C o m m o n w e a l t h o f V i r g i n i a , E x R e l .D oKce.n

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Richmond Division

COMMONWEALTH OF VIRGINIA, ex rel. Kenneth T. Cuccinelli, II, in his official capacity as Attorney General of Virginia, Plaintiff, v. KATHLEEN SEBELIUS, Secretary of the Department of Health and Human Services, in her official capacity, Defendant.	))))))))))))))	Civil Action No. 3:10-cv-00188-HEH

APPENDIX OF EXHIBITS IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

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3	CBO, THE LONG-TERM BUDGET OUTLOOK (June 2009) (excerpts)
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6	Katherine Baicker & Amitabh Chandra, *Myths and Misconceptions About U.S. Health Insurance*, 27 HEALTH AFFAIRS w533 (2008) (excerpts)
7	Jonathan Gruber, PUBLIC FINANCE AND PUBLIC POLICY (3d ed. 2009) (excerpts)
8	Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. OF HEALTH ECON. 225 (2005) (excerpts)
9	Mark V. Pauly, *Risks and Benefits in Health Care: The View from Economics*, 26 HEALTH AFFAIRS 653 (2007) (excerpts)
10	CBO, *How Many People Lack Health Insurance and For How Long?*, at 4, 9 (May 2003) (excerpts)
11	June E. O’Neill & Dave M. O’Neill, *Who Are the Uninsured?: An Analysis of America’s Uninsured Population, Their Characteristics, and Their Health* (2009) (excerpts)
12	National Center for Health Statistics, HEALTH, UNITED STATES, 2009 (2010) (excerpts)
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16	Families USA Foundation, *Health Reform: Help for Americans with Pre-Existing Conditions* at 2 (2010)
17	Sara Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 NEW ENGL. J. MED. e29 (2010)
18	Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008) (excerpts)
19	Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs 2008*, 27 HEALTH AFFAIRS w399 (2008)
20	CBO, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS (2006) (excerpts)
21	CEA, ECONOMIC REPORT OF THE PRESIDENT (Feb. 2010) (excerpts)
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23	M.E. Martinez & R.A. Cohen, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-June 2009*, National Center for Health Statistics (Dec. 2009) (excerpts)
24	U.S. Census Bureau, Census Population Survey, *Annual Social and Economic Supplement* (2009) (Table H101, data on coverage status by age) (available at www.census.gov/hhes/www/cpstables/032009/health/ h01_001.htm)
25	William H. Frist, *An Individual Mandate for Health Insurance Would Benefit All*, U.S. NEWS & WORLD REPORT (Sept. 28, 2009) (available at politics.usnews.com/opinion/articles/2009/09/28/frist-an-individual-mandate-for-health-insurance-would-benefit-all.html)
26	Alan C. Monheit, et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23 HEALTH AFFAIRS 167 (2004)
27	Stephen T. Parente & Tarren Bragdon, *Healthier Choice: An Examination of Market-Based Reforms for New York's Uninsured*, MEDICAL PROGRESS REPORT No. 10 (Manhattan Institute, Sept. 2009) (excerpts)

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28	Jonathan Gruber, Mass. Inst. of Tech., *The Senate Bill Lowers Non-Group Premiums: Updated for New CBO Estimates*, at 1 (Nov. 27, 2009) (available at www.whitehouse.gov/files/documents/Gruber_Report_4.pdf)
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32	CBO, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 23-25 (Nov. 30, 2009) (excerpts)
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35	Joint Comm. on Taxation, 111th Cong., *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in Combination with the "Patient Protection and Affordable Care Act"* (Mar. 21, 2010) (excerpts)

Exhibit 1

111TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
111–443

THE RECONCILIATION ACT OF 2010

REPORT

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 4872

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 202 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010

together with

MINORITY VIEWS

VOLUME II
DIVISION II–III

MARCH 17, 2010.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

dropped from 61 percent to 38 percent.[5] The number of uninsured Americans is expected to hit 61 million by 2020.[6] In no uncertain terms, the U.S. health care system is in crisis and has been for some time. Reform is needed. Inaction is not an option.

H.R. 3200, America's Affordable Health Choices Act, adopts the health care reform principles outlined by President Barack Obama. Specifically, the bill preserves and strengthens the employer-based health care system, includes protections for small businesses, creates a health insurance marketplace where individuals can choose between private insurance and the public health insurance option, ensures low and middle income Americans have access to affordability credits to help offset the costs of insurance and saves over $500 billion in future health outlays of Medicare and Medicaid through reforms to the system.

Together, these critical reforms are fundamental to the long-term health and security of this country.

II. Committee Action Including Legislative History and Votes in Committee

LEGISLATIVE HISTORY

For more than 70 years, Congress and Presidents have attempted to reform the nation's health care system, most recently under President Clinton in 1993–94. The election of the Democratic majority in Congress in 2006 and President Obama in 2008 have led to renewed efforts toward national health care reform. The legislative history described in this report is limited to legislative action beginning in the 110th Congress.

110TH CONGRESS (2007–2008)

HEARINGS IN THE HOUSE OF REPRESENTATIVES

Committee on Education and Labor

On March 15, 2007, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a hearing entitled "Examining Innovative Approaches to Covering the Uninsured Through Employer-Provided Health Benefits." The panel included: Joan Alker, Deputy Executive Director, Center for Children and Families; Brian England, Owner, British American Auto Repair Columbia; Andrew Webber, President and Chief Executive Officer, National Business Coalition on Health; and Linda Blumberg, Ph.D., Economist and Principal Research Associate, Urban Institute.

On May 22, 2007, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a hearing entitled "Health Care Reform: Recommendations to Im-

[5] National Small Business Association, "2008 NSBA Small & Mid-Sized Business Survey," Table at 14, available at: *http:www.nsba.biz/docs/2008bizsurvey.pdf.*

[6] 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," Exhibit ES–2: Trend in the Number of Uninsured, 2009–2020 Under Current Law and Path Proposal, February 2009, available at: *http:www.commonwealthfund.org//media/Files/Publications/Fund%20Report/2009/Feb/The%20Path%20to%20a%20High%20Performance%20US%20Health%20System/1237*__Commission__path__high__perform__US__hlt__sys__WEB__rev__03052009.pdf.

prove Coordination of Federal and State Initiatives.” The panel included: Congressman John Tierney (D–MA); Congressman Tom Price (R–GA); Congresswoman Tammy Baldwin (D–WI); Mila Kofman, J.D., Associate Research Professor, Health Policy Institute, Georgetown University; John Colmers, Secretary, State of Maryland Department of Health and Mental Hygiene; Steven Goldman, Commissioner, New Jersey Department of Banking and Insurance; John Morrison, Auditor and Commissioner, Montana Insurance and Securities; Amy Moore, Partner, Covington & Burling, LLP; and Kevin Covert, Board Member, American Benefits Council.

On September 25, 2008, the Committee on Education and Labor held a hearing entitled “Safeguarding Retiree Health Benefits.” The panel included: C. William Jones, Chairman, ProtectSeniors.org; Bill Kadereit, President, National Retiree Legislative Network; David Lillie, Retiree, Raytheon Missile Systems; Scott Macey, Senior Vice President and Director of Government Affairs, Aon Consulting, Inc; Norman Stein, Douglas Arant Professor of Law, University of Alabama; and Dale Yamanoto, President and Founder, Red Quill Consulting.

Committee on Energy & Commerce

On September 18, 2008, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled “America’s Need for Health Reform.” The panel included: Ronald E. Bachman, F.S.A., M.A.A.A., Senior Fellow, Center for Health Transformation; Governor Jon S. Corzine, State of New Jersey; Karen Davis, President, The Commonwealth Fund; Elizabeth Edwards, Senior Fellow, Center for American Progress; William J. Fox, F.S.A., M.A.A.A., Principal and Consulting Actuary, Milliman Inc.; E.J. “Ned” Holland, Jr., Senior Vice President, Human Resources and Communication, EMBARQ; Patricia Owen, President/Founder, FACES DaySpa; Stephen T. Parente, Ph.D., Director, Medical Industry Leadership Institute, and Associate Professor of Finance, Carlson School of Management, University of Minnesota; and Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University.

Committee on Ways and Means

On November 17, 2007, the Subcommittee on Income Security and Family Support in the Committee on Ways and Means held a hearing entitled “Impact of Gaps in Health Coverage on Income Security.” The panel included: Sherena Johnson, former foster youth, Morrow, GA; Sara R. Collins, Ph.D., Assistant Vice President, Program on the Future of Health Insurance, Commonwealth Fund; Ron Pollack, Founding Executive Director, Families USA; Bruce Lesley, President, First Focus; and Brian J. Gottlob, Senior Fellow, Milton and Rose D. Friedman Foundation, Indianapolis, IN.

On April 15, 2008, the Subcommittee on Health in the Committee on Ways and Means held a two-panel hearing entitled “Instability of Health Coverage in America.” The first panel included former Senator Dave Durenberger (R–MN). The second panel included: Diane Rowland, Sc.D., Executive Vice President, Kaiser Family Foundation; John Z. Ayanian, M.D., Professor of Medicine and Health Care Policy, Harvard Medical School; Michael O’Grady,

Senior Fellow, National Opinion Research Center, University of Chicago; Stan Brock, Founder and Volunteer Director of Operations, Remote Area Medical, Knoxville, TN; and Stephen Finan, Associate Director of Policy, American Cancer Society.

On May 14, 2008, the Subcommittee on Health in the Committee on Ways and Means held a hearing entitled "Health Savings Accounts and Consumer Driven Health Care: Cost Containment or Cost-Shift." The panel included: John F. Dicken, Health Care Director, U.S. Government Accountability Office (GAO); Michael E. Chernew, Ph.D., Professor of Health Care Policy, Harvard Medical School; Linda J. Blumberg, Ph.D., Principal Research Associate, Urban Institute; Judy Waxman, Vice President and Director of Health and Reproductive Rights, National Women's Law Center; and Wayne Sensor, CEO, Alegent Health.

On June 10, 2008, the Subcommittee on Health in the Committee on Ways and Means held a two-panel hearing entitled "Addressing Disparities in Health and Healthcare: Issues for Reform." The first panel included: Delegate Donna M. Christensen (D–USVI); former Congresswoman Hilda L. Solis (D–CA); Delegate Madeleine Z. Bordallo (D–GU); and Congressman Jerry Moran (R–KS). The second panel included: Marsha Little-Blanton, Dr.P.H., Senior Advisor on Race, Ethnicity and Healthcare, Kaiser Family Foundation; Mohammed Akhter, M.D., M.P.H., Executive Director, National Medical Association; Deena Jang, J.D., Policy Director, Asian and Pacific Islander American Health Forum; Anthony B. Iton, M.D., J.D., M.P.H., Director of Public Health and Health Officer, Alameda County, CA; Sally Satel, M.D., Resident Scholar, American Enterprise Institute; and Michael A. Rodriguez, M.D., M.P.H., Associate Professor and Vice Chair of Research, Department of Family Medicine, University of California, Los Angeles.

On September 11, 2008, the Subcommittee on Health in the Committee on Ways and Means held a hearing entitled "Reforming Medicare's Physician Payment System." The panel included: Bruce C. Vladeck, Ph.D., Senior Health Policy Advisor and Executive Director of Health Sciences, Ernst & Young, LLP; Gail Wilensky, Ph.D., Senior Fellow, Project Hope; Nancy H. Nielsen, M.D., Ph.D., President, American Medical Association; and Donald M. Crane, President and Chief Executive Officer, California Association of Physician Groups.

On September 23, 2008, the Subcommittee on Health in the Committee on Ways and Means held a hearing entitled the "Health of the Private Health Insurance Market." The panel included: Karen Davis, President, Commonwealth Fund; Bruce Bodaken, Chairman and Chief Executive Officer, Blue Shield of California; Roger Feldman, Ph.D., Blue Cross Professor of Health Insurance, University of Minnesota; and Mila Kofman, Superintendent of Insurance, Maine Bureau of Insurance.

HEARINGS IN THE SENATE

Committee on Health, Education, Labor and Pension

On January 10, 2007, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing entitled "Health Care Coverage and Access." The panel included: Peter Meade, Executive

Vice President, Blue Cross Blue Shield of Massachusetts; John McDonough, Executive Director, Health Care for All; Karen Davis, President, Commonwealth Fund; Andy Stern, President, SEIU; Debra Ness, President, National Partnership for Women and Families; Larry Burton, Executive Vice President, Business Roundtable; Peter Harbage, New America Foundation; Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute; John Goodman, President, National Center for Policy Analysis; and Pat Vredevoogd Combs, National Association of Realtors, and owner, Coldwell-Banker-AJS Realty.

On February 12, 2008, the Senate HELP Committee held a hearing entitled "Addressing Healthcare Workforce Issues for the Future." The panel included: A. Bruce Steinwald, Director, Healthcare GAO; Kevin Grumbach, M.D., Director, Center for California Health Workforce Studies, University of California San Francisco, and Chair, Department of Family and Community Medicine; Roderick S. Hooker, Ph.D., P.A., Director of Research, Rheumatology Section, Medical Service Department of Veterans Affairs, Dallas VA Medical Center; Edward S. Salsberg, M.P.A., Director, Center for Workforce Studies, Association of American Medical Colleges; James Q. Swift, D.D.S., Board President, American Dental Education Association; Bruce Auerbach, M.D., President Elect, Massachusetts Medical Society, and Vice President and Chief of Emergency Medicine, Sturdy Memorial Hospital; Beth Landon, M.H.A., M.B.A., Director, Alaska Center for Rural Health, University of Alaska; Jennifer Laurent, M.S., FNP–BC, President, Vermont Nurse Practitioner Association; and John E. Maupin, Jr., D.D.S., M.B.A., President, Morehouse School of Medicine.

Committee on Finance

On March 14, 2007, the Senate Committee on Finance held a hearing entitled "Course for Health Care Reform: Moving Toward Universal Coverage." The panel included: James J. Mongan, M.D., President and Chief Executive Officer, Partners HealthCare; Stuart H. Altman, Ph.D., Dean, Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University; John Sheils, Vice President, The Lewin Group; and Richard G. Frank, Ph.D., Vice Chair, Citizens' Health Care Working Group.

On May 6, 2008, the Senate Committee on Finance held a hearing entitled "Seizing the New Opportunity for Health Reform." The panel included the Honorable Tommy Thompson and the Honorable Donna Shalala, both former Secretaries of Health and Human Services.

On June 3, 2008, the Senate Committee on Finance held a hearing entitled "Rising Costs, Low Quality in Health Care: The Necessity for Reform." The panel included: Paul B. Ginsburg, Ph.D., President, Center for Studying Health System Change; Elizabeth McGlynn, Ph.D., Associate Director, RAND Health, and Distinguished Chair in Health Quality; Arlene Holt Baker, Executive Vice President, AFL–CIO; and Felicia Fields, Group Vice President, Human Resources and Corporate Services, Ford Motor Company.

On June 10, 2008, the Senate Committee on Finance held a hearing entitled "47 Million and Counting: Why the Health Care Mar-

ketplace is Broken." The panel included: Lisa Kelly, cancer patient; Raymond Arth, President and CEO, Phoenix Faucets; Ron Williams, Chairman and Chief Executive Officer, Aetna, Inc.; and Mark Hall, Professor of Law and Public Health, Wake Forest University School of Law and School of Medicine.

On September 9, 2008, the Senate Committee on Finance held a hearing entitled "Improving Health Care Quality: An Integral Step Toward Health Reform." The panel included: Peter V. Lee, J.D., Executive Director of National Health Policy, Pacific Business Group on Health; Samuel Nussbaum, M.D., Executive Vice President for Clinical Health Policy and Chief Medical Officer, WellPoint, Inc.; Gregory Schoen, M.D., Regional Medical Director, Fairview Northland Health Services; Kevin B. Weiss, M.D., President and CEO, American Board of Medical Specialties; and William L. Roper, M.D., M.P.H., Dean, School of Medicine, University of North Carolina (UNC), and Vice Chancellor for Medical Affairs and CEO, UNC Health Care System.

On September 23, 2008, the Senate Committee on Finance held a hearing entitled "Covering the Uninsured: Making Health Insurance Markets Work." The panel included: John Bertko, F.S.A., M.A.A.A., Adjunct Staff, The RAND Corporation, and Former Chief Actuary, Humana, Inc., Flagstaff, AZ; Andrew Dreyfuss, Executive Vice President, Health Care Services, Blue Cross Blue Shield of Massachusetts; Pam MacEwan, Executive Vice President, Public Affairs and Governance, Group Health Cooperative; and Kim Holland, State of Oklahoma Insurance Commissioner.

On November 19, 2008, the Senate Committee on Finance held a hearing entitled "Health Care Reform: An Economic Perspective." The panel included: Ivan G. Seidenberg, Chairman and Chief Executive Officer, Verizon Communications, Inc.; Andy Stern, President, SEIU; Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University; and Amitabh Chandra, Ph.D., Assistant Professor of Public Policy, John F. Kennedy School of Government, Harvard University.

111TH CONGRESS (2009–2010)

HEARINGS IN THE HOUSE OF REPRESENTATIVES

Committee on Education and Labor

On March 10, 2009, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a panel entitled "Strengthening Employer-Based Health Care." The panel included: Mark Derbyshire, Small Business Owner; Bruce Pyenson, Principal and Consulting Actuary, Milliman, Inc.; John Sheridan, CEO, Cooper University Hospital; Kenneth Thorpe, Chair of the Health Policy and Management Department, Emory University; E. Neil Trautwein, Vice President, Employee Benefits Counsel, National Retail Federation; and Jim Winkler, Health Management Practice Leader, Hewitt Associates.

On April 23, 2009, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a panel entitled "Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families." The panel included:

Karen Davenport, Director of Health Policy, Center for American Progress; David Himmelstein, Associate Professor of Medicine, Harvard University; Michael Langan, Principal, Towers Perrin; William Oemichan, President and CEO, Cooperative Network; Ron Pollack, Executive Director, FamiliesUSA; Janet Trautwein, Executive Vice President and CEO, National Association of Health Underwriters; and William Vaughn, Senior Health Policy Analyst, Consumers Union.

On June 10, 2009, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a hearing entitled "Examining the Single Payer Health Care Option." The panel included: Congressman John Conyers, Jr. (D–MI); Marcia Angell, M.D., Senior Lecturer in Social Medicine, Harvard Medical School; David Gratzer, Senior Fellow, Manhattan Institute; Geri Jenkins, R.N., Co-President, California Nurses Association/National Nurses Organizing Committee; and Walter Tsou M.D., M.P.H., National Board Advisor, Physicians for a National Health Program.

Committee on Energy & Commerce

On March 10, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: Designing a High Performing Healthcare System." The panel included: Doug Elmendorf, Director, Congressional Budget Office; Glenn Hackbarth, Chairman, Medicare Payment Advisory Commission; Jack C. Ebeler, Vice Chair, Committee on Health Insurance Status and Its Consequences, Institute of Medicine; Alan Levine, Secretary, Louisiana Department of Health and Hospitals; Atul Gawande, M.D., Associate Professor of Surgery, Harvard Medical School, and Associate Professor, Department of Health Policy and Management, Harvard School of Public Health; and M. Todd Williamson, M.D., President, Medical Association of Georgia Policy Studies.

On March 17, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: Ensuring Affordable Coverage." The panel included: Uwe E. Reinhardt, Ph.D., Professor of Political Economy, Economics and Public Affairs, Princeton University; Sally C. Pipes, B.A., President and Chief Executive Officer, Pacific Research Institute; Judy Feder, Ph.D., Senior Fellow, Center for American Progress Action Fund; Mila Kofman, J.D., Superintendent of Insurance, State of Maine Bureau of Insurance; Jon Kingsdale, Ph.D., Executive Director, Commonwealth Health Insurance Connector Authority, MA; Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University; Katherine Baicker, Ph.D., Professor of Health Economics, Harvard School of Public Health; and Edmund F. Haislmaier, B.A., Senior Research Fellow, Center for Health, Heritage Foundation.

On March 24, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: Improving Access to Care." The panel included: Brian D. Smedley, Ph.D., Vice President and Director, Health Policy Institute, Joint Center for Political and Economic Studies; Michael John Kitchell, M.D., President-Elect,

Iowa Medical Society, McFarland Clinic PC; Michael A. Sitorius, M.D., Professor and Chairman, Department of Family Medicine, University of Nebraska Medical Center; Risa Lavizzo-Mourey, M.D., M.B.A., President and CEO, Robert Wood Johnson Foundation; Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, Professor of Pediatrics, George Washington University; Jeffrey P. Harris, M.D., F.A.C.P., President, American College of Physicians; James R. Bean, M.D., President, American Association of Neurological Surgeons; and Diane Rowland, Sc.D., Executive Director, Kaiser Commission on Medicaid and the Uninsured.

On March 27, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: The Role of Public Health." The panel included: E. Besser, M.D., Acting Director, CDC, and Acting Administrator, Agency for Toxic Substances and Disease Registry; Jonathan E. Fielding, M.D., M.P.H., Chair, Task Force on Community Preventive Services, and Director, L.A. County Department of Public Health and County Health Officer; Heather Howard, J.D., Commissioner, New Jersey Department of Health and Senior Services; David Satcher, M.D., Ph.D., Former U.S. Surgeon General, and Director, Satcher Health Leadership Institute, Morehouse School of Medicine; Barbara Spivak, M.D., President, Mt. Auburn Cambridge Independent Practice Association, Inc.; Devon Herrick, Ph.D., Senior Fellow, National Center for Policy Analysis; and Jeffrey Levi, Ph.D., Executive Director, Trust for Americas Health.

On April 2, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: Saving Money, Saving Lives." The panel included: Jonathan Skinner, Ph.D., Professor of Economics, Dartmouth Institute for Health Policy and Clinical Practice; Christine K. Cassel, M.D., President and CEO, American Board of Internal Medicine and ABIM Foundation; John Goodman, Ph.D., President and CEO, National Center for Policy Analysis; Bruce Sigsbee, M.D., M.S., President Elect, American Academy of Neurology, and Medical Director, Pen Bay Physicians and Associates; Dennis Smith, M.P.A., Senior Research Fellow in Health Care Reform, Heritage Foundation; Jerry Avorn, M.D., Professor of Medicine, Harvard Medical School; Paul Ginsburg, Ph.D., President, Center for Studying Health System Change; Regina Herzlinger, Ph.D., Professor of Business Administration, Harvard Business School; Ronald Bachman, F.S.A., M.A.A.A., Senior Fellow, Center for Health Transformation; and Diane Archer, J.D., Director, Health Care Project, Institute for America's Future.

On June 16, 2009, the Subcommittee on Oversight and Investigation of the Committee on Energy and Commerce held a hearing entitled "Termination of Individual Health Policies by Insurance Companies." The panel included: Don Hamm, CEO, Assurant Health; Richard Collins, CEO, Golden Rule Insurance Company, UnitedHealth Group; Brian A. Sassi, President and CEO, Consumer Business, WellPoint, Inc.; Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University; Robin Beaton, Policyholder; Wittney Horton, Policyholder; and Peggy Raddatz, Relative of Policyholder.

Committee on Ways & Means

On March 11, 2009, the Committee on Ways and Means held a hearing entitled "Expanding Coverage, Improving Quality and Controlling Costs." The panel included: John Z. Ayanian, M.D., M.P.P., on behalf of the Institute of Medicine Committee on Health Insurance Status and Its Consequences; Karen Davis, President, Commonwealth Fund; and John M. Pickering, Principal, Consulting Actuary, Milliman, Inc.

On March 17, 2009, the Subcommittee on Health in the Committee on Ways and Means held a hearing entitled "MedPAC's Annual March Report to the Congress on Medicare Payment Policy." The panel featured Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission.

On April 1, 2009, the Committee of Ways and Means held a hearing entitled "Reforming the Health Care Delivery System." The hearing consisted of two panels. The first panel included: Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission; Elliot S. Fisher, M.D., M.P.H., Director, Population Health and Policy, Dartmouth Institute for Health Policy and Clinical Practice, and Professor of Medicine and Community and Family Medicine, Dartmouth Medical School; and Robert A. Berenson, M.D., Senior Fellow, Urban Institute. The second panel included: Glenn D. Steele, Jr., M.D., Ph.D., President and CMO, Geisinger Health System; L. Allen Dobson, Jr., M.D., F.A.A.F.P., Vice President for Clinical Practice Development, Carolinas Health System; and Brent C. James, M.D., M.Stat., Chief Quality Officer and Chief Medical Officer, Institute for Health Care Delivery Research, Intermountain Healthcare.

On April 22, 2009, the Committee on Ways and Means held a hearing entitled "Insurance Market Reforms." The panel included: Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy and Professor of Economics and Public Affairs, Princeton University; William Vaughn, Senior Policy Analyst, Consumers Union; William D. Hobson, Jr., M.S., President and CEO, Watts Healthcare Corporation; David Borris, Owner, Hel's Kitchen Catering, Northbrook, Ill.; Kenneth L. Sperling, Global Health Management Leader, Hewitt Associates, on behalf of National Coalition on Benefits; and Linda Blumberg, Ph.D., Principal Research Associate, Urban Institute.

On April 29, 2009, the Committee on Ways and Means held a hearing entitled "Employer Sponsored Insurance." The panel included: Elise Gould, Ph.D., M.P.Aff., Director of Health Policy Research, Economic Policy Institute; J. Randal MacDonald, Senior Vice President for Human Resources, IBM Corporation; Kelly Conklin, Owner, Foley-Waite Associates; Denny Dennis, Senior Research Fellow, NFIB Research Foundation; John Shells, Senior Vice President, Lewin Group; and Gerald Shea, Special Assistant to the President, AFL–CIO.

On May 6, 2009, the Committee on Ways and Means held a hearing on "Health Care Reform" with Kathleen Sebelius, the Secretary for Health and Human Services.

HEARINGS IN THE SENATE

Committee on Health, Education, Labor and Pensions

On January 29, 2009, the Senate HELP Committee held a hearing entitled "Crossing the Quality Chasm in Health Reform." The panel included: Nancy Davenport-Ennis, CEO, National Patient Advocate Foundation; Karen Davis, President, Commonwealth Fund; Rhonda Robinson-Beale, M.D., Chief Medical Officer, Optum Health Behavioral Solutions, Golden Valley, MN; Elizabeth Teisberg, Ph.D., Associate Professor, University of Virginia's Darden School of Business; and Christine K. Cassel, M.D., President, American Board of Internal Medicine.

On February 23, 2009, the Senate HELP Committee held a hearing entitled "Principles of Integrative Health: A Path to Health Care Reform." The panel included: Cathy Baase, M.D., Global Director Health Services, Dow Chemical Company; Robert M. Duggan, M.A., M.Ac., President, Tai Sophia Institute; James S. Gordon, M.D., Founder and Director, Center for Mind-Body Medicine; Wayne B. Jonas, M.D., President, Samueli Institute; Sister Charlotte Rose Kerr, R.S.M., R.N., B.S.N., M.P.H., M.Ac., Practitioner and Professor Emeritus, Tai Sophia Institute; Mary Jo Kreitzer, Ph.D., R.N., Founder and Director, University of Minnesota Center for Spirituality & Healing; Herbert Benson, M.D., Director Emeritus, Benson-Henry Institute for Mind Body Medicine, Massachusetts General Hospital; Brian M. Berman, M.D., Director, Center for Integrative Medicine, University of Maryland School of Medicine; Susan Hartnoll Berman, Executive Director, Institute for Integrative Health; Ron Z. Goetzel, Ph.D., Research Professor and Director, Institute for Health and Productivity Studies, Rollins School of Public Health, Emory University; Kathi J. Kemper, M.D., M.P.H., F.A.A.P., Caryl J. Guth Chair for Complementary and Integrative Medicine, Division of Health Sciences, Wake Forest University; and Simon Mills, Project Lead, United Kingdom Department of Health project: Integrated Self Care in Family Practice.

