going to kill me, it's the insurance company."<sup>29</sup>

*Limited Benefits Don't Cover Needs of Disabled and Result in Medical Debt*

*Sandra—Portland, ME.* Sandra is disabled with chronic fatigue syndrome and needs a scooter to get around. At first, her insurance company decided to only provide partial payment for her scooter and then later said it would only pay for a manual wheelchair. Sandra had to provide further documentation from her doctor that she couldn't use a wheelchair. The appeals process with her insurance company took more than 1 year. Sandra continues to incur major out-of-pocket medical expenses, including \$25,000 last year.<sup>30</sup>

*Self-Employed, Can Only Afford Individual Coverage With Limited Benefits*

*Bea—Charlotte, NC.* After she was laid off from her county social worker job, Bea opened her own practice but has struggled to afford adequate health insurance. She can only afford catastrophic coverage which does not cover her pre-existing conditions, including her arthritis. I quickly realized that the American dream of owning your business is only for the young and healthy."<sup>31</sup>

<sup>25</sup> <http://link.brightcove.com/services/link/bcpid1544602725/bclid1551048399/bctid1797029791>.

<sup>26</sup> <http://link.brightcove.com/services/link/bcpid1544602725/bclid1551048397/bctid1780555026>.

<sup>27</sup> <http://link.brightcove.com/services/link/bcpid1460683554/bctid1701199083>.

<sup>28</sup> <http://link.brightcove.com/services/link/bcpid1460683554/bctid1676207968>.

<sup>29</sup> <http://link.brightcove.com/services/link/bcpid1460683554/bctid1674044182>.

<sup>30</sup> <http://link.brightcove.com/services/link/bcpid1460683554/bctid1662507287>.

<sup>31</sup> <http://link.brightcove.com/services/link/bcpid1460683554/bctid1648122600>.

*Catastrophic Insurance Policy did not Cover \$25,000 of Care for Cancer Patient Who Incurred Medical Debt*

*Molly—Nashville, TN.* After being diagnosed with uterine cancer last year, Molly had to undergo three surgeries and 6 months of chemotherapy and was unable to work for about 8 months. Her insurance policy covered catastrophic medical expenses, but she still had about \$25,000 in out-of-pocket medical expenses for the care she received. Her friends were able to help her pay many of her bills, but she was left with about \$12,000 in unpaid medical debt and a damaged credit record. The stress of my illness was enough for me to deal with, but then seeing all the bills I had to pay was just too much for me to handle," Molly says.<sup>32</sup>

*Limited Benefits of Individual Policy: Policy Does not Cover Pregnancy Expenses*

*Tina—Pittsburgh, PA.* When Tina was pregnant a couple of years ago she found out that her individual health insurance policy did not cover any of her maternity expenses. She developed reclaims and diabetes during her pregnancy and none of the care she required for these conditions was covered. Tina faced the prospect of having to pay nearly \$50,000 in pregnancy-related expenses out-of-pocket. Fortunately, a local journalist took up her cause and contacted the insurance company. Her insurer agreed to cover her expenses through her son's 1-month appointment. Her policy was then cancelled but now her husband has a new job that provides coverage for her family.<sup>33</sup>

*Limited Benefits Result in Delayed Care*

*Tom—Hutchinson, MN.* Tom and his wife own their own pottery studio and have paid for their own health insurance over the years. About 5 years ago, Tom developed a debilitating hip condition. The pain got so bad that his doctor recommended that he undergo hip replacement surgery. Under his insurance policy, Tom would have had to pay \$10,000 for the surgery, which he could not afford. He ended up putting off his surgery for 3 years until he qualified for Medicare. Two days after he turned 65, Tom had his surgery and his costs under Medicare were just one-third of what he would have paid under his individual insurance plan. Delaying the procedure had its own cost: his muscles atrophied considerably and it took him longer to recover from his surgery.<sup>34</sup>

*Out-of-Network Doctor Care in Emergency and Inadequate Network for Hospital Emergency Room Care*

*Andrea—Murphy, TX.* Andrea's son was having difficulty breathing shortly after he was born and was rushed to the hospital's Neo-Natal Intensive Care Unit (NICU) for treatment. Two days later he was doing fine and was discharged to go home. Andrea was then informed by her insurance company that the Doctor who treated her son in the NICU was not part of the insurer's network. Less than half of the \$1,145 NICU bill was covered by her plan even though he needed emergency care. When she had to bring her son back a second time to the ER, she was charged \$600 for his care. Andrea discovered that there are no hospital emergency rooms in Texas that will take her insurance. Her family spends \$7,000 annually on health insurance.<sup>35</sup>

TOWARD THE SOLUTIONS

Solving the problems faced by the underinsured will require fundamental reforms of our health care system. It is relatively easy to review the situation of the individuals' plights that are profiled above and conclude that deductibles should be lower, benefits should be more comprehensive, networks should provide appropriate access, and caps in annual or lifetime benefits should be prohibited, for example. But the underlying problem is that health care costs are high as a percent of GDP and continue to grow at a rate faster than the rate of other goods and services. This differential growth rate translates to higher premiums, higher co-payments, and higher burdens on individuals and families. As long as this growth in health care costs continues unabated, we will struggle as a nation to address the very difficult challenge of coming up with how to best pay for health care.

Consumers Union believes that the problems faced by the underinsured can best be addressed by health reforms that provide for broad risk pooling, with comprehen-

<sup>32</sup> <http://link.brightcove.com/services/link/bcpid1460683554/bctid1640102888>.

<sup>33</sup> <http://link.brightcove.com/services/link/bcpid1460683554/bctid1607328839>.

<sup>34</sup> <http://link.brightcove.com/services/link/bcpid1544602725/bclid1540999549/bctid1549643949>.

<sup>35</sup> <http://link.brightcove.com/services/link/bcpid1544602725/bclid1540999549/bctid1561157743>.

sive, quality coverage for all. A health care system that allows for pre-existing condition exclusions, caps in benefits, and underwriting can not address the underlying problems. Another element of reform must be payment reform that increases the chance that appropriate treatment is provided—not too much treatment, not too little treatment.

A key building block that will make this kind of coverage affordable is increased comparative effectiveness research. Congress took an important step by including funding for expanded comparative effectiveness research in the stimulus bill.

Consumers Union developed a program—*Consumer Reports Best Buy Drugs*—that demonstrates why this type of research is so important. We have translated the unbiased systematic reviews—comparative effectiveness studies—for 21 categories of drugs. The source of our studies are reviews prepared by the Drug Effectiveness Review Project, which is based at Oregon Health and Science University. Our reports show that individuals can often save between \$1,000 and \$2,000 a year simply by switching from a high-priced drug to a best buy drug that is equally safe and effective. A simulation study of potential savings of switching from high priced drugs to best buy drugs in four categories of drugs used for heart conditions resulted in potential annual nationwide savings of \$2.7 billion, 8 percent of drug expenditures for those four categories.<sup>36</sup>

Our project has demonstrated that health care outcome is not compromised when value is taken into account in making drug choices. We commend Congress for including this important provision in the stimulus bill and urge you to work toward reforms in the future that create a system where coverage decisions can be based on the results of such unbiased research.<sup>37</sup>

Health insurance coverage should assure that consumers do not face financial barriers to getting needed health care. Coverage should be comprehensive so that needed health care does not result in financial burdens such as debt and hardship.

The reality is that in this country—and in this economy—just about all of us are at risk of becoming underinsured. The cause might be a pink slip, a major accident, a birth defect, serious illness such as cancer, pregnancy, or being eligible only for a limited, loophole-laden individual policy. The issue for your consideration is not whether the count of the underinsured is 15 million or 25 million. The real issue is the growth of health care costs, at a rate much higher than GDP, and the responses of payers to increase deductibles and decrease coverage. The problem of the underinsured must be addressed in the context of overall system reform that helps move to a system that rewards prevention, bases decisions on evidence, and is committed to getting better value for our health care dollar, whether that dollar comes from taxpayers, consumers, or employers.

Mr. Chairman, members of the committee, the growing problem of the uninsured and underinsured cries out for your prompt attention. We look forward to working with you to shape solutions that will assure that the United States rises to the challenge of transforming our health care system so that we are no longer at risk of facing financial hardship or financial barriers to care just when we need care the most. Thank you for considering our views.

Senator BINGAMAN. Thank you very much.

Ms. Rowland, go right ahead.

**STATEMENT OF DIANE ROWLAND, D.SC., EXECUTIVE VICE PRESIDENT, THE HENRY J. DAISER FAMILY FOUNDATION AND EXECUTIVE DIRECTOR, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, WASHINGTON, DC**

Ms. ROWLAND. Thank you, Mr. Chairman and members of the committee. My statement today will focus on why health insurance in the scope of coverage matters for family's health, well-being and financial security. We know from the experience of the uninsured that health insurance helps to improve access to basic, primary and

<sup>36</sup>Julie Donohue, Michael A. Fischer, Haiden A. Huskamp, and Joel S. Weissman, *Potential Savings from an Evidence-Based Consumer-Oriented Public Education Campaign on Prescription Drugs*, Health Services Research, November 2008.

<sup>37</sup>We note that we strongly support assuring the research address the needs of individuals of various races, ethnicity, age and sex. In addition, there should be an exceptions process that is timely and appropriate.

preventive care and lowers the likelihood of postponing or foregoing needed care and medications due to costs.

It also helps to promote more stable health care arrangements that can provide for ongoing medical care. Having insurance is clearly better than being uninsured. But the scope of health insurance coverage varies widely across plans.

Families face increasing health insurance premiums plus higher deductibles and more cost sharing when they seek care and increasing financial burden for families especially in these tough economic times. How well health insurance protects families from large medical bills is one measure of the adequacy of health insurance. In surveys we have done, 3 in 10 adults reported problems paying their medical bills. And they had health insurance to help them.

These families reported that they had to make difficult choices including limiting paying for other necessities such as food, heat or housing, using savings or borrowing money and considering filing for bankruptcy. Such cost considerations lead to skipped medical tests and failure to follow through on needed treatment. Insured families facing health spending that exceeds 10 percent of after-tax income can be considered as underinsured and that the coverage they have is insufficient to protect them from the financial toll of health spending.

In interviews we've held with diverse working families across the United States in the spring of 2008, we found families with health insurance were often struggling to afford the combination of premiums, co-pays, deductibles and cost for services not covered by their plan with these costs rising far faster than their paychecks. One of the clearest examples of the holes in health coverage is the experience of families where cancer has taken a toll. In a report we just issued with the American Cancer Society, we profile some of the cancer patients who have fallen through the cracks in our private health insurance system and have resulted in substantial medical debts and detriment to their health and well-being.

Most families with cancer have private health insurance. But many face high health care costs that alter their care. Five percent of the uninsured said that they had delayed or decided not to get care due to costs as cancer victims putting their life and survival at risk due to their costs not being covered by insurance.

These experiences document the challenges families face today even those with private health insurance coverage when seeking medical care. High levels of cost sharing and caps on covered benefits can compromise the level of protection health insurance provides and lead to both reduced access to needed care and serious financial burdens and medical debt. As consideration of health reform moves forward it will be important to assess both the scope of coverage provided and the level of financial assistance offered against a substantial medical cost, especially for those with chronic and serious illness and those with limited income.

As you move forward I would like to share with you now the voice of one of the interviews we conducted in Wichita, KS, an individual struggling with medical bills who was telling us at his kitchen table about health care costs and the impact on him. So with

that I'll end my statement by turning to the video from Ron Gaston. Thank you.

[Video presentation.]

Mr. GASTON. Those add up and then when you have other blood tests.

FEMALE SPEAKER ON VIDEO. Ron Gaston had his life mapped out and then he got sick.

Mr. GASTON. I was going to work 5 more years. Then I was going to retire and let Medicare and all of that stuff take care of it. Maybe even pick up a little supplemental insurance to cover what it doesn't care. A lot of people do. But, man, this is going to wipe us out.

FEMALE SPEAKER ON VIDEO. Like most working Americans, Ron gets coverage through his employer, in this case a local paper supplier in Wichita. But he's like many Americans in another way too.

Mr. GASTON. You only pay a \$15 co-pay. And those add up. And you have another blood test and stuff, a total of \$125.

FEMALE VOICE ON VIDEO. The annual deductible for Ron and his ailing wife has skyrocketed to almost \$4,800 a year. Premiums have doubled to \$1,200 a year. All the while his income, \$30,000 annually has remained fairly static.

The Gastons couldn't squeeze anything more out of their family budget. And that's why Ron delayed seeing the doctor.

Mr. GASTON. I didn't have any problems. I mean, I just told them all, my wife and my daughter said, "Hey, you need to go get a physical." I said, "No, I don't. I feel just fine."

And then, gosh, a year and a half ago I got up one morning and my stomach hurt so bad. I was like screaming in pain. I couldn't walk, couldn't sit, couldn't lay down.

Female voice on video. A mass was discovered on his kidney. But even then Ron waited another 6 months to get treatment.

Mr. GASTON. He said, "You have cancer." I said, "Wow." I said, "What is this going to cost me?"

FEMALE VOICE ON VIDEO. Finally surgery revealed it was not cancer. Still Ron ended up with \$15,000 in out-of-pocket medical expenses, debt that he is now paying off in \$10 or \$15 increments to various providers. Years ago when his wife was sick, Ron dipped into his retirement savings to pay off medical debt. But he is too close to retirement now to do that again.

Mr. GASTON. I wake up at night. How am I going to pay this? What am I going to do?—Lifting heavy boxes. What will I do? What am I going to do for a second job anyhow?

FEMALE VOICE ON VIDEO. A postscript. Since our interview Ron was laid off from his job of 27 years. He hopes he will be able to find a new job with health benefits.

Ron and his wife won't qualify for Medicaid and they are several years away from qualifying for Medicare. The life Ron had mapped out now seems a distant hope.

Ms. ROWLAND. I think Ron's story reflects some of the challenges you face in crafting health care reform. I think the people like Ron are waiting for this Congress to help bring them some of the protection they need. Thank you.

[The prepared statement of Ms. Rowland follows:]

## PREPARED STATEMENT OF DIANE ROWLAND, D.SC.

## SUMMARY

- Health insurance helps to improve access to basic primary and preventive care and lowers the likelihood of postponing or foregoing needed care and medications due to costs by promoting more stable health care arrangements.
- While having insurance is clearly better than being uninsured, the scope of health insurance coverage varies widely across plans. Families face increasing health insurance premiums plus higher deductibles and more cost-sharing when they seek care resulting in a growing financial burden for families.
- How well health insurance is working to protect families from large medical bills is one measure of the adequacy of health insurance. Among the insured non-elderly population, 3 in 10 adults in October 2008 reported problems paying medical bills (compared, however, to 60 percent of the uninsured). Families are often forced to make difficult choices, including limiting paying for other necessities such as food, heat, or housing; using savings or borrowing money; and considering filing for bankruptcy; cost considerations lead to skipped medical tests and failure to follow through on needed treatment.
- Interviews held with diverse working families across the United States in the spring of 2008 showed families with health insurance often struggled to afford the combination of premiums, copays, deductibles, and costs for services not covered by their plan, with these costs rising faster than their paychecks.
- Insured families facing health spending that exceeds 10 percent of after-tax income can be considered as “underinsured” in that the coverage they have is insufficient to protect them from the financial toll of health spending. By 2004, researchers estimated that 45.4 million non-elderly people met this definition of underinsured compared to 39.5 million people in similar circumstances in 2001.
- One of the clearest examples of the holes in health care coverage is the experience of families where cancer has taken a toll. Most have private health insurance, but many face high health care costs that alter their care—5 percent of the insured (and 27 percent of the uninsured) said they had delayed or decided not to get care due to costs, putting their life and survival at risk due to costs not covered by insurance.
- These experiences document the challenges families face today—even those with private health insurance coverage—when seeking medical care. High levels of cost-sharing and caps on covered benefits can compromise the level of protection health insurance provides and lead to both reduced access to needed care and serious financial burdens and medical debt. As consideration of health reform moves forward, it will be important to assess both the scope of coverage provided and the level of financial assistance offered against the substantial medical costs especially for those with chronic and serious illness.

