
**Statement by**

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**Before the U.S. Senate**

**Committee on Finance**

**Roundtable on Health Care Coverage**

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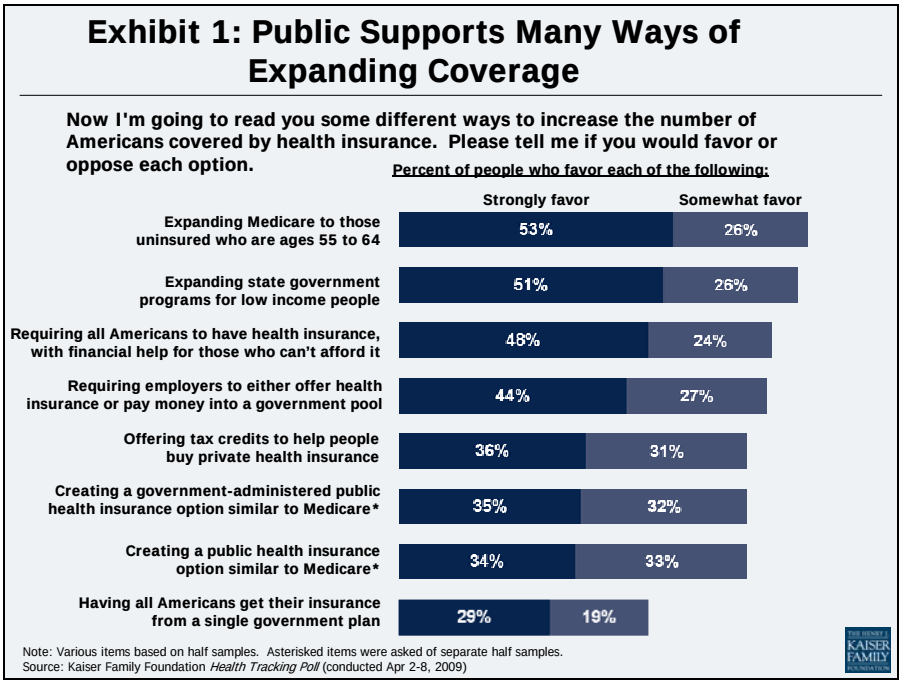
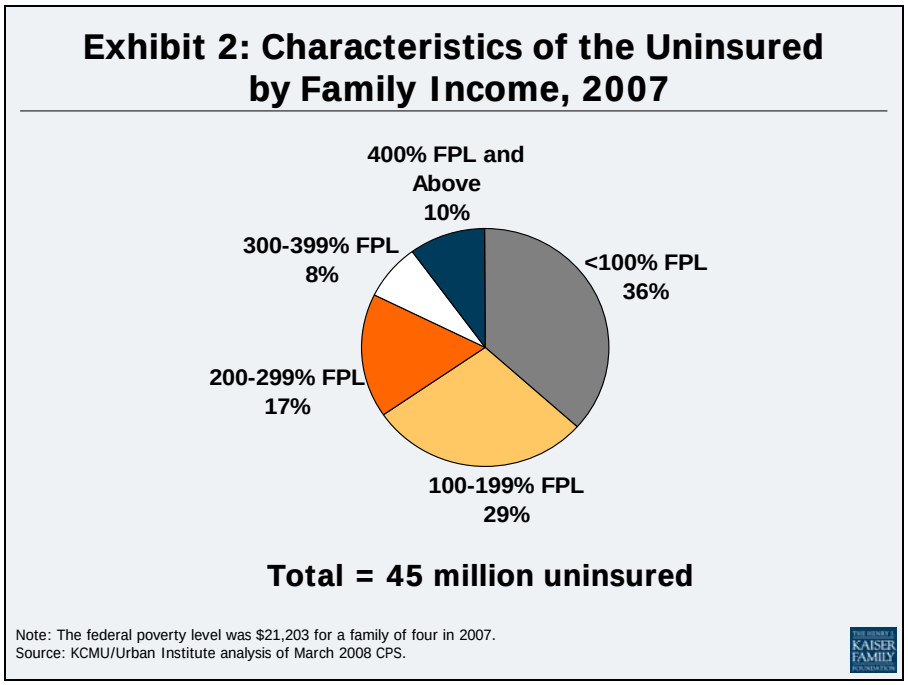
Thank you for the opportunity to participate in this roundtable discussion on health insurance coverage and the challenge of ensuring access to quality and affordable coverage for all Americans. I am Gary Claxton, a Vice President of the Kaiser Family Foundation, and Director of the Foundation's Health Care Marketplace Project. The Kaiser Family Foundation is a non-profit, private operating foundation that provides facts, information and analysis about the major health care issues facing the nation. Our work documents the public's continuing concern about access to and the cost of health insurance, as well as the health and financial consequences for those without adequate coverage.