On February 24, 2009, the Senate HELP Committee held a hearing entitled "Addressing Underinsurance in National Health Reform." The panel included: Cathy Schoen, M.S., Senior Vice President, Commonwealth Fund; Gail Shearer, M.S., Director of Health Policy Analysis, Consumers Union; Diane Rowland, D.Sc., Executive Vice President, Henry J. Kaiser Family Foundation, and Executive Director, Kaiser Commission on Medicaid and the Uninsured; and Grace-Marie Turner, President, Galen Institute.

On March 24, 2009, the Senate HELP Committee held a hearing entitled "Addressing Insurance Market Reform in National Health Reform." The panel included: Janet Trautwein, Executive Vice President and CEO, National Association of Health Underwriters; Ronald A. Williams, M.S., Chairman and Chief Executive Officer, Aetna, Inc.; Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University; Karen Ignagni, M.B.A., President and CEO, America's Health Insurance Plans; Len Nichols, Ph.D., Director, Health Policy Program, New America Foundation; Katherine Baicker, Ph.D., Professor of Health Economics, Department of Health Policy and Management, Harvard School of Public

Health; and Sandy Praeger, Health Insurance Commissioner, State of Kansas.

On April 28, 2009, the Senate HELP Committee held a hearing entitled "Learning from the States: Individual State Experiences with Health Care Reform Coverage Initiatives in the Context of National Reform." The panel included: Jon Kingsdale, Ph.D., Executive Director, Commonwealth Health Insurance Connector Authority, MA; Susan Besio, Director, Office of Vermont Health Access, State of Vermont Human Services Agency; Harry Chen, M.D., Emergency Room Physician and Board Member, Vermont Program for Quality in Health Care; Brent James, Executive Director, IHC Institute for Health Care Delivery Research, Intermountain Health Care, Inc.; Honorable David Clark (R), Majority Leader, Utah House of Representatives; Ruth Liu, Senior Director for Health Policy, Legal and Government Relations, Kaiser Permanente; and Eileen McAnneny, Senior Vice-President of Government Affairs and Associate General Counsel, Associated Industries of Massachusetts.

On April 30, 2009, the Senate HELP Committee held a hearing entitled "Primary Health Care Access Reform: Community Health Centers and the National Health Service Corps." The panel included: Cynthia Bascetta, Director of Health Care, GAO; Dan Hawkins, Senior Vice President, National Association of Community Health Centers; Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, George Washington University School of Public Health; Caswell A. Evans, Jr., D.D.S, M.P.H., Associate Dean for Prevention and Public Health Sciences, University of Illinois at Chicago College of Dentistry; Yvonne Davis, Board Member, Community Health Center; John Matthew, M.D., Health Center, Plainfield, VT; and Lisa Nichols, Executive Director, Midtown Community Center, Ogden, UT.

On June 11, 2009, the Senate HELP Committee held a two-panel hearing entitled "Health Care Reform." The first panel included: Margaret Flowers, M.D., Maryland Co-Chair, Physicians for a National Health Program; Ron Williams, CEO, Aetna, Inc; Randel Johnson, Vice President for Labor, Immigration, and Employee Benefits, U.S. Chamber of Commerce; William Dennis, Senior Research Fellow, National Federation of Independent Business; Mary Andrus, Co-Chair of the Health Care Taskforce, Consortium for Citizens with Disabilities; Samantha Rosman, M.D., Board of Trustees, American Medical Association; Ray Scheppach, Ph.D., Executive Director, National Governors' Association; Gerald Shea, Special Assistant to the President, AFL–CIO; Dennis Rivera, Chair, SEIU Healthcare; Katherine Baicker, Ph.D., Professor of Health Economics, Harvard School of Public Health; Jonathan Gruber, Ph.D., Associate Head, MIT Department of Economics; Janet Trautwein, Executive Vice-President and CEO, National Association of Health Underwriters; Sandy Praeger, Kansas Insurance Commissioner; Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute; and Steve Burd, President and CEO, Safeway, Inc. The second panel included: Gary Raskob, Ph.D., Dean, University of Oklahoma College of Public Health; Jeffrey Levi, Ph.D., Executive Director, Trust for America's Health; Fay Raines, Ph.D., President, American Association of Colleges of Nursing; Wayne Jonas, M.D., President and CEO, Samueli Institute;

Delos Cosgrove, M.D., CEO, Cleveland Clinic; Brent James, M.D., M.Stat., Executive Director, Institute for Health Care Delivery Research, Intermountain Health Care, Inc.; Charles Kahn, M.P.H., President, Federation of American Hospitals; John Rother, J.D., Executive Vice President for Policy and Strategy, AARP; and Judith Palfrey, M.D., President-Elect, American Academy of Pediatric.

Committee on Finance

On February 25, 2009, the Senate Committee on Finance held a hearing entitled "Scoring Health Care Reform: CBO's Budget Options" with Douglas Elmendorf, Ph.D., Director of the Congressional Budget Office.

On March 12, 2009, the Senate Committee on Finance held a hearing entitled "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future." The panel included: David C. Goodman, M.D., M.S., Director of the Center for Health Policy Research, Dartmouth College; Allan H. Goroll, M.D., M.A.C.P., Professor of Medicine, Harvard Medical School; Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, George Washington University; and Steven A. Wartman, M.D., Ph.D., M.A.C.P., President and CEO, Association of Academic Health Centers.

On March 25, 2009, the Senate Committee on Finance held a hearing entitled "The Role of Long-Term Care in Health Reform." The panel included: Judy Feder, Ph.D., Senior Fellow, Center for American Progress Action Fund; Raymond C. Scheppach, Ph.D., Executive Director, National Governors Association; Dennis G. Smith, Senior Research Fellow in Health Care Reform, Heritage Foundation; and Joshua M. Wiener, Ph.D., Senior Fellow, RTI International.

On April 21, 2009, the Senate Committee on Finance held a hearing entitled "Reforming America's Health Care Delivery System." The panel included: Allan M. Korn, M.D., Senior Vice President, Chief Medical Officer, Office of Clinical Affairs, Blue Cross Blue Shield Association; Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission; Peter V. Lee, J.D., Executive Director of National Health Policy, Pacific Business Group on Health; Mark B. McClellan, M.D., Director, Engelberg Center for Health Care Reform, Brookings Institute; Lewis Morris, J.D., Chief Counsel to the Inspector General, Office of Counsel to the Inspector General; Mary D. Naylor, Ph.D., F.A.A.N., R.N., Marian S. Ware Professor in Gerontology, University of Pennsylvania School of Nursing; Debra Ness, President, National Partnership for Women and Families; Frank G. Opelka, M.D., F.A.C.S., Vice Chancellor for Clinical Affairs and Professor of Surgery, Office of the Chancellor, Louisiana State University Health Science Center; Glenn Steele, Jr., M.D., Ph.D., President, Geisinger Health System; John Tooker, M.D., M.B.A., F.A.C.P., Executive Vice President and Chief Executive Officer, American College of Physicians; Richard J. Umbdenstock, F.A.C.H.E., President and CEO, American Hospital Association; Ron Williams, Chairman and CEO, Aetna, Inc.; and Paul J. Diaz, J.D., President and CEO, Kindred Healthcare, Inc.

On May 5, 2009, the Senate Committee on Finance held a hearing entitled "Expanding Health Care Coverage." The panel included: Stuart M. Butler, Ph.D., Vice President, Domestic and Economic Policy Studies, Heritage Foundation; John Castellani, President, Business Roundtable; Gary Claxton, Vice President and Director, Health Care Marketplace Project, Henry J. Kaiser Family Foundation; Donald A. Danner, President and CEO, National Federation of Independent Business; Jennie Chin Hansen, R.N., M.S., F.A.A.N., President, AARP; Karen Ignagni, President and CEO, America's Health Insurance Plan; R. Bruce Josten, Executive Vice President, Government Affairs, U.S. Chamber of Commerce; Len Nichols, Ph.D., Director, Health Policy Program, New America Foundation; Ron Pollack, J.D., Executive Director, Families USA; Sandy Praeger, Chair, Health Insurance and Managed Care Committee, National Association of Insurance Commissioners; Sara Rosenbaum, J.D., Chair, Department of Health Policy, George Washington School of Public Health and Health Services; Diane Rowland, Sc.D., Executive Vice President, Henry J. Kaiser Family Foundation; Raymond C. Scheppach, Ph.D., Executive Director, National Governors Association; Scott Serota, President and Chief Executive Officer, Blue Cross and Blue Shield Association; and Andy Stern, President, SEIU.

On May 12, 2009, the Senate Committee on Finance held a hearing entitled "Financing Comprehensive Health Care Reform." The panel included: Stuart H. Altman, Ph.D., Sol C. Chaikin Professor of National Health Policy, Heller School for Social Policy and Management, Brandeis University; Joseph R. Antos, Ph.D., Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute; Katherine Baicker, Ph.D., Professor of Health Economics, Harvard School of Public Health; Leonard Burman, Ph.D., Director, Tax Policy Center, Urban Institute; Robert Greenstein, Ph.D., Executive Director, Center on Budget and Policy Priorities; Jonathan Gruber, Ph.D., Professor of Economics, Massachusetts Institute of Technology; Michael F. Jacobson, Ph.D., Executive Director, Center for Science in the Public Interest; James A. Klein, President, American Benefits Council; Edward Kleinbard, Chief of Staff, Joint Committee on Taxation; Gerald M. Shea, Special Assistant to the President, AFL–CIO; John Sheils, Senior Vice President, Lewin Group; Gail Wilensky, Ph.D., Senior Fellow, Project HOPE; and Steven Wojcik, Vice President of Public Policy, National Business Group on Health.

INTRODUCTION AND CONSIDERATION OF AMERICA'S AFFORDABLE HEALTH CHOICES ACT, H.R. 3200

On June 19, 2009, Congressman George Miller (D-CA), along with Congressmen Henry Waxman (D–CA), Charles Rangel (D–NY) and John Dingell (D–MI) released the Tri-Committee draft proposal for health care reform.

Committee on Education & Labor Consideration of the Tri-Committee Draft Proposal for Health Care Reform

On June 23, 2009, the House Education and Labor Committee held a hearing to discuss the draft proposal for health care reform that was jointly developed by the House Ways and Means, Energy

and Commerce, and Education and Labor Committees. The draft was designed to achieve President Obama's goals of controlling health care cost, preserving health care choices, and ensuring quality, affordable health care for all Americans. The hearing entitled "The Tri-Committee Draft Proposal for Health Care Reform" consisted of three panels. The first panel included: Christina Romer, Ph.D., Chair, Council of Economic Advisers, Office of the President; Ron Pollack, Founding Executive Director, Families USA; Gerald Shea, Special Assistant to the President, AFL–CIO; Paul J. Speranza, Senior Vice President, General Counsel and Secretary, Wegmans Food Markets, Inc.; Jacob Hacker, Ph.D., Professor and Co-Director, Berkeley Center on Health, Economic, and Family Security, University of California Berkeley; Michael J. Stapley, President and Chief Executive Officer, Deseret Mutual; John Arensmeyer, Chief Executive Officer, Small Business Majority; and Fran Visco, President, National Breast Cancer Coalition. The second panel included: Karen Pollitz, Research Professor and Project Director, Health Policy Institute, Georgetown University; Celia Wcislo, Assistant Division Director, SEIU; James A. Klein, President, American Benefits Council; William Vaughan, Senior Health Policy Analyst, Consumers Union; Robert E. Moffit, Ph.D., Director, Center for Health Policy Studies, Heritage Foundation; ReShonda Young, Small Business Owner, Alpha Express, Inc. on behalf of the Main Street Alliance; and Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, George Washington University.

Committee on Energy & Commerce Consideration of the Tri-Committee Draft Proposal for Health Care Reform

On June 23, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Comprehensive Health Reform Discussion, Day 1." The panel included: Richard Kirsch, National Campaign Manager, Health Care for America Now; Ralph G. Neas, Chief Executive Officer, National Coalition on Health Care; Stephen T. Parente, Ph.D., Director, Medical Industry Leadership Institute; Marian Wright Edelman, President, Children's Defense Fund; Jennie Chin Hansen, President, AARP; David L. Shern, Ph.D., President and Chief Executive Officer, Mental Health America; Erik Novak, M.D., Orthopedic Surgeon, Patients United Now; Shona Robertson-Holmes, Patient at Mayo Clinic; Jeffrey Levi, Ph.D., Executive Director, Trust for America's Health; Brian D. Smedley, Ph.D., Vice President and Director, Health Policy Institute, Joint Center for Political and Economic Studies; and Mark Kestner, M.D., Chief Medical Officer, Alegent Health.

On June 24, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a three-panel hearing entitled "Comprehensive Health Reform Discussion, Day 2." The first panel on single-payer health care included: Sidney M. Wolfe, M.D., Director, Health Research Group at Public Citizen; Steffie Woolhandler, M.D., Associate Professor of Medicine, Harvard Medical School, and Co-Founder, Physicians for a National Health Program; and John C. Goodman, Ph.D., President and CEO, National Center for Policy Analysis. The second panel on state, local and tribal views included: the Honorable Michael O. Leavitt, Former Secretary, U.S.

Department of Health and Human Services; the Honorable Joseph Vitale (D), Chairman, Committee on Health, Human Services, and Senior Citizens, New Jersey State Senate; W. Ron Allen, Chairman, Jamestown S'Klallam Tribe; the Honorable Jay Webber (R), New Jersey State Assembly; Raymond C. Scheppach, Ph.D., Executive Director, National Governors Association; Robert S. Freeman, Deputy Executive Director, CenCal Health, California Association of Health Insuring Organizations; and Ron Pollack, Executive Director, Families USA. The third panel on drug and device manufacturer views included: Thomas Miller, CEO, Workflow and Solutions Division, Siemens Medical Solutions, USA; Kathleen Buto, Vice President for Health Policy, Johnson & Johnson; William Vaughan, Senior Health Policy Analyst, Consumers Union; Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute; and A. Kelly, Senior Vice President, Government Affairs and Public Policy, National Association of Chain Drug Stores.

On June 25, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a four-panel hearing entitled "Comprehensive Health Reform Discussion, Day 3." The first panel on Medicare payment included Glenn M. Hackbarth, Chair of the Medicare Payment Advisory Commission, and the Honorable Daniel R. Levinson, Inspector General of the U.S. Department of Health and Human Services. The second panel on doctor, nurse, hospital, and other provider views included: Ted D. Epperly, M.D., President, American Academy of Family Physicians; M. Todd Williamson, M.D., President, Medical Association of Georgia; Karl J. Ulrich, M.D., Clinic President and CEO, Marshfield Clinic; Janet Wright, M.D., Vice President, Science and Quality, American College of Cardiology; Kathleen M. White, Ph.D., Chair, Congress on Nursing Practice and Economics, American Nurses Association; Patricia Gabow, M.D., Chief Executive Officer, Denver Health and Hospital Authority, National Association of Public Hospitals; Dan Hawkins, Senior Vice President, Public Policy and Research, National Association of Community Health Centers; Bruce T. Roberts, R.Ph., Executive Vice President and CEO, National Community Pharmacists Association; Bruce Yarwood, President and CEO, American Health Care Association; and Alissa Fox, Senior Vice President, Office of Policy and Representation, Blue Cross Blue Shield Association. The third panel on employer and employee views included: Kelly Conklin, Owner, Foley-Waite Custom Woodworking, Main Street Alliance; John Arensmeyer, Founder and CEO, Small Business Majority; Gerald M. Shea, Special Assistant to the President, AFL–CIO; Dennis Rivera, Health Care Chair, SEIU; John Castellani, President, Business Roundtable Institute for Corporate Ethics; John Sheils, Senior Vice President, Lewin Group; and Martin Reiser, Manager of Government Policy, Xerox Corporation, National Coalition on Benefits. The fourth panel on insurers' views included: Howard A. Kahn, Chief Executive Officer, L.A. Care Health Plan; Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University; Karen Ignagni, President and CEO, America's Health Insurance Plans; and Janet Trautwein, Executive Vice President and CEO, National Association of Health Underwriters.

Committee on Ways & Means Consideration of the Tri-Committee Draft Proposal for Health Care Reform

On June 24, 2009, the Committee on Ways and Means had a hearing entitled "Health Reform in the 21st Century: Proposals to Reform the Health System." The hearing consisted of three panels. The first panel included: Karen Pollitz, Policy Director, Health Policy Institute, Georgetown Public Policy Institute; John F. Holahan, Ph.D., Director, Health Policy Research Center, Urban Institute; and David Gratzer, M.D., Senior Fellow, Manhattan Institute for Policy Research. The second panel included: Richard Kirsch, National Campaign Manager, Health Care for America NOW; Mike Draper, Owner, SMASH; Peter V. Lee, Executive Director for National Health Policy, Pacific Business Group on Health; Gerald Shea, Special Assistant to the President, AFL-CIO; Jennie Chin Hansen, President, AARP; and Randel K. Johnson, Senior Vice President, Labor, Immigration and Employee Benefits, U.S. Chamber of Commerce. The third panel included: Dan Baxter, Medical Director, William F. Ryan Community Health Network, NY; Ted Epperly, M.D., President, American Academy of Family Physicians; Donna Policastro, Executive Director, Rhode Island State Nurses Association on behalf of the American Nurses Association; Chip Kahn, President, Federation of American Hospitals; Larry Minnix, President and CEO, American Association of Homes and Services for the Aging; Ronald Williams, Chairman and CEO, Aetna, Inc.; and Richard Warner, M.D., Member, Kansas Medical Society House of Delegates, AMA Alternate Delegate, and past President, Kansas Medical Society.

Introduction of America's Affordable Health Choices Act, H.R. 3200

On July 15, 2009, after taking into consideration comments on the discussion draft from a very wide range of voices, Chairmen George Miller, Henry Waxman, Charles Rangel, and Congressman John Dingell introduced America's Affordable Health Choices Act, H.R. 3200. The bill seeks to control rising health care costs, strengthen the employer-based health care system, and ensure that all Americans have access to quality and affordable health care coverage.

Committee on Education & Labor Mark-up of H.R. 3200

The Full Committee met on July 15–17, 2009 to mark up H.R. 3200. The Committee passed by voice vote an amendment in the nature of a substitute offered by Chairman George Miller (D–CA). There were 42 other amendments offered and debated. Of the amendments offered, 20 passed, 17 failed, 4 were withdrawn, and one was ruled not germane.

America's Affordable Health Choices Act of 2009

H.R. 3200 was reported favorably to the House with an amendment in the nature of a substitute. By a vote of 26–22, the Committee authorized the Chairman to transmit the bill, with an amendment in the nature of a substitute, to the Committee on the Budget in compliance with section 310 of the Congressional Budget Act of 1974 as the first part of the Committee's recommendations, pursuant to the reconciliation instruction in S. Con Res. 13.

The amendment offered by Representative McKeon (R–CA) would have created a new title at the end of Division A titled Title IV—Small Business Health Fairness. This title would include rules governing association health plans; clarification of treatment of single employer arrangements; enforcement provisions related to association health plans; and other provisions related to association health plans. The amendment was defeated by a roll call vote of 21–27.

The amendment offered by Representative Castle (R–DE) would have allowed variation in cost-sharing and premiums charged by the qualified health benefits plans dependent upon participant participation in employer prevention and wellness programs. The amendment was withdrawn and no further action was taken on it.

The second amendment offered by Representative Wilson (R–SC) would add to H.R. 3200 a Sense of the House of Representatives that any members who vote in support of the public health insurance option are urged to forgo their right to participate in the FEHBP and enroll under the public option. The amendment was passed by voice vote.

The third amendment offered by Representative Price (R–GA) would have established provisions for defined contribution health plans. The amendment was defeated by a roll call vote of 19–29.

The fourth amendment offered by Representative Price (R–GA) would have struck the physician billing language in Section 225(c). The amendment was defeated by a roll call vote of 19–29.

The second amendment offered by Representative McMorris Rodgers (R–WA) would have exempted plans established and maintained by Indian tribal governments. The amendment was defeated by voice vote.

Committee on Ways & Means Mark-up of H.R. 3200

On July 16, 2009, the Committee on Ways and Means met to mark-up H.R. 3200, America's Affordable Health Choices Act and reported the bill as amended by a vote of 23–18.

Committee on Energy & Commerce Mark-up of H.R. 3200

Beginning on July 16, 2009, the Committee on Energy and Commerce met to mark-up H.R. 3200, America's Affordable Health Choices Act. In addition to July 16, 2009, the Committee considered H.R. 3200 on July 17, 20, 30 and 31. The Committee reported the bill as amended by a vote of 31–28.

SENATE CONSIDERATION OF THE AFFORDABLE HEALTH CHOICES ACT

Beginning on June 17, 2009 the HELP Committee met to markup the Affordable Health Choices Act. The Committee reported the bill as amended on July 15, 2009 by a vote of 13–10.

III. SUMMARY OF THE BILL

America's Affordable Health Choices Act makes critical reforms to this nation's broken health care system. It will lower costs, preserve choice, and expand access to quality, affordable care. To protect families struggling with health care costs and inadequate coverage, the bill ensures that health insurance companies can no

longer compete based on risk selection. By prohibiting rate increases based on pre-existing conditions, gender and occupation, the bill requires that insurance companies instead compete based on quality and efficiency. In addition, H.R. 3200 will lower the cost of health care by eliminating co-pays and deductibles for preventive care, capping annual out-of-pocket expenses, prohibiting lifetime limits, and allowing the uninsured, part-time workers, and employees of some small businesses to obtain group rates by purchasing health care through the HIE.

H.R. 3200 will expand choice of health insurance, especially in many parts of the country where families have very limited choices because of the nature of the insurance market. The HIE will serve as an organized and transparent "marketplace for the purchase of health insurance"[7] where individuals and employees (phased-in over time) can shop and compare health insurance options. To participate in the HIE, insurers will be required to meet the insurance market reforms and consumer protections and offer the essential benefits package established by the new independent benefits advisory committee. Individuals and families under 400 percent of poverty who qualify for affordability credits will be able to use that money in the HIE to help offset the costs of their health care coverage.

One health insurance choice within the HIE will be the public health insurance option. The public option will be required to operate on the same level as private insurance companies, adhering to the same market reforms and consumer protections, and it will be required to be financed from its premiums. Rates will vary geographically just as private insurers do. The public plan option will be able to utilize payment rates similar to Medicare with provider rates at Medicare plus 5 percent. However, beginning in Y4 the Secretary will have the authority to use an administrative process to set rates (at levels that do not increase costs) in order to promote payment accuracy and the delivery of affordable and efficient care.

The inclusion of a public option in the HIE will help to rein in the costs of health insurance while preserving access. At all times, the Secretary retains the authority to utilize innovative payment mechanisms and policies to improve health outcomes, reduce health disparities, and promote quality and integrated care. Furthermore, the public option will represent choice in many communities where one insurer dominates the market. Consequently, the public health insurance option has the ability to increase competition and control costs. However, no one, including employers who put their employees into the HIE, can place or force anyone into the public option. The decision to enroll in a private plan or the public option is always left to individuals and families to decide for themselves.

H.R. 3200 is built upon the premise of shared responsibility among individuals, employers and the government, so that everyone contributes and has access to affordable, quality health care. America's Affordable Health Choices Act gives employers the choice

[7] Linda Blumberg and Karen Pollitz, Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals, the Urban Institute & Robert Wood Johnson Foundation (April 2009).

to either offer health insurance or pay a percentage of payroll for their employees to go into the HIE.

Beginning in 2013, employers "playing" will be required to offer health coverage to all of their full-time employees and contribute 72.5 percent of the premium for an individual and 65 percent for a family premium. For part-time workers, employers will have the choice to either offer health coverage on a pro rata basis or pay the required penalty. There will be no minimum benefit requirement for existing employer-sponsored health plans until the end of 2018. At that time, employers who "play" will be required to offer coverage that is no less than the minimum benefit level within the Exchange and must include the insurance market reforms.

Employers may also choose to "pay" instead of play. A "pay" employer would be required to make a contribution equal to 8 percent of their payroll to the HIE. However, recognizing the difficulties small businesses face, the bill includes a number of provisions to help small employers. For example, H.R. 3200 exempts employers with payrolls of $250,000 or less from the pay or play requirements. For employers with payroll between $250,000 and $400,000 the contribution amount phases-up from 2 to 8 percent so that only employers with payrolls greater than $400,000 will pay the full 8 percent.

Whether obtaining coverage through an employer, a spouse or the HIE, H.R. 3200 requires that individuals either enroll in health care coverage or pay 2.5 percent of their adjusted gross income capped at the total cost of the average cost premium offered in the HIE. Recognizing that high health care costs prevent many Americans from securing health care coverage, H.R. 3200 provides for affordability credits to help eligible low- and middle-income individuals and families purchase coverage in the HIE. In addition, for those who can demonstrate that they are unable to afford health insurance, the Health Choices Commissioner (Commissioner) retains the authority to develop and grant hardship waivers.

The affordability credits provided for under the bill will be available to individuals and families with incomes between 133 to 400 percent of the federal poverty level. Medicaid will be expanded so that anyone below 133 percent of poverty will be Medicaid eligible and that expansion will be fully federally financed. Employees who are offered health insurance through an employer will be unable to go into the HIE and receive affordability credits unless that employer coverage is deemed unaffordable. An unaffordable employer offer is one where the employees' share of the premium and cost sharing are more than 11 percent of family income.

Finally, as millions of Americans gain coverage, investments in the health care workforce are critical to ensuring all Americans have access to needed care. H.R. 3200 includes significant investments to help train more primary care and public health physicians as well as nurses. It puts into place incentives to encourage more people to become doctors and nurses (particularly in rural areas). Some of the workforce provisions include: (1) increased funding for the National Health Service Corp.; (2) expanded scholarships and loans for health professionals who work in shortage professions and areas; (3) steps to increase physician training outside of the hospital and redistribute unfilled graduate medical edu-

cation residency slots so that more primary care physicians can be trained; and (4) grants through the Department of Labor to help train and retain nurses.

IV. Committee Views

The Committee on Education and Labor of the 111th Congress is committed to containing the cost of health care and ensuring that every American has access to affordable, quality health care coverage. H.R. 3200 includes critical reforms to the health care system that are needed to reduce surging premium and health care costs that families, businesses and governments are struggling to afford. The bill cuts over a half trillion dollars from the health care system, ensures that no one is ever one illness away from bankruptcy and creates a system where 97 percent of Americans will have health care coverage by 2015.

Overview

Health care reform is a critical issue in this country. There are 47 million people in the United States without health care coverage and almost nine million of them are children.[8] Meanwhile, health care costs are rising for nearly everyone. The United States spends over $2.4 trillion—more than 18 percent of GDP—on health care services and products—far more than other industrialized countries.[9] In addition, health care costs continue to grow faster than the economy as a whole, and individuals and families are burdened by the weight of these escalating expenses. Yet, for all this spending, the United States' scores are average or worse on many key indicators of health care quality. Health care reform is critical to restoring prosperity for our nation's families and H.R. 3200 will ensure that coverage is truly affordable and dependable for hardworking Americans.