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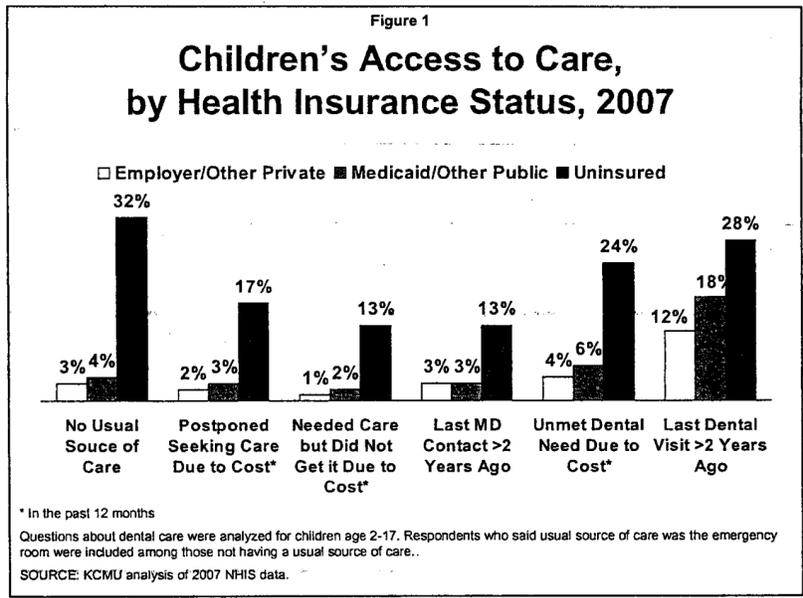
Mr. Chairman and members of the committee, thank you for the opportunity to be with you today to discuss the status of health insurance coverage in America and the gaps and limits to coverage that leave millions of Americans poorly protected when confronting illness. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation, and Executive Director of the Foundation’s Kaiser Commission on Medicaid and the Uninsured. I am also an adjunct professor of Health Policy and Management at the Bloomberg School of Public Health at The Johns Hopkins University.

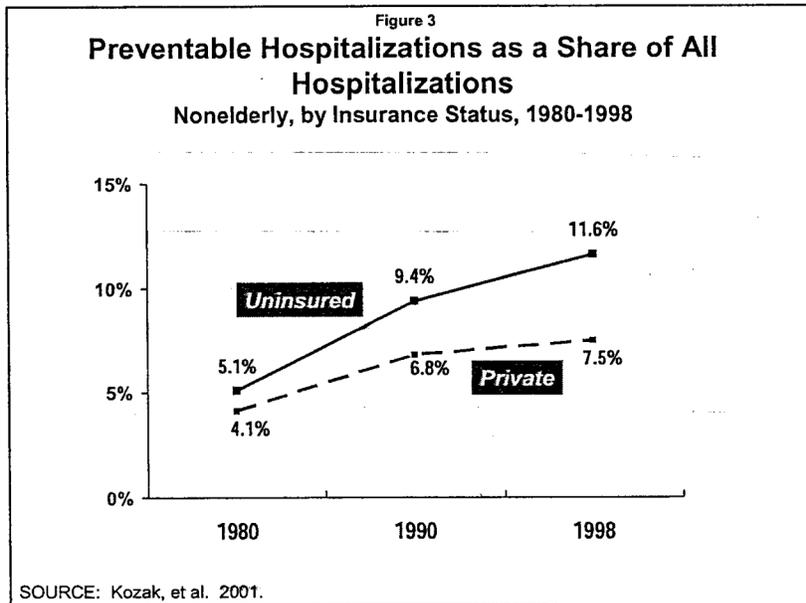
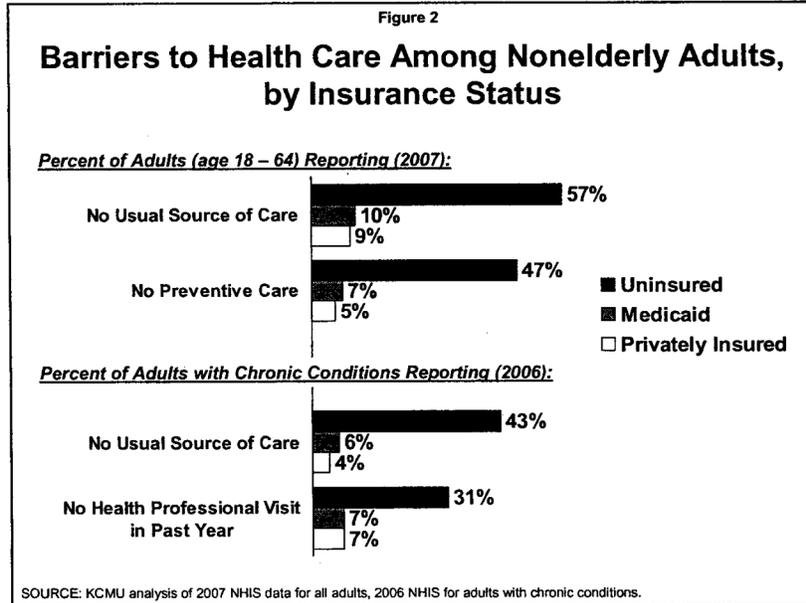
My statement today will focus on why health insurance and the scope of coverage matters for a family’s health, well-being, and financial security. The evidence is clear and strong showing that being without health insurance affects the health care people receive and leaves the uninsured with diminished access to health services and poorer health than their insured counterparts. The consequences of inadequate insurance for the many “underinsured” Americans are less well-documented, but both affordability and adequacy of coverage are major challenges to be addressed in reforming our health care system.

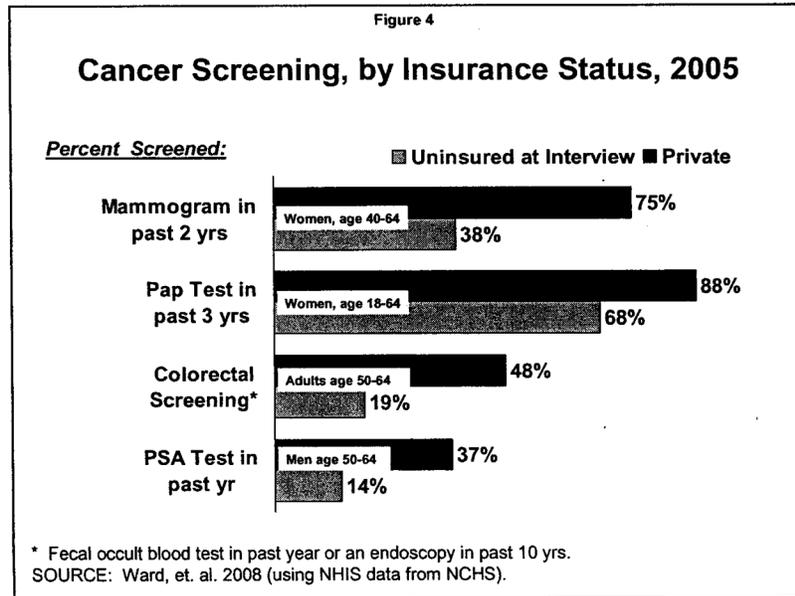
## HEALTH INSURANCE MATTERS

Health insurance is a key link to receiving health care when needed. Having coverage helps to improve access to basic primary and preventive care and lowers the likelihood of postponing or foregoing needed care and medications due to costs. It helps to promote more stable health care arrangements leading to early detection and preventive care. The uninsured use fewer preventive and screening services, are sicker when diagnosed, receive fewer therapeutic services, have higher mortality

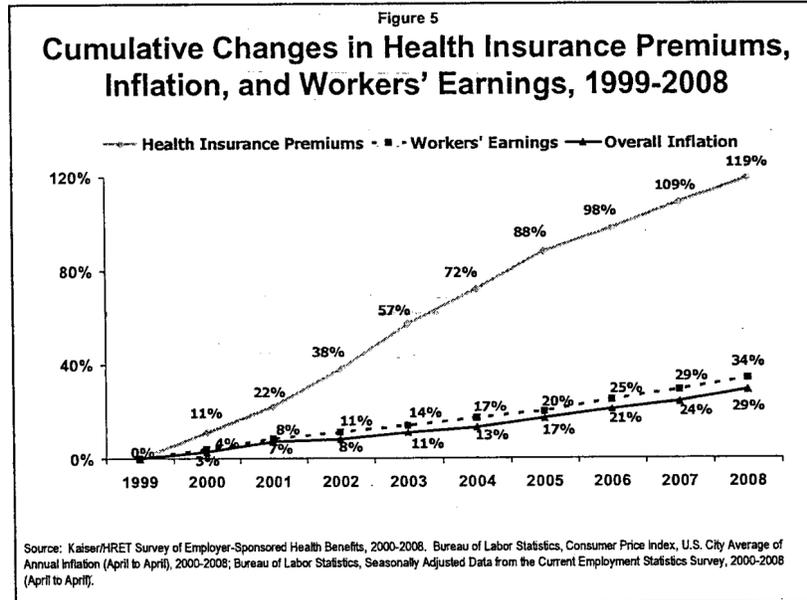
and disability rates, and lower annual earnings because of poorer health than those with health insurance (Figures 1 and 2).<sup>1</sup> The uninsured are less likely to have a usual source of care and be connected to the health care system for ongoing preventive and primary care. They are also at greater risk of being hospitalized for preventable conditions and less likely to receive critical screening services that could lead to early detection and better treatment options for cancer (Figures 3 and 4).<sup>2,3</sup> On all measures, those with health insurance have better access to care than the uninsured.



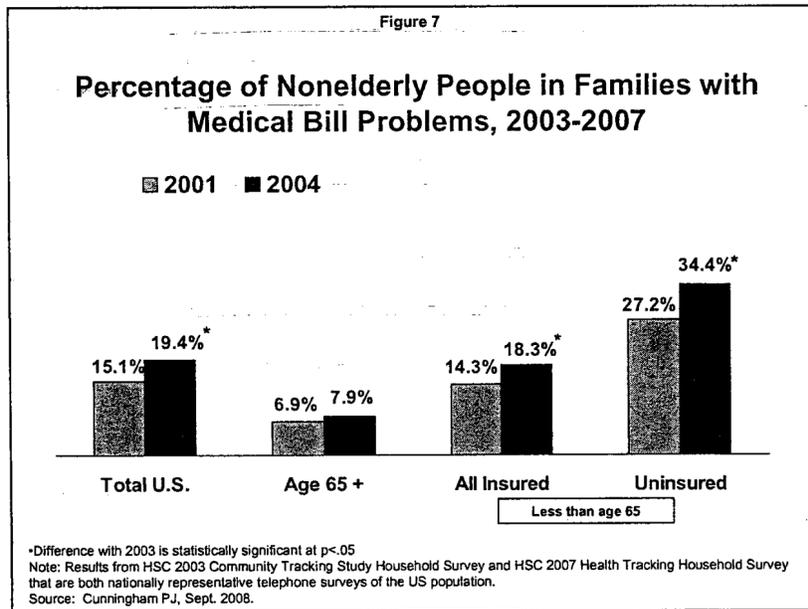
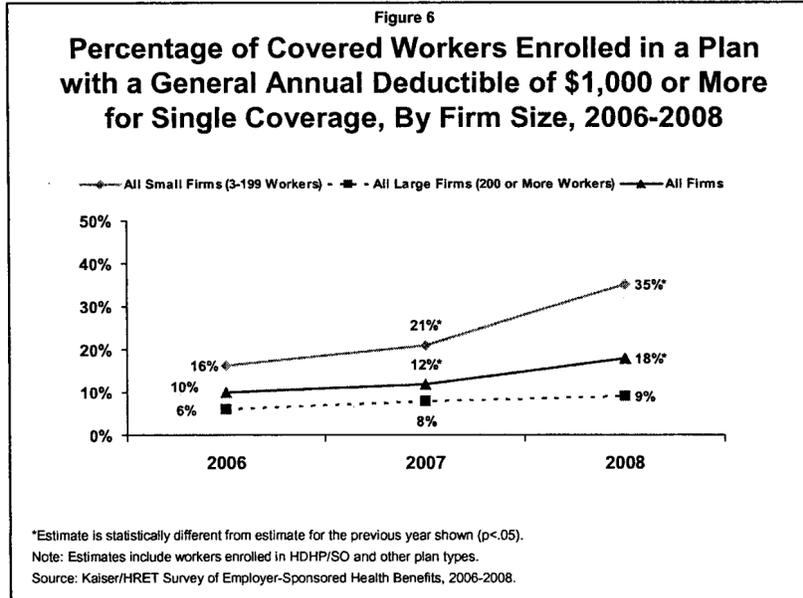




While having insurance is clearly better than being uninsured, the scope of health insurance coverage varies widely across plans and can result in costs and limits that leave some of the insured ill-equipped to afford the care they or a family member needs. Rising health care costs for families have continued to outpace increases in salaries and wages over the last decade, greatly increasing the financial burden for health care for families. In the past decade premiums for employer-sponsored group coverage have more than doubled, with a cumulative growth rate of 119 percent, compared to only a 34 percent growth in worker's earnings (Figure 5).<sup>4</sup>



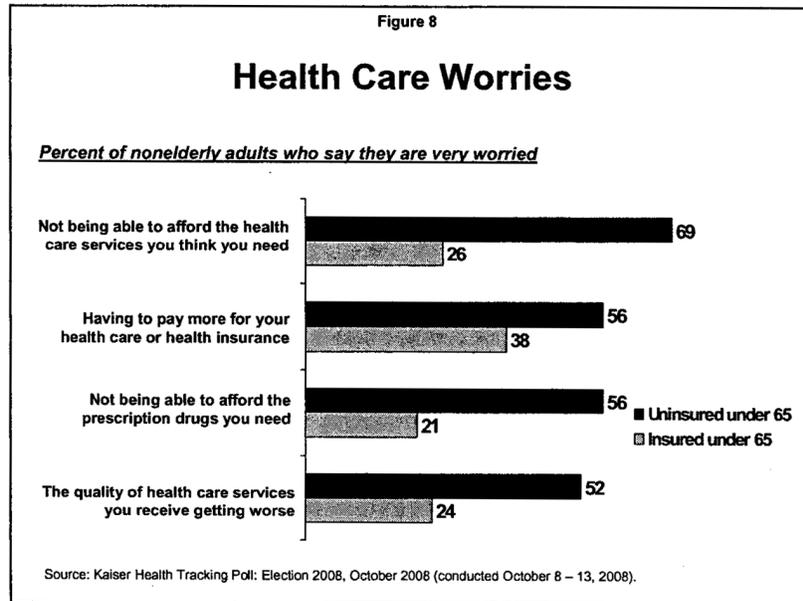
Today, families face not only increasing health insurance premiums, but also pay higher deductibles and more cost-sharing when they seek care. In 2006, 10 percent of workers with employer-sponsored health insurance were enrolled in a plan with a general deductible of \$1,000 or more for single coverage; 2 years later in 2008, 18 percent of such workers and over a third of covered workers in small firms (defined as under 200 workers) had high deductibles (Figure 6).<sup>5</sup> Both the premium workers pay for coverage and their out-of-pocket costs are increasingly a financial burden for families. From 2003 to 2007, the share of non-elderly people in families with medical bill problems increased from 14 to 18 percent for insured families (Figure 7).<sup>6</sup> Out-of-pocket costs have been climbing as cost-sharing, deductibles, and limits on covered benefits grow.