A recent Kaiser poll shows that a majority of Americans continue to support health reform despite extremely difficult economic conditions. A majority of the public (59%) believes health care reform is more important than ever, compared with the 37% who say we cannot afford health reform given the serious economic problems facing the country.[1] Respondents expressed support for a variety of approaches to expand coverage, including expanding public programs for the poor and requiring individuals to have health insurance with financial assistance for the poor (Exhibit 1). These findings suggest that, with a depressed economy and rising unemployment, people understand that their access to affordable health care is fragile. The support for reform also may reflect people's experiences with the cost of medical care. Almost 3 in 10 (29%) of poll respondents reported that they or a member of their household did not fill a prescription because of cost, and 27% reported skipping a recommended medical test or treatment. Roughly a quarter said that in the past year they or a family member had problems paying medical bills; this percentage rises to more than 40% among people who are uninsured, report fair or poor health, earn less than $30,000 per year, are African American, or have put off health care due to costs.



Research demonstrates that health insurance is a key link to ensuring that people receive the health care they need when they need it.[2] 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 in better health.[3] 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 less likely to receive critical screening services that could lead to early detection and better treatment options for cancer.[4] On all measures, those with health insurance have better access to care than the uninsured.

More than 45 million people do not have health insurance, and millions more have coverage that does not protect them from high medical costs if they become seriously ill. Extending access to meaningful coverage to all of those without it is an enormous challenge and will mean addressing several difficult issues. The primary issue that will need to be addressed is the cost of coverage. About two-thirds (66%) of the uninsured in 2007 were in families with incomes below twice the federal poverty level (or $42,400 for a family of four in 2007), and another 17% had family incomes between two and three times the poverty level (Exhibit 2). Health insurance is expensive – the average premiums for employer-sponsored coverage in 2008 were $4,704 for single coverage and $12,680 for family coverage[5] – which means that many of the uninsured will not be able to afford health insurance without significant financial assistance. Although current premiums for nongroup coverage are much cheaper and apparently more affordable than group premiums, the costs in the nongroup market reflect the better than average health of non-group enrollees (coverage is underwritten for health) as well as the relatively high cost sharing and coverage limitations that characterize many policies in that market.[6] Analysis by researchers at the U.S. Department of Health and Human Services (HHS) found that in 2003, over half of nonelderly people (53%) with nongroup coverage were in families with out-of-pocket health spending for premiums and cost-sharing that exceeded 10% of their disposable income, including 21% in families where out-of-pocket spending exceeded 20% of disposable income.[7] While premium payments, which nongroup enrollees must pay entirely out-of-pocket, were an important factor in this out-of-pocket burden, higher out-of-pocket spending for health services also contributed. About 13% of people with nongroup insurance were in families where out-of-pocket spending for medical services exceeded 10% of disposable income, including 6% with family out-of-pocket spending for medical services that exceeded 20% of disposable income.[8] This raises the question of whether the out-of-pocket liability associated with current nongroup coverage would provide sufficient financial protection and access to services for the low and moderate income families reform proposals are trying to reach.[9]




A second issue is assuring that health insurance provides the range of services that people need and protects them from too-high out-of-pocket costs when they need care. While having insurance is clearly better than being uninsured, the scope of currently available 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.

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 U.S. in the spring of 2008 to learn more about their ability to pay for health care.[10] 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 copayments, deductibles, and out-of-pocket costs for care not covered by the insurer that posed a severe financial strain. While copayments 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.