The Uninsured

The number of uninsured persons in the United States continues to grow, from 44.8 million in 2005 to 47.0 million in 2006. The percentage of uninsured is also rising, from 15.3 percent of the total population in 2005 to 15.8 percent in 2006.[10]

More than two-thirds of the uninsured live in a household with one full-time worker. These increasing numbers can be attributed to the rising cost of health care, a decline in manufacturing jobs and an increase in workers employed in the service industries and small businesses, which are less likely to provide insurance.[11] Roughly two-thirds of Americans without health insurance have incomes 200 percent below the federal poverty level—or approximately $44,000 for a family of four.[12] Not surprisingly, those in households with annual incomes below $25,000 are even less likely

[8] Supra note 2.

[9] National Coalition on Health Care, "Facts on the Cost of Health Insurance and Health Care," (2007), available at: *http:www.nchc.org/facts/cost.shtml*

[10] U.S. Census Bureau, "Health Insurance Coverage: 2006—Highlights." (Aug. 27, 2007), available at: *http:www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html*

[11] Robert Pear. "Without Health Benefits, a Good Life Turns Fragile," N.Y. Times (Mar. 5, 2007).

[12] Kaiser Family Foundation, "The Uninsured: A Primer," (Oct. 2008). *http:www.kff.org/uninsured/upload/7451–04.pdf.*

to be insured. In 2006, twenty-five percent of these Americans were uninsured in comparison to 16 percent of the total population.[13]

Approximately 162 million non-elderly workers and their dependents received health coverage through their employment-based health plans.[14] However, millions of other working Americans are unable to participate in an employer-sponsored plan, either because the employer does not offer coverage or the employee is not eligible under the plan. In 2005, 20 percent of "wage and salary" workers had an employer that did not offer any coverage to their workers. And 18 percent were not eligible for the health plan that was offered by their employer.[15] For example, some firms do not offer coverage to part-time employees and some do not offer coverage to workers who have been employed for less than a specific amount of time.

While employer-sponsored plans still remain the dominant source of health coverage for most Americans, the percentage of people obtaining health coverage through these plans has been steadily shrinking. For example, 60 percent of employers offered benefits in 2007, compared with 69 percent in 2000. Most of this decline can be attributed to the decline in small businesses (less than 200 workers) offering coverage.[16] Among firms with less than 10 workers, the offer rate dropped from 57 percent in 2000 to 45 percent in 2007.[17] For employers who have stopped offering coverage, almost three out of four say that premiums are too expensive.[18]

Unaffordable Health Care Coverage

Employers and workers alike are increasingly concerned about the rising costs of health care and insurance. Premiums for employer-sponsored health coverage are rising much faster than workers' earnings and inflation. Between spring 2006 and spring 2007, premiums for coverage offered by employers across the United States increased by 6.1 percent—more than twice the growth in the Consumer Price Index (CPI). The average annual cost of employer-sponsored health insurance was nearing $13,000 in 2008. In response to these steady premium hikes, many companies are asking their employees to cover some of the new costs. For instance, workers taking single coverage through an employer paid 12 percent more for their coverage in 2007 than in 2006. Premiums for a family of four paid by workers increased by 10 percent from 2006 to 2007.[19]

These increases are of great concern, and more and more workers believe that they may not be able to afford their share of the cost

[13] Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006" Current Population Reports (2006) at 60–233. See also, U.S. Department of Commerce, Economics and Statistics Administration, August 2007.

[14] Elise Gould, "The Erosion of Employer-Sponsored Health Insurance," Economic Policy Institute (Oct. 8, 2008).

[15] Supra note 9.

[16] Kaiser Commission on Medicaid and the Uninsured, "2007 Employer Health Benefits Survey—Summary of Findings," (Sept. 2007) at 29, available at: *http:www.kff.org/insurance/7672/index.cfm*

[17] Paul Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey." Employee Benefit Research Institute, October 2007.

[18] Kaiser Family Foundation/HRET, "Employer Health Benefits 2007 Annual Survey." (Sept. 2007).

[19] Id.

of coverage. In a recent poll by the Pew Research Center,[20] forty-four percent of workers surveyed say that affording health insurance is difficult or very difficult. In addition, almost three out of four uninsured workers who chose not to participate in their employer's health plan in 2002 said the plan was too costly. Workers also know that if they lose their job, they are likely to lose access to affordable health care coverage.

In addition, among those employers that offer benefits, a large percentage of firms report that in the next year not only are they very or somewhat likely to increase the amount workers contribute to premiums (45 percent), but they will also increase deductible amounts (37 percent), office visit cost sharing (42 percent) or the amount that employees have to pay for prescription drugs (41 percent).[21]

The problem of being "underinsured" has also become increasingly relevant. One recent study estimated that 29 percent of individuals who have insurance are "underinsured" and have coverage that is inadequate to secure them access to needed care or protect again catastrophic medical bills.[22]

The Commonwealth Fund found that 25 million adults who had health coverage in 2007 were underinsured[23]—a 60 percent increase from the 16 million Americans who were underinsured in 2003.[24] Another study found that while 16 percent of adults spent more than 10 percent of their family income on health care service in 1996. By 2003 the proportion of adults bearing these health-related "catastrophic financial burdens" had increased to 19 percent to about 49 million individuals.[25] Another study found that financial burdens had increased to the point that private health insurance coverage no longer provided adequate financial protection for low-income families.[26]

In addition, many families have little room within their family budgets for large or unexpected out-of-pocket health care expenses. In 2003, an estimated 77 million Americans—nearly two out of five adults—had difficulty paying medical bills.[27] Even working age adults who were continually insured had problems paying their medical bills and carried medical debt as a result. Nearly half of all bankruptcies in the United States are related, in part, to health care expenses. And of those facing medical bankruptcies, roughly

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[20] Pew Research Center for the People and the Press poll, conducted January 9–13, 2008, available at: *http:people-press.org/reports/dispaly.php3?ReportID*= 395.

[21] Supra note 16.

[22] Consumer Reports, "Health Insurance: CR Investigates Health Care," September 2007, available at: *http:www.consumerreports.org/cro/health-fitness/health-care/health-insurance–9–07/overview/0709*__ __

[23] According to the Commonwealth Fund study, families are identified as underinsured if they had out-of-pocket medical spending that absorbed at least 10 percent of family income, or for low-income adults (200 percent below the federal poverty level), medical spending consumed at least 5 percent of family income.

[24] Cathy Schoen et al, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Health Affairs 27 no. 4 (2008).

[25] J. Banthin and D. Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger than 65 Years, 1996 to 2003," JAMA (2006).

[26] J. Banthin, P. Cunningham and D. Bernard. "Financial Burdens of Health Care, 2001–2004," Health Affairs 27, no.1 (2008) at 188–195.

[27] Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills," The Commonwealth Fund (Aug. 2005).

three-quarters had health insurance at the onset of their bankrupting illness.[28]

The risk of being underinsured or experiencing financial problems due to health spending varies not only by family income, but also by health status. According to Judy Feder, Senior Fellow at the Center for American Progress, "health care affordability is particularly elusive for individuals with chronic illness and other conditions that require on-going, often costly, medical care."[29] Individuals who are older and have chronic conditions such as diabetes, heart disease, or arthritis, or have experienced a stroke, are more likely to spend a high proportion of their income on health expenses. If these individuals do not have an employer-sponsored health plan, or if they lose this coverage, their ability to purchase coverage in the non-group market is limited at best. The non-group market systematically denies coverage, limits benefits, and charges excessive premiums to individuals with pre-existing conditions or those who are perceived to be at high-risk. Ironically, the people who are more likely to become sick—the very population that insurance is supposed to protect—are also more likely to be underinsured and face grave financial problems.

The Consequences of being Uninsured or Underinsured

Being uninsured makes it more likely that a person will not receive adequate medical care. Individuals without insurance often go without or delay care, and the care they do receive is likely to be lower quality than the care received by insured individuals. An estimated 18,000 to 22,000 Americans die each year because they do not have health coverage.[30] The length of time a person goes without health insurance also makes a difference—people who are uninsured for at least a year report being in worse health than those uninsured for a shorter period of time.[31] Finally, lack of coverage and coverage stability is particularly burdensome on the seriously and chronically ill, whose care is often delayed or denied when they cannot pay.[32]

HEALTH CARE COSTS AND SPENDING: THE COST OF DOING NOTHING

H.R. 3200 ensures quality and affordable health care choices for all Americans while also controlling costs in a system in which costs have spiraled out of control. The United States spends over $2.4 trillion on health care each year.[33] As noted earlier, health care expenditures in the United States constitute approximately 18 percent of the current Gross Domestic Product (GDP).[34] If health care costs continue to grow at historical rates, the share of GDP

[28] David Himmelstein, Elizabeth Warren, D. Thorne, and S. Woolhandler, "Illness and Injury as Contributors to Bankruptcy," Health Affairs (2005).
[29] Judy Feder, Testimony before the Committee on Energy and Commerce Committee (hereinafter Feder) (Mar. 17, 2009).
[30] "Insuring America's Health: Principles and Recommendations," Institute of Medicine (Jan. 14, 2004).
[31] Id.
[32] Institute of Medicine, "Care Without Coverage: Too Little, Too Late" (May 2002), available at: *http:www.iom.edu/Object.File/Master/4/160/Uninsured2FINAL.pdf*
[33] Supra note 9.
[34] Executive Office of the President, Council of Economic Advisors, "The Economic Case for Health Care Reform," available at *http:www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/ (June 2009).*

devoted to health care in the United States is projected to reach 34 percent by 2040.[35]

International Comparisons

The United States devotes a far larger share of GDP to health care spending more than two times per person on health care than any other OECD (Organization for Economic Co-operation and Development) country.[36] While health care expenditures in the United States are about 18 percent of GDP[37] the OECD reports that the next highest country was Switzerland—with 11.3 percent—and in most other high-income countries, the share was less than 10 percent.[38]

Despite outpacing other countries with investments in health care, the U.S. fails to produce better health outcomes in fundamental ways. OECD data shows that life expectancy in the United States is lower than in any other high-income country, as well as in many middle-income countries.[39] Similarly, the infant mortality rate in the United States is substantially higher than that of other developed countries. While many factors other than health care expenditures may affect life expectancy and infant mortality rates—for example, demographics, lifestyle behaviors, income inequality, non-health disparities, and measurement differences across countries[40]—the Council of Economic Advisors (CEA) has concluded that "the fact that the United States lags behind lower spending countries is strongly suggestive of substantial inefficiency in our current system."[41] Indeed, according to estimates by the CEA based on the spending and outcomes in other countries, efficiency improvements in the U.S. health care system potentially could free up resources equal to 5 percent of U.S. GDP.[42]

Analyzing health care spending over time, the CEA also notes that while health care spending has increased in other countries as well, the spending by the U.S. has not yielded the same outcomes as other countries. In 1970, the United States devoted only a moderately higher fraction of GDP to health care than other high-income countries, whereas in 2009 the United States spends dramatically more.[43] Yet, during that same period, life expectancy has actually risen less in the United States than in other countries.[44] This data suggests that much of the increased U.S. spending is inefficient.[45]

[35] Id.

[36] Marcia Angell Testimony before the Committee on Education and Labor Committee (hereinafter Angell) (Jun. 10, 2009).

[37] Supra note 34.

[38] Id.

[39] Id.

[40] Robert Wood Johnson Foundation, Commission to Build a Healthier America, "Beyond Health Care: New Directions to a Healthier America" (Apr. 2009).

[41] Supra note 34.

[42] Id.

[43] Id.

[44] Garber, Alan M., and J. Skinner, "Is American Health Care Uniquely Inefficient?" Journal of Economic Perspectives (2008) at 27–50.

[45] Supra note 34.

Cost of the Uninsured

While the U.S. health care system currently leaves 47 million Americans uninsured[46] and approximately 25 million underinsured,[47] the CEA projects that the number of uninsured could increase to 72 million by 2040.[48] Such increases in the numbers of uninsured people will create additional uncompensated care costs, which include costs incurred by hospitals and physicians for the charity care they provide to the uninsured as well as bad debt such as unpaid bills.[49] Both the federal government and state governments use tax revenues to pay health care providers for a portion of these costs through programs such as Disproportionate Share Hospital (DSH) payments and grants to Community Health Centers.[50] In 2008, total government spending to reimburse uncompensated care costs incurred by medical providers was approximately $42.9 billion.[51] The CEA projects that if the U.S. does not slow the real growth rate of health spending and a subsequent rise in the uninsured, the real annual tax burden of uncompensated care for an average family of four will rise from $627 in 2008 to $1,652 (in 2008 dollars) by 2030.[52]

Costs to Individuals and Families

As the cost of health care skyrockets, families and employers offering health insurance struggle to absorb the increased costs. In 2008, employer-based premiums increased by 5 percent. That growth was even greater for small firms. On average, they incurred a premium increase of 5.5 percent, and, for those with 24 or fewer workers, their respective increase was 6.8 percent.[53] Much of the increase in health care costs has been shifted onto workers. In 2008, the average annual premium for a family of four was $12,700, and workers contributed approximately $3,400 of that total which was 12 percent more than the year before. Workers are now paying $1,600 more for family coverage than they did 10 years ago.[54] Over the last decade, health care costs have risen on average four times faster than workers' earnings.[55]

These dramatic increases in health care costs have serious implications for American households. Some economists believe that, over the long run, workers pay for the rising cost of health insurance through lower wages.[56] To illustrate this relationship, the CEA has analyzed historical and projected average annual total compensation (measured in 2008 dollars), which includes wages as

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[46] National Coalition on Health Care, available at: *www.nchc.org/facts/cost.shtml (2009).*

[47] "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Commonwealth Fund (2008)

[48] Supra note 34.

[49] American Hospital Association, "Uncompensated Hospital Care Fact Sheet" (Nov. 2005), available at *http:www.aha.org/aha/content/2005/pdf/0511 UncompensatedCareFactSheet.pdf.*

[50] Hadley, Jack, J. Holahan, T. Coughlin, and D. Miller. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs (2008).

[51] Id.

[52] Supra note 34.

[53] The Henry J. Kaiser Family Foundation. Employee Health Benefits: 2008 Annual Survey, (Sept. 2008).

[54] Angell.

[55] See, National Coalition on Health Care, available at: *www.nchc.org/facts/cost.shtml* (2009).

[56] Pauly, Mark V., "Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance" (1998).

well as non-wage benefits such as health insurance.[57] Their analysis indicates that health insurance premiums are growing more rapidly than total compensation in percentage terms, and as a result, an increasing share of total compensation that a worker receives goes to cover health insurance premiums.[58] Moreover, the CEA notes that households with employer-sponsored health insurance could also be affected by rapid cost growth as employers shift to less generous plans with higher annual deductibles.[59] It is important to note, however, that the wage stagnation experienced by workers over recent decades cannot be attributed solely to rising health care costs. For example, low-wage workers have experienced real wage declines in recent years despite few such workers having access to or participating in employment-based health insurance coverage.[60] More economic dynamics are at work in the wage squeeze on workers, but rising health costs contribute to the downward pressure.

H.R. 3200 Will Increase Standards of Living and Create New Jobs

By slowing the growth in health care costs, standards of living will improve and resources will be freed to improve and expand the health care system. The CEA projects that slowing growth by 1.5 percentage points per year will save a family $2,600 by 2020.[61] By 2030 that savings would be increased to nearly $10,000.[62]

Furthermore, the CEA estimates that the coverage expansions that will result from health reform will produce a net benefit of approximately $100 billion a year, or about two-thirds of a percent of GDP.[63] According to its analysis, health care reform will lower the unemployment rate in the United States and could add as many as 500,000 jobs on an annual basis.[64] By producing a more healthy and productive workforce, health care reform will improve standards of living and help strengthen the U.S. economy.

Shared Responsibility & Employment-Based Health Care Insurance

In order to control costs and expand access to quality affordable health care, everyone must be covered and employers, individuals and the government must share in this responsibility. Consistent with the minimum wage and overtime laws, H.R. 3200 creates a fundamental right to a minimum level of health care contribution and/or coverage through an employer. As noted earlier, two-thirds of Americans receive health coverage through an employer, and H.R. 3200 builds upon the current employer-based system by implementing a 'pay or play' requirement.

The employer responsibility to provide and/or contribute to the health care of its workers will stabilize the employer-based health care system. Because the Employee Retirement Income Security Act of 1974 (ERISA) currently contains no requirement that an em-

[57] Supra note 34 (relying on the 1996 to 2006 Medical Expenditure Panel Survey-Insurance Component).
[58] Id.
[59] Id.
[60] Economic Policy Institute, "Increasing Health Costs Can't Explain Earnings Dip for Low-Wage Workers," Economic Snapshot (April 12, 2006).
[61] Supra note 34.
[62] Id.
[63] Id.
[64] Id.

ployer offer employee benefits, employers who do not offer health insurance to their workers gain an unfair economic advantage relative to those employers who do provide coverage, and millions of hard-working Americans and their families are left without health insurance. It is a vicious cycle because these uninsured workers turn to emergency rooms for health care which in turn increases costs for employers and families with health insurance. It is estimated that in 2008 premiums were about 8 percent or $1,100 higher due to this hidden cost shift.[65]

Strengthening the Employer-Based System

Millions of employers voluntarily decide to offer health benefits because it is in their economic interest. Employers are not taxed on their contributions to employees' health care, and these costs are deductible as a business expense.[66] In addition, large employers can offer health care coverage at a much lower cost because they can negotiate with insurers and have a larger pool of employees to spread the risk. Furthermore, employers recognize that investments in health care can produce gains in employee health which means fewer missed days, higher productivity and better overall job satisfaction.

Despite the incentives to offer health coverage, skyrocketing health care costs make it difficult for employers, particularly small businesses, to offer comprehensive health insurance. As noted earlier, while approximately 63 percent of the under–65 population and their dependents have insurance through employment,[67] the number of employers offering health care coverage has been declining over the last decade. The number of people getting health coverage through an employer dropped by 3 million between 2000 and 2007,[68] largely due to increasing costs. In addition, the Center for American Progress projects that as a result of layoffs, approximately 14,000 Americans lose their employer-sponsored coverage each day.[69] Overall, since 1999 premiums have increased 120 percent and at a rate that is on average four times faster than workers' earnings.[70]

However, even without an employer shared responsibility requirement, 86 percent of employers surveyed report that they will continue offering health care despite increasing costs.[71] Many of these employers are large ones who use health care benefits as a means to recruit and retain employees. Health care benefits are "highly valued by employees, and risk-averse employers may be reluctant to take advantage of the option of dropping coverage" even though they can currently do so.[72]

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[65] Ben Furnas and Peter Harbage, "The Cost Shift from the Uninsured," The Center for American Progress (Mar. 2009).
[66] Paul Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," Health Affairs (May/June 2008) at 675.
[67] Supra note 10.
[68] Id.
[69] Center for American Progress (Feb. 2009), available at: *http:www.americanprogressaction.org/issues/2009/03/health—losses.html.*
[70] National Coalition on Health Care, "Health Insurance Costs," (2009), available at: *www.nchc.org/facts/cost.shtml*
[71] Supra note 61.
[72] Hacker at 10.

H.R. 3200 generally will not change what many employers are already doing. Beginning in 2013, the bill requires employers already offering health insurance to make an offer to all full-time employees and contribute 72.5 percent of the cost toward an individual policy and 65 percent toward a family policy. Today, employers on average contribute 83 percent toward the coverage of individual premiums and 71 percent toward the coverage of family premiums.[73]

The second phase of requirements under H.R. 3200 for existing employer health plans does not take effect until the end of 2018. At that time, in addition to making the required contribution amount, every employer-sponsored health plan will have to, at a minimum meet the essential benefit standards defined by the benefits committee, as well as satisfy the insurance reform standards specified in the bill. Employer health insurance plans will be required to be equivalent to no less than 70 percent of the actuarial value minus the cost sharing components of the essential benefit package. The majority of employers already meet this standard. According to the Congressional Research Service, the typical employer-sponsored PPO has an estimated actuarial value between 80–84 percent, while the typical employer-sponsored health savings account (HSA) and a qualified high deductible health plan (HDHP) has an estimated actuarial value of 76 percent, excluding contributions by an employer.[74]

While many employer plans already meet the bill's requirements, there are some notable omissions. For example, 10 percent of employer plans do not offer mental health and substance use disorder benefits and many include caps on lifetime limits and out of pocket expenses. In these cases, employers will have over 8 years to modify their plans and meet the requirements. Finally, H.R. 3200 extends the same benefit and insurance reform standards in all new employer and HIE plans, so that individuals and families have access in either case to affordable quality health coverage.

Protecting Small Business

For small business, health reform "is their number one need." [75] Forty-percent report that high costs have a "negative effect on other parts of their business, such as high employee turnover or preventing business growth." [76] According to the Small Business Majority, a non-profit independent group representing 27 million small businesses, small businesses spend 18 percent more than large employers for health care coverage.[77] The result is that in 2008, the percent of firms offering health insurance with three to nine employees dropped from 57 percent to 49 percent.[78]

[73] "Employee Benefits in the United States, March 2008," Bureau of Labor Statistics (Aug. 7, 2008).

[74] Chris Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service (May 29, 2009) at 3–4.

[75] John Arensmeyer, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Arensmeyer)(Jun. 23, 2009) at 1.

[76] Taking the Pulse on Main Street, "Small Businesses, Health Insurance and Priorities for Reform (Jan. 2009).

[77] Arensmeyer at 2.

[78] Id.

Small businesses have small purchasing pools and one of the biggest obstacles they face in securing affordable health coverage is the lack of bargaining power they have against the insurance companies. In addition, the administrative costs paid by small businesses can be up to 27 percent of premiums to pay for marketing and paperwork costs and underwriting.[79]

LaShonda Young, a small business owner, testified to the Committee about the problems she has had in seeking coverage for her forty employees. She received eight bids and each was from the same insurance company. She testified her experience isn't unique, as there are only one or two health insurers in her area.[80] She went on to testify that, "it's been years since we've been able to afford group health insurance . . . we got quotes from a couple of different places, [the] quotes came in at about 13 percent of payroll. [We're] willing to pay our fair share but we just couldn't afford 13 percent . . . "[81] Even if she was able to afford the coverage, she knew that it wouldn't cover the pre-existing conditions of her employees for up to 18 months and there was no guarantee the costs would remain stable.[82] As a result, small employers like Young are looking to other ways to help their employees find coverage on their own. Young testified that her company offers small stipends to employees to buy insurance on their own.

High health care costs also present an enormous obstacle for those trying to start or maintain a new business. While small businesses have traditionally played an essential role during prior economic recoveries, the high cost of health care is deterring entrepreneurs from starting a business in the first place. Louise Hardaway started her own business near Nashville, Tennessee. When attempting to get health care insurance she was quoted $12,800 a month to cover herself, her husband, business partner, and her business partner's spouse and child. Due to her inability to find affordable health care coverage Ms. Hardaway went out of business and went to work for another company where she could get health care.[83]

Recognizing the economic reality for many small businesses, in addition to driving down health care costs overall, H.R. 3200 contains numerous provisions such as tax credits and access to the HIE to help these employers provide coverage and alleviate their costs. In addition, the bill exempts employers from the pay or play requirement if they have payrolls of $250,000 or less. For employers with payrolls above $250,000 who choose not to offer coverage and would rather pay a penalty, that penalty is phased-up so that only employers with payrolls over $400,000 must pay the 8 percent penalty.

The Small Business Majority reports that small businesses, workers and the economy stand to save billions of dollars with the

[79] "The Economic Impact of Healthcare Reform on Small Business," Small Business Majority (Jun. 11, 2009) .

[80] LaShonda Young, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Young)(Jun. 23, 2009) at 2.

[81] Young at 2.

[82] Id.

[83] Simona Covel, "Sick and Getting Sicker," Wall St. Journal (Jul. 23, 2009).

enactment of health care reform.[84] Absent health care reform small businesses will spend $2.4 trillion in health care costs over the next ten years. With health reform, small businesses will save 36 percent of those costs, as much as $855 billion. Without health reform, small businesses stand to lose $52.1 billion in profits due to high health care costs over the next ten years. Health reform will decrease these losses and save $29.2 billion. Reduced health care costs will allow employers to reinvest in their business and their workers. Without health reform, individuals working for small businesses could lose up to $834 billion in lost wages as employers pass increased health care costs onto their employees over the next ten years. Health reform could save workers over $300 billion over the next ten years.[85] Reduced health care costs will allow employers to reinvest in their business and their workers.

THE HEALTH INSURANCE EXCHANGE WILL HELP SMALL EMPLOYERS

H.R. 3200 creates a health insurance exchange (HIE) for the uninsured and employees of small businesses to purchase health insurance in the initial years after enactment. Due to the disadvantages small businesses face when trying to purchase health care coverage on their own, both proponents and opponents of the bill believe that a health insurance exchange is essential for small business: "a broad, well-functioning marketplace offering consistency, fairness and healthy competition will vastly improve the availability and affordability of coverage to small businesses and the self-employed."[86] Furthermore, it "can be a vehicle that facilitates and monitors the movement of the system toward achievements of many national health care reform goals." Eighty-percent of small business owners in a recent state survey stated they favor a health insurance pool that they can put their employees into to buy coverage.[87]

A health insurance exchange is an organized marketplace where individuals and some employers can go to purchase health insurance. The HIE is advantageous to those looking to purchase insurance because it provides transparency when individuals and families shop for their health insurance. Currently, insurers are regulated by a patchwork of state laws. Beyond licensing requirements to sell insurance, private health insurance companies and health maintenance organizations (HMO) operate with considerable autonomy. The result is that policies can vary greatly and many policies leave people underinsured.

The robust HIE will not only organize the marketplace but also include insurance reforms and consumer protections, administer affordability credits, and provide people with choice of plans. The HIE will require that insurers, both private and public, adhere to the same rules. To help consumers make educated decisions the Commissioner will conduct outreach and provide assistance to consumers. The Commissioner will ensure that information is readily available in plain language and is provided in a culturally and linguistically appropriate manner. Furthermore, qualified health ben-

[84] Supra note 76.
[85] Id.
[86] Arensmeyer at 4.
[87] Id.

efits plans (QHBP) including those participating in the HIE will be required to comply with transparency requirements established by the Commissioner, including the accurate and timely disclosure of plan documents, plan terms and conditions, as well as information on cost-sharing and payments with respect to out-of-network coverage, claims denials and other information to help educate consumers.

In addition to monitoring and streamlining the insurance industry, the HIE will play a significant role in containing health care costs. Health care costs are comprised of both the underlying costs of providing health care services as well as the administrative costs related to the provisions of coverage.[88] The HIE will require participating plans to offer standardized benefit packages which will increase the ability to compare plans and "reinforce incentives for insurers to price premiums as competitively as possible."[89] Lower cost plans in the HIE will help those employers who "play" by putting their employees into HIE because they will be responsible for a set contribution amount regardless of the plan an employee choose.[90] Furthermore, the affordability credits available to individuals in the HIE who do not enter the exchange with an employer contribution are tied to the average of the lowest three plans which will then incentivize individuals to choose low-cost plans. By the same token, insurers will be incentivized to offer low-cost plans in order to get more business.[91]

Access & Cost Containment Through A Public Health Insurance Option

The inclusion of a strong public health insurance option in the HIE will save over one hundred billion dollars and provide choice to millions of consumers who currently have little or no choice when looking for a health plan. Its inclusion in the HIE will promote value and innovation in the private health insurance industry by increasing competition. The result is that the public option will lower costs for consumers across the private market.