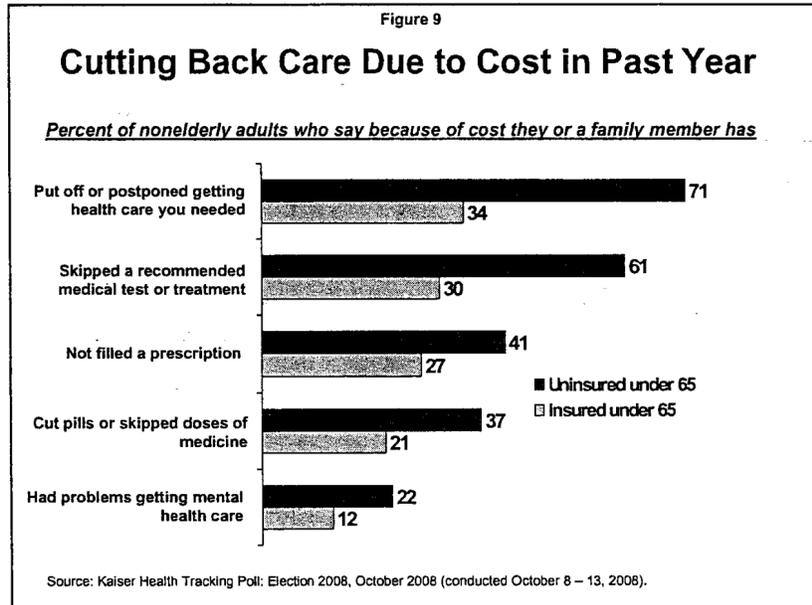
PROBLEMS PAYING MEDICAL BILLS

How well health insurance is working to protect families from large medical bills is one measure of the adequacy of health insurance. Millions of Americans—both insured and uninsured—worry about their ability to obtain and pay for health care.

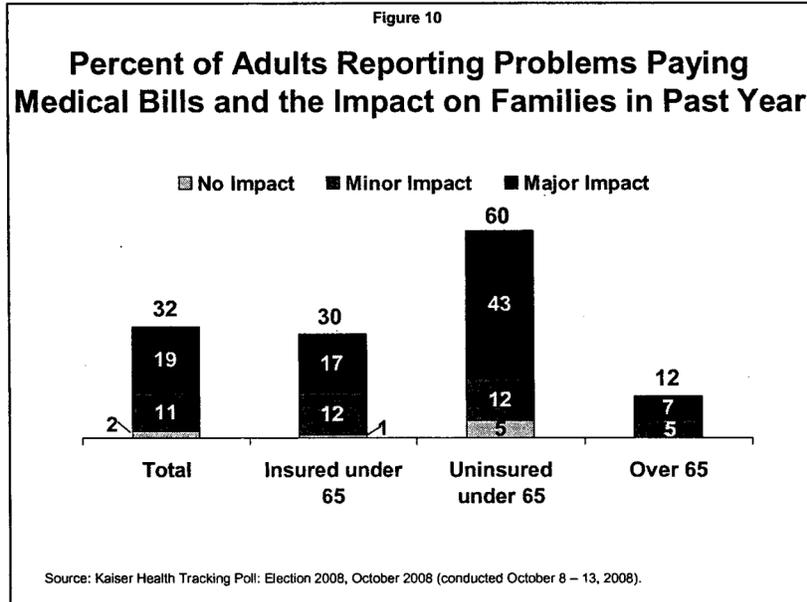
The uninsured are more likely to be worried about their ability to afford the health care services and medications they need than those with insurance. Yet, among the insured non-elderly population, one in four adults say they are very worried about their ability to afford needed care and over a third of the insured are very worried about having to pay more for health care or health insurance (Figure 8).<sup>7</sup>



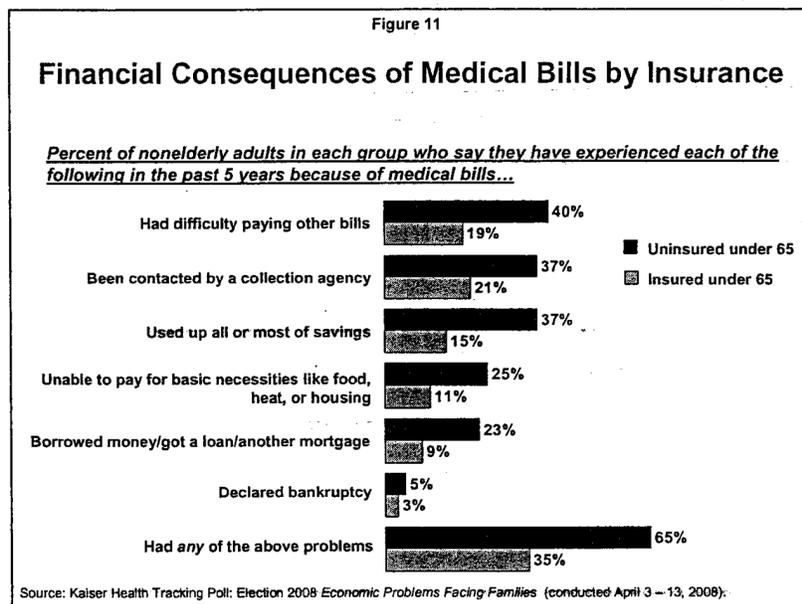
Their concerns too often cause them to cut back on care due to cost—with many of the insured putting off or postponing needed health care (34 percent), skipping a recommended medical visit or treatment (30 percent), not filling prescriptions (27 percent) or skipping doses and cutting pills (21 percent) due to cost (Figure 9). Failure to get needed care can lead to adverse health outcomes and the need for more intensive and often costly care.<sup>8</sup>



In our October 2008 survey, almost one in three adults (32 percent) reported that their family had problems paying medical bills in the past year and nearly one in five (19 percent) reported that these bills had a major impact on their family. Even among the insured non-elderly population, 3 in 10 adults reported problems paying medical bills with almost one in five of those with problems (17 percent) reporting that these bills are having a major impact on their families. As expected, the uninsured non-elderly population has had a particularly hard time in paying medical bills with three out of five (60 percent) reporting that they have had problems paying medical bills in the past year and over two out of five with problems (43 percent) reporting that these medical bills have had a major impact on their family (Figure 10). Most notably, those over 65 with Medicare coverage are less likely to report problems with medical bills.<sup>9</sup>



Medical bills can severely impact a family's ability to pay for household necessities. Individuals in families with problems paying medical bills are often forced to make difficult sacrifices, including limiting paying for other necessities such as food, heat, or housing; using savings or borrowing money; and even considering filing for bankruptcy. Over the last 5 years, among non-elderly insured adults, 21 percent reported they had been contacted by a collection agency, 15 percent said they had used all or most of their savings, and 3 percent reported they had declared bankruptcy because of medical bills (Figure 11).<sup>10</sup> Again, the uninsured faced even greater challenges.



#### LOOKING AT HOW HEALTH CARE COSTS IMPACT FAMILY BUDGETS

In order to understand more about the circumstances and the financial and health care challenges facing low- and middle-income working families, the Kaiser Family Foundation interviewed the heads of household in 27 diverse working families across the United States in the spring of 2008 to learn more about their ability to pay for health care. Our study found that health care costs are indeed a strain on family budgets, even for families with insurance coverage. In numerous cases, families had monthly health care bills totaling hundreds of dollars—a significant share of their earnings.

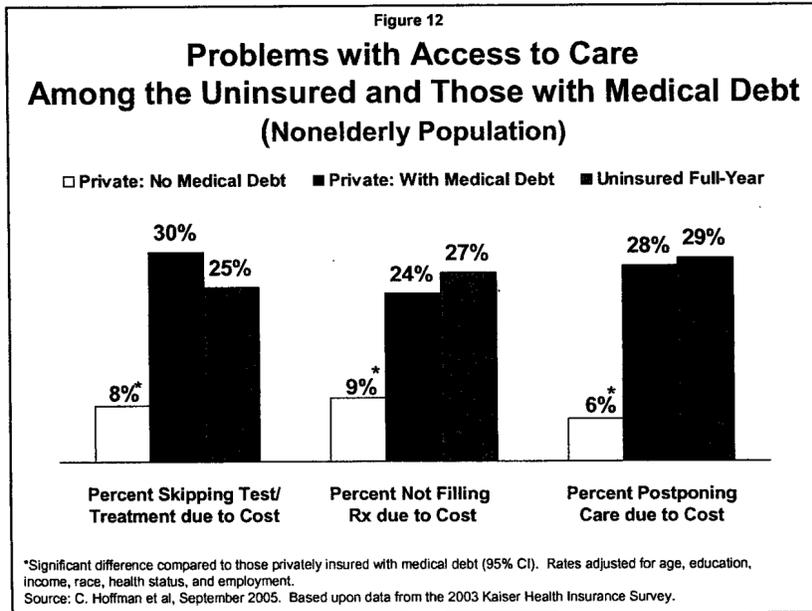
A case from our family interviews highlights how medical bills can mount and leave a family struggling with medical debt. Ron, 59, and his wife from Wichita, KS have had significant health problems and struggle to pay their bills on a monthly income of \$1,815—or about \$30,000 a year. She suffers from congestive heart failure and diabetes and he was diagnosed with diverticulitis. Subsequently, a sonogram and CAT scans revealed a mass on his kidney, raising concern that he had cancer and resulting in surgery. Although Ron has worked for the same company for 26 years and at the time of our interview had health insurance through his job, health care costs had taken a toll on his family finances. A \$4,750 deductible; \$90 a month in copays for his wife's six prescription medications for diabetes, heart disease and glaucoma; and unexpected and costly medical needs for himself and his wife have meant very high out-of-pocket costs and substantial medical debt for previous hospital and doctor care. Facing aggressive collection, Ron borrowed money from his 401(k) plan to pay thousands of dollars owed for a hospitalization 6 years ago when his wife got pneumonia and currently is paying \$25 a month to reduce the \$1,800 medical debt. Ron's experience demonstrates the financial consequences of limits on what insurance covers and the impact of health bills on the overall financial well-being of a family. Unfortunately for Ron and his wife, life has gotten even more precarious: in December of 2008, Ron was laid off from his job of 27 years.<sup>11</sup>

Families with health insurance, like Ron, in our study often struggled to afford the combination of premiums, copays, deductibles, and costs for services not covered by their plan, with these costs rising faster than their paychecks. Frequently, private insurance did not cover dental and vision care, and dental care, in particular, had saddled families with large expenses. Some insured families, despite having coverage, avoided using services because they could not afford the out-of-pocket costs. Costs often mounted up quickly, especially when a member of a family had

ongoing needs for chronic care or prescription drugs. Even in generally healthy families, one-time health crises like a broken arm or hospitalization resulted in large, sometimes staggering, bills. Families without insurance were still worse off, having to pay all their medical bills out-of-pocket.

Our interviews found both insured and uninsured families had substantial unpaid bills for medical care—some owed tens of thousands of dollars. Most families with medical debt were trying to pay it off in small amounts like \$5 or \$25 or \$50, month by month or when they could; they were unsure how they would manage to pay it all back. The couple above had begun to use retirement savings to pay down their medical debts; another family had considered filing for bankruptcy. Beyond the burden of the medical debt itself, the debt also prevented those who were relatively new to the workforce from getting established financially, and compromised families' credit and ability to borrow and save, jeopardizing their hopes and plans for the future—for example, to purchase a home, or retire. Iris, who is only 23, has severe back pain from a car accident, asthma, and severe allergies, but relies on over-the-counter medications and an old asthma pump. She has \$7,500 of medical debt she cannot afford and is already concerned that the debt from her medical conditions at a young age will hurt her credit, which may prevent her from buying a house or a car in the future.

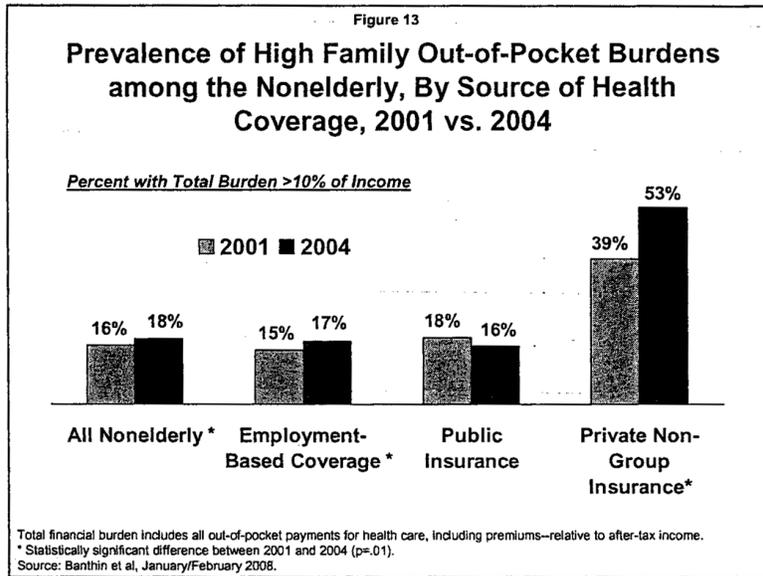
Families especially turn to cost-cutting measures when health care costs and medical debt have already strained their family resources. Families with private insurance and medical debt were three times as likely to skip tests as those with private insurance and no medical debt and in fact behave more comparably to the uninsured in how they access the health care system (Figure 12). Most notably, over a quarter of both privately insured individuals with medical debt (28 percent) and uninsured individuals (29 percent) postponed care due to cost compared to only 6 percent of the privately insured without medical debt.<sup>12</sup> The inadequate coverage and financial burdens for health care are leaving families to make choices based on their pocketbook rather than their health care needs.