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, nearly a quarter reported the plan paid less than expected for a medical bill for their family member and one in ten reached the limit the plan would pay for cancer treatment. 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 one in ten turned to relatives for help. Although those without insurance faced significantly more challenges, 7% of people who said the person with cancer was insured reported being unable to pay for basic necessities and 3% said they needed to declare bankruptcy. Cost considerations not only affected financial stability for the family but in some cases compromised treatment for the cancer – 5% of the insured and 27% of the uninsured said they had delayed or decided not to get care due to costs. 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.[11, 12]

A recent report which we conducted jointly with the American Cancer Society highlights some of the serious challenges that cancer patients can face in paying for life-saving care, even when they have private health insurance. The report 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 a cancer diagnosis can lead to large medical debts, personal bankruptcy, or delayed or forgone medical treatment due to high out of pocket expenses, and can threaten a patient's access to employer-sponsored health insurance if they become too sick to work and are unable to afford COBRA premiums. In addition to the cost-sharing and deductibles, which can add up to large amounts for patients during the course of cancer treatment, people can face maximum limits on their benefits or find that their policy does not pay for treatments recommended by their doctor. One profiled patient faced a cap of $250 per illness for coverage of radiation and another had an annual limit of $10,000 for outpatient costs – amounts easily exceeded in the course of treatment for many cancers.[13]

As the cancer patient profiles point out, having health insurance does not always protect patients from high costs. The analysis by HHS researchers of 2003 health spending, discussed above, found that almost 9% of the nonelderly were in families with out-of-pocket spending for health services (not including premiums) exceeding 10% of disposable income. For about half of these people (4% of the nonelderly), family out-of-pocket spending for health services exceeded 20% of disable income. Protection from high out-of-pocket costs varied significantly among people with different types of coverage. For people with employer-sponsored insurance, 6% were in families where out-of-pocket spending on health services exceeded 10% of disposable income, while 13% of people with nongroup insurance had family out-of-pocket spending for health services exceeding 10% of income. An even higher percentage (17%) of people with public coverage were in families with high out-of-pocket spending for health services; people with public coverage had much lower average levels of out-of-pocket spending on services, but because their incomes are so low, a relatively high percentage exceeded 10% of disposable income.[14]

These studies, and many others, highlight the consequences for families when their health insurance does not protect them from the high out-of-pocket costs that can result from severe or chronic illness. Assuring that health insurance premiums are affordable is not a sufficient assurance that health care is accessible and affordable. High levels of cost-sharing and caps on covered benefits can compromise the level of protection health insurance provides and lead both to reduced access to needed care and to serious financial burdens and medical debt.

A third issue is assuring that people who have access to financial assistance also have a place to purchase coverage, even when they are in poor health. People without access to employer-sponsored coverage or Medicaid generally must purchase nongroup coverage, either directly from an insurer or through an association. In most states insurers are able to deny coverage to applicants with health problems, and in some states may charge them higher premiums, limit available benefits, or both. In many cases more general pre-existing condition exclusion provisions permit insurers to deny claims for a specified period that are associated with conditions that can be shown to have existed when the coverage was issued. These practices protect insurer risk pools and help lower premiums, but they inhibit movement across the marketplace, subject applicants and policyholders to uncertainty about their coverage, and limit meaningful access to coverage for people that have developed health problems. State high risk pools in a number of states and the portability provisions in the Health Insurance Portability and Accountability Act (HIPAA) provide access to coverage for people with health problems, although premium costs can be high and coverage options are limited. A few states require nongroup insurers to cover all applicants without varying rates by health status. These states are able to assure access to people with health problems, but have had a difficult time maintaining affordable premiums rates for healthier people.

Many health reform proposals would eliminate restrictive practices, ending the use of health status in coverage decisions and rating. Proponents envision creating a competitive market where carriers compete on price, service and quality rather than on risk selection. This type of transformation is feasible if health reform can substantially increase participation by those without group coverage so that nongroup insurers are getting a reasonable mix of healthy and less-healthy people. If access is assured, less-healthy people will seek coverage, so the goal must be to make coverage attractive for healthier people as well. This will require meaningful premiums subsidies to make coverage affordable for the significant number of lower and moderate income people currently without insurance. Other policies, such as legal requirement to have coverage, automatic enrollment of uninsured people unless they opt-out, or meaningful penalties for people who decline opportunities to enroll, may be needed to protect the reformed market from adverse selection and higher premiums, and to permit the desired type of competition among insurers.