The public health insurance option will provide access to meaningful choice, something many Americans have never had when searching for a health plan. Many areas only have one or two dominant insurance options that control the market and thus have no downward pressure on costs.[92] Furthermore, "it is often in [these insurers'] interest to pay higher rates to key doctors and hospitals because they can pass on these costs to individuals and employers."[93] For insurers trying to enter a market, this practice makes it difficult for them to compete and reduce costs.

While the public option will be subject to the same standards as private plans, the public option can use administrative efficiencies to control costs. On average, private insurance overhead was about 11.7 percent of premiums which is significantly higher when com-

[88] Linda Bloomberg and Karen Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals" (Apr. 2009).
[89] *Id*.
[90] However, an employer is always permitted to contribute an amount greater than the minimum should it choose.
[91] *Id*.
[92] Hacker at 5.
[93] *Id*.

pared to public insurers (Medicare is estimated at 3.6 percent and Medicaid at 6.8 percent).[94] In addition, because the public option is a health plan available nationwide it will have a broad reach and be able to obtain larger volume discounts and will not operate for profit.[95] Accordingly, the public option in H.R. 3200 will serve as a "benchmark for private plans, a backup to allow consumers access to a good plan with broad access to providers in all parts of the country, and to serve as a cost-control backstop."[96]

Ultimately, it will be up to consumers in the HIE to decide whether to enroll in the public option or a private plan. H.R. 3200 intends to create a level playing field for both to compete. Consumers will be able to compare what each plan offers—private plans or the public option—and decide which plan serves them and their families best.[97]

Ensuring Access to Health Care Through Insurance Market Reforms

Comprehensive insurance reforms are another critical element of health reform. Guaranteeing access to health care and protecting against medical debt largely depends on implementing comprehensive insurance reforms. About "20 percent of the population accounts for 80 percent of health spending;" the "sickest one-percent accounting for nearly one-quarter of health expenditures."[98] This uneven distribution of medical care creates incentives for insurance companies to avoid risk altogether rather than trying to spread it among the insured population.[99] As a result, health insurers—particularly in the individual market—have adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy.[100] These practices include: denying health coverage based on pre-existing conditions or medical history,[101] even minor ones; charging higher, and often unaffordable, rates based on one's health; excluding pre-existing medical conditions from coverage; charging different premiums based on gender;[102] and rescinding policies after claims are made based on an assertion that an insured's original application was incomplete.[103] In addition, while "state and federal laws give individuals the right

[94] John Holahan and Linda Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform," Urban Institute (2009).
[95] Hacker at 7.
[96] *Id.*
[97] *Id.*
[98] Karen Pollitz, testimony before the Committee on Energy and Commerce, Subcommittee on Health (hereinafter Pollitz) (Mar. 17, 2009).
[99] Linda Blumberg, testimony before the Committee on Ways And Means (April 22, 2009).
[100] Mila Kofman, testimony before the Committee on Energy and Commerce, Subcommittee on ealth (hereinafter Koffman)(Mar. 17, 2009); Blumberg, *supra* 94.
[101] *See* Fran Visco, testimony before the Committee on Education and Labor (June 22, 2009). Ms Visco testifying on behalf of the National Breast Coalition, stressed how no insurance or inadequate insurance has had a devastating effect on women diagnosed with breast cancer.
[102] A 2008 report by the National Women's Law Center examined individual insurance policies in 47 states and the District of Columbia and found that most of the states engage in a practice called "gender rating" where insurance companies arbitrarily charge women and men different rates for individual insurance premiums. Specifically, they found that women under 55 are charged more for health insurance than men (at age 25, 4% to 45% more; at age 40, 4 to 48% more). In addition, the report discovered that the vast majority of individual policies do not cover maternity leave, and in 9 states and the District of Columbia, insurers can reject survivors of domestic violence and those who have had C-sections. *See: Nowhere to Turn: How the Individual Insurance Market Fails Women*, National Women's Law Center (2008).
[103] *Id*, Pollitz, supra 98.

to renew their health insurance coverage, guaranteed renewability provides no protection against rate increases."[104]

Discrimination based on health, gender and other factors has severe economic consequences for those who have been unable to find affordable health coverage and for those who have coverage, but are under-insured.[105] As noted earlier, these practices have resulted in about 57 million Americans having debt because of medical bills,[106] and over 42 million of that number has some sort of medical coverage.[107] Medical debt is now the leading cause of personal bankruptcy.[108]

A key element to health reform is to prohibit risk selection practices and to support those factors based on quality and efficiency. Where states have prohibited these discriminatory practices, consumers have benefitted. For example, since 1993, Maine requires insurers to provide health insurance to individuals or small businesses on a "guarantee issue" basis. In addition, it also has an "adjusted community rating" so that prices for policies are set based on "the collective claims experience of anyone with a policy" and not on any one individual's medical history.[109]

H.R. 3200 includes insurance market reforms ending discriminatory practices conducted by insurance companies. These reforms will apply both inside and outside the HIE to end the discriminatory practices currently practiced by insurance companies. The bill requires that all policies be sold on a guaranteed issue basis; prohibits insurers from excluding coverage based on pre-existing conditions; and prohibits insurers from charging higher rates based on health status, gender, or other factors. It would allow premiums to vary based only on age (no more than 2:1),[110] geography and family size. In addition, the bill prohibits lifetime and annual limits on benefits so that families no longer face bankruptcy as a result of a serious medical illness.

STRENGTHENING THE HEALTH CARE WORKFORCE

As millions of new people gain access to health care coverage, H.R. 3200 recognizes that significant investments in the health care workforce are needed. There is mounting evidence that the nationwide healthcare workforce shortage is accelerating. The Health Resources and Services Administration, within the Department of Health and Human Services, reported in January of this year that twenty states were experiencing scarcities of physicians and

[104] *Id.*

[105] *Id*; Pollitz, *supra* 98. While 47 million Americans have no health insurance at all, almost as many are underinsured.

[106] Pollitz, *supra* 98, testified that "when out-of-pocket spending for medical bills (not including premiums) exceeds just 2.5% of family income, patients become burdened by medical debt, face barriers to accessing care, and have problems paying other bills."

[107] Pollitz, *supra* 98.

[108] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007*, The American Journal of Medicine (2009) at 3, finding that in 2007, 62.1% of all bankruptcies in the United States were medical, compared with 8 percent in 2001. *See also:* Pollitz, *supra* 98; Kofman, *supra* 100, both of whom testified that most medical bankruptcies are filed by insured people.

[109] Kofman, *supra* 100.

[110] Pollitz, *supra* 98, testified that age is "a strong proxy for health status."

nurses.[111] In particular, dramatic shortages in the health care workforce are seen in primary care and nursing.

Indeed, demand for primary care physicians outpaces supply more than in other specialty group.[112] Specifically, the Association of American Medical Colleges (AAMC) estimates that primary care accounts for 37 percent of the total projected shortage in 2025.[113] Primary care physicians are leaving the practice of medicine sooner than other physician specialties at the same time that fewer medical students and residents are choosing to make the practice of general internal medicine and primary care their central career goal.[114] For many students, the costs of medical education are so high that they feel compelled to specialize in more lucrative subspecialties in order to manage their debt.[115]

While registered nurses constitute the largest single healthcare profession in the United States, there is a worsening nursing shortage.[116] In 2000, the national supply of full time registered nurses was estimated at 1.89 million while the demand was estimated at 2 million, a shortage of 110,000 nurses.[117] Studies published in both *The New England Journal of Medicine* and *The Journal of the American Medical Association* confirms that the shortage of registered nurses is influencing the delivery of health care in the United States and negatively affecting patient outcomes.[118]

The current nursing shortage is a product of several trends including: a diminishing pipeline of new students to nursing, a decline in RN earnings relative to other career options, an aging nursing workforce, low job satisfaction and poor working conditions that contribute to high attrition rates.[119] Compounding these problems is the fact that nursing colleges and universities across the country are struggling to expand enrollment to meet the rising demand for nursing care. According to an American Association of Colleges of Nursing report, nursing schools turned away 49,948 qualified applicants from baccalaureate and graduate nursing programs in 2008 due to insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints.[120]

The shortage of health care workers in this country disproportionately impacts those Americans residing in rural areas. The National Health Service Corps (NHSC) was established in the Emergency Health Personnel Act of 1970 (P.L. 91–623) to improve the distribution of health workers in underserved rural areas by providing scholarship support to students in qualified medical professions in exchange for a period of service in a Health Professional Shortage Area (HPSA).

[111] *See*, http:newsroom.hrsa.gov/insidehrsa/jan2009
[112] "The Complexities of Physician Supply and Demand: Projections Through 2025," Association of American Medical Colleges (AAMC) (Nov. 2008).
[113] *Id*.
[114] Lipner RS, Bylsma WH. Arnold GK, Fortna GS, Tooker J. Cassel CK. Who is maintaining certification in internal medicine-and why? A national survey 10 years after initial certification. Ann Intern Med. (2005)
[115] Pear, Robert. "Shortage of Doctors an Obstacle to Obama Goals." The NY Times (Apr. 26, 2009).
[116] *See*, Henry J. Kaiser Family Foundation, "Addressing the Nursing Shortage" (Jun. 2008).
[117] *Id*.
[118] *Id*.
[119] *Id*.
[120] *See*, American Association of Colleges of Nursing, "Enrollment and Graduations in Baccalaureate and Graduate programs in Nursing (2008–2009), *available* at: www.acne.nche.edu/IDS.

Administered by the Health Resources and Services Administration, in 2008, 14,000 students applied to the program for financial assistance. However, the Agency was only budgeted to grant one of every seven requests.[121]

H.R. 3200 includes significant investments in the health care workforce to directly address the shortages outlined. The legislation provides resources to help train more primary care physicians as well as registered nurses. It puts into place incentives to encourage more people to become doctors and nurses, particularly in rural areas. Specifically, the bill increases funding for the National Health Service Corps in order to expand scholarships and loans for health professionals that work in shortage professions and areas. In addition, it creates an advisory committee on health workforce evaluation to assess the adequacy and appropriateness of the health workforce, and to make recommendations to the Secretary of Health and Human Services on federal workforce policies to ensure the health workforce is meeting the nation's needs.

V. Section-by-Section Summary[122]

Division I

Title I—Protections and Standards for Qualified Health Benefits Plans

Subtitle A—General Standards

Sec. 100. Purpose; Table of Contents of Division; General Definitions

Purpose

The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending. In addition, this division achieves this purpose by building on what works in today's health care system, while repairing the aspects that are broken. Insurance reforms that this division encompasses are:

- Enacting insurance market reforms
- Creating a new Health Insurance Exchange, with a public health insurance option alongside private plans
- Including sliding scale affordability credits
- Initiating shared responsibility among workers, employers, and the government

This division institutes health delivery system reforms both to increase quality and to reduce growth in health spending so that health care becomes more affordable for businesses, families, and government.

General Definitions (Created within this Act)

- Acceptable Coverage—qualified health benefits plan coverage, coverage under a grandfathered health insurance coverage or current group health plan, Medicare Part A, Medicaid, Military Health

[121] *See*, http:newsroom.hrsa.gov/insidersa/jan2009.

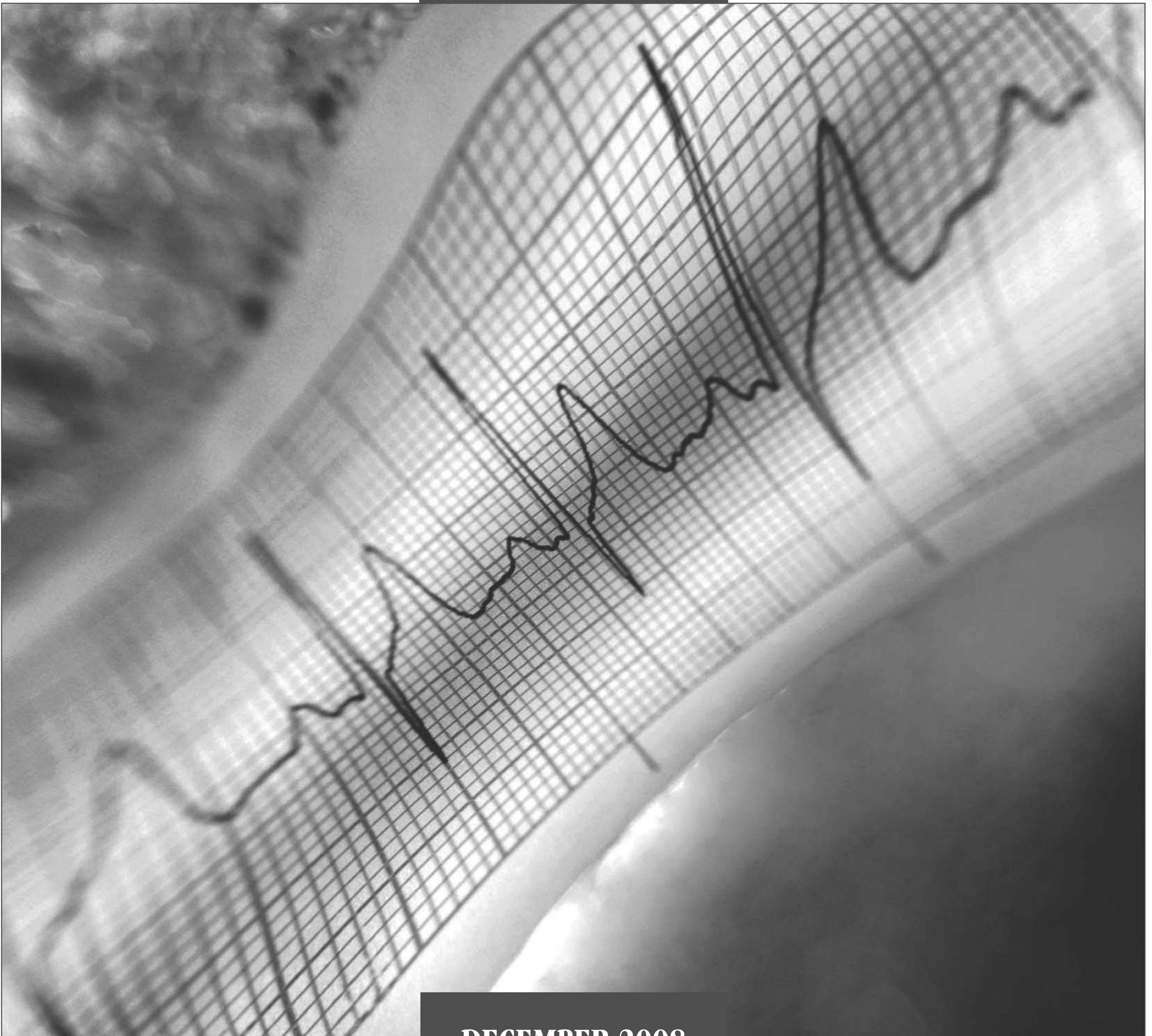
[122] This section-by-section summary is based in part on a summary initially prepared by the Congressional Research Service elaborated upon to reflect the views of the Committee.

Exhibit 2

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Key Issues in Analyzing Major Health Insurance Proposals



DECEMBER 2008

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are paid for their services. Although those considerations are closely related, this report analyzes the following questions:

- For insurance policies with the same scope and total cost, how does the share of that cost that individuals have to pay affect whether they purchase insurance? How would various types of subsidies that reduce the cost to them directly or indirectly—or mandates to offer or purchase coverage—affect the rates and sources of insurance coverage?

- How does the cost of an insurance policy vary with the scope of its coverage, insurers' use of various cost-management techniques, and the types of people it covers? How would health care spending and average policy premiums be affected by extending coverage to people who are now uninsured?

- Taking the demand for insurance overall and the premiums charged for various options as given, how are individuals' decisions about which policy to choose affected by the laws and regulations governing those choices? How would consumers respond to changes in the structure of or incentives governing the insurance market?

- What impact do factors affecting the supply of health care services and the level and mechanism of payments to providers have on the costs of health care and insurance premiums? How would changes in those supply factors interact with demand to determine future spending on health care?

Proposals to modify the health insurance system that include subsidies would probably have the most immediate and direct impact on the federal budget. Their costs would depend primarily on the nature and extent of those subsidies, the number of people who take advantage of them, and the scope of insurance coverage that is purchased or provided as a result. This report also considers other effects, including any federal administrative costs and challenges that might be involved in implementing a proposal; the effects on eligibility for and spending under other federal programs; the impact of provisions that seek to reduce spending on health care by encouraging consumers to make healthier choices and providers to change some of the ways in which they practice medicine; and other macroeconomic effects or budgetary implications that a proposal might have.

The question of whether and how any net increases in federal spending for health care and health insurance would be financed by policy changes outside the health sector is beyond the scope of this report. Whether a proposal makes health insurance more affordable for a given individual or family would depend not only on its impact on the health insurance premiums that they face but also on the effect that its financing mechanisms have on the household's budget. To the extent that such proposals are financed by provisions that fall outside the health sector—through increases in tax revenues or reductions in spending for other federal programs—those effects are not addressed in this report.

As background for the discussion of the broad policy options presented in subsequent chapters of this report, the remainder of this chapter describes the primary sources of health insurance coverage, the reasons that people lack coverage, the extent and nature of the coverage that is currently purchased, and the main components and drivers of health care spending.

Health Insurance Coverage

The primary purpose of health insurance is to protect individuals against the risk of financial hardship when they need expensive medical care. In principle, most people would be willing to pay an insurance premium that was somewhat higher than their own expected costs for health care in order to avoid that risk, but in practice many people with low income or high expected costs might consider the premiums they would face to be unaffordable.

Over the years, various policies have been adopted that subsidize insurance coverage for certain groups. Medicare provides highly subsidized coverage to the elderly and also insures several million people under the age of 65 who are disabled—two groups that have relatively high costs for health care. The Medicaid program and related initiatives offer free or low-priced coverage to many children and (to a more limited degree) their parents; Medicaid also covers many elderly and disabled individuals who have low income and few assets (and thus would have difficulty paying for insurance). Most employers offer health insurance to their workers and most workers enroll in a plan, motivated in part by a tax subsidy for employment-based insurance. People may also be able to purchase coverage in the individual insurance market, but that coverage is not generally subsidized. Those sources of

Table 1-1.

Sources of Insurance Coverage and Insurance Status of the Nonelderly Population, 2009

	Number (Millions)	Percent
	Source of Coverage	
Employment-Based[a]	160	61
Individually Purchased	10	4
Medicare	7	3
Medicaid[b]	43	17
Other[c]	12	4
	Insurance Status	
Insured, Any Source[d]	216	83
Uninsured	45	17

Source: Congressional Budget Office's health insurance simulation model.

Note: The nonelderly population excludes people in institutions and residents of U.S. territories.

a. Includes coverage obtained through local, state, and federal employers.

b. Includes the State Children's Health Insurance Program.

c. Includes military and other sources of coverage.

d. The sum of people by their sources of coverage exceeds the total number who are insured because about 14.5 million people are covered by more than one source at a time.

coverage also vary in the ease of enrollment, which affects their attractiveness.

Because health insurance provides more benefits to people who incur relatively high costs for health care, health insurance coverage generally—or specific health insurance plans—may attract enrollees with above-average costs, a phenomenon known as "adverse selection." Conversely, people with low expected costs for health care may be reluctant to pay an insurance premium that reflects the average costs of all enrollees, or they might prefer to wait until they develop a health problem to sign up for coverage. To the extent that such adverse selection occurs, average insurance premiums (or the costs of government subsidies for insurance) would tend to rise to reflect the higher spending per enrollee. The potential for adverse selection exists with almost any health insurance plan, but the manner in which it arises and the mechanisms used to address it differ across insurance markets.

The availability of health insurance affects not only who enrolls but also how much health care people consume. People who are insured are likely to use more health care than they would if they had to pay the full costs of those services—a phenomenon economists call "moral hazard." To offset that tendency toward increased use, health insurance policies typically feature some degree of cost sharing by enrollees. Health plans may also seek to control their costs and premiums by using various methods of managing care and by varying the range of benefits offered. Of course, those features also affect the premiums for health insurance policies and the attractiveness of the coverage to enrollees.

Sources of Insurance Coverage

In the United States, most people obtain health insurance coverage from either public or private sources, but about 17 percent of the nonelderly population will be uninsured in 2009 (see Table 1-1).[3] Insurance obtained through an individual's employment is the primary source of coverage for the nonelderly.

Employment-Based Insurance. In 2009, roughly 160 million people under the age of 65—or about three out of every five nonelderly Americans—are expected to have health insurance that is provided through an employer or other job-related arrangement, such as a plan offered through a labor union. That figure includes active workers, spouses and dependents who are covered by family policies, and nonelderly retirees.

One prominent feature of employment-based insurance is that employers generally contribute a large share of the total premium; that is, the amount that is directly and visibly deducted from workers' paychecks for health insurance (called the employees' contribution) usually represents a relatively small share of the average cost per enrollee. According to a survey of firms conducted in 2008, employers contribute 73 percent of the cost of a family policy for their workers and 84 percent of the cost

3. Estimates of health insurance coverage presented in this report are derived from a simulation model that the Congressional Budget Office (CBO) developed in order to analyze the effects of various policy options on coverage and spending for health care. For a detailed description of that model and the data and evidence on which it is based, see *CBO's Health Insurance Simulation Model: A Technical Description,* Background Paper (October 2007).

of single coverage, on average.[4] One reason employers make those contributions is to encourage broad participation by their employees, so as to limit the potential for adverse selection.

Although employers may appear to pay most of the costs of their workers' health insurance, economists generally agree that workers ultimately bear those costs. Employers' contributions are simply a form of compensation, and if labor markets are competitive (which is generally the case), an employee's total compensation should equal his or her contribution to the revenue of the firm. Thus, when an employer offers to pay for health insurance, it pays less in wages and other forms of compensation than it otherwise would, keeping total compensation about the same.[5]

That relationship can be difficult to observe and may not hold perfectly for every worker at every instant. In particular, workers who turned down an employer's offer of subsidized health insurance generally would not see an immediate or corresponding increase in their wages. Moreover, firms offering health insurance actually tend to pay higher wages than firms that do not do so, but those differences in total compensation reflect disparities in the skill and productivity of the workers, not a failure to pass on the costs of providing insurance. For their part, many employers behave as though they do bear the costs of the insurance plans they offer (as reflected in their efforts to control those costs). Nevertheless, the available evidence indicates that employees as a group ultimately bear the costs of any payments an employer makes for health insurance.[6]

How the costs of employers' contributions are allocated among different types of workers and how quickly wages would adjust to changes in those contributions is less clear. In principle, workers who would obtain more benefits from health insurance coverage—such as older workers, who have higher average costs for health care—would be willing to accept a greater reduction in their wages than other workers would accept in return for that coverage. The extent to which that phenomenon occurs in practice, however, is uncertain.[7] Similarly, it could take labor markets several years to adjust to unexpected changes in employers' costs for health care. For purposes of estimating the impact of proposed legislation, however, CBO makes the simplifying assumption that total compensation is fixed and that changes in the costs of health insurance translate immediately into offsetting changes in wages and other forms of compensation; the JCT staff makes the same assumption when estimating the effects of proposals on revenue collections.

Compared with the individual insurance market, employment-based coverage offers several advantages, particularly for employees of larger firms. Unlike wages, the employer's costs for providing that coverage are excluded from the enrollee's taxable income. As a result, that portion of employees' compensation is not subject to individual income and payroll taxes. In addition, most employees are also able to exclude the portion of the premium that they pay. For a typical worker, that favorable tax treatment provides a subsidy from the government that reduces the net cost of employment-based health insurance by about 30 percent.

That tax subsidy provides an incentive for workers to obtain insurance through their employer and for their employer to provide it. Because out-of-pocket costs for health care do not generally receive a tax subsidy, workers also have an incentive to secure more extensive coverage, thereby increasing the share of spending for health care that is covered and decreasing the share that they pay out of pocket. The value of the exclusion from taxation is generally somewhat larger for workers with higher income because they face higher income tax rates (although they may also face lower rates of payroll taxation).

4. Henry J. Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET), *Employer Health Benefits: 2008 Annual Survey* (Washington, D.C.: Kaiser/HRET, September 2008).

5. Even if a given labor market was not competitive, firms operating in that market would still be expected to hold total compensation fixed, so that other forms of compensation would be reduced to offset the costs of providing health insurance. The allocation of compensation among wages, health insurance, and other fringe benefits would reflect the preferences of workers and the firms' efforts to attract employees.

6. For a discussion of that evidence, see Jonathan Gruber, "Health Insurance and the Labor Market," in A.J. Culyer and J.P. Newhouse, eds., *Handbook of Health Economics,* vol. 1 (Amsterdam: North Holland, 2006), pp. 645–706.

7. One study examined the impact of a state mandate to cover maternity benefits and found that reductions in the wages of women of child-bearing age and their spouses roughly offset the average costs of providing those benefits. See Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review,* vol. 84, no. 3 (June 1994), pp. 622–641.

Box 1-1.

Regulation of Health Insurance and the Employee Retirement Income Security Act

In the United States, some forms of private health insurance are subject to both state and federal regulation, but others are exempt from state regulation. That distinction, which is a common source of confusion, stems from the treatment of employment-based health plans under the Employee Retirement Income Security Act of 1974 (ERISA). Under that act, employers that bear the financial risk of covering their workers' health insurance claims—and thus effectively serve as the insurer—are exempt from state insurance laws and regulations. If, instead, an employer contracts with an insurance company to provide coverage and that company bears the associated financial risk, then state insurance laws and oversight apply.

The main practical effect of the difference in treatment is that employers who serve as the insurer for their employees are exempt from the benefit mandates and other insurance regulations that many states impose (such as requirements to cover certain treatments, procedures, or types of providers). A rationale for that arrangement is that an employer with operations in several states would otherwise be unable to offer the same coverage to all of its employees, given the variation in state mandates and regulations; similarly, complying with the differing requirements in each state might be cumbersome for such an employer.

Of the roughly 160 million people whose primary insurance will come from an employment-based plan in 2009, the Congressional Budget Office estimates that about 88 million will have coverage from an employer that bears the financial risk of providing it and that 72 million will have coverage from an insurer that is subject to state regulation. (Policies covering another 10 million enrollees that are bought in the individual insurance market are also regulated by the states.) Large firms are more likely to bear insurance risk for their workers; according to one survey, 86 percent of workers at firms with 5,000 or more employees were in such plans in 2007, compared with 12 percent of workers at firms with fewer than 200 employees.[1]

Confusion about the implications of ERISA may stem in part from the terminology that is used to describe its provisions and from subtle distinctions about the roles of employers and insurers. Employers that bear insurance risk are referred to as having "self-insured" or "self-funded" plans, whereas employers that contract with an insurer are said to have "insured" or "fully insured" plans. Many employers that bear insurance risk still use insurers to carry out some functions, such as developing networks of providers, negotiating payment rates, processing claims, and so forth. In those cases, the insurance company is called a third-party administrator. Further, employers may qualify for ERISA's exemptions even if they purchase a separate insurance policy (known as reinsurance or "stop loss" coverage) to protect themselves against unusually high claims, so long as the employer continues to bear sufficient financial risk.

1. William Pierron and Paul Fronstin, *ERISA Pre-emption: Implications for Health Reform and Coverage,* Issue Brief No. 314 (Washington, D.C.: Employee Benefit Research Institute, February 2008), www.ebri.org.

Table 1-2.