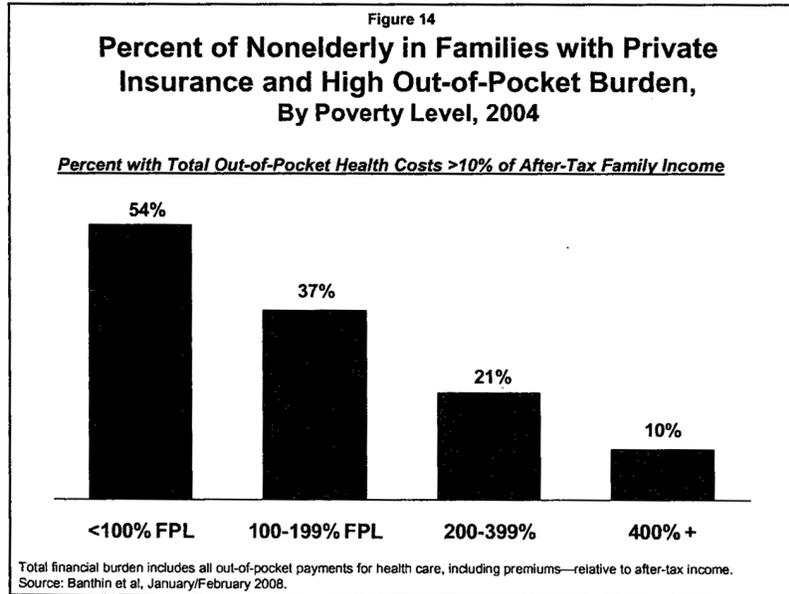


FINANCIAL BURDEN FOR HEALTH CARE

The share of family after-tax income going to pay for health care services is a measure of the adequacy of health insurance protection. Analysis by researchers at the U.S. Department of Health and Human Services documents the increase in out-of-pocket burdens and health spending relative to income for families from 2001 to 2004 (Figures 13 and 14). Health care costs for a family's share of premiums, cost-

sharing, and out-of-pocket spending that exceed 10 percent of after-tax income are considered a high financial burden. Families facing health spending at this level can be considered as “underinsured” in that the coverage they have is insufficient to protect them from the financial toll of health spending. It appears that the number of families falling into this group is growing. By 2004, the researchers estimated that 45.4 million non-elderly people lived in families with health care costs greater than 10 percent of their after-tax income compared to 39.5 million people in similar circumstances in 2001.<sup>13</sup>

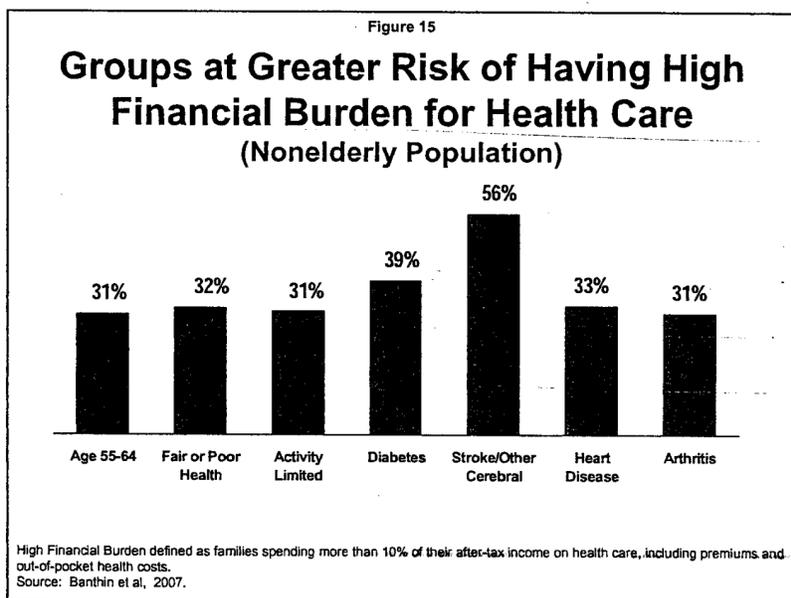




The nature of one's health insurance is a critical component of determining whether a family faces high expenditures for health care. Public insurance through Medicaid for low-income families offers the broadest protection with low cost-sharing and comprehensive benefits. Employer-based coverage varies widely, but offers coverage that protects the majority from high costs. However, in 2004, nearly one in five (17 percent) families with coverage through their employer faced substantial out-of-pocket costs exceeding 10 percent of income.

The least protection and greatest burden was among those purchasing non-group private insurance with over half of these families (53 percent) encountering health spending in excess of 10 percent of their after-tax income. Those in the non-group market pay the full share of the premium and generally have benefits that are less generous with higher deductibles and more cost-sharing than in coverage available through employer-based group policies. On average, their out-of-pocket costs for premiums are more than twice as high as that paid by persons with job-based group coverage, and their out-of-pocket spending for health services is almost 50 percent greater.

Most notably those with the fewest financial resources as well as the greatest health needs face the greatest health care burdens. In 2004 over half (54 percent) of the non-elderly in families with incomes below the poverty level and more than a third (37 percent) of the near-poor faced spending that exceeded 10 percent of after-tax income compared to 1 in 10 from families with incomes over 400 percent of poverty (roughly \$88,000 for a family of four today) (Figure 14). One in three non-elderly people in fair or poor health or with a disability are dealing with medical costs above 10 percent of their incomes. Persons with chronic conditions are at an even greater risk—almost 40 percent of non-elderly diabetics and over half (56 percent) of families affected by stroke fall into the high costs burden group (Figure 15).<sup>14</sup>

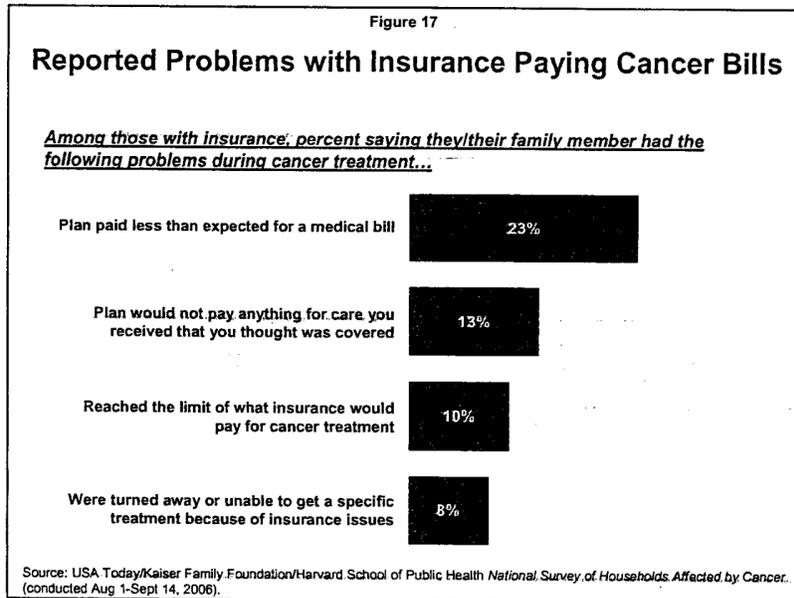
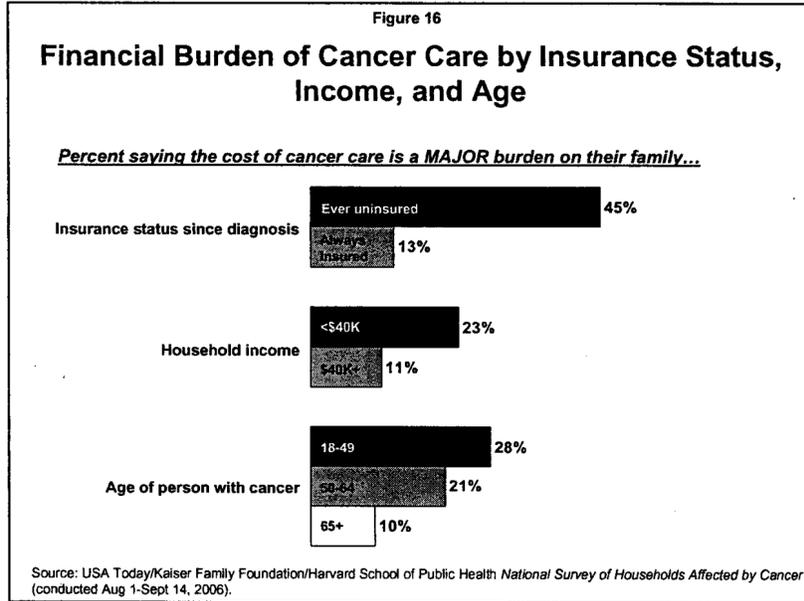


Again, in our interviews of families, we found that out-of-pocket costs can be steep even for families with private coverage. Families that had private coverage through their jobs or had purchased it on their own, in several cases, faced copays, deductibles, and out-of-pocket costs for care not covered by the insurer that posed a severe financial strain. While copays for prescription drugs and doctor visits were often nominal on a unit basis, families who had ongoing or multiple needs were confronted with large cumulative costs. Deductibles reaching as high as \$6,000 exposed some families to medical costs their budgets could not absorb, resulting in large medical debts. When private insurers limited coverage, as for mental health care or prescription drugs, or excluded particular services, such as dental care, families—although insured—were uninsured for this care, and like the uninsured, avoided seeking care due to cost.

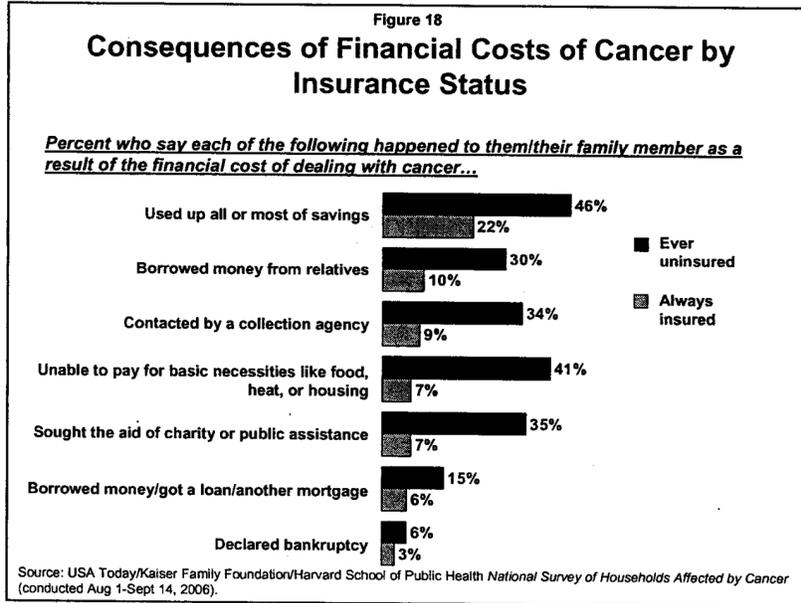
#### CANCER: A HIGH COST DIAGNOSIS

One of the fears that many American families have is that the illness of a family member and the desire to provide the fullest and best treatment will lead to financial ruin. When someone we hold dear is ill, being able to provide treatment and hopefully a cure is paramount, but unfortunately today even those with health insurance may face devastating medical bills that both compromise treatment and sap financial resources. One of the clearest examples of the holes in health care coverage is the experience of families where cancer has taken a toll.

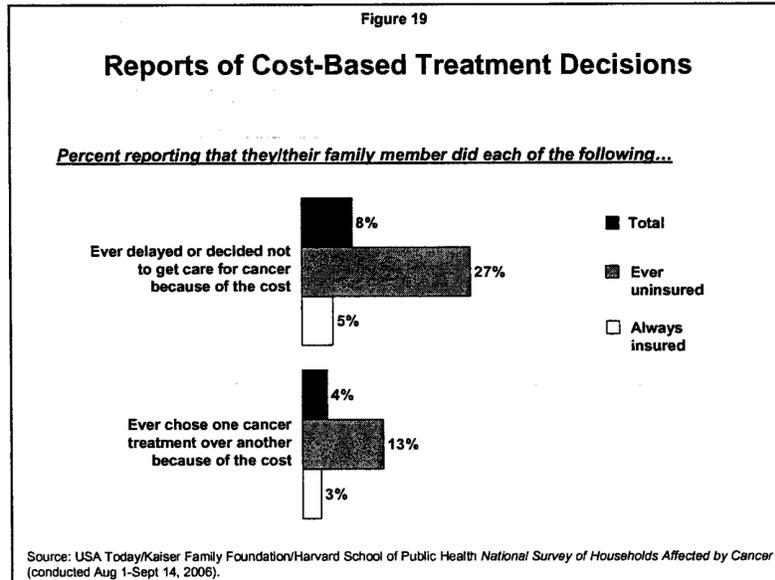
The majority of cancer patients under age 65 have private health insurance. Yet, despite having private health insurance some face high health care costs that can put both their treatment and physical and financial well-being at risk. In our 2006 Kaiser/Harvard/USA Today survey of households affected by cancer in 2006, 13 percent of people who said the person with cancer was insured (and 45 percent of those who were uninsured at some point during cancer treatment) reported that the cost of cancer care was a major burden on their family (Figure 16). Among those with insurance, nearly a quarter reported the plan paid less than expected for a medical bill for their family member and 1 in 10 reached the limit the plan would pay for cancer treatment (Figure 17).



As a result, nearly a quarter of those with insurance reported that as a result of the financial cost of dealing with cancer they had used up all or most of their savings and 1 in 10 turned to relatives for help. Although those without insurance faced significantly more challenges, 7 percent of people who said the person with cancer was insured reported being unable to pay for basic necessities and 3 percent said they needed to declare bankruptcy (Figure 18).



Cost considerations not only affected financial stability for the family but in some cases compromised treatment for the cancer—5 percent of the insured and 27 percent of the uninsured said they had delayed or decided not to get care due to costs (Figure 19). These are people who stopped or postponed treatment for a deadly disease, putting their life and survival at risk due to costs not covered by insurance.<sup>15</sup>



Our recent report conducted jointly with the American Cancer Society profiles the situations faced by 20 cancer patients who had called in to the American Cancer

Society Health Insurance Assistance Service. Their stories show that even with private insurance a diagnosis of cancer can lead to large medical debts, filing for personal bankruptcy, and going without potentially lifesaving treatments and point out the shortcomings of their private health insurance coverage. Even when cancer patients have relatively comprehensive coverage through their private health insurance coverage, the sizeable costs from co-payments, deductibles, and co-insurance can easily mount up.<sup>16</sup>

One of the profiled patients, Keith Blessington, has been in and out of the hospital since he was diagnosed with stomach cancer. When his COBRA ran out his only option was to join a high-risk pool that includes a monthly premium of \$1,100, a \$1,000 deductible, and 20 percent cost-sharing. Keith has already gone through his 401K, has not paid his mortgage for a few months, and is borrowing money from a credit card to pay for care for his ailing mother and his various medical bills. As Keith mentions in his own words,

“[W]hen you have medical problems, a lot of people think it’s just their doctor and the hospital. But that is not the case. There are so many outside groups that you get bills from . . . you could have five different doctors bills for one treatment that you had and you don’t even know who the four others are. But, they touch base and they submit a bill and you don’t know for sure if they will accept your insurance until they actually submit.”

Keith is now \$60,000 in debt and that figure climbs an additional \$6,000 every month.

In addition to the cost-sharing and deductibles, many patients find maximum caps on their benefits or that their policy does not pay for treatments recommended by their doctor. Among our profiled patients, some faced a cap of \$250 for coverage of radiation and \$10,000 for outpatient costs—amounts easily exceeded in the course of treatment for many cancers. For example, Debra Gauvin, 52, diagnosed with stage II breast cancer had employer-sponsored insurance that covered 80 percent of her lumpectomy. However, she quickly met the \$20,000 annual maximum on her insurance plan, which left her responsible for her treatment costs. She currently owes \$18,000 for surgery and chemotherapy. Although she was able to receive a 61 percent discount for the radiation she still needs, the remaining costs of the radiation treatment were too significant of a financial burden for Debra so she decided to postpone her radiation until 2009, when her insurance would help cover the costs.<sup>17</sup> Such cost considerations can both compromise treatment objectives and health outcomes.

#### IMPLICATIONS FOR HEALTH REFORM

These experiences document the challenges families face today—even those with private health insurance coverage—when seeking medical care. High levels of cost-sharing and caps on covered benefits can compromise the level of protection health insurance provides and lead to both reduced access to needed care and serious financial burdens and medical debt. As our family budget study shows for low- and moderate-income people, especially those with chronic health problems, even modest levels of cost-sharing can mount up, impeding access to care and resulting in financial burdens. Likewise, as the cancer patient profiles demonstrate, those with serious illnesses can have their care and outcomes jeopardized by limits and gaps in coverage even when they have health insurance.