The changes envisioned for the nongroup market are transformative, but they are likely to cause some dislocation for people who have benefited from current market

practices. There is understandably a desire to move forward with reform while finding ways to cushion the impact on people who like their current arrangements. Preserving some of the current market practices during a phase-in period is one option, but this may not make sense given the tens of millions of previously uninsured people who may come into the nongroup market under some reform scenarios. It is quite likely that the number of new participants will match or exceed the number of people currently insured in the nongroup market. Further, many people who currently have nongroup coverage also may want to change the coverage they have when premium subsidies become available. Permitting these new enrollees to join a more open and freely operating nongroup market would seem to be a desirable policy goal. A potential approach, which is similar to how federal changes in the Medicare supplemental insurance market were enacted, would be change market rules for newly enrolling people while permitting people with nongroup coverage already to maintain it, perhaps for a limited period of time. This could cushion the impact that rating reforms and any new benefit rules may have on people who are not covered in this market, while allowing less restrictive practices to be implemented.

The Committee faces a number of difficult challenges as it develops legislation to ensure that all Americans have access to quality and affordable health care. As the Committee and the Congress move forward on this critical task, budget constraints and the high cost of health insurance will undoubtedly lead to pressure to limit the scope of coverage and impose substantial cost-sharing to hold down federal costs. To achieve the goal of making quality health care affordable for all, however, cost concerns will need to be balanced against the expectation that health reform will bring improved coverage and lower health spending for families. Financial assistance will be needed if we want low and moderate income families to purchase coverage, and reasonable limits on out-of-pocket costs will be necessary if we want the coverage that is attained to provide meaning financial protection and access to services.

Thank you for your consideration.

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[1] Kaiser Family Foundation *Health Tracking Poll* (conducted Apr 2-8, 2009).
[2] Rowland, D. "The Adequacy of Health Insurance." Testimony before the Health, Education, Labor, and Pensions Committee of the U.S. Senate. *Addressing Underinsurance in National Health Reform,* Hearing, (February 24, 2009).
[3] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer," October 2008.
[4] Ward E, Halpern M, Schrag N, Cokkinides V, DeSantis C, Bandi P, Siegel R, Stewart A and A Jemal. 2008. "Association of Insurance with Cancer Care Utilization and Outcomes." *A Cancer Journal for Clinicians*, 58:9-31.
[5] Employer Health Benefits 2008 Annual Survey, *Kaiser Family Foundation and Health Research & Educational Trust (HRET)*, September 2008.
[6] Kaiser Family Foundation, "Comparison of Expenditures in Nongroup and Employer-Sponsored Insurance," February 2007.
[7] The analysis calculates out of pocket burden at the family level and assigns that burden to each person in the family. Because people are them categorized by their primary type of insurance coverage, in some instances the family out-of-pocket burden associated with a person will include spending by family members with different types of insurance.

[8] Banthin J and DM Bernard. 2006, “Changes in Financial Burdens for Health Care.” *Journal of the American Medical Association,* 296(22): 2712-2719.
[9] Altman, D. “Pulling It Together, From Drew Altman: What Do We Want Insurance To Be?” *Kaiser Family Foundation,* September 2008.
[10] Kaiser Commission on Medicaid and the Uninsured, “Snapshots from the Kitchen Table: Family Budgets and Health Care,” February 2009.
[11] USA Today/Kaiser Family Foundation/Harvard School of Public Health *National Survey of Households Affected by Cancer* (conducted Aug 1-Sept 14, 2006).
[12] Rowland, D. "The Adequacy of Health Insurance." Testimony before the Health, Education, Labor, and Pensions Committee of the U.S. Senate. *Addressing Underinsurance in National Health Reform,* Hearing, (February 24, 2009).
[13] Schwartz K, Claxton G, Martin K, and C Schmidt, “Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System,” *Kaiser Family Foundation and American Cancer Society,* February 2009.
[14] Banthin J and DM Bernard. 2006, “Changes in Financial Burdens for Health Care.” *Journal of the American Medical Association,* 296(22): 2712-2719.