Share of Employees Offered Health Insurance, by Size of Firm, 2009

Size of Firm (Number of employees)	Total Employees Number (Millions)	Total Employees Percent	Employees Offered Health Insurance Number (Millions)	Employees Offered Health Insurance Percent
Fewer than 25	31.0	22	14.9	48
25 to 99	17.6	13	12.7	72
100 to 999	27.2	19	21.0	77
1,000 or More	63.9	46	54.9	86
All	139.7	100	103.5	74

Source: Congressional Budget Office's health insurance simulation model.

Employment-based insurance offers a number of other advantages. For example, because sales and marketing costs for insurers are relatively fixed, as the number of enrollees covered by an employer's policy increases, those fixed costs can be spread over a larger number of enrollees. As a result, the average premium needed to purchase a given amount of coverage is lower for employees of larger firms. Some analysts have suggested that employers also act as employees' agents, using their power to bargain for lower premiums, sorting out the employees' options, and making it easier for them to choose an insurance plan.[8] In particular, employers may take steps that substantially simplify the process of enrolling in a health insurance plan, and the use of automatic payroll deduction to pay for employees' premiums may also encourage participation.

Another important feature of employment-based insurance is that policies offered by firms of all sizes are subject to certain federal requirements, but most policies offered by larger firms are exempt from state insurance laws and regulations. That distinction stems from the provisions of the Employee Retirement Income Security Act, which are described in Box 1-1. As a result, policies offered by smaller employers generally must comply with requirements that vary by state regarding the benefits they cover, the premiums that insurers may charge, and other terms of purchase. (Those regulations are discussed further in Chapter 4.) Policies provided in the large-group market, by contrast, generally face few legal constraints regarding their benefits and premiums. One exception is that, among workers who are similarly situated (that is, workers who are in the same class of employment and work in the same geographic location), employers may not vary employees' contributions to premiums on the basis of their health.

Whether employers offer coverage largely reflects the aggregate preferences of their workers, but for several reasons smaller firms are less likely to offer insurance than larger firms. Overall, about half of the workers at very small firms (those that have fewer than 25 employees) are offered coverage and are eligible for it, compared with 77 percent of the workers at firms with 100 to 999 employees and 86 percent of the workers at firms with 1,000 or more employees (see Table 1-2).[9] One reason is that households with lower income find it more difficult to accept lower wages in return for health insurance, and smaller firms are more likely to employ low-wage workers. Another reason is that policies purchased by smaller firms incur higher administrative costs per enrollee, so the share of the policy premium that covers medical costs is lower, reducing the attractiveness of such policies. Because employees of larger firms constitute most of the total workforce, the percentage of all workers who are offered coverage—about three out of four—is closer to the proportion for larger firms.

The share of workers who are enrolled in employment-based coverage has varied somewhat over time, partly reflecting changes in the mix of employment and partly tracking fluctuations in the business cycle. According to recent surveys of employers, that share rose from 62 percent in 1999 to 65 percent in 2001 but has fallen since then and stands at 60 percent in 2008.[10] The coverage rate has been somewhat more volatile for smaller firms (those with fewer than 200 workers); that rate was

8. Jeff Liebman and Richard Zeckhauser, *Simple Humans, Complex Insurance, Subtle Subsidies,* Working Paper No. 14330 (Cambridge, Mass.: National Bureau of Economic Research, September 2008).

9. Among firms that have similar numbers of workers, the share of firms reporting that they offer coverage to their employees is generally larger than the share of employees reporting that they have an offer, but that discrepancy simply reflects the fact that some workers at firms that offer coverage are not eligible to enroll in it. For example, many part-time workers are ineligible.

10. Kaiser/HRET, *Employer Health Benefits: 2008 Annual Survey*; and *Employer Health Benefits: 1999 Annual Survey* (October 1999).

52 percent in 1996, rose to 58 percent in 2001, and fell back to 52 percent in 2008. Studies have attributed the recent decline in enrollment to a combination of modest reductions in the number of employers offering insurance, shifts in employment toward firms and industries that are less likely to offer health insurance coverage, and a reduction in enrollment rates among workers who are offered coverage. The estimated impact of each of those factors varies, however, depending on the specific years examined, the data used, and the methodology employed.

One source of employment-based health insurance that has received considerable attention is the Federal Employees Health Benefits (FEHB) program, which provides coverage to about 8 million active and retired federal employees in 2008. Under that program, several private health insurance plans are available nationwide, and in most regions employees have a range of local plans available to them as well. The federal government covers 75 percent of the cost of each participating plan up to a limit set at 72 percent of the national average premium; to purchase a policy more expensive than that, the enrollee has to pay the added costs (although those payments may also be excluded from taxable income).[11] Like employees of private firms that offer a choice of insurance plans, federal workers may generally sign up for coverage or change plans only during an annual open-enrollment season—a rule that limits their opportunities to wait until they develop a health problem to enroll or to switch plans for health reasons and thus limits the degree of adverse selection that can occur.

Although employment-based insurance has certain advantages, the central role of employers in sponsoring coverage also has disadvantages. Unlike federal workers, many employees are not offered a choice of insurance plans, and others may have only a few plans from which to select, so the plan in which they enroll might not fit their preferences. Furthermore, employees and their dependents typically have to change plans when changing jobs and could become uninsured if their new employer does not offer coverage—potentially making them reluctant to switch jobs in the first place (a phenomenon known as "job lock").[12] In addition, employees who become disabled or too sick to keep their job may eventually lose their employment-based coverage.

Individually Purchased Insurance. Overall, CBO estimates that about 10 million nonelderly individuals will be covered by a policy purchased in the individual insurance market in 2009. In principle, anyone may purchase coverage in that market—to cover only themselves or their family as well—but in practice that option may be more attractive to some people than to others. (Such coverage is sometimes called "nongroup" insurance to distinguish it from group coverage, which is primarily employment based.)

The potential for adverse selection may be stronger in the individual market than in the employment-based market, partly because people can apply for individual insurance at any time and may therefore wait until a health problem arises before seeking coverage and partly because applicants do not have to be healthy enough to work. To address those possibilities, insurers usually "underwrite" the policy—a process by which they assess the health risk of applicants. Although most applicants end up being quoted a standard premium rate (which usually varies by age), underwriting can result in adjustments to premiums, adjustments to benefits (for example, to exclude coverage of known health conditions), or denials of coverage. As a result, individuals who have more health problems may face higher premiums when they apply for coverage. Some states, however, prohibit or limit those practices—which generally has the effect of reducing premiums charged to older or less healthy applicants and raising premiums for younger and healthier applicants (as discussed further in Chapter 4).

Individual insurance products have some other advantages and disadvantages compared with employment-based coverage. Some applicants may be able to obtain basic insurance protection (such as "catastrophic coverage" plans) in the individual market at a relatively low cost. That market generally offers consumers a greater choice of plans, and the coverage may be portable from one job to another. Insurers incur greater administrative costs for policies sold in the individual market, however,

11. For more information, see Mark Merlis, "The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform" (briefing prepared for the Henry J. Kaiser Family Foundation, May 30, 2003).

12. Workers who previously held employment-based insurance may seek coverage in the individual insurance market, and insurers must generally offer them a policy if they apply, but some workers may find the terms of that coverage unattractive. See Chapter 4 for additional discussion.

and those costs are built into the policy premiums. Compared with the enrollment process for an employment-based plan, the effort required of applicants to search for a policy and sign up for coverage in the individual market can be considerably greater. In general, individually purchased coverage does not receive favorable tax treatment, which also makes its effective price higher.[13]

Reflecting those disadvantages, participation in the individual insurance market is relatively low. Only about 1 percent of nonelderly adults who are offered employment-based coverage (either by their own employer or through a spouse) elect to purchase individual coverage. Even among people who lack other coverage options, only about 20 percent elect to purchase a policy in the individual market; the rest are uninsured. In many cases, individually purchased policies are held for relatively short periods of time—serving to cover individuals between jobs, for a short period following college (a point at which children may become ineligible for coverage under their parents' plan), or between retirement and age 65 (the age of eligibility for Medicare).

Medicare. Medicare provides coverage for about 37 million people who are age 65 or older, and it also covers about 7 million nonelderly people who are disabled (and generally become eligible after a two-year waiting period) or have severe kidney disease.[14] In 2008, about 80 percent of Medicare's beneficiaries are insured through the traditional fee-for-service program, which pays providers for services directly using prices set administratively; the rest have chosen to receive coverage through private insurers that contract with Medicare to provide program benefits in return for a fixed monthly payment per enrollee (known as the Medicare Advantage option). About 3 percent of people under age 65 are covered by Medicare (see Table 1-1 on page 4), but their average costs to the program are substantial—more than $35,000 per person in 2007 for those with kidney failure and roughly $8,000 per person for other disabled enrollees.

13. Exceptions include self-employed individuals, who may deduct the costs of their health insurance from their taxable income, and individuals who claim itemized medical deductions in excess of 7.5 percent of their adjusted gross income. See Chapter 2 for additional discussion.

14. According to the most recent estimates from the Census Bureau, about 700,000 elderly people, or roughly 2 percent of individuals age 65 or older, were uninsured in 2007.

When it was created, Medicare had two primary components: Part A, which generally covers hospital care and other services provided by institutions; and Part B, which generally covers physicians' services and various forms of outpatient care. Enrollment in Part A is free of charge and essentially automatic for individuals (and their spouses) who have sufficient earnings subject to payroll taxes to qualify for Social Security benefits; certain others may enroll but must pay a monthly premium. To participate in Part B, enrollees must pay a monthly premium that covers about 25 percent of the program's average costs. Although participation is voluntary, seniors who choose not to participate in Part B when they are first eligible are subject to penalties if they decide to enroll at a later date—penalties that are intended to discourage eligible individuals from waiting to develop a health problem before they enroll. As a result of those provisions, nearly 95 percent of individuals who are eligible to enroll in Part B do so. Many of those who do not enroll have retiree coverage from a former employer that limits the benefits they would receive from enrolling in Part B (and may also exempt them from the late-enrollment penalty).

A voluntary outpatient prescription drug benefit—known as Part D—was added to Medicare in 2006; its premium subsidy and penalty for late enrollment are similar to Part B's. About 70 percent of the people who are eligible to participate in Part D have chosen to do so.[15] Analysis by the Centers for Medicare and Medicaid Services (CMS) indicates that a majority of those non-enrollees have drug coverage from another source that is at least as comprehensive as the Medicare benefit, but about 10 percent of the Medicare population appears to lack substantial drug coverage.

Medicaid and the State Children's Health Insurance Program. Medicaid is the main source of health insurance coverage for Americans who have very low income, and the smaller State Children's Health Insurance Program (SCHIP) provides coverage for children in families that have somewhat higher income. Unlike the Medicare program, which does not take into account income or assets when determining eligibility and is federally financed, Medicaid and SCHIP are needs-based assistance programs that are jointly financed by the federal government and state governments.

15. That figure includes retirees who continue to receive drug coverage from a former employer if that employer receives a subsidy payment from Medicare on their behalf.

CBO estimates that at any given point in 2009, roughly 64 million nonelderly individuals will be eligible for Medicaid or SCHIP coverage and that about 43 million will be enrolled.[16] Eligibility for Medicaid was originally limited to very low income families with dependent children and to poor elderly or disabled individuals. Over the past two decades, coverage has been extended to children in families with somewhat higher income and to pregnant women. Nonelderly, nondisabled adults who have no children are generally ineligible for the program. Able-bodied parents and children represent about three-fourths of all Medicaid enrollees, but about 70 percent of the program's spending is for the remaining enrollees who are either elderly or disabled and have low income and few assets.

Subject to broad federal requirements governing eligibility and benefits, the Medicaid program is largely administered by the states, and thus its specific features may vary considerably from state to state. On average, the federal government covers about 57 percent of the costs of the health care services received by enrollees (the share varies among states and is higher for states with relatively low per capita income). State Medicaid programs cover a comprehensive set of services, including hospital care (both inpatient and outpatient), physicians' services, nursing home care, home health care, and certain additional services for children. States have the authority to cover other services and populations and have used that authority extensively.[17] They may also apply to the federal government for waivers from various federal Medicaid rules.

16. That figure represents average enrollment and excludes nonelderly individuals living in institutions (such as nursing homes) and people living in U.S. territories. CBO has also projected that the total number of individuals enrolled in Medicaid at any point during 2009 (including elderly and institutionalized enrollees and residents of territories) will be 65 million, of which about 59 million will be nonelderly. Many of those individuals will be enrolled in the program for only part of the year.

17. According to one estimate, total spending on optional populations and benefits accounted for about 60 percent of the program's expenditures in 2001. Of that total, 30 percent was spent to provide optional benefits to mandatory groups; 50 percent, to provide mandatory benefits to optional groups; and 20 percent, to provide optional benefits to optional groups. See Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (Washington, D.C.: Henry J. Kaiser Family Foundation, June 2005), p. 11.

SCHIP was established in 1997 to provide coverage to children whose family income is above the eligibility levels for Medicaid. States generally cover children in families that have income up to 200 percent of the federal poverty level (or about $44,000 for a family of four in 2009), but some states have higher income limits and some cover parents as well as their children. Like Medicaid, SCHIP is jointly funded by the federal government and the states, but the federal share of costs is higher for SCHIP—covering 70 percent of health care claims, on average. States have a fair amount of discretion in designing and implementing their programs: They may expand Medicaid, create a new state system specifically for SCHIP, or use some combination of the two approaches.[18]

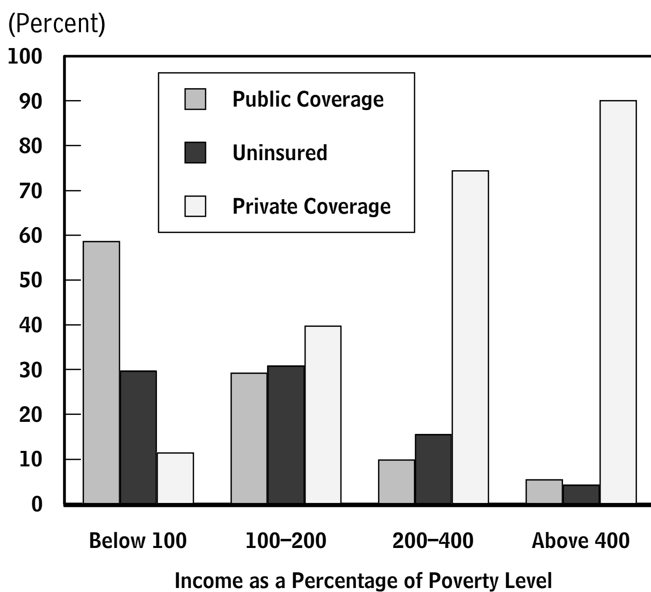
SCHIP is currently authorized in law through March 2009. Consistent with statutory guidelines, CBO assumes in its baseline spending projections that federal funding for the program in later years will continue at $5.0 billion, the base amount provided for the first half of fiscal year 2009. In fiscal year 2008, the program's budget authority was $6 billion and its outlays were about $7 billion. Because average costs per enrollee are expected to rise, CBO projects that average enrollment would decline from a peak of about 5.3 million in 2008 to about 2 million in 2018 under that assumption about future funding. (References to Medicaid in the remainder of this chapter also include SCHIP.)

Other Sources of Coverage. A significant number of people obtain insurance coverage from various other sources including the military, universities (for students), and other organizations. CBO estimates that roughly 12 million people will be covered under such arrangements in 2009. Although military coverage could be considered a form of employment-based insurance, it is typically counted separately. The Department of Veterans Affairs provides some health care to military veterans, but its programs are not considered a comprehensive health insurance plan; similarly, the Indian Health Service provides some care to Native Americans and Alaska natives but is not counted as a source of health insurance (such programs are discussed more extensively in Chapter 6).

18. For additional information, see Congressional Budget Office, *The State Children's Health Insurance Program* (May 2007).

Figure 1-1.

Patterns of Health Insurance Coverage for Nonelderly People, by Family Income Relative to the Federal Poverty Level, 2009



Source: Congressional Budget Office's health insurance simulation model.

The Uninsured Population

About 45 million people, or about 15 percent of the total U.S. population, will be uninsured at any given point in 2009, by CBO's most recent estimates. Because the elderly have near-universal coverage from Medicare, many analyses of the uninsured focus on the nonelderly population, about 17 percent of which is expected to lack coverage in 2009. Those estimates for 2009 do not reflect the recent deterioration in economic conditions, which could result in a larger uninsured population.

In many cases, people's insurance status varies over the course of a year. For example, CBO's analysis of survey data showed that between 57 million and 59 million people—or roughly one-fourth of the nonelderly n population—were uninsured at some point during 1998. The average number of people who were uninsured at a give point in 1998 was smaller—between 39 million and 44 million, of which 21 million to 31 million were uninsured for all of that year.[19] CBO also found that for those who became uninsured at some point between July 1996 and June 1997, nearly half had spells of uninsurance lasting four months or less and about one in six had spells lasting two years or more.

According to CBO's projections, the average number of people who are uninsured at any one time will rise to about 54 million, or about 19 percent of the nonelderly population, by 2019. The number of uninsured individuals is expected to increase because health insurance premiums are likely to rise considerably faster than income, which will make insurance more difficult to afford.

Characteristics of the Uninsured. The purchase of health insurance in the United States is voluntary, so the main reason that people are uninsured is that they are unwilling or unable to purchase coverage. Several characteristics are associated with insurance status—including income, age, being offered insurance at work, or being eligible for public coverage—but whether they are a causal factor or are merely correlated with coverage rates is not always clear.

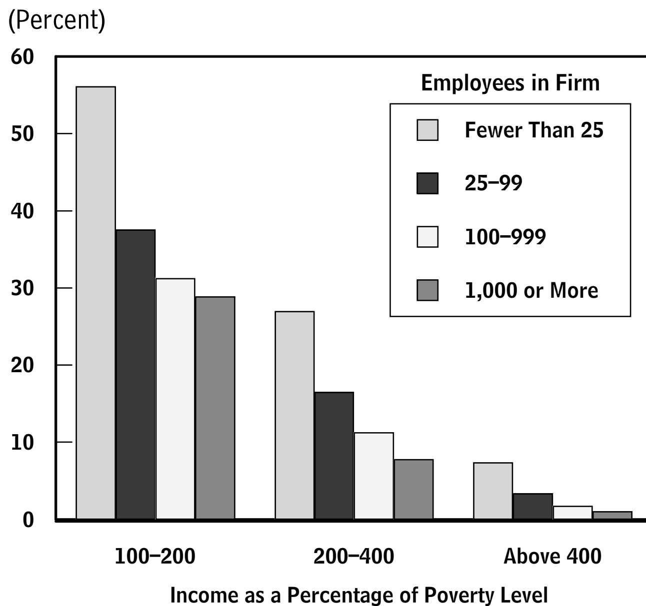
Because the costs of health insurance can represent a substantial share of income for lower-income individuals and families who are not eligible for subsidized public coverage, it is not surprising that coverage patterns are strongly correlated with income. In particular, as income rises, the share of nonelderly people who are uninsured or have public coverage declines and the share with private coverage rises (see Figure 1-1). In 2009, the highest rates of uninsurance—about 30 percent—will be found among people whose family income is below 200 percent of the federal poverty level. For people in that group that have insurance, those with family income below the poverty line will be much more likely to have public coverage, whereas those with income above the poverty line will be more likely to have private insurance. Only about 12 percent of people below the poverty line will have private coverage; that rate rises to 40 percent for those between 100 percent and 200 percent of the poverty level. For people whose income is between 200 percent and 400 percent of the poverty level, by contrast, 74 percent have private coverage and 16 percent are uninsured. For people with income above 400 percent of the poverty level, 90 percent have private coverage and 4 percent are uninsured.

19. Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003).

Figure 1-2.

Uninsurance Rates of Full-Time Workers, by Size of Firm and Family Income Relative to the Poverty Level, 2009

(Percent)



Source: Congressional Budget Office's health insurance simulation model.

Another characteristic that is associated with the lack of health insurance, at least among adults, is age. Younger adults are particularly likely to be uninsured—about 27 percent of those ages 18 to 34 lacked coverage, compared with about 14 percent of those ages 45 to 64 in 2007—possibly reflecting a lower perceived need for using health care services (younger people are generally healthier) as well as lower average income and assets.[20] Those younger adults make up about one-fourth of the nonelderly population but represent about 40 percent of the uninsured. Children under the age of 18 account for about the same share of that population but are much less likely to be uninsured.

Not surprisingly, rates of coverage are also associated with whether an individual (or a close family member) is offered insurance at work. In part that correlation probably reflects differences in income—firms with more low-wage workers are less likely to offer coverage—but even within a given income range, workers in relatively small firms (which are less likely to offer coverage) are much more likely to be uninsured than workers in larger firms (see Figure 1-2). For example, among full-time workers whose income is between 100 percent and 200 percent of the federal poverty level, CBO projects that 56 percent of those employed by very small firms (fewer than 25 employees) will be uninsured in 2009, compared with 30 percent for those employed by larger firms (those with 100 or more workers). Determining cause and effect is difficult, however, because workers with less of a desire for insurance or who consider coverage unaffordable would be more likely to join firms that do not offer coverage and pay those workers higher wages instead.

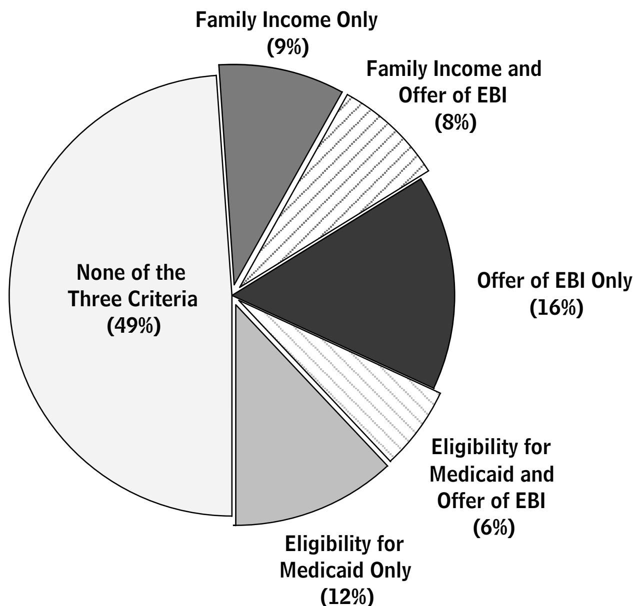
Looking at income levels and insurance options simultaneously may provide additional insights about the uninsured population. For example, CBO projects that among the uninsured in 2009, 17 percent will have family income above 300 percent of the poverty level (about $65,000 for a family of four); 18 percent will be eligible for but not enrolled in Medicaid; and 30 percent will be offered, but will decline, coverage from an employer (see Figure 1-3). Some people will be in more than one of those categories at the same time—so overall, about half of the uninsured will meet at least one of those three criteria. Conversely, the rest of the uninsured are projected to have relatively low income and to lack both an offer of employment-based coverage and eligibility for public coverage.

The reasons people remain uninsured even though they are offered employment-based coverage or are eligible for Medicaid are not always clear. In the case of employment-based coverage, the share of the premium that the employee must pay may be relatively high, or the employee may simply place a low value on having insurance. As for Medicaid, studies indicate a mixture of reasons for failing to enroll. Some people may not be aware that they are eligible; others may be deterred by the application process or see some stigma associated with a program for low-income families. An additional factor is that people who are eligible for Medicaid may be enrolled when they are hospitalized and then may gain retroactive coverage for recent medical expenses; thus, eligibility—even without enrollment—gives them some degree of protection against high medical costs and may reduce the incentive to enroll sooner.

20. U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2007,* P60-235 (August 2008).

Figure 1-3.

Projected Distribution of the Uninsured Nonelderly Population, by Selected Characteristics, 2009



Source: Congressional Budget Office.

Note: This analysis categorizes uninsured nonelderly people according to whether they will meet any of the following criteria in 2009: Their family income will be above 300 percent of the federal poverty level; they will have an offer of employment-based insurance (EBI); or they will be eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). The Congressional Budget Office estimates that a very small number of people will have family income above 300 percent of the federal poverty level and will be eligible for Medicaid or SCHIP.

Use of Health Care by the Uninsured. How the uninsured obtain health care affects both their incentives to seek insurance coverage and the impact that policies designed to reduce the number of uninsured have on spending and health. Many of the uninsured receive care from free clinics and other community health centers, which are funded by a combination of federal and state sources and private donations. Others may use traditional health care providers—hospitals as well as physicians in private practice—and pay all charges for the services they receive.

In many cases, however, people who are uninsured receive treatments from traditional providers for which they either do not pay or pay very little, which is known as "uncompensated care." Hospitals that participate in Medicare and offer emergency services are required by law to stabilize any patient who arrives, regardless of whether he or she has insurance or is able to pay for that care. In addition, most hospitals are nonprofit organizations and thus have some obligation to provide care for free or for a minimal charge to members of their community who could not afford it otherwise. For-profit hospitals also provide such charity or reduced-price care.[21]

Estimates of how much uncompensated care the uninsured receive vary depending on the data sources and methods used and the categories of spending that are included in the analysis. Some measures of uncompensated care compare the amount that providers are actually paid for their services with their list prices or posted charges for those services. A more useful comparison, however, is with the total payments that providers would receive for the same service when treating a privately insured patient, because that amount (which is generally much lower than the list price) more closely resembles their costs.

A recent study by Hadley and others, which used that analytic approach, examined a sample of medical claims for uninsured individuals and projected that they would receive about $28 billion in uncompensated care in 2008.[22] That study also examined reports by doctors and hospitals and derived a higher estimate: Their gross costs of providing uncompensated care would be about $43 billion in 2008, of which $8 billion would come from doctors and $35 billion would come from hospitals. But as the study noted, at least a portion of those costs could be offset by added payments under Medicare and Medicaid to hospitals that treat a disproportionate share of low-income patients (and by similar dedicated payments made under other federal and state programs). Another recent study found that, as a group, office-based

21. For a discussion, see Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits* (December 2006).

22. Jack Hadley and others, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs,* Web Exclusive (August 25, 2008), pp. W399–W415. That study also reported that uncompensated care would total about $56 billion in 2008 if all costs not paid out of pocket by the uninsured were included in the tally. But that amount would seem to be an overestimate because the study found that, even though no payments were made by insurers, about half of those costs were directly compensated by various third parties (such as workers' compensation programs).

Table 1-3.

Health Care Expenditures in 2008, by Insurance Status

Insurance Status	Out-of-Pocket Spending	Third-Party Payments: Insurance	Third-Party Payments: Other[a]	Uncompensated Care	Total
			Dollars of Spending		
Uninsured for Full Year	583	0	567	536	1,686
Insured for Part of the Year	550	2,030	260	145	2,983
Privately Insured for Full Year	681	3,018	215	0	3,915
Insured for Full Year	654	3,563	246	0	4,463
			Shares of Spending (Percent)		
Uninsured for Full Year	35	0	34	32	100
Insured for Part of the Year	18	68	9	5	100
Privately Insured for Full Year	17	77	5	0	100
Insured for Full Year	15	80	6	0	100

Source: Congressional Budget Office based on data from Jack Hadley and others, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs*, Web Exclusive (August 25, 2008), pp. W399–W415. The authors used data from the Medical Expenditure Panel Survey, 2002–2004, and adjusted the data to 2008.

a. Includes workers' compensation, veterans' benefits, and other payments not counted as health insurance.

physicians roughly "broke even" when treating uninsured patients because some of those patients paid more than the doctors would have received for treating a privately insured patient.[23] (The issue of whether and to what extent the net costs of providing uncompensated care are shifted to other payers in the health sector is discussed in Chapter 5.)