In the struggle to bring affordable health insurance coverage to all Americans, budget constraints and the high cost of health insurance will undoubtedly put pressure on policymakers to limit the scope of coverage and impose substantial cost-sharing to hold down Federal costs. Cost concerns, however, need to be balanced against the expectation that health reform will bring improved coverage and lower health spending for families. As consideration of health reform moves forward, it will be important to assess both the scope of coverage provided and the level of financial assistance offered against substantial medical costs especially for those with chronic and serious illness.

Thank you for your consideration.

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Senator BINGAMAN. Thank you very much.  
Ms. Turner, why don't you go right ahead?

**STATEMENT OF GRACE-MARIE TURNER, PRESIDENT,  
GALEN INSTITUTE, ALEXANDRIA, VA**

Ms. TURNER. Thank you, Senator. I am grateful to Senator Kennedy and to Ranking Member Enzi for inviting me to testify. And thank you to Senator Bingaman for chairing this hearing today. As a native of the land of enchantment it's a special privilege to be here today.

I want to thank the committee and your dedicated staff for the incredibly hard work you are doing to bring the issue of health reform to the forefront of the national debate. I founded the Galen Institute in 1995 because I believe that this issue is so important. And we focus exclusively on health reform.

As today's witnesses and many other experts have shown, the growing number of Americans, even those with insurance, are facing health costs that put serious financial pressure on them, especially during the Nation's economic crisis. But solving this problem must be integrated with other considerations, especially the cost of health insurance and the likelihood of causing other distortions inside and outside the health sector. If the government were to require all Americans to have comprehensive health insurance that protects them against all but routine medical expenditures, the requirement would lead to higher cost for health insurance.

The full cost of employment-based health insurance is often hidden from workers. But the consequences are not. Economists have demonstrated that an increase in health insurance premiums results in lower wages and lost jobs for workers and increases the ranks of the uninsured.

Large and small companies as well as families must balance spending on health insurance with other needs. A number of employers have found that creative benefit designs that engage employees as partners in managing health cost allow them to continue providing health insurance and to continue to contain costs for both the company and employees. Maintaining this flexibility in benefit design is crucial to keeping health insurance affordable and therefore to keeping as many people as possible insured.

In my testimony I describe the positive results of several companies in increasing access to health insurance for their workers and containing costs. Deloitte Center for Health Solutions found, for example, that the cost of consumer directed health plans increased by only 2.6 percent in 2006, about a third the rate of increase in the cost of traditional insurance plans.

Some innovative benefit designs give people and companies a way to couple spending accounts with affordable health insurance. The account is used to pay for routine health expenditures such as doctor's visits. The high deductible insurance covers larger medical costs, especially hospitalizations, surgeries and cancer care.

Many also cover preventive care. And several surveys have shown that the use of preventive care actually increases with the use of these consumer-directed plans. Health savings accounts in particular also have stop loss provisions that protect policy holders against major medical costs.

They are statutory requirements that allow only \$5,000 in out-of-pocket expenditures for individuals and \$10,000 for families. While that may seem like a lot, much of that can be funded through savings in the policy accounts as well as protecting them against \$100,000, \$200,000, even larger medical bills. A growing number of people are choosing to buy this type of policy to protect them against large medical expenditures.

President Obama has said many times during the campaign if you've got health care already then you can keep it, if you're satisfied with it. A government-mandated benefits package with lower deductibles would rob tens of millions of Americans of this choice.

Expanding access to health plans like Medicare and Medicaid is not a solution since they also often fail to meet the test of providing comprehensive coverage and access to care. Medicare has limits on hospital care and many other gaps in coverage that force seniors to seek additional insurance through retiree health plans, through Medigap plans or by selecting Medicare advantage plans that provide them access to more comprehensive coverage than traditional Medicare pays. Medicaid pays physicians so little that recipients often have to go to hospital emergency rooms because they can't find a private physician just to seek routine care.

Making sure that everyone has health insurance to protect against large medical bills is a wise and worthwhile policy goal. Then we can focus on how to provide access to routine and preventive care, especially focusing on those with the greatest needs and the most limited resources. Otherwise we could find that the ranks of the uninsured have grown through an effort to make health insurance more generous for a dwindling few.

Thank you very much. I look forward to your questions.

[The prepared statement of Ms. Turner follows:]

## PREPARED STATEMENT OF GRACE-MARIE TURNER

## EXECUTIVE SUMMARY

There is little debate about the need to make sure that all Americans have the security of insurance that protects them from medical bills they can't afford and that provides them access to the care they need. But no part of the health sector, and no one goal, can be considered in isolation from the impact it will have on other goals and aspects of health care and coverage. That is particularly true when considering the issue of the underinsured and of requiring more generous, more comprehensive coverage. Solving this problem must be integrated with other considerations, especially the risks of driving up costs and causing other adverse consequences.

If the government were to require all Americans to have comprehensive insurance that protects them against all but routine medical expenses, the requirement would lead to higher costs for health insurance. The full cost of employment-based health insurance is often hidden from workers, but the consequences are not. Economists have demonstrated that an increase in health insurance premiums results in lower wages and lost jobs for workers and increases the ranks of the uninsured.

Expanding access to public plans such as Medicare and Medicaid is not a solution. These programs have defined benefit packages, but they also often fail to meet the test of providing comprehensive coverage and access to care.

Large and small companies as well as families must balance spending on health insurance with other needs. A number of employers have found that creative benefit designs that engage employees as partners in managing costs allow them to continue providing coverage and to contain costs for both the company and employees, often while also providing access to preventive care and wellness programs. Maintaining this flexibility in benefit design is crucial to keeping health insurance affordable.

President Obama said many times during the campaign, "If you've got health care already, and probably the majority of you do, then you can keep your plan if you are satisfied with it." A government-mandated benefits package would rob tens of millions of Americans of this choice.

There is no question that health costs create financial hardship for millions of Americans. Making sure that everyone has health insurance to protect against large medical bills would seem to be a wise and worthwhile policy goal. Then we can focus on how to provide access to routine and preventive care, especially focusing on helping those with the greatest needs and most limited resources. Otherwise, we could find that the ranks of the uninsured have grown through an effort to make health insurance more generous for a dwindling few.

## ADDRESSING UNDERINSURANCE IN NATIONAL HEALTH REFORM

I am most grateful to Chairman Kennedy and Ranking Member Enzi for inviting me to testify this morning before your committee on "Addressing Underinsurance in National Health Reform." And thank you, Mr. Bingaman, for chairing this hearing today. As a native of the Land of Enchantment, it is a special privilege to speak here today.

I also want to thank the committee and your dedicated staff for the incredibly hard work you are doing to bring the issue of health reform to the forefront of the national debate. I founded the Galen Institute in 1995 as a research organization devoted to the study of health reform because I believe that making progress on this issue is so crucial to our Nation's future. We focus at the Galen Institute on policy initiatives to expand coverage to the uninsured and provide incentives to achieve more affordable care and coverage.

I would like to focus on several issues involving the underinsured as they pertain to the larger goal of providing health insurance to all.

There is little or no debate about the need, in a country as wealthy and compassionate as ours, to make sure that all Americans have the security of coverage that protects them from medical bills they can't afford and that provides them access to the care they need. But no part of the health sector, and no one goal, can be considered in isolation from the impact it will have on other goals and other aspects of health care and coverage. That is particularly true when considering the issue of the underinsured.

As Catherine Schoen and many other experts have shown, a growing number of Americans, even those with insurance, are facing health costs that put serious financial pressure on them, especially at a time when the financial security of tens

if not hundreds of millions of Americans are threatened by the Nation's economic crisis.

But solving this problem must be integrated with other considerations, especially the cost of health insurance and the likelihood of causing other distortions inside and outside the health sector.

In my testimony, I will make two key points: (1) Flexibility in benefits is crucial in keeping health insurance affordable. (2) If the government were to require all Americans to have comprehensive insurance that protects them against all but routine medical costs, the requirement would lead to higher costs for insurance, resulting in lower wages and lost jobs for workers and in increasing the number of uninsured.

#### FLEXIBILITY IN INSURANCE

Ms. Schoen defines in her writings in *Health Affairs*<sup>1</sup> and elsewhere that those who are insured are considered underinsured "if they experienced at least one of three indicators of financial exposure relative to income: (1) out-of-pocket medical expenses for care amounted to 10 percent of income or more; (2) among low-income adults (below 200 percent of the Federal poverty level), medical expenses amounted to at least 5 percent of income; or (3) deductibles equaled or exceeded 5 percent of income."

This third provision would mean that if a family with an income of \$60,000 a year had purchased a health insurance policy with a \$3,000 deductible, they would be considered underinsured, even if they chose that option—as they very well might do in order to save on insurance premiums and make sure they are protected against major medical expenses.

A growing number of people are struggling to pay for health care and health insurance. Millions of them are choosing to buy a more affordable, higher-deductible policy, yet under this definition, they would be considered underinsured.

This gets to the fundamental definition of health insurance: Should it provide financial protection against major medical bills or protect against most expenditures on health care?

The policy debate in Washington and State capitals around the country often is confused by what we mean by "insurance." In other sectors of the economy, insurance means protection against costs that people could not afford to pay without considerable financial difficulty, if at all. That is why we buy automobile insurance to protect us against collision, injury, and loss of our vehicle, or homeowner's insurance to protect against the risk of fire, theft, or other serious and expensive damage.

But with health insurance, we start with the premise that it should protect us against exposure to all but minimal costs, with copayments for doctors' visits of \$15 or \$20 and \$5 or \$10 for prescription drugs. The rest of the costs of the office visits or medicine are run through insurance, driving up the cost of the coverage. In the trade-off, accessing care for more serious illnesses may be more difficult and people may be exposed to expensive copayments for larger medical bills.

Returning to the true meaning of insurance would help reduce this problem. Making sure that everyone has health insurance to protect against large medical bills would seem to me to be a wise and worthwhile policy goal. Then we can focus on how to provide access to routine and preventive care, especially focusing on helping those with the greatest needs and most limited resources.

The two stories of Wal-Mart and General Motors tell the much larger picture of the opportunities and challenges facing health policymakers today.

Wal-Mart reported last week that all but 5.5 percent of its employees now have health insurance, compared with a nationwide uninsured rate of 18 percent. *The Washington Post* reported in a February 13, 2009, article<sup>2</sup> that an important tool that Wal-Mart has used to reduce its uninsured numbers is flexibility in its benefit offerings. "Employees said they wanted more choices, especially low-cost emergency coverage options. Wal-Mart responded with a menu of deductibles, co-payments and maximum out-of-pocket costs. It teamed up with the Internet site WebMD to simplify enrollment, created electronic health records and expanded its \$4 generic drug plan from the 350 medications available to customers to more than 2,000 for employees," the *Post* reported. "Many workers have chosen low-premium, high-deductible plans that analysts say provide less coverage for preventive and primary care. The company tries to mitigate that with an upfront credit of between \$100 and \$500 that can be used on any medical expense." And for major surgeries and other major medical treatments, Wal-Mart negotiates with providers to get the best prices on high-quality care. For example, the company has teamed up with the Mayo Clinic to provide care for employees needing transplant surgery.

There are hundreds of stories like this from around the country as employers seek to find the best care at the most affordable prices so they can continue to provide their employees with health insurance.<sup>3</sup> Flexibility in health benefit offerings helps employers achieve those goals.

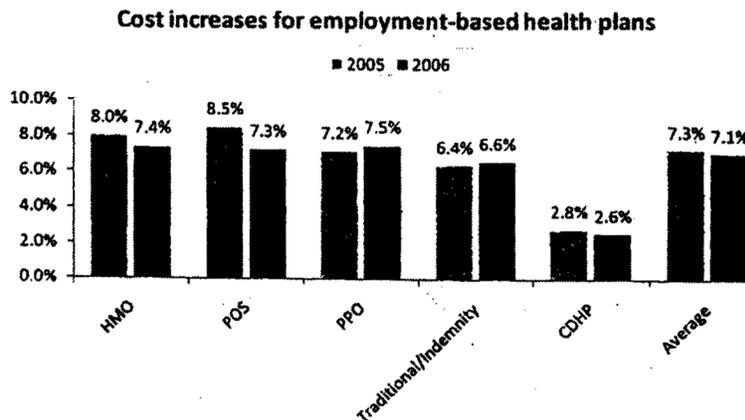
One tool is Health Savings Accounts (HSAs) that permit individuals to combine health insurance with a tax-free health spending and savings account. The account is used to pay for routine health expenses, such as doctors' visits, for services not covered by insurance, and to create a cushion to pay premiums in lean economic times. The high-deductible insurance policy covers larger medical expenses, especially hospitalization and surgeries. Federal law also allows the insurance contract to cover preventive care, such as cancer screenings, mammograms, and prostate tests. Several surveys have shown the use of preventive care actually increases with these plans.<sup>4</sup> And HSAs do have a built-in stop-loss that protects policyholders against major medical costs.

Target offers its employees a range of health insurance choices. One HSA option costs them as little as \$20 a month, and Target contributes \$400 a year to health spending accounts for individuals and \$800 for families.<sup>5</sup> John Mulligan, Target's vice president for pay and benefits, says, "These plans engage our team members in a decisionmaking process that gives them greater ownership and control of their health care dollars." The company offers its 360,000 employees Decision Guides to help them compare prices and quality and to estimate their costs, plus access to wellness programs, a nurse hotline, and other support tools.<sup>6</sup>

Whole Foods' CEO John Mackey toured the country talking to employees about health benefits options. Afterward, employees voted to switch to new account-based health plans with higher-deductible insurance coverage, Health Reimbursement Arrangements (HRA). Whole Foods puts up to \$1,800 a year into a spending account for each employee, with Mackey pointing out that this is not charity but part of the employee's compensation package. If they don't spend the money on medical care, it rolls over and the company adds more the next year. Some workers have as much as \$8,000 in their accounts. Whole Foods saves money and still covers 100 percent of its employees' health insurance premiums.<sup>7</sup>

Companies that have introduced health plans with new incentives for consumers to be engaged as partners in managing health costs generally have seen lower-than-average health cost increases. Annual premium increases for employment-based coverage averaged about 6 percent for the last 3 years, down from double digits earlier in the decade.<sup>8</sup>

The most impressive results have come from consumer-directed plans such as HSAs and HRAs. Deloitte's Center for Health Solutions found that the cost of consumer-directed health plans (CDHPs) increased by only 2.6 percent in 2006 among the 152 major companies it surveyed. This is about a third the rate of increase for traditional plans.<sup>9</sup>



Source: "Reducing Corporate Health Care Costs: 2006 Survey," Human Capital Practice of Deloitte Consulting LLP and the Deloitte Center for Health Solutions, 2006.

The fact that these employers are able to manage costs through flexibility in structuring health benefits gives them more control over costs and makes it more likely they will be able to continue offering coverage.

Contrast that with General Motors and the other major automobile manufacturers. High health costs associated with extremely generous health benefit packages are major factors in the companies' severe financial distress.

Nonetheless, there are discussions in the health policy debate about a proposal from President Obama and others that all plans participating in his proposed Health Exchange would have to provide insurance equivalent to the generous and comprehensive BlueCross BlueShield Standard Option Plan.

Rather than a mandate that could cause more employers to drop coverage, continued flexibility in benefits will allow individuals and employers more choices in shaping their health benefit packages to fit their needs and their budgets and is likely to lead to more people having insurance than if government were to direct all plans to meet a high benefits threshold.

#### CHALLENGES IN PUBLIC PLANS

Employers and private insurers are not the only ones struggling with the trade-offs between costs and benefits. Public plans such as Medicare and Medicaid have defined benefit packages, but they also often fail to meet the test of providing access to comprehensive coverage. Expanding access to public programs is not a solution.

Medicare, for example, was the last major health plan in the country to offer a prescription drug benefit, long after private plans recognized that this was an essential part of quality medical coverage. Medicare also has limits on hospital care and other gaps in coverage that force seniors to seek additional insurance through retiree health plans, private Medigap plans, or by selecting Medicare Advantage plans that offer more benefits and more comprehensive coverage than traditional Medicare. Many Medicare patients also are having a difficult time finding a physician as payment rates fail to keep pace with providers' costs.

Medicaid also looks like a generous benefits package on paper, but when I served on the Medicaid Commission (2005–2006), we heard dozens of testimonies about the problems recipients have in actually accessing care. In many States, Medicaid pays physicians so little that they cannot afford to see Medicaid patients, forcing patients to go to hospital emergency rooms to seek even routine care. And seniors who are dually-eligible for Medicare and Medicaid often face the greatest difficulties as they are switched from one program to another depending upon where their care is being delivered. This often results in loss of medical records, duplicative tests, over- or under-treatment with prescription drugs, and a serious lack of coordination among the many medical professionals providing them care. My colleague Robert Helms of the American Enterprise Institute and I offered a recommendation, which was adopted by the Commission, calling for more State flexibility in coordinating care for dual eligibles.<sup>10</sup>

Therefore, I believe the evidence supports the need for greater flexibility in benefit structures for both public and private health plans, not in rigid benefit structures, to provide greater access to coverage.

#### COST IS THE ISSUE

In decades of opinion surveys about health care, the cost of care and coverage is inevitably at the top of the list of concerns. If health coverage is to be more generous, someone must pay.

Professor Mark Pauly of the University of Pennsylvania's Wharton School has done extensive research on employment-based health insurance,<sup>11</sup> and he concludes that workers ultimately pay for their insurance through lost wages and sometimes through lost jobs.

The Kaiser Family Foundation reported in its latest employer benefits survey<sup>12</sup> that the average cost of an individual policy offered through the workplace is \$4,704, with the worker contributing \$721 and the firm, \$3,983. The average job-based family policy costs \$12,680, and the worker's contribution is significantly higher, at \$3,354 (a large reason that many employees decline the family coverage), with the employer paying \$9,325.

Tax law provisions shield health insurance from income and payroll taxes. While health insurance is part of the compensation package of workers, this provision means that the full cost of employment-based health insurance is most often hidden from workers. However, rising health costs are a major factor in depressing worker take-home pay.

If Washington were to direct all employers and consumers to obtain comprehensive health coverage, workers ultimately would pay in lower wages and even lost jobs.

Economist Katherine Baicker and others have demonstrated that an increase in health insurance premiums also increases the ranks of the uninsured and the unemployed.<sup>13</sup> “Understanding the relationship between health insurance costs and labor markets is of growing policy importance,” write the authors. “Together [our] estimates demonstrate that the labor market effects of rising health insurance are far from neutral.”

They suggest that the cost of employer mandates is likely to be passed on to workers in the form of lower wages. They also suggest that if some groups of workers are exempt from an employer mandate, such as part-time workers or employees in small firms, then employers may increase their reliance on these workers, undermining the goal of the mandate.<sup>14</sup>

The authors conclude that “rising health insurance premiums will place an increasing burden on workers and increase the ranks of both the uninsured and the unemployed.”

It is important to recognize that requiring health insurance packages to be more generous than they are today will have other consequences. In order to provide the opportunity for balance between pay and insurance, it is essential that employers and health insurers continue to have flexibility in trying to keep costs down through benefit design. Otherwise, we could find that the ranks of the uninsured have grown through an effort to make health insurance more generous for a dwindling number of insured workers.

And at the micro level, individuals and families must balance their need for access to needed medical care and protection against large medical bills with other demands on their resources, including food, housing, transportation, training and education.

Having a health insurance policy with a \$1,000 or \$2,000 deductible may seem high until a family is faced with \$50,000 to \$100,000 or more in medical bills that they cannot pay.

President Obama said during the second presidential debate, Oct. 7, 2008,<sup>15</sup> and many times during the campaign, “If you’ve got health care already, and probably the majority of you do, then you can keep your plan if you are satisfied with it.”

A government-mandated benefits package would rob tens of millions of Americans of this choice.

#### CONCLUSION

There are many, many problems to be addressed in health reform in the United States. The need for protection against major medical expenses is high among them. But the goals of health reform cannot be considered apart from their cost. I am concerned about focusing on the issue of underinsurance in isolation from the costs, resource limitations, and complexities of our health sector. A requirement from Washington that all policies must be generous and comprehensive could lead to other distortions, including loss of jobs, wages, and insurance. In addition, there are serious medical workforce issues which also must be considered. If people are to be able to obtain care, we must address these shortages, especially the need for more primary care physicians. Finally, the Federal and State governments need to find more creative ways to reduce their health expenditures so these growing costs do not crowd out other needed functions of government.

Thank you for the opportunity to testify before you today. I look forward to your questions.

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Senator BINGAMAN. Thank you all for your good testimony. Let me start with a couple of questions.

Ms. Schoen, in your view it's important to establish a minimum benefit level, as I understand it in your insurance design principles. I just heard Ms. Turner say that would be a big mistake to have a government-mandated benefit level. You also made reference to Massachusetts. Could you describe what they've done in Massachusetts on this issue of establishing a minimum benefit level and how it's worked?

Ms. SCHOEN. Yes, thank you for the question. I think the emphasis on minimum is important. Ms. Turner talked about HSAs setting a standard of \$5,000 out-of-pocket as the maximum. We're talking about putting a minimum and to—that would be credible insurance.

In fact, if you think of requiring people to have insurance or if you think if using a tax credit to buy insurance you need to define what would qualify. What Massachusetts did is took the decision on what exactly those benefits should be and said this is a very difficult issue. We want multiple stakeholders to be part of that decision.

There were general principles on access and financial protection. Then a group after the legislature acted came together and looked at various benefit designs on thinking about what the minimum would be. You could be more generous, but you couldn't go below.

They came up with several standards. Benefits should be very broad in scope. You shouldn't have an insurance package which simply doesn't cover something that you need.

There should be financial protection. There should be a point at which the plan starts picking up out-of-pocket costs above a certain level. There was a discussion on how high that threshold should be and worrying about lifetime limits.

When you talk to actuaries right now it's very difficult to compare plans. One says 500,000. Another says a million. It costs pennies to put some of these lifetime maximums in them. Evening it out makes it possible to compare.

So what Massachusetts did was put a floor under it in their connector which makes it very easy to compare. They have a bronze, silver and gold set of benefit designs. But they're not rigid. There's quite a bit of variation within actuarial equivalents. So they said we want principles of access and protection.

The other thing that was important was they looked at essential care. Preventive care is out from underneath the deductible to encourage primary care. Some of the designs we've seen private companies use that say if we have essential medications like insulin, you don't want to discourage use of it, so that went into the consideration.

That was the effort. It did in fact rule out some of the insurance that was being sold on the market. There were policies with artificial limits, didn't cover days of hospital, didn't cover doctors, didn't cover drugs. Those are no longer considered credible insurance. There is a floor when you're buying insurance that's protective.

Senator BINGAMAN. So, if I understand correctly, the system that was adopted in Massachusetts under Governor Romney, provided that everybody has to get coverage. And it provided that everyone, every insurance company that sold coverage in Massachusetts had to meet that minimum benefit level that was established by this board.

Ms. SCHOEN. I actually live in western Massachusetts. The requirement is on me to show I have an insurance policy that meets the standard. All the carriers send us very simple letters to say, we were insured. And we were insured on a package that meets the standard.

We could do this through the tax code, the Federal tax code for exemptions could say this meets the standards.

Senator BINGAMAN. Let me ask Ms. Turner. What is wrong with that kind of approach as you see it?

Ms. TURNER. Actually, the Federal Employee Health Benefit Plan has very comprehensive coverage. But it is even less specific in what coverage. It has to make sure the doctor visits are covered, that hospitalization is covered, emergency room care is covered.

But within that parameter there is even more flexibility and benefit design. And competition among the market, in the marketplace, can actually lead to the companies being forced to provide more comprehensive coverage because people aren't going to want to buy a policy that doesn't cover cancer care.

Senator BINGAMAN. Well let me just ask, though, is it in the public's interest to encourage competition between insurers as to whether or not they're going to cover a particular ailment that peo-

ple come up with? If there's a general consensus, as I guess there is in Massachusetts, that a particular ailment is common enough that it ought to be covered.

Why would we want to allow or encourage insurance companies to compete on the basis on whether they cover it or not? Why is that a good thing for the public?

Ms. TURNER. There are 1,900 mandates of what policies must cover in the States now. And there's evidence that that is driving up the cost of health insurance by as much as 30, and in some States even 50 percent.

Senator BINGAMAN. Is this in Massachusetts?

Ms. TURNER. Cost is a huge issue with the Massachusetts plan. Specific mandates and the problem that I believe members would have in specifying what needs to be covered and what isn't. Everybody needs something. And if you wind up deciding what's going to be covered and what's not then what is going to be left out.

It's very difficult to leave anything out because in a political world, you know, you really don't want to leave anyone out. So, the question is what's covered? It's much better to do this, I believe, on an actuarial basis and to make sure people are covered and that there are dollar thresholds rather than benefit design thresholds because there's really no end to the number of benefits that can and should be covered by policies.

Senator BINGAMAN. I've used my time.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman. I appreciate the tremendous testimony and charts, that are now a part of the record, from you. It was very helpful.

One of the things I always think about with health insurance is that when I buy my car insurance I know that I'm not paying for the oil changes or the tire replacement. When I buy my health insurance I am buying the change of oil and maybe the tire replacement. And I know that drives up the cost because there's a profit that's built into that part of it.

Minimum benefit level seems to leave enough flexibility to do just about anything that we want to do until we start putting in the details of what that minimum benefit level is. I've done some looking in the preventive care, that we all emphasize, is covered by a lot of insurance, but only used by 25 percent of the people that have it. What are we going to do to drive up the usage if they're paying for it, when they're not using it?

In the area of competition, I've been watching that a little bit. I do see some benefits to competition in the health insurance market. I know you don't have to look any further than the Medicare Part D.

Seniors are getting the drugs they need. The program has 85 percent satisfaction rate. And it costs 37 percent less than originally expected.

One of the reasons for that is we have a lot more companies vying for it than we ever anticipated. Pre-Part D in Wyoming there were two firms providing prescription drug coverage. Now there are 48. And yes that does make it difficult for our seniors to make the comparisons.

We did some programs that make that a little bit easier. But that's what happens with choice. But we have found that one of the reasons for the 85 percent satisfaction rate is because they can choose something that they actually like.

I'll ask Ms. Turner, based on Part D experience, what kind of market reforms can be made to increase that competition? How do we get it increased?

Ms. TURNER. I do think that Part D is a really wonderful example of how market competition can not only drive broad choice, but also get costs down. That the Part D benefit is coming in at 40 percent under expected expenditures at this point. Seniors have done it. You know, they've been offered a range of plans and seniors have picked the plans that provide the best care and the best coverage for the drugs and the services that they need at the best price.

So the companies have been forced to provide not only comprehensive coverage, but also affordable coverage or they're going to be left out of the market. I think that model is something that not only could work in other public programs, but it's a model that could, I think, be utilized in other parts of the economy as well, health sector. Thank you.

Senator ENZI. Thank you. I do think that the current tax treatment of health insurance is unfair. The Federal Government subsidizes the health insurance premiums for those who get health insurance through their job. The highest tax subsidies go to the people with the highest incomes and the most generous plans.

Replacing the current tax exemption with a tax deduction, a tax credit or a combination of the two would make insurance more affordable for the uninsured and those who are shopping on the individual market. I know that with my time, I don't have time for all of you to answer that question right now. Thank you, Mr. Chairman.

Senator BINGAMAN. Thank you very much. Let me call on Senator Casey at this point.

#### SENATOR CASEY

Senator CASEY. Thank you very much. I want to thank each of you for your testimony today. You've highlighted a problem that I think persists across the country.

I know, like a lot of States, in Pennsylvania we have a lot of the challenges that you've outlined today, a growing number of uninsured and underinsured. I'm told that if the national number is more than one in four of the uninsured or underinsured of incomes greater than 200 percent of poverty, that in our State that number is actually 36 percent. So we have in many ways a larger challenge.

I wanted to highlight a letter that our office received from a constituent and see if there's a reaction you have in terms of how we can meet this challenge. A woman from Berks County, PA from the eastern side of our State, Trisha Urban wrote to us. And I'm summarizing what she wrote.

Her 30-year-old husband died of a heart attack the day after she delivered her first child. Her husband had a child heart defect and missed his doctor's visit because their health insurance had been

dropped and their medical bills were over \$100,000. As you can tell from the brief information, his death may have been preventable.

She wrote to us offering to testify. She wanted us to share her story with Members of Congress. Medical bills currently may soon take the family's home.

What do we say to an American with that story, an American family in light of the challenge we face overall? Any of you want to take a stab at that? I know it's a tough question. It's overly broad. But I wanted to get your reaction.

Ms. Rowland.

Ms. ROWLAND. I think all the stories that we have from our cancer study, of profiles of cancer individuals as well as our kitchen table snapshots that we released today really reveal that Americans are struggling with these health care bills. I think the thing that we have to focus on is that when people have cost concerns they delay care even when it's really important to get it. To have up-front and comprehensive care that provides for preventive services and gets the cancer victim in when they're there at stage one instead of stage three, that allows the family that you're talking about to know that they should be in a medical home and a good treatment setting to get ongoing monitoring for this heart condition would be an important part of any health care reform.

As you look at the principles for health care reform, I think it's both the benefits that are being offered, the level of financial protection and gearing so that families at the lower end of the income spectrum don't have too great a burden. So it really is doing cost-adjusted cost sharing. If you're going to put cost sharing in, remember \$5,000 for a family earning \$30,000 is very different than \$5,000 for a family earning \$150,000.

Senator CASEY. Ms. Shearer.

Ms. SHEARER. It's hard to add to that answer. But I think that the most important thing is that Members of Congress and members of the Administration redouble their efforts and their commitment to solving this problem. You know, as the Chairman mentioned this came up at the summit yesterday. It's going to be discussed at another summit next week.

I think that the message that we're all hearing is that people were hurting before. But as of October people are hurting, you know, the level of hurt has just expanded exponentially. And I think that this really cries out for this Congress, this Administration to just redouble their efforts and pass some legislation to relieve this suffering.

Ms. TURNER. Can I also say, in my written testimony talk about Wal-Mart. The *Washington Post* had an article last Friday on some of Wal-Mart's benefit design, really trying to get more of its employees covered. And they actually have a benefits package that would have been enormously helpful to the urban family.

They, for less than \$50 a month, have a package that covers preventive care. The company puts \$500 into an account to make sure that people don't miss on routine doctor visits. But then it covers everything over a certain threshold. So they would absolutely not have been exposed to \$100,000 or anything even remotely close to that.

What I think we need is a package that provides access to routine care, but that doesn't skimp on the larger end of the extraordinarily important medical services that really can be a difference between life and death for someone.

Senator CASEY. I know we're almost out of time, but Ms. Schoen, anything that you wanted to add?

Ms. SCHOEN. I think just to underscore what's been said.

Senator CASEY. Fifteen seconds.