The uninsured generally use fewer health care services than people who have insurance, although estimates regarding the magnitude of the difference also vary. The study by Hadley and others estimated that an individual who is uninsured for all of 2008 will use about $1,700 worth of care—including about $540 in uncompensated care—or less than half as much as someone who is privately insured all year would use (see Table 1-3). The disparity in the amount spent for care is even larger; subtracting uncompensated care yields an estimate that spending incurred by and on behalf of people who are uninsured for the entire year (about $1,160) is about 30 percent of the amount spent for people who are privately insured all year (about $3,900). Spending by and for those who are insured for part of the year (about $3,000) falls between those two points. According to those estimates, average out-of-pocket payments are similar for each group, although those payments cover a higher share of total spending for the uninsured.

Reflecting a range of other findings on that topic, CBO estimates a somewhat smaller disparity in the use of health care services than the study by Hadley and others would indicate.[24] According to several other studies and CBO's own analysis of data for the nonelderly population, the uninsured do use fewer health care services than the insured, but the difference is generally in the range of 30 percent to 50 percent. (See Chapter 3 for a more extensive discussion of those estimates.) Studies comparing the insured and uninsured populations usually account for any differences that are observed in the demographic characteristics and health status of those populations, which would affect their use of health care.

23. Jonathan Gruber and David Rodriguez, *How Much Uncompensated Care Do Doctors Provide?* Working Paper No. 13585 (Cambridge, Mass.: National Bureau of Economic Research, November 2007).

24. If the study by Hadley and others underestimated the number of services used by uninsured individuals, its estimate of uncompensated care could also be correspondingly low. (That factor could account for the higher estimate of uncompensated care that study derived using reports by doctors and hospitals.) If, instead, the study overestimated the number of services used by insured individuals, that would not necessarily affect the estimate of uncompensated care.

Thus, CBO would expect an uninsured person to use 30 percent to 50 percent fewer health care services, on average, than a person who is similar in other respects but has typical private insurance coverage. Among people who have similar demographic characteristics and health status, there are two possible reasons why those who are uninsured would use fewer services than those who are insured: First, some of the uninsured may simply be less inclined to seek health care, resulting in less use of services; and second, the prospect of having to pay the full cost of the services they receive gives them an incentive to use less medical care or less expensive services.

A related consideration is whether the lack of insurance has adverse effects on health. Some studies examining the treatment of serious health conditions have found relatively clear links between insurance coverage and health outcomes.[25] For example, uninsured individuals who develop cancer generally have poorer outcomes and die more quickly than cancer patients who have private health insurance. That difference is attributed partly to later diagnosis for the uninsured; broader analyses of the uninsured population have found that they are less likely to receive screening tests, such as mammograms. Similarly, uninsured individuals who have heart disease are less likely to receive expensive treatments for it and also have higher rates of mortality than those who have heart disease but are privately insured.

For more routine care, however, disentangling the effects on health of being uninsured from the impact of other factors that are associated with lack of insurance is more difficult. One recent and comprehensive review of the literature noted that most studies of such effects on health simply compare insured and uninsured individuals and thus do not account for underlying differences between those populations.[26] Some studies with a better design have examined the effects of expanding eligibility for public insurance programs and have found specific health benefits for the targeted populations, but broad health improvements stemming from insurance coverage have been difficult to identify. For example, one recent study found that the creation of Medicare had no discernible effect on the mortality rates of the elderly during the first 10 years of the program's operation.[27] Of course, reduced mortality is a relatively crude measure of the benefits conferred by medical care, but the ability to analyze other outcomes, such as quality of life, is constrained because those effects are more difficult to measure.

Nature and Extent of Coverage

In addition to differences in the sources of and financing for health insurance and health care, coverage varies by the type of health plan providing it, the scope of services that are covered, and the cost-sharing requirements and limits that apply. That variation largely reflects different approaches to controlling costs for insured individuals and can have substantial effects on the premiums charged for an insurance policy (as discussed in Chapter 3).

Types of Plans. Through the 1980s, private health insurance coverage in the United States typically took the form of an "**indemnity**" **policy**, which reimbursed enrollees for their incurred costs, left it to them and their doctors to determine what care to provide, and largely allowed doctors and hospitals to set the prices for those services. As health care costs grew rapidly in the 1980s, however, private insurance coverage began to shift from indemnity policies toward other types of health plans, involving various degrees of managed care (as described below) and negotiated pricing.

One form of managed care plan that emerged was a **preferred provider organization** (PPO). PPOs establish lists or networks of preferred doctors and hospitals and—to give enrollees an incentive to use those providers—charge

25. For a summary of those studies, see Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: National Academy Press, 2002), www.iom.edu.

26. Helen Levy and David Meltzer, "The Impact of Health Insurance on Health," *Annual Review of Public Health,* vol. 29 (April 2008), pp. 399–409. One study that sheds some light on the impact of health insurance on health is the RAND Health Insurance Experiment, which randomly assigned large groups of nonelderly individuals to different health insurance plans and tracked their experience over several years. In general, the study found that participants who faced cost sharing did not have worse health than those who got all of their care for free; one exception was lower-income participants with prior health problems, who did not control their blood pressure as effectively when they faced cost sharing. An important limitation of the study, however, is that no participants lacked insurance. For additional discussion of those findings, see Congressional Budget Office, *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes* (December 2006), pp. 54–55.

27. Amy Finkelstein and Robin McKnight, "What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending," *Journal of Public Economics,* vol. 92, no. 7 (July 2008), pp. 1644–1668.

more for care received outside the plan's network. The preferred providers thus gain a higher volume of patients and, in return, usually accept lower negotiated payment rates for each service from the health plan. According to a major survey of employers conducted by the Kaiser Family Foundation, PPOs are the most common type of managed care plan, accounting for about 58 percent of enrollees in employment-based plans in 2008.[28] (That survey is the primary source of statistics about coverage and benefits cited in this subsection.)

At the same time, more stringent forms of managed care, such as **health maintenance organizations** (HMOs), also grew in prominence. Like PPOs, those plans establish networks of providers; unlike PPOs, they offer no coverage for services received outside their networks (except for emergencies). HMOs have also instituted various measures to limit the use of certain services, such as requiring patients to get a referral from a primary care physician in order to see a specialist or to obtain prior authorization from the plan before using some types of specialty care. Some HMOs are fully integrated; the plan owns the hospitals, and doctors work on salary. A more common arrangement, however, is to have a network of independent hospitals and physicians' practices in which providers either receive a fixed payment per patient (in the case of some primary care physicians) or are paid negotiated rates on a fee-for-service basis. As a share of enrollment in employment-based plans, HMOs peaked at roughly 30 percent in the mid-1990s and then fell, reaching about 20 percent in 2008.

Point-of-service (POS) plans have emerged as a kind of middle ground between PPOs and HMOs. Like PPOs they allow enrollees to go outside a plan's network for care (albeit at a higher charge), but like HMOs they typically require enrollees to secure referrals for specialty care from a primary care physician within the plan's network. More common among small firms, they accounted for 12 percent of enrollment in employment-based plans in 2008.

Another design option that has arisen in recent years is a **consumer-directed health plan**, which combines a high-deductible insurance policy with an account that enrollees can use to finance their out-of-pocket payments on a tax-preferred basis. (In other respects, those plans are usually similar to PPOs.) As of 2008, those plans account for about 8 percent of enrollment in employment-based coverage; one form of consumer-directed plan (known as a **health savings account**) can also be purchased in the individual insurance market.[29]

Scope of Covered Services. Both public and private health insurance plans generally cover hospitalizations, visits to doctors and other outpatient care, tests and imaging services (such as X-rays), and prescription drugs. Coverage varies to a greater extent for dental care and vision-related services, particularly when care is discretionary (for example, laser surgery to correct vision problems is typically not covered). According to a 2004 survey of employers, about 20 percent offered vision benefits and two-thirds offered dental benefits (although nearly all firms with more than 500 employees offered dental benefits and about half of those firms offered vision benefits).[30] Another source of variation is government requirements to cover certain types of benefits (such as infertility treatments) or the services of specific providers (such as chiropractors), which some states impose and others do not. Those mandates generally affect policies offered in the individual market and by small employers.

Cost-Sharing Requirements. A more significant way in which health insurance plans vary, even among the broad categories of plans noted above, is their cost-sharing structure. Most plans include one or more of the following provisions:

- An annual deductible (expenses that enrollees must pay out of pocket before the insurer begins paying for services),
- Coinsurance (a specified percentage) or copayments (a specified amount) that enrollees pay out of pocket to providers after satisfying any deductible, and
- An out-of-pocket maximum (a cap on the total amount that an individual or family pays out of pocket in a given year).

Those features not only affect the share of health care costs covered by the insurance policy but also influence total spending for health care.

28. Kaiser/HRET, *Employer Health Benefits: 2008 Annual Survey.*

29. For additional discussion of those plans, see Congressional Budget Office, *Consumer-Directed Health Plans*.

30. Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans 2004* (New York: Mercer, 2004).

Cost-sharing requirements typically differ by type of plan. According to the 2008 Kaiser/HRET survey of employment-based health insurance plans, almost 20 percent of HMO enrollees face a deductible in 2008, compared with about 68 percent of PPO enrollees. Among PPO enrollees, deductibles for care received within the plan's provider network average about $560 for single coverage and about $1,300 for family coverage in 2008. For hospital care, some enrollees face separate deductibles, and most (about 69 percent) are subject to coinsurance or copayments.

Most HMO and PPO plans that have a deductible exempt visits to a physician's office for care received within the network. Enrollees typically have a fixed copayment of around $20 for seeing a primary care physician and around $25 for seeing a specialist physician within their network. For visits outside the network, PPO enrollees who have met the deductible typically pay coinsurance in the range of 30 percent to 35 percent (thus encouraging enrollees to use network providers and also limiting the plan's liability for those costs). Most people who have employment-based insurance must also pay a portion of the costs for advanced diagnostic tests and outpatient surgery (coinsurance is more common) and for emergency room and urgent care visits (copayments are more common).

Most plans also limit total out-of-pocket spending that enrollees might incur in a given year. For PPO plans, median levels of the out-of-pocket maximum are roughly $2,000 for single coverage and $4,000 for family coverage in 2008, although those limits vary considerably across plans. Nearly half of HMOs do not have an out-of-pocket limit, but those plans typically have no deductible and relatively low cost sharing for individual services, so enrollees would be unlikely to incur very high out-of-pocket costs in the aggregate.

Many plans vary the amount of coinsurance by the type of service or exempt some services from the general deductible in an attempt to create differing incentives for enrollees to use certain types of care. For example, preventive services may have little or no cost sharing, either because insurers want to encourage their use or because those benefits are attractive to enrollees. Similarly, plans typically exempt prescription drugs from their general deductible and require relatively low copayments for less expensive generic drugs. Conversely, plans that cover dental and vision services may charge a separate deductible for them, require higher rates of cost sharing, or limit the maximum annual benefits that enrollees can receive.

Cost-sharing requirements tend to be higher in the individual insurance market, reflecting not only insurers' efforts to control the health care spending of their enrollees but also enrollees' desire for lower premiums (because those policies are generally not subsidized through the tax code). One survey of policies purchased in the individual market in late 2006 and early 2007 found that about 70 percent of single policies had deductibles of more than $1,000 and about two-thirds of family policies had deductibles of more than $2,000.[31] Largely because they cover a smaller share of enrollees' health care costs, the premiums for those policies are generally lower than the average premiums observed for employment-based insurance (even though the premiums for individually purchased policies include higher administrative costs per policy).

Cost-sharing requirements in the Medicaid program tend to be much lower than those in employment-based or individually purchased plans—typically $1 to $3 for a doctor's visit or $2 to $3 for a brand-name drug prescription—reflecting the limited income of Medicaid recipients. Cost-sharing requirements may be more substantial under SCHIP but are generally limited to about 5 percent of enrollees' family income.

Cost sharing under the Medicare program varies widely by service. In 2009, enrollees will face a deductible of about $135 for physicians' services and will be charged 20 percent coinsurance beyond that point. Some services, such as lab tests and home health care, are free to the enrollee. Most hospital admissions require a deductible of about $1,070, however, and the effective coinsurance rates for some skilled nursing care and outpatient hospital services may exceed 30 percent. In addition, the program does not cap annual out-of-pocket costs. To limit their financial exposure, most Medicare enrollees have some form of supplemental insurance that covers most or all of their cost-sharing obligations. That supplemental coverage typically comes from a former employer, the Medicaid program, a Medicare Advantage plan, or an individually purchased medigap policy.

31. AHIP Center for Policy Research, *Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, D.C.: America's Health Insurance Plans, December 2007).

CHAPTER

2

Approaches for Reducing the Number of Uninsured People

About one in six nonelderly people in the United States will be without health insurance at any given time during 2009. Those without insurance will include nearly 10 million children, over 14 million adults living in families with children, and another 21 million adults who do not reside with children. Nearly two-thirds of the uninsured are in families whose income is less than 200 percent of the federal poverty level.

Concerns about the number of people who lack health insurance have generated proposals that seek to increase coverage rates substantially or to achieve universal or near-universal coverage. Coverage could be expanded by:

- Subsidizing health insurance premiums, either through the tax system or spending programs, which would make insurance less expensive for people who are eligible.
- Mandating health insurance coverage, either by requiring individuals to obtain coverage or by requiring employers to offer health insurance to their workers. If effective penalties were imposed on those who did not comply, a mandate would increase insurance coverage by making it more costly for individuals to be uninsured and for employers not to offer coverage to their employees.
- Automatically enrolling individuals in health plans, giving them the option to refuse coverage or switch plans. Recent studies suggest that automatic enrollment in plans that subsidize savings for retirement substantially increases participation rates, especially among young and low-income workers.

The three approaches could also be used in combination to reduce the number of people who are uninsured.

At the federal level, **subsidies** for health insurance premiums have been provided through spending programs and tax provisions. Millions of low-income children and their parents receive subsidized health insurance coverage through Medicaid and the State Children's Health Insurance Program; tax subsidies, such as the exemption of employer-paid premiums from taxation, encourage middle- and higher-income taxpayers to purchase private health insurance (primarily through their employer). Those subsidies, however, are distributed unevenly. Some low-income adults—particularly those who are under the age of 65, childless, and able-bodied—are generally not eligible for Medicaid or SCHIP. Taxpayers who do not work for a firm that offers coverage may not receive any tax subsidies for purchasing private health insurance.

Coverage could be expanded by restructuring tax subsidies, spending programs, or both. However, redesigning existing subsidies or creating new benefits raises several issues. First, the form of the subsidy can determine who would benefit. Tax preferences, such as the current-law exclusion or a tax deduction, reduce taxes but do not provide benefits to those who do not have any income tax liability. A refundable tax credit would provide full benefits to individuals, regardless of whether they have any income tax liability, but might require some people to file returns solely to obtain the subsidy. A second consideration is costs, which could be high depending on the numbers of uninsured receiving the subsidies and the amounts necessary to encourage them to enroll in health plans. Targeting benefits toward specific segments of the population would reduce costs but could also add to the burden of administering a program. A third consideration is the impact of the subsidies on people who already have coverage; although subsidies would probably increase coverage on net, some subsidies would go to people who would have coverage anyway, and the availability of subsi-

denied coverage in the private market because of their health problems.[6]

Guaranteed Issue and Renewal. The federal government and many states have taken various steps to require that insurers offer coverage to applicants (a practice known as guaranteed issue) and that they renew policies that are not delinquent (guaranteed renewal). The existing provisions differ between the individual and small-group markets, however. The Health Insurance Portability and Accountability Act (HIPAA) requires insurers that offer coverage to small businesses (those who have fewer than 50 employees) to accept all applicants; before the enactment of that federal legislation in 1996, most states had the same or similar requirements.

By contrast, only a handful of states currently require insurers in the individual insurance market to offer policies to all individuals and families who apply for coverage, and federal legislation does not generally mandate that such offers be made. HIPAA prohibits insurers from failing to renew policies for health reasons, however, whether those policies are purchased in the individual market or by employers. Insurers may still terminate policies for fraud or failure to pay premiums, and they may also require that plans purchased by employers meet a participation requirement (for example, that a specified percentage of employees remain enrolled in the plan).

Federal legislation has addressed in a more limited way the question of guaranteed offers of coverage in the individual market and the related issue of whether new policies may exclude coverage for preexisting medical conditions—steps designed to increase the portability of insurance coverage. Specifically, HIPAA essentially requires insurers to offer coverage to anyone who had held insurance through a previous job but was losing or had recently lost that coverage (for example, because he or she changed jobs). The requirements differ somewhat depending on whether the new coverage is purchased in the individual market or comes through the new employer's group plan, but under most circumstances the new policy may not limit coverage for preexisting conditions. The law, however, does not restrict the premium that insurers may charge for new policies purchased in the individual market.

HIPAA allows states to take additional steps to regulate the portability of insurance, and many states have done so. For individuals who were not previously insured, however, states generally give insurers broad latitude to exclude certain benefits or services from coverage in the individual market. Currently, 38 states permit health care services that are related to preexisting conditions to be excluded from coverage permanently, and most states also allow insurers to determine whether a condition was in fact preexisting by examining more closely the medical history of enrollees when they submit a claim. Proposals that limit the ability of insurers to exclude high-risk individuals and preexisting conditions from coverage might benefit less healthy individuals, who might not be offered coverage otherwise, but the effects of those proposals on insurance premiums would depend on the rules that apply in each state.

Direct Regulation of Premiums. All insurers—whether they cover health care, property, automobiles and their drivers, or another type of risk—seek to set premiums so that the aggregate payments will at least cover the expected payouts for the policies they sell as well as the administrative and other costs they incur in providing insurance. Other things being equal, expected costs for health insurance are higher for older people and for people with more, or more serious, health problems. In theory, that relationship could yield premiums for individually purchased coverage that vary widely, with some enrollees paying many multiples of the average quote for a given policy to reflect their higher expected costs for health care.

In practice, however, premiums in the individual insurance market do not vary as widely as do individuals' expected costs for health care, for several reasons. First, insurers may find it difficult or costly to obtain information about each applicant's health status, so assessments of the applicant's expected costs (a practice known as "medical underwriting") are far from perfect. Second, to the extent that underwriting efforts are successful, insurers tend to limit coverage for or screen out applicants who have preexisting health problems that are costly to treat. According to a 2005 study, about 70 percent of appli-

6. Many other laws and regulations govern health insurance but are beyond the scope of this report. State insurance agencies are generally charged with monitoring the financial health of insurance firms to ensure that they will be able to meet their promises to pay claims. Furthermore, many of those agencies regulate the sales practices of insurers. Federal law also establishes reporting and disclosure requirements and fiduciary standards for the plans' administrators. All of those regulations can also affect insurance premiums and coverage.

cants for individual coverage are quoted a standard rate based only on their age; about 20 percent are either charged a higher premium (generally not exceeding twice the standard rate for their age group) or are sold a modified package that does not cover treatments for their preexisting health conditions (at least for some period of time); and about 10 percent are denied coverage.[7] Some applicants are charged a premium that is only modestly higher than the standard rate, so the share of applicants that are either charged a substantially higher premium or denied coverage is probably on the order of 20 percent.

A third reason that premiums in the individual market vary less than do enrollees' expected health care costs is the states' regulation of those premiums, which takes various forms. Many states restrict premium "rating"—that is, they directly limit the extent to which premiums are allowed to vary according to the age or health status of enrollees. The specific restrictions vary widely, however, in ways that differ between the individual and small-group markets. According to one survey of states' practices in the individual insurance market, three states require **pure community rating** of premiums, meaning that insurers may vary premiums for a given policy only by the size of the enrolling family and their place of residence within the state.[8] Six other states allow **adjusted community rating**, meaning that health insurance premiums are allowed to vary by family size and residence as well as by age and sex—but not by health status. Twelve states apply **rating bands** that allow premiums to vary on the basis of age and sex but prohibit insurers from deviating from the standard rate by more than a specified percentage for reasons relating to health.

Regulations may also affect the extent to which premiums can be changed over time. In the individual market, states generally preclude the practice—sometimes called "re-underwriting" or experience rating—of adjusting a particular enrollee's premium on the basis of his or her insurance claims or changes in health status after purchasing the policy. Thus, premiums for a given policy would generally increase over time to reflect higher expected costs for health care on average, but they do not vary across individuals to reflect updated estimates of each one's expected health costs. Insurers could circumvent those restrictions, however, by raising premiums for all enrollees in an existing policy and simultaneously offering a new, cheaper product whose applicants would be subject to underwriting. That practice would tend to discourage individuals who had developed expensive health conditions after enrolling in the original policy from changing plans, so they would pay the new, higher premium for that policy. It is not clear how common that practice is, however.

Premiums charged to small employers may be somewhat less volatile than are premiums in the individual market, for several reasons. First, those premiums reflect the average costs of their enrollees, so high expected costs for one person would be spread across all enrollees. Second, insurance is regulated more extensively in the small-group market than in the individual market. According to a 2003 survey, 35 states employed rating bands in the small-group market, 10 used adjusted community rating, 2 used pure community rating, and only 3 states and the District of Columbia chose not to regulate rates offered to small firms.[9] Some states also limit the degree to which premiums for small employers can increase from one year to the next to reflect enrollees' costs or changes in their health status (for example, permitting no more than a 15 percent adjustment for those reasons). In other states, however, high health care costs for an employee or a dependent in one year can lead to substantial increases in the average premium charged to the employer in the following year, and lower-than-expected claims can lead to corresponding reductions in premiums.

The overall effect of those state regulations is generally to compress the range of premiums offered. Although insurers could comply with a rating band by reducing the

7. See Mark Merlis, *Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform*, NHPF Background Paper (Washington, D.C.: National Health Policy Forum, April 13, 2005). In principle, insurers could charge a higher premium to applicants who have very high expected costs, but in practice they appear to assume that individuals who would be willing to pay premiums exceeding twice the standard rate would be likely to have even higher covered costs for health care—so rather than charge a very high premium, insurers generally deny coverage to such applicants instead.

8. Ibid. A recent analysis also found that in three states, a dominant insurer used community rating even though the state did not require all insurers to adopt that practice; see Congressional Budget Office, *The Price Sensitivity of Demand for Nongroup Health Insurance*, Background Paper (August 2005).

9. General Accounting Office, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses,* GAO-03-1133 (September 2003).

premiums charged to the least healthy enrollees or groups, they could also satisfy those regulations by raising their standard rates. In practice, they appear to do some of both, and rating restrictions have been found to increase premiums for healthier enrollees, decrease them for sicker enrollees, and to raise average premiums (primarily because of the resulting increase in enrollment of predictably higher-cost individuals).[10] The net impact of regulation of premiums on the number of people who have insurance coverage is difficult to predict in the abstract because some people face increases in premiums and others face decreases.

High-Risk Pools. Another approach to reducing health insurance premiums is to separate people with the highest health risks from the rest of the pool and partially subsidize their coverage. High-risk pools, as they are called, are a mechanism employed in varied forms by more than 30 states, primarily to assist individuals who are unable to obtain health insurance for medical reasons. Typically, such individuals must apply for private insurance and be denied coverage or be quoted a high premium before they can enroll in the pool. Enrollees are then charged a premium that usually ranges between 125 percent and 150 percent of the standard rate for their age group.

Those premiums are generally insufficient to cover those enrollees' costs for health care, however, so high-risk pools require subsidies to remain solvent (typically averaging several thousand dollars per enrollee). To limit the cost of those subsidies, states may cap enrollment in high-risk pools. As of 2007, however, all states with pools but one (Florida) appeared to be accepting new applicants.[11] In many cases, the costs of subsidizing high-risk pools are financed by an assessment or tax on other health insurance policies sold in the state; in recent years, the federal government has also provided some financial assistance to defray the costs of starting and operating high-risk pools.

As of 2007, about 200,000 people were enrolled in high-risk pools nationwide—about half of that total came from five states—so those enrollees account for about 2 percent of the approximately 10 million nonelderly people who purchase health insurance in the individual market.

High-risk pools obviously reduce the health insurance premiums that their enrollees pay, but covering those high-cost individuals separately could also lower premiums for other purchasers because it would reduce the average costs of the remaining enrollees. The strength of that ripple effect on premiums depends on the extent to which premiums are allowed to vary within the state. At one extreme, if no rating restrictions were in place and all enrollees were charged a premium exactly in accordance with their own expected expenses—or if high-risk applicants had been denied coverage—then establishing a new pool for those with the highest expected costs would have no effect on the premiums of other policyholders. In a community-rated state, by contrast, separating high risks could reduce premiums for the remaining enrollees in rough proportion to the share of covered costs that high-risk enrollees had generated. In states with rating bands, the likely effect would fall between those extremes; reductions in the costs of covering high-risk enrollees could make the bands less constraining and thus could lead insurers to reduce their standard rates.

Effects of Proposals on Insurance Markets

Proposals to change the regulations governing insurance markets would generally have modest effects on the federal budget, and many of them would entail trade-offs between reducing average policy premiums and making insurance less expensive for individuals with health problems. Although generalizing about the precise effects of such proposals is difficult because their content might vary substantially, some indication of the likely magnitudes of budgetary effects and changes in insurance premiums and coverage can be gleaned from the Congressional Budget Office's recent analysis of legislative proposals to modify state regulations or to allow individuals to buy insurance across state lines. In addition, some quantitative or qualitative information can be provided to help illustrate the potential effects of or key considerations surrounding proposals for which CBO has not previously generated a cost estimate.

The Health Insurance Marketplace Modernization and Affordability Act of 2006 is one example of a proposal

10. See M. Susan Marquis and Stephen H. Long, "Effects of 'Second Generation' Small Group Health Insurance Market Reforms, 1993 to 1997," *Inquiry*, vol. 38, no. 4 (Winter 2001/2002), pp. 365–380; and Amy Davidoff, Linda Blumberg, and Len Nichols, "State Health Insurance Market Reforms and Access to Insurance for High Risk Employees," *Journal of Health Economics*, vol. 24, no. 4 (July 2005), pp. 725–750.

11. Information on the status of high-risk pools comes from www.statehealthfacts.org. See also Bernadette Fernandez, *Health Insurance: State High-Risk Pools*, RL31745 (Congressional Research Service, October 1, 2008).

affecting the regulation of insurance markets that CBO has analyzed.[12] That legislation would have created a more uniform set of regulatory standards for the individual and small-group health insurance markets—standards that would have fallen somewhere between the strictest and most lenient state regulations currently in place. CBO estimated that those changes would decrease the average premium paid by policyholders in those markets by 2 percent to 3 percent, primarily by overriding some benefit mandates and reducing costs that insurers incur in complying with varying state rules. The legislation would have increased insurance coverage by about 600,000 people, on net, but it would have tended to increase premiums (and thus reduce coverage) for people with health problems.

CBO also estimated the budgetary impact of that legislation, concluding that it would increase federal revenues by about $3 billion over 10 years and would reduce federal spending for Medicaid by about $1 billion over that period. The increase in revenues would reflect a net reduction in spending on employment-based health insurance (stemming from the decline in average premiums). Reflecting CBO's assumption that total compensation would not change, that development would shift some compensation from a form that is tax-preferred (health insurance premiums) to a form that is taxable (wages and salaries). Because employment-based insurance would become somewhat less expensive under the proposal, some people who would be covered by Medicaid under current law would switch to private coverage and federal Medicaid spending would decline.

Alternatively, proposals could allow individuals to avoid the requirements set in their home state by purchasing insurance across state lines. In particular, that approach would allow individuals who are relatively healthy and live in states that regulate insurance more extensively to purchase a less expensive policy.[13] CBO analyzed one proposal to allow cross-state purchasing of insurance—the Health Care Choice Act of 2005—and concluded that over 10 years it would increase federal revenues by about $13 billion and federal spending for Medicaid by about $1 billion.[14] The increase in revenues would result largely from a reduction of about 1 million in the number of people who receive health insurance through employment-based plans, which would occur because individually purchased insurance would become relatively attractive (especially to people with lower expected health care costs). The increase in Medicaid spending would reflect the net impact of an increase in spending for people who would lose private coverage and a decrease in spending for those who would gain it. Overall, CBO estimated that the legislation would not have a substantial effect on the number of people who have health insurance because the number who would gain coverage (including previously uninsured people who would purchase coverage in the individual market) would roughly offset the number who lost it.

CBO's previous estimates of federal proposals to add new regulatory requirements also indicate the important influence that existing state practices have on those estimates. For example, the effect of the requirement under HIPAA to guarantee renewal of insurance policies was judged to be limited because nearly all states already had such a requirement in place. Similarly, CBO estimated that HIPAA's requirement for portability of insurance from group to individual coverage would have a relatively small effect on insurance premiums in the individual market. Although insurers would have to offer coverage to relatively unhealthy individuals who would otherwise have been turned down, CBO estimated that in most cases the premiums for those policies could be set to reflect the expected costs for health care for those enrollees and thus would not have a substantial effect on premiums for other enrollees.[15]

Rather than add or remove regulations, the federal government could seek to affect the operation of insurance markets by offering additional subsidies for high-risk

12. Congressional Budget Office, cost estimate for S. 1955, the Health Insurance Marketplace Modernization and Affordability Act of 2006 (May 3, 2006).

13. A similar approach would facilitate the formation of association health plans, which can be offered by trade, industry, or professional associations to their member firms. That option would be attractive for smaller firms with relatively healthy workers that are located in states that regulate premiums more extensively or have more extensive benefit mandates. For an analysis of a recent legislative proposal, see Congressional Budget Office, cost estimate for H.R. 525, Small Business Health Fairness Act of 2005 (April 8, 2005).

14. Congressional Budget Office, cost estimate for H.R. 2355, Health Care Choice Act of 2005 (September 12, 2005).

15. See Statement of Joseph Antos, Assistant Director for Health and Human Resources, Congressional Budget Office, before the Subcommittee on Civil Service, House Committee on Government Reform and Oversight, October 8, 1997.

pools. The costs of such proposals and their effects on coverage rates and premiums would depend primarily on the following factors:

- The number of individuals who would be eligible for and enrolled in those pools;
- The scope of the insurance coverage they would receive;
- The premiums they would have to pay themselves; and
- The mechanism used to subsidize the difference between enrollees' costs for covered health care services and those premium payments.

Because nearly all states with high-risk pools are accepting new applicants, there may not be substantial unmet demand in those states given the coverage and premiums they currently feature (although additional subsidies could encourage more active efforts by states to enroll eligible individuals). Lower premiums for enrollees and more extensive coverage would generate higher enrollment but would also increase subsidy payments and make it more likely that individuals who would have been insured otherwise would switch into the high-risk pool.

The financing of subsidies for high-risk pools raises a number of issues. Larger federal subsidies could lead more states to create high-risk pools and could encourage states to expand existing pools, but they could also cause some substitution of federal funds for existing state funds. Proposals might also address whether payments would be made to states that currently require guaranteed issue and use community rating or narrow rating bands in the individual market; residents of those states might never meet the eligibility terms for a high-risk pool. Payments could be made to those states in an effort to reduce premiums in the individual market, but doing so would raise the cost of the proposal. More generally, the impact of a proposal on the federal budget would depend on whether and to what extent the costs of the subsidy payments were shared between the federal and state governments; a higher federal share would encourage states to participate but would also reduce the incentive for them to control the pool's costs.

Revealing the Relative Costs of Health Plans

Most Americans with health insurance are shielded from—or may not be aware of—the price of their coverage, either in absolute terms or relative to other options. Many employers pay a large share of the premium for their workers; even though employees as a group ultimately bear that cost, they may not know its magnitude. Moreover, the tax code subsidizes employment-based health insurance by excluding the employer's contributions to the premium from the employee's taxable wages and income; in most cases, the employee's contribution is also excluded. Those features encourage people to have insurance coverage, but they also lead workers to buy more extensive insurance than they would if they faced the full price of their policy; those features also may limit the extent of price competition in the insurance market.

Some proposals would make consumers bear the cost of their health insurance more directly, either by paying the full cost themselves or by paying the added cost of more expensive policies. Proposals could achieve that goal by:

- Reducing or eliminating the current tax subsidy for employment-based insurance, perhaps replacing it with a tax credit or some other fixed-dollar subsidy (an approach discussed in Chapter 2); or
- Establishing a managed competition system, in which a range of plans is offered and the employer's or the government's contribution to the premium is a fixed amount—for example, the premium of the average plan or the least expensive plan available—thus requiring consumers to pay the additional cost of more expensive plans.

Those approaches—taken separately or in combination—would provide stronger incentives for enrollees to weigh the expected benefits and costs of policies when making their decisions about purchasing insurance. As a result, enrollees would generally choose health insurance policies that were less extensive, less expensive, or both, compared with the choices made under current law. A related option would be to give workers more readily accessible information about the full costs of their coverage, including the employer's contribution. Whether and how that information might affect their choice of a health plan is less clear, however.

Reducing or Eliminating the Tax Exclusion

The current tax treatment of health insurance premiums constitutes a relatively large subsidy—known as a tax expenditure—for the purchase of employment-based insurance, amounting to $145 billion in forgone federal income taxes and $101 billion in forgone federal payroll taxes in 2007.[16] Individuals living in states that have income taxes receive an additional subsidy because those states generally follow federal definitions of taxable income and thus exclude the costs of employment-based health insurance as well. The total tax subsidy averages about 30 percent and generally ranges from about 20 percent to 40 percent of the premium for most workers, depending on their tax bracket and state of residence.[17]

Although the subsidy provides an incentive to purchase insurance—and to do so through one's employer—it also encourages people to buy policies that are more extensive or more expensive than they would purchase otherwise. Reducing or eliminating that exclusion thus could have a large effect on insurance premiums and coverage because it could substantially increase the effective price of any given policy—by 25 percent for someone who had been receiving a 20 percent subsidy and by two-thirds for someone who had been receiving a 40 percent subsidy.[18] (The impact of such changes on whether people purchase insurance is discussed in Chapter 2.)

Relevant Studies. Several studies have attempted to quantify how removing or limiting the favorable tax treatment for employment-based insurance would affect insurance coverage, insurance premiums, and total spending on health care. Ideally, a study would compare systemwide outcomes with and without those tax preferences, holding all other factors equal. In practice, however, that type of comparison cannot be readily made because income and payroll tax rates are largely determined at the federal level—so the rules are similar across all states at any given time. Although federal tax rates have changed over time, many other aspects of the health care system and the national economy have simultaneously changed, making it difficult to separate cause and effect when comparing one period with another. As a consequence of those methodological challenges, the findings of older studies using aggregate data on tax rates and insurance premiums vary widely, depending on the period they examined and the assumptions they made.

Two recent studies have attempted to address those methodological issues more carefully, but some concerns remain about using their results to estimate the impact of eliminating the tax exclusion. A 2004 study by Gruber and Lettau examined how employers' spending on health insurance varied across states with different tax structures, exploiting the fact that state income tax rates changed at different times (and did so in ways that were not caused by trends in health insurance).[19] Extrapolating from those results, they estimated that eliminating the tax exclusion for health insurance premiums—which in the sample that they studied would increase the effective price of health insurance by 58 percent, on average—would yield a 29 percent reduction in health care spending by employers who continued to offer coverage. In other words, the reduction in those employers' contributions would be about half as large (in percentage terms) as the increase in the effective price facing enrollees.

Gruber and Lettau's paper improved substantially on earlier work by better isolating the effect of the net price of health insurance on premiums, but it still has limitations. In particular, their estimate is based on relatively small differences in state tax rates, and extrapolating the effects of those differences could overstate the impact of larger changes. One way that employers could reduce premiums would be to limit the extent of the coverage they offer (for example, by increasing cost-sharing requirements). But that approach would also heighten the variability of health costs for employees, and workers might become increasingly reluctant to accept higher levels of cost sharing as their degree of financial risk grew. At the same time, more rigorous management efforts by health plans (or shifts in enrollment toward more tightly managed

16. Joint Committee on Taxation, *Tax Expenditures for Health Care*, JCX-66-08 (July 30, 2008).

17. One offsetting consideration is that excluding health insurance premiums from taxable wages reduces future Social Security benefits, which are based on average earnings, at the same time that it reduces payroll tax payments.

18. Assume, for example, that an insurance policy has a total premium of $5,000. Someone receiving a 20 percent tax subsidy would thus pay $4,000 on net. If the tax subsidy was eliminated, that person would pay $5,000, or 25 percent more. Someone receiving a 40 percent tax subsidy would currently pay $3,000 for that policy. If the tax subsidy was eliminated, that person would pay $5,000, or 67 percent more.

19. Jonathan Gruber and Michael Lettau, "How Elastic Is the Firm's Demand for Health Insurance?" *Journal of Public Economics*, vol. 88, no. 7 (July 2004), pp. 1273–1294.

plans) would yield somewhat lower premiums, but more substantial reductions might become increasingly difficult to achieve. In other words, existing differences in employers' contributions across states could largely reflect the use of cost-control options that represent the "low-hanging fruit."

Another limitation of the study is that it includes the impact of employers changing the share of the premium they pay in response to different tax rates. In that case, employees would see their contributions rise but the total premium for their coverage would not change. Even with that effect included, the impact of changes in tax rates that the study found barely meets the standard threshold for statistical significance—that is, the odds of getting their results by pure chance (assuming that the true effect of the tax exclusion was zero) were only slightly less than one in twenty. Gruber and Lettau estimated, on the basis of other studies, that reductions in the share of the premium that employers cover would account for about one-fourth of the effect on employers' spending that they report. But if that component was removed, the remaining effect they found might not meet a test of statistical significance.

A more recent study by Heim and Lurie avoided some of those methodological problems but was based on a relatively small segment of the population that may not be representative. The study analyzed spending on health insurance premiums for self-employed individuals, who were able to deduct a growing proportion of their premiums from their taxable income over time.[20] Their results, which were similar to Gruber and Lettau's estimate, imply that the reduction in premiums that would result from scaling back the tax exclusion for health insurance would be about half as large as the resulting price increase; that is, an increase of about 50 percent in the net price of health insurance would lead people to choose policies with premiums that were about 25 percent lower than otherwise. An advantage of their study is that it accounts for the full effect on insurance premiums rather than the impact on employers' contributions, because in their study the employer and the employee are the same person. The self-employed, however, may differ in both observable and unobservable ways from people who work in a firm; to the extent that their study did not fully account for those differences, caution must be used in extrapolating their results to a broader population.

CBO's Assessment. Reflecting the limitations of those two studies, CBO's assessment is that removing the tax preference would have a smaller effect on the level of premiums that individuals choose. Specifically, CBO estimates that a 50 percent increase in the price of health insurance, all else being equal, would lead people to select plans with premiums that are between 15 percent and 20 percent lower than the premiums they would pay under current law. Reaching that point would probably take several years, as health plans, employers, and enrollees adjusted their offerings and choices. A portion of that ultimate decrease in premiums would come from reductions in the extent of coverage that enrollees purchased (that is, fewer benefits covered or higher cost-sharing requirements), and the remainder would come from choosing plans that exercise tighter management over the use of health care (that is, plans might have more features typical of health maintenance organizations such as utilization review, restricted provider networks, or gatekeeper requirements).

The effect of a specific policy proposal would depend primarily on what changes it made in the tax treatment of health insurance. Removing the exclusion of premiums from income and payroll taxation would increase the after-tax price of health insurance by roughly 50 percent, on average, for people currently covered by employment-based insurance. Removing the exclusion only for income tax purposes (keeping the payroll tax exclusion in place) would raise the average price by roughly 30 percent, which would ultimately yield health insurance premiums that are 9 percent to 12 percent lower. In both cases, the reduction in overall spending on health care would be smaller than the reduction in premiums because some costs would be shifted from covered spending to out-of-pocket spending.

Alternatively, proposals could cap the amount of premium payments that may be excluded from workers' taxable income—the effects of which would depend critically on the level at which the cap was set. Workers whose premiums exceeded the cap by a substantial margin would have strong incentives to switch to a less expensive plan. Workers whose premiums fell below the cap, however, would not be affected, so the overall impact on premiums would generally be smaller. One objective of

20. Bradley T. Heim and Ithai Lurie, "Do Increased Premium Subsidies Affect How Much Health Insurance Is Purchased? Evidence from the Self-Employed" (draft, Department of Treasury, Office of Tax Analysis, January 7, 2008).

CBO

capping the exclusion might be to target employees who have relatively extensive insurance coverage and, as a result, above-average premiums. Workers who reside in areas with higher-than-average medical costs or whose firms have higher premiums because their covered workforce is older or in poorer health could also be affected by a fixed-dollar cap, however, even if the generosity of their health plan was not above average.

The effects of reducing, eliminating, or capping the exclusion for employment-based insurance would also depend on a number of issues relating to implementation. Insurers and employers would have to report to both employees and the Internal Revenue Service the amount of premiums subject to tax. However, calculating the average premium and allocating those costs among employees could be difficult, particularly for large employers whose plans cover employees' expenses for health care as they are incurred (in which case timely data may not be available). Limiting or eliminating the exclusion would also create incentives for employers to misrepresent benefits as company overhead or to reallocate costs among subsidiaries so as to reduce their employees' tax liability. (Those considerations would affect the proposal's impact on revenues as well as the incentives for workers to choose less expensive policies.)

Another source of uncertainty is whether the 41 states (and the District of Columbia) that have their own income tax would continue to follow the federal lead in the tax treatment of premiums for employment-based coverage. If, instead, some states took action to maintain the full exclusion of premiums from taxable income, the incentive for workers to choose a less expensive plan would be smaller. The extent of that difference would depend on the number of states that did not conform their tax systems to mirror the federal tax change and on the tax rate structure in those states.

Establishing a Managed Competition System

The term "managed competition" refers to a purchasing strategy that seeks to create stronger incentives for consumers to be cost-conscious in their choice of health plans and for plans to compete more intensely on the basis of premiums and quality of care.[21] Under that approach, a sponsor—such as an employer or government agency—would offer a choice of health plans and would make a fixed-dollar contribution toward the cost of insurance. Enrollees would thus bear the cost of any difference in premiums across plans (although that effect would be muted if enrollees could continue to exclude their own premium payments from taxation). Sponsors would give enrollees comparative information about their options. Some versions of managed competition would also involve standardizing the benefits offered—to a greater or lesser degree—in order to foster stronger price competition. In addition, sponsors could adjust payments to health plans to account for differences in the health status of their enrollees (in an effort to limit the impact of those differences on the plans' premiums).

Background. Most employers do not use the principles of managed competition to purchase health insurance benefits for their employees. Indeed, surveys indicate that most firms that offer health insurance do not give their employees a choice of health plans. That statistic is somewhat misleading, however, because most firms have few employees. Large firms are much more likely than small firms to offer a choice of plans, and they also account for the majority of workers. Consequently, about 57 percent of workers who are offered insurance have a choice of plans. In the case of firms that do not offer their workers a choice of plans, health plans still compete on the basis of their price and value but do so in an effort to be chosen by the employer. For small employers in particular, the administrative costs of offering several competing plans and the potential problems of adverse selection that could arise may outweigh the benefits of giving their employees more options.

Even among firms offering a choice of plans, fixed-dollar contributions to employees' insurance premiums—another key feature of managed competition—are less common than fixed-percentage contributions. A 2002 survey found that among Fortune 500 companies (which generally offer their employees a choice of plans), only about one-quarter took the fixed-dollar approach.[22] The following example illustrates the incentives created by each approach. Suppose that an employer makes two plans available—one with a total premium of $4,000 per

21. See Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs*, vol. 12 (Supplement 1993), pp. 24–48.

22. James Maxwell and Peter Temin, "Managed Competition Versus Industrial Purchasing of Health Care Among the Fortune 500," *Journal of Health Politics, Policy, and Law*, vol. 27, no. 1 (2002), pp. 5–30.

year and one with a premium of $5,000. If that employer pays 80 percent of the total premium for each plan, an employee who chooses the more costly plan pays an additional $200 (20 percent of the $1,000 difference in premiums between the two plans). Under a managed competition system, however, the employer would contribute the same amount to both plans (for example, 80 percent of the *average* premium, or $3,600). Employees would face the full $1,000 price difference between the two plans and would therefore have a much stronger incentive to choose the lower-cost plan. Making employees pay the full difference in premiums could also stimulate greater competition among insurance plans to keep their premiums down. (Whether enrollees actually faced that full difference would also depend on whether their premium payments were tax-preferred.)

Some proposals that are based on the principles of managed competition would require health plans to offer a standard benefit package. In principle, standardizing benefits would promote competition among health plans by making it easier for consumers to compare their options; that step would also help prevent plans from structuring their benefit packages to attract enrollees who are less likely to use medical care (which could in turn reduce the plan's premiums and thus distort the comparison of plans). In practice, however, some aspects of health benefits are easier to standardize than others. For example, specifying uniform levels of cost sharing is relatively straightforward, but other aspects—such as definitions of covered services and utilization review procedures—can affect a consumer's ability to use certain benefits and are more to difficult to standardize.[23] Moreover, having standard benefits has two disadvantages. First, by limiting consumers' options, standardization would make some people worse off (specifically, those who would prefer a different design). Second, rigid standardization could prevent health plans from developing innovative designs that might lead to more efficient delivery of care.

Another important design issue is whether the sponsor's payments to insurers would vary to reflect differences in expected health care costs for different enrollees—a process known as risk adjustment. Under managed competition systems, all enrollees in a given health plan would typically pay the same premium—so if payments to plans were not adjusted, plans that attracted less healthy members would have higher premiums as a result.[24] Because enrollees would have strong financial incentives to switch out of those plans, the adoption of managed competition could trigger an "adverse selection spiral" for plans offering the most extensive coverage or doing little to manage benefits. In fact, some employers that implemented a managed competition system dropped such plans as their premiums skyrocketed and their enrollments plummeted.[25] (Health plans might also drop out of a managed competition system for other reasons that make them broadly unpopular with enrollees, such as being poorly run.)

In principle, adjusting the sponsors' payments to plans to account for expected differences in their enrollees' health care costs would limit the impact of adverse selection. If those adjustments worked well, the premiums that enrollees faced would vary across plans because of differences in the value of their benefits or the efficiency of their operation, but not because of differences in their mix of enrollees. Government programs currently use risk adjustment in cases in which private health plans compete against a government-administered option (as with Medicare Advantage plans or Medicaid HMOs) and against one another to deliver program benefits (as with the prescription drug plans in Medicare).

In practice, however, risk-adjustment methods are imprecise, so fully offsetting the effects of enrollees' characteristics on a plan's premium may not be feasible. Those methods do not need to account for all differences in health care spending across enrollees to be effective; indeed, comparisons of predicted spending using risk-adjustment models with actual spending will inevitably find some enrollees who used more care than was expected and some who used less. What matters is

23. For a discussion of this issue, see Mark McClellan and Sontine Kalba, "Benefit Diversity in Medicare: Choice, Competition, and Selection," in Richard Kronick and Joy de Beyer, eds., *Medicare HMOs: Making Them Work for the Chronically Ill* (Chicago: Health Administration Press, 1999), pp. 133–160.

24. Under a managed competition system, insurers could be allowed to vary individuals' premiums so that the premiums reflected each enrollee's expected costs for health care, in which case those premiums would already be adjusted for risk. In many respects, such an arrangement would resemble the current market for individually purchased insurance.

25. David M. Cutler and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics*, vol. 113, no. 2 (May 1998), pp. 433–466.

accounting for the predictable differences in spending that might affect an enrollee's choice of a health plan or a health plan's efforts to attract or discourage particular types of members. Some experts have indicated that at least 20 percent to 25 percent of health care spending may be predictable from one year to the next, yet studies show that existing risk-adjustment methods account for no more than half of that variation.[26] That degree of predictive power may be sufficient to prevent widespread problems from arising because of selection pressures. Even so, individual health plans could receive overpayments or underpayments relative to the true expected health care costs of their enrollees.

Relevant Studies. Limited evidence is available about the effects of managed competition on health care costs. A few studies have conducted in-depth analyses of particular employers that implemented that approach. Other studies have compared employers that make fixed-dollar contributions to their employees' insurance premiums with employers that use other contribution formulas. Both types of studies have limitations—employers who adopted managed competition (or their workers) may differ from firms that did not, and all of those studies have used data from the mid-1990s or earlier. A more recent example comes from the new Medicare drug benefit, which incorporates many elements of managed competition, but it has not been operating long enough to permit detailed analysis. In any event, comparisons with alternative designs for the drug benefit would be hypothetical because the same approach was adopted nationwide.

The available evidence indicates that, when compared with systems in which employers make a larger premium contribution for more expensive health plans, setting the employer contribution as a fixed-dollar amount reduces total health insurance premiums (the amount paid by employers and employees combined) by 5 percent to 10 percent.[27] Employers that have implemented managed competition have seen large numbers of their employees switch to lower-cost plans, which is an important source of the cost reductions. Some evidence indicates that adopting managed competition has also led insurance plans to lower their premiums; whether the plans did so because of changes in benefit design, tighter management of benefits, or reductions in profits or administrative costs is not clear. Studies of managed competition systems have generally not involved standardization of benefits or risk-adjustment of premium payments, however, so the effects of those features are more difficult to determine.

CBO's Assessment. The effects of specific proposals on average premiums would depend on how extensively they adopted the key features of a managed competition system; those proposals could vary along several dimensions. First, proposals would tend to have a larger impact if they gave sponsors clearly defined roles in overseeing the competition among health plans on the basis of price and quality. For example, sponsors could be responsible for enforcing the requirements that plans must satisfy to be included in the system; providing comparative information to consumers on the plans' premiums, benefits, and quality of care; and managing the enrollment process. Less structured systems that relied more on individual enrollees to gather that information would have less of an impact because the cost to enrollees of doing so would be greater and the pressure on insurers to demonstrate value would thus be less intense.

A second key consideration in determining the effects of a managed competition proposal is whether and to what extent enrollees would be required to pay the full additional cost of more expensive plans. The incentives for enrollees to choose lower-cost plans would be strongest if sponsors made a fixed-dollar contribution toward the premium. That contribution could be based on the premium for the lowest-cost plan that is available, the average premium, or some other fixed reference point. The key feature is that enrollees would be able to capture the savings from joining a less expensive plan, which

26. Newhouse, Buntin, and Chapman, "Risk Adjustment and Medicare." Studies finding that at least 20 percent to 25 percent of health care spending is predictable largely reflect comparisons of individuals' average spending over several years and thus account for any reason that one person's spending is higher than another's. Risk-adjustment models, by contrast, generally adjust payments using information only about individuals' age and sex and the diseases or health conditions with which they have been diagnosed. Those models thus do not take into account other differences among individuals (such as their preferences about health care) that affect their spending. Those features reflect an apparent reluctance to assign different adjustment factors to people who have the same demographic characteristics and health problems.

27. For a discussion of that evidence, see Congressional Budget Office, *Designing a Premium Support System for Medicare* (December 2006), pp. 31–35.

the impact on health care spending of the changing mix of doctors' activities. A survey of patients did find that waiting times to schedule an appointment roughly doubled, indicating that the supply of services did not increase as much as patients would have wanted when care became free to them. Moreover, total contacts with patients rose for lower-income families (whose demand for care increased most sharply) but fell for higher-income families—indicating that the overall supply of services was constrained, at least in the short run.

A more recent example comes from Taiwan, which implemented universal health insurance in 1995. One study examined the effects on services used by adults and found that among the one-quarter who were previously uninsured, the number of visits to physicians increased by about 70 percent and the number of hospital admissions more than doubled; use rates for people who had been insured previously were largely unchanged.[31] Another analysis found that the overall rate of hospital admissions in Taiwan grew by about 10 percent between 1994 and 1996.[32] Those figures would suggest that Taiwan's health care system was able to accommodate the increase in demand, but another factor was that payments to physicians working in primary care clinics were raised by about 20 percent. That change helps explain why the number of physicians working in such clinics, which had been increasing by about 5 percent per year, grew by 10 percent in 1995. (Whether those doctors shifted from the hospital sector, which accounted for about 60 percent of physicians' employment, or came from another source is not clear.)

Uncompensated Care and Cost Shifting

Another issue that arises when analyzing providers' payments is whether relatively low payments by public programs or the costs of providing uncompensated care to the uninsured result in higher payment rates for private insurers—a process known as cost shifting. In many cases, uninsured individuals pay much less than the costs of the care they receive, so doctors and hospitals might seek to make up those losses by charging more to private health plans. Similar pressures to raise private payment rates could occur if payments from public programs did not cover the average costs of their patients (which could be termed "undercompensated" care). To the extent that costs are being shifted, proposals that reduced the uninsured population or switched enrollees from public to private insurance plans would have ripple effects on private payment rates and thus on private insurance premiums.

The evidence indicating that private payment rates are higher than public rates—and that they also appear to exceed the costs of treating privately insured patients—is sometimes taken as proof of cost shifting. There are, however, other explanations. In general, a firm that has some monopoly power will be more profitable if it charges different prices to different sets of purchasers that reflect differences in the groups' willingness to pay (a practice known as price discrimination). The fact that hospitals receive different payment rates from public and private insurers may reflect that same behavior. Differences in payment rates across different types of insurers do not, however, mean that costs have been shifted from one type to another. The key question about cost shifting is whether an *increase* in the rates paid on behalf of some patients (including people who used to receive charity care but would now have insurance) would cause a *decline* in the rates paid by others (such as private insurers).

Whether and how such cost shifting would occur depends on several other factors, including the amount of uncompensated care that is provided, the adequacy of public payment rates, and the degree of competition facing hospitals and doctors. Recent estimates (discussed below) indicate that hospitals provided about $35 billion in uncompensated care in 2008, but the available evidence suggests that less than half of those costs—and probably much less—were shifted to private insurers. Estimates of uncompensated care provided by doctors are considerably smaller, and cost shifting does not appear to be a substantial factor affecting payment rates for physicians. Although assessing the adequacy of Medicare's payments to doctors and hospitals is more difficult, MedPAC's analysis indicates that those payments are sufficient to cover the costs of efficient providers in 2008; that finding suggests that Medicare's payments do not

31. Shou-Hsia Cheng and Tung-Liang Chiang, "The Effect of Universal Health Insurance on Health Care Utilization in Taiwan: Results from a Natural Experiment," *Journal of the American Medical Association*, vol. 278, no. 2 (July 9, 1997), pp. 89–93.

32. Jui-Fen Rachel Lu and William C. Hsiao, "Does Universal Health Insurance Make Health Care Unaffordable? Lessons from Taiwan," *Health Affairs*, vol. 22, no. 3 (May/June 2003), pp. 77–88. That study also found that subsequent efforts by the government to institute a global budget for health care services helped control the growth of spending in that country. For a discussion of such global budgets, see Chapter 8 of this report.

generate cost shifting in competitive markets. Medicaid's payment rates for doctors and hospitals probably fall below the costs of treating that program's enrollees, but whether the costs of those shortfalls are shifted is not clear.