Ms. SCHOEN. I think it's vitally urgent. And we're often penny wise and pound foolish. Medicaid is now paying for cancer deaths.

We wait until the tumor is at stage four, then you spend down. We are not saving money by the way we've designed our benefits. We are in fact, incurring adverse outcomes.

We're hurting people's health. So I think this is part of a larger issue. We need to get control of the way that we pay as well as our insurance system.

Senator CASEY. I know we're out of time. But I guess the other scenario is people that actually have coverage may not go for treatment. They may not engage in any kind of preventive strategy. So that's a whole other set of questions.

I'm out of time. Thank you very much.

Senator BINGAMAN. Senator Alexander.

#### SENATOR ALEXANDER

Senator ALEXANDER. Thank you, Mr. Chairman. And thank each of you for coming. Very interesting testimony.

I attended the Health Summit yesterday that President Obama held which I appreciated. I think all of us there want to work with him, and there's a consensus in the room that we need to have a solution where every American has access to health insurance.

There seems to be a broad consensus, that while harder to implement, that that included a significant involvement by the private sector. We'll see how that works as we go, but we have that objective.

But the focus of the meeting was not how do we deal with the uninsured, it was how do we control health care costs. That was the purpose of the meeting. And the testimony that the President wanted to present to us which we've heard before is that if we don't do something about controlling the growth of health care costs we're going to bankrupt the country.

Today, 45 percent of our Gross Domestic Product is the amount of our debt. On the course we're going according to testimony yesterday, it would be two to three hundred times the amount of our debt. So everyone also agreed that, we need to control the growth of costs.

So my question is, how do we reconcile making sure that every American is insured, which is also our goal on the Republican side and also the goal on the Democratic side, with controlling health care costs. I was intrigued with Ms. Turner's comment about the definition of insurance. And wonder if others on the panel agree with it.

I mean, your suggestion is that the definition of insurance might be to provide financial protection for major medical bills rather than protect against most expenditures on health care. Or as Sen-

ator Enzi put it, that insurance might be for the catastrophe or the serious medical problem and that there might be a different attitude toward the oil changes or the tire changes. So my question—and Senator Bingaman asked the question well—what would be the public interest in allowing competition for that?

Well, maybe the question might be, that the answer might be controlling all costs—which we have to do. Is it not a possible solution or maybe this is what you all recommend any way that we have a minimum benefit for these major expenses? And that we encourage competition for everything else.

Is that practical? Would that control cost? And does that differ significantly than the way Massachusetts did it? Ms. Turner, then maybe Ms. Schoen, your comment on that.

Ms. TURNER. Thank you, Senator. I absolutely agree that the debate gets confused—thinking about routine costs and major medical expenditures and putting them into the same package.

Whole Foods, another example, decided that it wanted to move to one of these account-based plans. It said we can save on insurance costs if we move the deductible up to say, \$2,000. But we're going to put \$1,800 into an account to make sure people have money to see the doctor to get routine care, to get the medicines they need. But anything above \$2,000 is going to be covered by the insurance policy.

Whole Foods pays 100 percent of the premium for the insurance. So, if you have that kind of a partnership in which you're really working with employees to help them monitor their own use of the system, but give them the resources to access routine care. And they're going to know more what that is than somebody at the health and human services. Then they also are protected against the larger costs.

But I would strongly encourage that it be a dollar threshold and not a benefits package because we just can't know what everyone is going to need.

Senator ALEXANDER. Now Ms. Schoen, what's wrong with that?

Ms. SCHOEN. I think for starters we need to look at where our spending is. We absolutely need caps, out-of-pocket protection. But if 50 percent of the healthiest people in the United States stopped going all together, just didn't use a single service, it counts for only 3 percent of the spending dollars.

Almost all of our national spending is among sicker patients, chronically ill and acute care. So, we want to address that long-term cost curve—it's not at this front end, it's at the high end. The same cost we're trying to protect people against.

We are going to have to do payment reform. We have a set of incentives that reward doing more with our volume rather than our outcomes and more prudent use of resources. A hospital that does extremely well taking care of someone and prevents a re-admission stands to lose money compared to—and does handoffs to primary care, stands to lose money over time because of volume of services in the hospital goes down.

I think we need to couple insurance reform with protecting patients and families. Thinking of those front-end costs around preventive care with positive incentives, a lot of the company examples are actually saying, how can we encourage and provide incen-

tives to get preventive care, particularly for diabetics and chronically ill to engage them. And then say what is happening in the insurance system that we are not paying differently.

The private sector has a lot of flexibility. But when you look closely they have no leverage. They are a very small share of the sicker population in any of their cities. We don't have coherent payment policies. Everyone is paying differently. We have layers and layers of cost, administrative cost, at insurance companies and hospitals.

I absolutely agree that costs are essential. And I think insurance, if designed well, will provide you a platform to start thinking much more creatively about the way we pay for care.

Senator ALEXANDER. Thank you, Mr. Chairman.

Senator BINGAMAN. Thank you.

Senator Hagan.

#### SENATOR HAGAN

Senator HAGAN. Thank you, Mr. Chairman. I think this is a very good meeting that you've put together. And I thank the panelists.

Just listening to the questions and the discussions, I think what you were just talking about, Ms. Schoen?

Ms. SCHOEN. It's actually pronounced Shane. Pronounced Shane, if you think of the cowboy movie.

Senator HAGAN. Shane.

Ms. SCHOEN. But beyond that, it doesn't look like that.

Senator HAGAN. It just seems like we're reiterating the need for the health information technology system so that we can, No. 1, have records available. And then be able to analyze the data from individual chronic diseases to individual institutions and across the country to see. Obviously we want the best outcome. But we also have got to have a better control on cost of health care in this country.

I was going to ask a question having to do with the risk segmentation. We're talking about a survey that showed that a number of adults in the United States are either uninsured or underinsured, either 41 or 42 percent which seems like an extremely high number. But I was just wondering about the breakdown of that, whether it is because there are not affordable options for health insurance for individuals or if it had to do with the young and healthy adults who feel like there's just no need at that point in their life to actually be covered.

Ms. Schoen, could you address that and anybody else?

Ms. SCHOEN. In the study that we did the underinsured were predominately low and modest incomes. So what you're seeing is an affordability. It's a mixture of young, middle-aged and older trying to figure out how to get a premium within an affordable range and then often having the packages available to them.

This would include people working for the small business market which often have very high deductibles, extraordinarily high and they've been going up or the individual insurance market. I want to stress Diane Rowland's testimony and Gail's also have it in, that it's not just the deductibles. But people are running into what I call insurance surprises.

There was a cap on total amount of radiation covered. No follow up care for cancer fully covered. It's something you wouldn't even know about until you get in that situation. That's where you get the risk segmentation.

There are prescription policies that don't exist at all that restrict insulin use. It's a subtle signal on who we want and who we don't. There are a lot of opportunities for risk segmentation that are quite subtle.

It's both this benefit limitation not covering it all or literally running out. My drugs are covered up until x dollars. And then I'm on my own.

It's this whole mix that people find themselves in the under-insured world.

Ms. ROWLAND. We've talked a little bit about mandated benefits. Well one of the mandated benefits in many States is mental health care. So that there are a lot of services that you would want to have as part of a package that are not just routine, but that can be very important for certain groups.

I think the real test of the adequacy of a health insurance plan is how well it covers someone with ongoing chronic illness. That's one of the places where if we can provide better early care and better coordinated care, we may actually save on the hospitalization side and be able to afford some of the other preventive services we need.

Ms. SHEARER. If I could just add to that one other problem that people have. Everybody doesn't have access to a wonderful employer based policy. Now State regulation varies.

But most people are in States where they will apply for an individual policy. If they have any pre-existing health conditions, if they've had a gap in coverage, they're probably going to end up either without a policy or with a policy filled with gaps that the gaps are designed around their needs. So it's a major part of the problem.

Ms. TURNER. I do think, that again argues that the thresholds for protection really do need to be dollar-denominated rather than sort of having a game. OK, we're going to cover what regulations say we must and then not cover other things.

I think that making sure people are protected financially is really the important consideration. Then doctors and patients can be more and have a greater role in making decisions about what care they need.

Senator HAGAN. Thank you, Mr. Chairman.

Senator BINGAMAN. I believe Senator Hatch was the first one at the hearing. So we should probably let him ask his questions at this point. Thank you.

#### SENATOR HATCH

Senator HATCH. Well thank you, Mr. Chairman. Welcome. We appreciate all of you being here and trying to help us with these very, very difficult issues and questions.

Let me go to you first, Ms. Shearer. In your testimony you stated,

“A necessary building block will be expanded research of comparative effectiveness so that we increase the knowledge base from making treatment and coverage decision. It would be better to cut the growth of health care costs and get better value for our health care dollar in order to be able to afford the coverage improvements and expansions necessary to eliminate the risk of being underinsured.”

Now I agree with the value and merits of doing comparative effectiveness studies, however only in terms of looking at clinical effectiveness and not for making treatment and coverage decisions based on costs. There's too much variability from patient to patient that directly affects the treatment outcomes. Therefore such decisions should be left up to the physician and patient who are most knowledgeable in their situation.

In fact, using comparative effectiveness to make broad-based coverage decisions has the potential to add unnecessary costs to the system. So my question is, do you agree that we should focus our comparative effectiveness efforts to ensure patient choice and protect medical innovation?

Ms. SHEARER. Well I think that the main focus is appropriately un-clinical research where there's a real need. But I'd like to tell you a few little stories about why I think that there is potential to save a lot of money through this kind of research. We have a program called Consumer Reports Best Buy Drugs where we identify alternative drugs that are equally effective and safe and less expensive.

Our researchers have found in looking at four categories of drugs for heart use, ace inhibitors, high blood pressure drugs and statins that if people switched from drugs that are more expensive to drugs that provide better value with no impact on health benefit, the potential savings are \$2.7 billion a year which is about 8 percent of the drug spending. So we think that even if the studies don't include cost there is the possibility for other groups, such as ours, to look at the data and find ways to bring these effectiveness results to the point of being able to help the system save money.

If you look at what happened at the drug effectiveness review project based in Oregon, they did not include Vioxx. Most of the States did not include Vioxx on their preferred drug list because of the comparative effectiveness research. That yielded tremendous benefits in terms of health care and cost.

So it's hard to make a blanket statement. I think there's a lot of potential for getting better value from this kind of research.

Senator HATCH. Well thank you.

Ms. Turner, in your testimony you make a point to state the flexibility in benefits is crucial to maintaining affordability.

Now last week Wal-Mart reported that almost 95 percent of its employees now have health care coverage due to a menu of coverage options with a variety of out-of-pocket costs and deductibles that meet each individual's unique needs. I don't know whether you've been asked this question or not because I had to be over on the floor. But what would be the impact on health care coverage, wages and jobs in these tough economic conditions if this flexibility is not preserved?

Ms. TURNER. That's really the crucial point, Senator Hatch, that companies are doing so much. It's under the radar really because it's not—

Senator HATCH. You talk about Fresh Foods. I mean, my gosh, people I understand love their approach.

Ms. TURNER. They do. And Wal-Mart for example takes very seriously not only helping people with routine costs. But also they're negotiating—they're working with the Mayo Clinic if somebody needs transplant surgery. So they're using their negotiating power to make sure that the large bills are covered and that they're getting the best deal and the best care as well on the small bills.

The flexibility of employers and the motivation of employers to make sure that their employees are getting the preventive and wellness care they need, as well as making sure they're getting the best care on the high end is crucial. I just think it would be such a shame to lose the incentive of employers to really look at health costs across the board and still make sure that their employees are healthy.

Senator HATCH. Well my colleagues on the other side hate health savings accounts even though they're working amazingly well on some of these companies. I guess it's because they think it's a Republican idea. But I don't think Republicans can take sole credit for that. I think it works.

Ms. TURNER. That's right.

Senator HATCH. Do I have time to ask one more question, Mr. Chairman?

Senator BINGAMAN. Sure, go right ahead.

Senator HATCH. Well let me ask one of Ms. Schoen. Your testimony recommends setting a minimum floor and standard for health insurance benefits. Having served in the U.S. Senate now in my 33d year, I can safely predict that every decent provider group out there will assert that their condition and service must be part of the minimum benefit package.

I mean, I guarantee you, they're going to want everything under the sun. And the end result will be a package that will be far from "minimum" in its form.

Now this in turn will raise the cost of coverage for millions of Americans and result in even greater numbers of uninsured and underinsured. Now how do you propose to address that challenge? And should we focus on actual value rather than defining benefits?

Ms. SCHOEN. I think focusing on value is incredibly important. The point I made in the testimony and I briefly mentioned what Massachusetts had done is thinking when we're talking about broad and scope it's not to limit for this disease or capping you. If you have cancer you're going to get no more than this, certain circumstances making it much more transparent.

To even cap the total amount of expenditures as has been suggested you have to say which expenditures would count toward that cap. So I think there are ways of looking at the interaction with premiums. Massachusetts went through a very interesting exercise where people looked at the implication of premiums for different decisions. Went broad and scope in terms of we're not limiting it to people with only certain diseases will get coverage and others will be excluded.

You won't have a surprise that if you need essential care—and we're talking about doctors, drugs, and hospitals when I'm talking about essentials. Because there were policies being sold that had no drug coverage and no physician coverage, literally none.

They had \$100 a day toward a hospital. So saying there's the floor. Then you can be more generous above it. And it's what most companies do.

When you look at the kind of floor that Massachusetts put in it was not below what any large company currently offers. So it was a reasonable package. Because you do—actually people do understand there's an implication for their premiums. I mean, they're thinking in terms of, I want affordable health care. And I also have to have affordable insurance.

Senator HATCH. My time is up. Thank you, Mr. Chairman.

Senator BINGAMAN. Senator Burr.

Senator BURR. Thank you, Mr. Chairman. If we haven't asked unanimous consent for our opening statements to be part of the record, may I ask that?

Senator BINGAMAN. We'll include any statement anyone wants to include in the record.

Senator BURR. Thank you, Mr. Chairman.

#### PREPARED STATEMENT OF SENATOR BURR

Mr. Chairman, thank you for holding this hearing today. I want to thank our witnesses for joining us as well.

Mr. Chairman, this is a timely, if somewhat narrowly focused hearing on an important aspect of health care reform. I understand that President Obama will be making some remarks to that point tonight and I look forward to hearing his thoughts. As I said at Senator Daschle's confirmation hearing, our goal should be to ensure affordable, high-quality health care coverage for all Americans. I believe that by addressing affordability, we can cure much of what ails our health care system.

American families are straining against an uncertain economic situation that is compounded by a health care system that is expensive and doesn't always deliver value where we need it. Because health care can be expensive, people tend to forgo needed medical treatment, especially so when our health insurance falls short of our needs.

What frustrates Americans about this situation is that we spend trillions of dollars on health care in this country, yet many feel like their coverage is inadequate if they have it. Americans currently spend around \$2 trillion on health care annually (16 percent of GDP). By 2013, that number is expected to double to \$4 trillion (21 percent of GDP). This spending trend is not projected to reduce the number of uninsured or underinsured.

I believe that before we can embark on the search of a solution, we need to understand why health care costs so much in this country. I am hopeful that our witnesses can articulate this for us today. In my view, we spend a lot of money on health care in this country, but we don't always buy value.

The government though isn't always a good judge of value. In our discussion today, we need to be careful about what constitutes "adequate" coverage. Mandating adequate coverage has not been

especially effective, when looked at holistically. Ideally, benefits mandates may ensure that people have adequate coverage, but that can be a moving target. I believe that experience with mandates has been a mixed bag and in some cases mandates create a costly barrier too high for many low-income Americans.

In the 110th Congress, Senator Coburn and I introduced the Universal Health Care Choice and Access Act. This bill contained several solutions to our health care problems—solutions that are mindful about what works in our current system. Whatever we do about the cost or availability of health care I think we should commit to not up-end what actually does work. Americans have the highest standard of care anywhere in the world, unfortunately the delivery and financing of that care breaks down from time to time. Our system is an engine of innovation that produces the advancements that extend life, defeat chronic diseases, and make minor health nuisances more livable. These are things we shouldn't take for granted. We should work to protect this country's crucible of medical innovation—but we can only do that by addressing the costly burden borne by American health care consumers.

Senator BURR. Mr. Chairman, I think most of us agree that one of the tasks before us is to make sure that we provide the resources in some way, shape or form so that every American can access coverage. And when I say access coverage, my hope is that we'll end up allowing them to construct what best meets their income, their health conditions, their age. Clearly this is going to be difficult, as we've seen, to try to achieve a consensus package.

Ms. Schoen, let me ask you, how do Americans rank in terms of out-of-pocket cost compared to counterparts in Canada and Europe?

Ms. SCHOEN. If you do the actual dollars? Very high. The only country that's up there with us is Switzerland in terms of dollars.

Senator BURR. But from out-of-pocket costs of the individual?

Ms. SCHOEN. Out-of-pocket costs. If you look at it as a percent of our national spending it doesn't look as high.

Senator BURR. I'm looking at the report that the Organization of Economic Cooperation and Development did where the out-of-pocket cost of the United States is 13 percent.

Ms. SCHOEN. Right.

Senator BURR. In the UK it is 13 percent.

Ms. SCHOEN. That's why I want to just try and make the distinction between the percent and the actual dollars. The UK currently spends about 8 percent of their national income on health care. We're at over 17 percent.

So when you take our 13 percent and multiply it times our \$8,000 to \$9,000 per person, the dollars are very high. That's the dilemma we've been in. Even when we protect people with insurance, their actual out-of-pocket costs relative to their wages are going up rapidly.

Senator BURR. The out-of-pocket cost for somebody in the UK is in fact, not 13 percent because they're being taxed a large amount to contribute to the cost of the government program. Yet on top of the government program they've still got 13 percent. In the case of Switzerland, 31 percent. In the case of Belgium, 22 percent. In the case of Poland, 28 percent.

As a percentage and not taking into account any of the other countries that I'm looking at, that we're comparing—

Ms. SCHOEN. I agree with you on the percents. I would be happy to give you the actual per person because what we're seeing is we have a very expensive health care system. We spend four times as much on insurance administration costs.

Senator BURR. A lion's share because we have allowed the benefit package to be dictated and with very little choice on the part of consumers. Consumers have a voice in many of the cases as to how the construction of the project goes.

I am 53 years old. My wife has told me we're not going to have any more children. But I can't buy a government program under FEHBP that doesn't have maternity.

I'm not going to use it. I know it. And I know I pay for it. But I can't buy a plan without it. And the reality is that that's frustrating for a lot of Americans.

What's the out-of-pocket cost for Medicare beneficiaries?

Ms. SCHOEN. It depends on whether they've bought a supplemental policy or they have Medicare only. It can be extremely high.

Senator BURR. The average though is 20 percent, isn't it?

Ms. SCHOEN. Again, it absolutely depends. And Diane may have more recent figures. When you take the Medicare only, the basic package people are very highly exposed. Most seniors have bought supplemental policies. So they limited their out-of-pocket.

Senator BURR. Let me turn to Ms. Rowland, if I can. From the perspective of adequate benefits, do you believe our government health coverage—and I'm specifically referring to FEHBP—program provides an adequate benefit?

Ms. ROWLAND. The FEHBP program clearly covers a full range. So I would qualify that as an adequate benefit package.

Senator BURR. Now under FEHBP we have a lot of different plans we can choose from. Some are high deductibles. But you're confident in the way that you've stated it, that adequate is that there's an entity that looked at it and if a member of FEHBP chooses to have the high deductible verses to have the thing that covers first dollar that that's adequate. That the consumer, me, the Federal employee, have made that choice.

Ms. ROWLAND. Yes. And in the end someone who incurs their high level of say, cancer treatment, may find that that policy leaves them with a substantial financial burden. But the benefit began as a standard benefit.

I would also point out that there's been a lot of discussion here about competition and Medicare Part D. But Medicare Part D does define what the benefit is so that it's not just an undefined benefit.

Senator BURR. It does define the benefit. But it defines it in the loosest terms. A minimum that must be met and for any senior then they can choose a plan that has a more exhaustive coverage that happens to, in the case of Ms. Schoen—or excuse me, Ms. Shearer talked about equivalent drugs.

If, in fact, a particular plan doesn't carry the drug you and your physician have decided is best suited for you, then you can choose another plan that might substitute that heart medication and might cover that particular drug. But the individual at the end of

the day chooses from those competitive bid plans which one best suits their needs and their income.

Ms. ROWLAND. Correct. But the benefit there is providing a service benefit, not just a dollar cap on spending for prescription drugs, which is my point. That it does have a definition of benefits which is similar to what we've talked about for general health insurance.

Senator BURR. I thank the Chair.

Senator BINGAMAN. Senator Coburn, you're the last one up. The vote has started. So go right ahead.

SENATOR COBURN

Senator COBURN. Thank you. I'm sorry I missed most of your testimony. I did read it last night. It was my bed partner for a good portion of the evening.

Let me just see if any of you disagree with the following. Does anybody disagree that preventive care outside of the deductible ought to be something that's important?

OK.

Does anybody disagree that there's a tremendous advantage to the medical home model?

Does anybody disagree there needs to be payment reform?

Does anybody disagree that the insurance products that are out there today are only less than two-thirds of the money that is actually paid for the insurance goes for either preventive care or treatment?

I'm asking the questions because the problem isn't access. The problem is cost. There's no transparency in the market.

You all, through your testimony and every other thing with the solutions that we're offering, the No. 1 problem is cost. So without transparency, without real markets, one of the reasons our costs are out of control is that there is no competition. Now we heard a moment ago about caps on all of these.

Medicare has got all sorts of caps. When people run out it's on them. So we're not going to have a cap-less system. We can't afford Medicare the way we have it today.

We need payment reform. I would absolutely agree with that. But we can't also deny the fact that Medicare has got caps, much more so than Medicaid does.

I'm interested, Ms. Schoen in the numbers in Massachusetts. I'm just going to ask if this is accurate or not. It may not be. But is it not true that the cost estimate that went up for the per year increase last year for the Massachusetts plan was 10 percent?

Ms. SCHOEN. I actually can't speak exactly to the cost estimate because the most recent numbers that John Kingsdale presented last week indicate rates are coming in quite low this year. They've actually had some reductions, particularly for the low-income they were very—

Senator COBURN. I mean last year their cost increase, on average, was up 10 percent for their care plan.

Ms. SCHOEN. For some of the plans, but not all. And they've been coming down. They're modified.

The other thing they found is when they consolidated their individual small group market and brought the healthy lives in, they had a dramatic decrease in the premiums with an improvement in

benefit policies. So bringing risk pools back together have been a big benefit.

Senator COBURN. I'm not against the risk pool concept. But it is true that the average family policy in Massachusetts is \$16,897. And the rest of the country, it's \$5,799, so 3½ times greater for a mandated set of benefits.

I want to talk for a minute with each of you about comparative effectiveness because the thing that I worry about is comparative effectiveness and there's no question we can do it on drugs and all sorts aside. The thing that often times isn't considered as a practicing physician is, I try to put people on generics. But side effects are a significant complication.

So some nongeneric drugs actually work better, even though they're much more because the patient will take the medicine. You know, I can give them another drug which costs a whole lot less. But if they don't take it I'm not helping them.

The thing that worries me about comparative effectiveness as a physician that's practiced 25 years or so is the art of medicine is totally ignored, totally ignored in comparative effectiveness. And what we see in England is the art is out. But we don't have the art of medicine practice because they've used comparative effectiveness based on cost.

I wonder if you all could address for me or at least assuage some of my concerns about using comparative effectiveness. And how you could use what I think is about 40 percent of the practice of medicine is art and 60 percent is science. Are my concerns legitimate? I guess that's what I'd ask.

Ms. TURNER. We actually invited an expert of the National Institute for Clinical Excellence in the UK to come over and talk with us about it. There are huge concerns, particularly about people who are outside the very center—20, 30, 40 percent of patients being able to access the medicines they needed because it is a gigantic political issue then to get those drugs covered. Many people wind up not actually having access to the care they need.

The National Institute for Clinical Excellence research shows it actually is driving up cost in the system. We can talk about some of the reasons for that later. But it's even when they use cost in the equation, it's still not helping to contain cost. And it does interfere with the practice of medicine, absolutely.

Senator COBURN. Other comments?

Ms. SHEARER. Let me just talk a little bit about what we have found. We have found that by providing information we can open conversations between physicians and patients. Right now often physicians are not aware that their patient is getting to the drug store and not able to pick up their medicine because they can't afford it.

We believe that the power of information is tremendous. We also believe that we need to have a process, ultimately, that provides for the exceptions. And maybe it's a question of step therapy or a protocol where we don't necessarily start with the most expensive. This Nation can't afford to keep starting with the most expensive treatment.

Hopefully we can find a way to work toward a model where we get better value and we achieve the information and the communication and ultimately save money.

Senator COBURN. Is it your assumption that we start with the most expensive initially?

Ms. SHEARER. In many cases we do.

Senator COBURN. I'm sorry. I have not seen that in any of the practice of medicine that I've been exposed to. I think probably what you're referring to is that we've had such great benefit from sub specialization. And then we use sub specialists for primary care.

Example, you strain your back. You come to me. The first thing I do is not order an MRI. I put you on muscle relaxers, pain relaxer, bed rest and do a good clinical exam.

If you go to an orthopedist or a neurosurgeon, the first thing they order is an MRI. So, you know, we have to sort some of that out. But the benefits of sub specialization have markedly given us greater health care. But also significantly raise the cost because we don't have the differentiation.

Could I continue for 1 more minute?

Senator BINGAMAN. Sure. I think I may go over and vote. Why don't you just conclude the hearing.

Senator COBURN. Alright. I will. Thank you very much.

Senator BINGAMAN. Thank you all. Let me thank all the witnesses. Thank you.

Senator COBURN. My biggest worry, we've all talked about health IT and how it can help us. We just spent a ton of money on that in the Stimulus package which won't be spent until after 2011, any of it. But health IT isn't going to help us any time until we have interoperability where the health IT can talk to everybody.

So that the pharmacist can e-mail back that the patient didn't pick up the prescription. In other words so we have the connection. We have the warning set up so that we can all talk.

Let me thank each of you. You know every American is interested in this, no matter what it is. But I'll tell you one thing they're interested in more, is that they want to know that they get to choose who is going to care for them. And they want to be involved in the decisionmaking.

That should be the rail that we run up against that we should not violate as we move toward this. And with that I will adjourn our hearing. Thank you.

[Additional material follows.]

## ADDITIONAL MATERIAL

## PREPARED STATEMENT OF SENATOR BROWN

Last week, the U.S. Department of Labor reported that there are currently 11.6 million unemployed Americans and that the unemployment rate has risen to 7.6 percent. Over the past year, the number of unemployed persons has increased by 4.1 million and the unemployment rate has risen by 2.7 percentage points. In a country that provides health coverage predominantly through employment, an economic decline not only causes jobs to disappear, it causes health coverage to disappear.

Much-needed and deserved attention has been devoted to the problem of uninsured Americans. In fact, the Institute of Medicine (IOM) will be releasing a report today, entitled, "America's Uninsured Crisis: Consequences for Health and Health Care." As Congress, policymakers, and experts continue to discuss and consider potential solutions to the crisis of uninsurance, it is imperative that we also examine the crisis of underinsurance—the ways that inadequate health insurance affects American families and contributes to the deterioration of our health care system.

Approximately 46 million Americans are uninsured. An additional 25 million Americans are underinsured—living with health insurance that does not adequately protect them from catastrophic health care expenses. Underinsured individuals are generally defined as adults between 19 and 64, whose out-of-pocket health care expenses, excluding premiums, are 10 percent or more of family income. It is estimated that 42 percent of U.S. adults were uninsured or underinsured in 2007.

It is important to note that this definition, while extremely useful, is actually incomplete. Other populations, including children in underinsured families and seniors who lack coverage to supplement Medicare, also face significant challenges in our health care system. I believe that Chairman Bingaman has rightly chosen to focus on one population at a time; however, we would do well to remember that underinsurance is common to every age group in all but the wealthiest segment of our society.

It is not a niche issue; it is a national issue.

Inadequate health coverage leaves Americans exposed to significant financial risk. Underinsurance can quickly undercut the financial stability of middle class families and turn financial stability into financial ruin.

Consumers Union found that 30 percent of the underinsured had out-of-pocket costs of \$3,000 or more for a single year and a Health Affairs study found that one quarter of underinsured people have deductibles of \$1,000 or more. Other Americans have coverage with lifetime caps on coverage that cut off support to individuals with cancer and other catastrophic conditions. A Commonwealth Fund survey found that 46 percent of the underinsured report being contacted by collection agencies for medical bills.

Those are the financial implications. The health care implications are even more alarming. According to a Health Affairs study, 53 percent of the underinsured forgo needed medical care—they may not fill their prescriptions, they may delay care or forgo a screening test. They may avoid health care until the lack of it catches up to

them, whether that means the need for more expensive treatments or a diagnosis that at one time was neutral and is now life threatening.

Underinsurance has not just hurt individuals financially; it has harmed them physically—sometimes irreversibly.

I would like to tell you the story of Denny and Debbie Byers from Columbus, OH. Denny worked construction for 34 years before he and his wife Debbie, a bank teller, retired and tried to purchase health insurance through the private market. While Denny was able to secure private health insurance, Debbie was unable to find coverage due to pre-existing allergies and asthma.

However, Denny quickly found out that his newly purchased health insurance did not cover his usual doctor's visits, nor did his insurance cover his two high blood pressure medications or his migraine medication. Denny has since chosen to pay out-of-pocket for generic versions of the blood pressure medications, but cannot afford the \$30 per pill price-tag associated with the migraine drug, for which there is no generic.

Denny has insurance that doesn't cover the care he needs. That's not coverage; it's a crock.

It's not enough to fight for affordable coverage, we must fight for real coverage. Coverage that provides financial protection for what people need, regardless of their current health status, regardless of their past health care needs, regardless of their income, regardless of their age.

Health insurance shouldn't be a vehicle for punishing the sick and rewarding the healthy.

It shouldn't be a hammer that beats health care costs down by arbitrarily denying care to those who need it.

Health insurance shouldn't be used to bring down costs; logic and knowledge and research and health system accountability and information technology and reasonable expectations should be used to bring down health care costs.

We need a health care system that provides the right care, at the right time, at the right level, and we need health insurance that covers it.

We don't need health insurers who cherry pick or health insurance that shortchanges its enrollees.

Underinsurance is a promise half-fulfilled, and when it comes to the health of our children, our parents, and ourselves—when it comes to the health of Denny and Debbie Byers of Columbus, OH—half-way is not good enough.

Thank you for holding this hearing, Mr. Chairman. I look forward to hearing from our witnesses.

[Whereupon, at 11:27 p.m. the hearing was adjourned.]

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