The Potential for Cost Shifting

Cost shifting could occur only under certain conditions, so it is useful to review them carefully. There are two basic scenarios: one that involves a provider market with limited competition, and one that involves a competitive provider market.

An extreme example of **limited competition** would be an isolated community that is served by a single hospital. Because of its monopoly power, such a hospital could negotiate payment rates from private insurers that exceed its costs for those patients. In response to a reduction in payments from public insurance programs or an increase in the amount of uncompensated care that it provides, that hospital might be able to secure higher payments from private insurers to offset its losses. In order for such cost shifting to occur, however, the hospital would have to have been charging private insurers less than it could have; that is, the hospital would have to have had monopoly power that it had refrained from using fully.[33]

Whether some hospitals have market power that they have failed to exploit is unclear. One reason that many hospitals might not have fully used their market power is that most of them are nonprofit organizations. As a result, their goals of serving the community and the corresponding makeup of their governing boards may lead them to charge private insurers less than the profit-maximizing price (that is, the price a monopolist would charge).[34] In other respects, however, the behavior of nonprofit and for-profit hospitals can be difficult to distinguish. For example, a recent study by CBO found that nonprofit and for-profit hospitals provided similar amounts of uncompensated care.[35] Whether a hospital's goal is to maximize profits, serve the community, or some combination of the two, the key questions remain: Would hospitals (and other providers) that have market power lower private payment rates if proposals either reduced uncompensated care or raised the payments that providers receive for enrollees in public programs? Or would hospitals still seek to charge private insurers a profit-maximizing price, either as an end in itself or as a means of financing other efforts to serve their community?

Cost shifting could also occur in a **competitive provider market** in order to offset the costs of uncompensated care or to make up for losses that might arise from relatively low public payment rates. Why would they accept those rates in the first place? In general, providers have some operating costs that do not vary with their patient load (fixed costs) and some that do (variable costs). If public payment rates were high enough to cover the variable costs of serving those patients—but contributed little or nothing toward covering providers' fixed costs—it would still be worthwhile for providers to accept those payments, at least in the short run. Providers could try to make up for losses from undercompensated care by charging more to private insurers. If competing providers had roughly comparable burdens of uncompensated and undercompensated care, then those higher private rates could probably be sustained in a competitive market.[36]

Providers facing shortfalls in payments would also have alternatives, however, including the option of reducing their costs. That approach would yield higher payment-to-cost ratios and could reduce the quality of care that patients receive, but it would not raise private payment rates. Indeed, with a lower cost structure, hospitals may reduce their rates for private insurers. By the same token, a decline in uncompensated or undercompensated care

33. To the extent that a hospital with market power charges prices that exceed its costs, the question of why competing hospitals have not entered those markets arises. The apparent persistence of limited competition among hospitals in many areas, however, indicates that some barriers to entering the market exist, at least in some areas of the country.

34. See Paul B. Ginsburg, "Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?" *Health Affairs*, Web Exclusive (October 8, 2003), pp. W3-472 to W3-479.

35. See Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits* (December 2006).

36. In the strict sense of the term, such markets might not be considered fully competitive because hospitals would have to feel compelled to continue serving patients for which they were under-compensated. Without that constraint, some hospitals would probably stop accepting those patients; those hospitals could then lower their fees to private payers and take private business away from competing hospitals (to the extent that they had sufficient capacity). Hospitals that continued to be undercompensated would suffer financial losses and would either have to receive outside assistance or eventually exit the market.

might allow providers to offer care of higher quality (at a higher cost), but it might not yield a corresponding reduction in private payment rates and could even cause private rates to increase.

Estimates of Uncompensated Care and the Adequacy of Public Payments

Estimates of how much uncompensated care the uninsured receive vary depending on the data sources used and on how the concept is defined and measured. Analysts generally define uncompensated care as care for which the provider is not paid in full by the patient or a third party.[37] It includes both charity care (for which little or no payment is expected) and bad debt (for cases in which payment is sought but not collected). Studies differ, however, in how they define "full" payment, with some comparing the payments that are received to the list prices that providers post. A more useful comparison, however, is to the total payments that providers would receive for the same service when treating a privately insured patient, because that amount (which is generally much lower than the list price) more closely resembles their costs.

A recent study by Hadley and others, which used that analytic approach, examined a sample of medical claims for uninsured individuals and projected that they would receive about $28 billion in uncompensated care in 2008.[38] That study also examined cost reports from hospitals and a survey of doctors and generated a different estimate: The gross costs of providing uncompensated care would be about $43 billion in 2008, of which $35 billion would come from hospitals and $8 billion from doctors. Total spending on hospital care in 2008 is estimated to be about $750 billion, so those figures would imply that uncompensated care accounts for about 5 percent of hospital revenues, on average. Those findings are consistent with CBO's analysis of uncompensated hospital care (cited above), which found that a sample of for-profit and nonprofit hospitals incurred costs for such care that averaged between 4 percent and 5 percent of their operating revenues.

Another point on which analysts disagree is whether to consider only the gross costs of providing uncompensated care or to net out offsetting payments that providers receive from sources other than insurers. As the Hadley study noted, about half of hospitals' aggregate costs for uncompensated care may be offset by added payments under Medicare and Medicaid to hospitals that treat a disproportionate share of low-income patients.[39] Whether hospitals seek to recoup from private payers the gross costs they incur for providing uncompensated care or their net costs after accounting for those offsetting payments is not clear; the answer depends in part on how well the offsetting payments are targeted toward hospitals that provide uncompensated care.

As for physicians, the figures cited above indicate that they provide a relatively small amount of uncompensated care—representing about 1 percent of the roughly $500 billion spent on physicians' and clinical services in 2008. Another study found that, on net, uncompensated care provided by office-based physicians was close to zero after the higher payments made by some uninsured individuals were taken into account.[40] That study also found that if those offsetting payments were ignored, the gross amount of uncompensated care provided by physicians was about $3 billion per year in the 2004–2005 period. Either way, the uncompensated care that physicians provide seems unlikely to have a substantial effect on private payment rates.

As with estimates of uncompensated care, assessments of the adequacy of payments from Medicare and Medicaid vary depending on the data and the points of comparison that are used. The data from hospitals' cost reports compiled by the American Hospital Association indicate that Medicare's payments covered about 91 percent of costs for those patients in 2006 (whereas private payments were reported to average about 130 percent of the costs of

37. By definition, no payments are received from insurers, but some care provided to uninsured individuals is paid for by other third-party sources, such as workers' compensation programs (for on-the-job injuries) or veterans' benefits.

38. Jack Hadley and others, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs*, Web Exclusive (August 25, 2008), pp. W399–W415. As discussed in Chapter 1, that study estimated that people who are uninsured for all of 2008 receive about $540 in uncompensated care, on average, and that people who are uninsured for part of that year receive about $150 in uncompensated care.

39. Conversely, a reduction in uncompensated care could provide a policy rationale to reduce those payments from Medicare and Medicaid.

40. Jonathan Gruber and David Rodriguez, *How Much Uncompensated Care Do Doctors Provide?* Working Paper No. 13585 (Cambridge, Mass.: National Bureau of Economic Research, November 2007).

treating those patients).[41] Correspondingly, the AHA estimated a shortfall in Medicare's payments to hospitals of about $19 billion in 2006. As noted above, however, those calculations depend partly on how hospitals' fixed costs are allocated.

MedPAC's most recent analysis indicates that Medicare's payments are sufficient to cover the costs of efficient hospitals. That assessment took into account hospitals' reported losses on Medicare patients, although MedPAC's calculations used a slightly different approach and found a smaller gap between payments and costs (about 5 percent in 2006, compared with AHA's estimate of 9 percent). That analysis also considered other indicators of whether payments were adequate, including beneficiaries' access to care, the volume of services provided to them, and hospitals' plans for expansion (a measure of financial health). Indeed, MedPAC's analysis suggests an alternative explanation: Instead of low Medicare payment rates causing private rates to be higher, high private payment rates at some hospitals may be leading them to relax their efforts to control costs. In turn, that tendency may have pushed up per-patient costs and thus caused payment-to-cost ratios for Medicare (and private) patients at those hospitals to be lower than they would be at hospitals that have lower per-patient costs.

As for Medicaid, AHA's analysis of hospitals' cost reports indicates that the program's payments covered about 86 percent of costs, on average, in 2006 (with the added Medicaid payments to hospitals that treat a disproportionate share of low-income patients included in that analysis). That calculation translates into an estimated shortfall in payments of about $11 billion. Medicaid's payment rates appear to be lower than Medicare's, so even if AHA's calculation overstates the shortfall, it seems likely that Medicaid's payment rates fall somewhat below hospitals' average costs for those patients.

Because physician markets are generally competitive, individual doctors or group practices would be able to shift costs to private payers only to the extent that Medicare and Medicaid payments did not cover their costs (which can be difficult to estimate). Even so, MedPAC's conclusion that Medicare's 2008 rates for doctors are adequate indicates that little scope for cost shifting exists in that sector. As for Medicaid, the available evidence indicates that many doctors do not accept Medicaid patients, which implies that those payments, in many cases, fail to cover doctors' costs. The extent to which doctors who accept Medicaid payments are able to shift costs to private payers depends in part on whether their competitors have comparable numbers of Medicaid patients.

41. American Hospital Association, *Trendwatch Chartbook 2008*.

Evidence About Cost Shifting

How much cost shifting actually occurs? Differences in public and private payment rates are sometimes taken as proof that costs are being shifted, but those differences reflect several factors, and it is not obvious whether or to what extent private payment rates would change as a result of changes in uncompensated care or public payment rates. Researchers who have attempted to evaluate whether hospitals shift costs to private payers have generally focused not on payment levels but on changes in the prices paid by private insurers following increases or (more commonly) reductions in Medicare or Medicaid fees.

Those studies have produced varied results, depending on the period studied and the methods used. The evidence that some cost shifting had occurred was relatively strong when researchers examined periods of less vigorous competition in the medical marketplace, such as the early 1980s. For example, a 1988 study that examined how hospitals in Illinois responded to cuts in Medicaid payments found that hospitals raised private prices to offset about half of the revenue from Medicaid that had been lost.[42] Other studies from that period suggest that financial pressures led to a limited amount of cost shifting and also encouraged hospitals to adopt cost-containment measures.[43] The early 1980s were conducive to cost shifting because private insurers usually paid hospitals on the basis of their charges and engaged in little price negotiation or selective contracting. In such an environment, it may have been relatively easy for hospitals that faced a

42. See David Dranove, "Pricing by Non-Profit Institutions: The Case of Hospital Cost-Shifting," *Journal of Health Economics*, vol. 7, no. 1 (1988), pp. 47–57.

43. Stephen Zuckerman, "Commercial Insurers and All-Payer Regulation: Evidence on Hospitals' Responses to Financial Need," *Journal of Health Economics*, vol. 6, no. 3 (September 1987), pp. 165–187, and Jack Hadley and Judith Feder, "Hospital Cost Shifting and Care for the Uninsured," *Health Affairs*, vol. 4, no. 3 (Fall 1985), pp. 67–80.

revenue shortfall on other patients to raise prices for private insurers.

After the mid-1980s, however, competitive pressures on hospitals intensified as private insurers became more aggressive in negotiating payments and establishing networks of preferred hospitals. Accordingly, the evidence of cost shifting generally became weaker.[44] For example, a study examining data from hospitals in California for the 1993–2001 period indicated that cost shifting in response to a 10 percent reduction in Medicare and Medicaid's fees increased the ratio of private payments to costs by 1.7 percent and 0.4 percent, respectively; that response for Medicare was generally lower than the effect that was estimated by applying a similar analytic approach to data from the 1980s.[45] In fact, one study suggested that cuts in public payment rates prompted hospitals with high numbers of Medicaid patients to *decrease* prices to private payers in an effort to attract more private patients.[46]

Overall, the impact of cost shifting on payment rates and premiums for private insurance seems likely to be relatively small. The available evidence indicates that hospitals shift less than half of the costs of reductions in public payment rates to private insurers—and in all probability, substantially less. Studies have not examined changes in uncompensated care as closely, but it seems reasonable to conclude that those costs are shifted to a comparable degree. Developments since the late 1990s—particularly consolidation of hospitals and pressure on private insurers to broaden their provider networks—appear to have strengthened hospitals' bargaining position, raising the possibility that more cost shifting will occur than was observed in the 1990s. Although payment-to-cost ratios for private insurers rose sharply between 2001 and 2004, it remains unclear whether hospitals have taken full advantage of their strengthened position or still have the degree of untapped market power that is necessary for cost shifting to occur in markets with limited competition.

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44. Michael A. Morrisey, *Cost Shifting in Health Care: Separating Evidence from Rhetoric* (Washington, D.C.: AEI Press, 1994); and Jack Hadley, Stephen Zuckerman, and Lisa I. Iezzoni, "Financial Pressure and Competition: Changes in Hospital Efficiency and Cost-Shifting Behavior," *Medical Care*, vol. 34, no. 3 (1996), pp. 205–219.

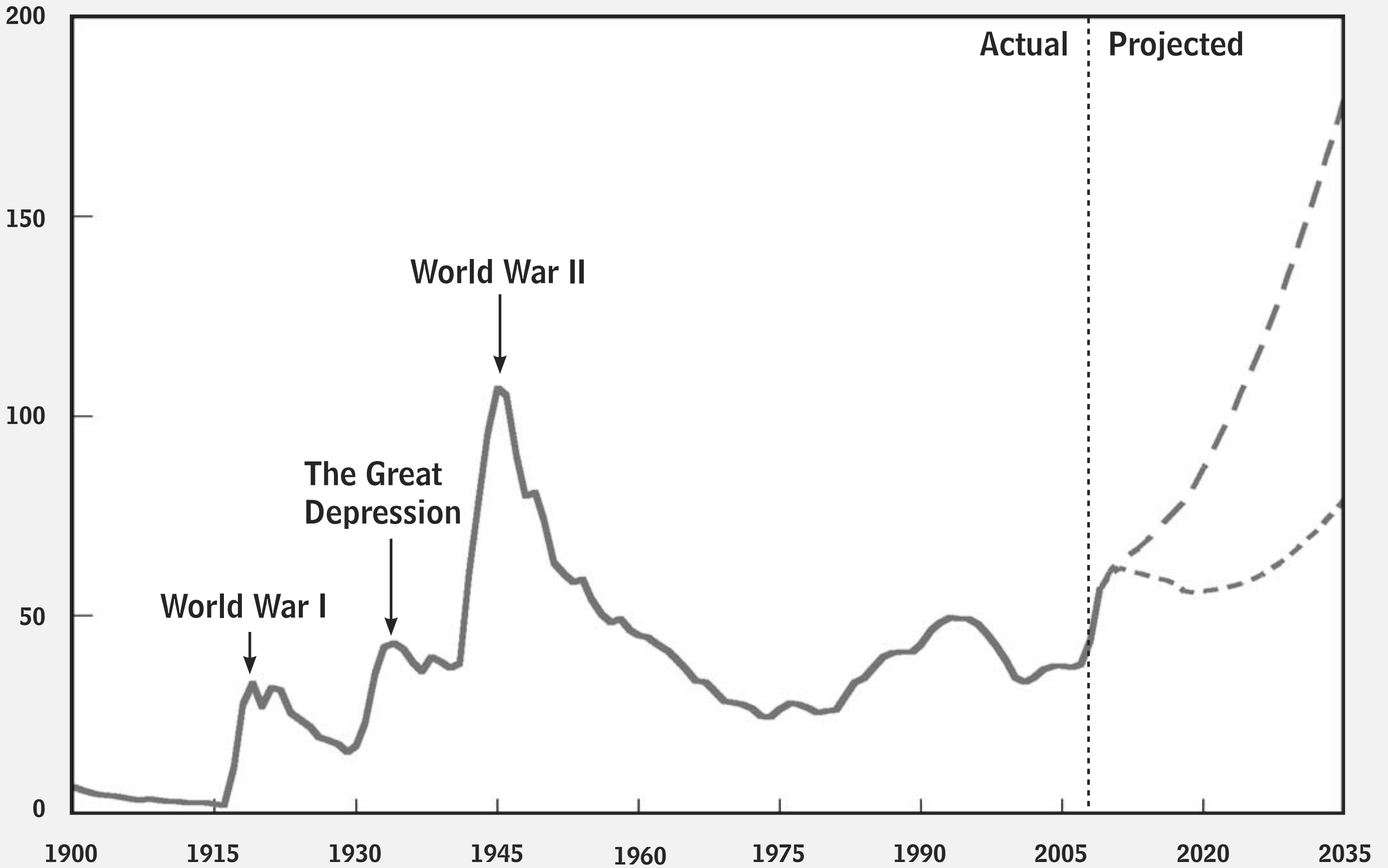
45. See Jack Zwanziger, Glenn A. Melnick, and Anil Bamezai, "Can Cost Shifting Continue in a Price Competitive Environment?" *Health Economics*, vol. 9, no. 3 (April 2000), pp. 211–226; and Jack Zwanziger and Anil Bamezai, "Evidence of Cost Shifting in California Hospitals," *Health Affairs*, vol. 25, no. 1 (January/February 2006), pp. 197–203. Although Zwanziger and colleagues concluded that the strength of cost shifting had not diminished by 1991, the 2006 paper generally finds less cost shifting in the more recent period. The estimated effect of a cut in Medicaid's fees was low in both periods.

46. See David Dranove and William D. White, "Medicaid-Dependent Hospitals and Their Patients: How Have They Fared?" *Health Services Research*, vol. 33, no. 2, pt. 1 (June 1998), pp. 163–185.

Exhibit 3

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

The Long-Term Budget Outlook



Federal Debt Held by the Public Under CBO's Two Budget Scenarios

JUNE 2009

CHAPTER

2

The Long-Term Outlook for Medicare, Medicaid, and Total Health Care Spending

Spending for health care in the United States has been growing faster than the economy for many years, posing a challenge not only for the federal government's two major health insurance programs, Medicare and Medicaid, but also for the private sector. Measured as a percentage of the nation's gross domestic product, total spending for health care increased from 4.7 percent in 1960 to 15.2 percent in 2007, the most recent year for which data are available.[1] Total spending for Medicare and Medicaid (which for the latter includes both federal and state spending) rose from 1.7 percent of GDP in fiscal year 1975 to 5.7 percent in fiscal year 2008. Over the same period, net federal spending for the two programs rose from 1.2 percent of GDP to 4.1 percent.[2]

The growth of health care spending in the long term will be determined primarily by growth in the cost of medical care per person. The aging of the population will also contribute to future spending growth, especially for Medicare, which will cover a growing number of beneficiaries as baby boomers become eligible for the program and life expectancy continues to rise. Those demographic trends are also projected to increase costs for Medicaid by boosting the demand for long-term care. The Congressional Budget Office projects, however, that spending for Medicare and Medicaid will increase much more rapidly than will their enrollments—because the programs' costs per beneficiary are growing faster than the economy.

CBO projects that without significant changes in policy, total spending for health care will be 31 percent of GDP by 2035 and will increase to 46 percent by 2080. Total spending for Medicare is projected to increase to 8 percent of GDP by 2035 and to 15 percent by 2080. Total spending for Medicaid is projected to increase to 5 percent of GDP by 2035 and to 7 percent by 2080.

Overview of the U.S. Health Care System

A combination of private and public sources finances health care in the United States. Most Americans under the age of 65 have private health insurance that they obtained through an employer. According to CBO's estimates, in 2010, about 56 percent of that population (150 million people) will have employment-based coverage, and about 5 percent (13 million people) will have private coverage purchased directly from an insurer.[3] At any given time during that year, in CBO's estimation, about 50 million people (19 percent of the nonelderly population) will be uninsured. In 2010, CBO projects, about 100 million people will be covered by Medicare and Medicaid, the two main sources of public financing for health care.

1. National health expenditures in 2007 totaled 16.2 percent of GDP. However, the concept of "total spending for health care" used in this report comprises spending for health services and supplies as defined in the national health expenditure accounts maintained by the Centers for Medicare and Medicaid Services. That spending includes all expenditures on personal health care, governments' administrative costs and public health activities, and the net costs of private health insurance. It excludes two categories of spending that are part of national health expenditures: amounts invested in research and in structures and equipment.

2. Those figures are net of premiums paid by Medicare beneficiaries and amounts paid by the states representing part of their share of the savings from shifting some Medicaid spending for prescription drugs to Part D of Medicare.

3. Some of those classified as having employment-based insurance will also have directly purchased coverage.

In 2007, total spending for health care (spending for health services and supplies) amounted to nearly $2.1 trillion, or 15.2 percent of the nation's GDP. Some 54 percent of that amount was financed privately; the rest of the spending came from public sources. Payments by private health insurers were the largest component of private spending, making up 37 percent of total expenditures on health care. Consumers' out-of-pocket expenses, which include payments made to satisfy deductibles, copayments for services covered by insurance, and payments for services not covered by insurance, accounted for 13 percent of those expenditures.[4] Other sources of private funds, such as philanthropy and certain employers (those that maintain on-site clinics for their workers), accounted for 4 percent of total health care spending.

Federal spending for Medicare made up 21 percent of total health care expenditures in 2007, and federal and state spending for Medicaid, 16 percent. A variety of other public programs accounted for 10 percent of total spending. Such programs included those run by state and local governments' health departments, the Department of Veterans Affairs, and the Department of Defense; workers' compensation programs; and the Children's Health Insurance Program.

From 1975 to 2007, the share of total health care spending that was financed privately shrank slightly, dropping from 59 percent to 54 percent, while the share that was financed publicly expanded correspondingly, increasing from 41 percent to 46 percent. During that period, consumers' out-of-pocket payments fell from 31 percent of total expenditures to 13 percent, and payments by private insurers rose from 25 percent to 37 percent.

Overview of the Medicare Program

Medicare provides federal health insurance for 45 million people who are elderly or disabled (the elderly make up about 85 percent of enrollees) or who have end-stage renal disease or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease). People become eligible for Medicare on the basis of age when they reach 65; disabled individuals become eligible for Medicare 24 months after they become eligible for benefits under Social Security's Disability Insurance program.

Part A of Medicare, or Hospital Insurance, covers inpatient services provided by hospitals as well as skilled nursing and hospice care. Part B, or Supplementary Medical Insurance, covers medical equipment and services provided by physicians and other practitioners and by hospitals' outpatient departments. Part B also covers a limited number of drugs, most of which must be administered by injection in a physician's office.[5] Depending on the circumstances, home health care may be covered under either Part A or Part B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a voluntary prescription drug benefit to the program, which became available in 2006 as Part D of Medicare.

The various parts of the program are financed through different means. Part A benefits are financed primarily by a payroll tax (2.9 percent of taxable earnings), the revenues from which are credited to the Hospital Insurance (HI) Trust Fund. The fund in turn pays for benefits and administrative costs under Part A and makes other authorized expenditures. For Part B, premiums paid by beneficiaries cover about one-quarter of its outlays, and general revenues cover the rest.[6] Enrollees' premiums under Part D are set to cover about one-quarter of the cost of the basic prescription drug benefit. However, receipts from premiums cover less than one-quarter of Part D's total cost because some of the federal outlays for it (such as subsidies for low-income beneficiaries and for employers

4. Out-of-pocket payments do not include the premiums that people pay for health insurance because premiums fund the payments that insurers provide, which are already included in the measure of private spending.

5. Certain other drugs are also covered under Part B, including oral cancer drugs if injectable forms are available, oral antinausea drugs that are used as part of a cancer treatment, and oral immunosuppressive drugs that are used after an organ transplant.

6. The standard premiums are set each year to cover 25 percent of projected average expenditures under Part B. For 2009, the standard monthly Part B premium is $96.40. Since 2007, higher-income beneficiaries have been required to pay higher premiums. For 2009, the income thresholds at which people are responsible for paying those higher premiums (which will be indexed for inflation in future years) are annual income of more than $85,000 for single individuals and income greater than $170,000 for couples. CBO estimates that about 5 percent of beneficiaries will pay the higher premiums in 2009. However, because of low inflation, most beneficiaries' premiums will remain at $96.40 through 2012, CBO projects. (See "Effect of a Zero Social Security COLA on Part B Premiums in Medicare," *CBO Director's Blog*, April 23, 2009, www.cbo.gov.)

Exhibit 4

EMBARGOED UNTIL TUESDAY, JUNE 2

EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS

THE ECONOMIC CASE FOR HEALTH CARE REFORM

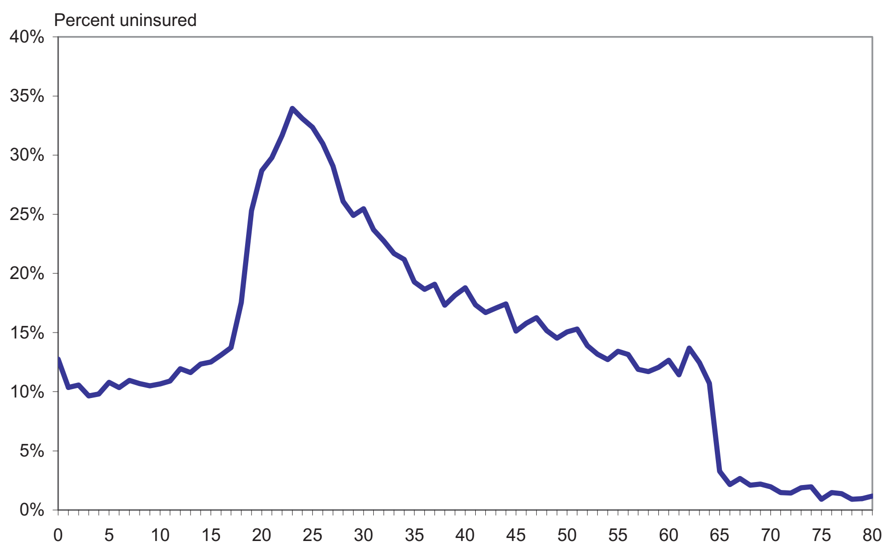
JUNE 2009

D. Trends in Insurance Coverage

In 2007, 45.7 million Americans did not have health insurance.[9] About one out of every six U.S. residents under the age of 65 is currently without health insurance.[10] Moreover, an even larger number of non-elderly individuals experience gaps in coverage over longer time periods. For example, one study found that 31.8 percent (82 million individuals) were uninsured for at least one month during the 2004 and 2005 calendar years.[11]

As Figure 6 demonstrates, the fraction of Americans without insurance varies substantially across ages, with the highest rates among young adults and the lowest rates among the elderly, virtually all of whom are covered by Medicare.

Figure 6: Percent of Americans Unisured by Age



Source: U.S. Census Bureau. 2008 Annual Social and Economic (ASEC) Supplement.

One reason for the large number of uninsured in the United States is high and increasing health care costs. Individuals may become uninsured if out-of-pocket premium requirements are no longer affordable. They may also become uninsured if employers no longer offer health insurance as part of workers' total compensation.[12] Recent work suggests that rising health insurance costs (which are highly correlated with overall health care spending) can explain more than one-half of the declines in overall rates of health insurance coverage during the 1990s.[13]

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[9] DeNavas-Walt et al. (2007).
[10] Based on CEA tabulations of the U.S. Census Bureau's March 2008 Current Population Survey.
[11] Rhoades and Cohen (2007). See also Cutler and Gelber (2009).
[12] See Chernew, Culter, and Keenan (2005). Cutler (2003) and Glied and Jack (2003) examine specifically declines in private coverage rates rather than overall coverage.
[13] Chernew, Cutler, and Keenan (2005).

Workers in small firms are especially vulnerable. In the United States, almost 96 percent of firms with 50 or more employees offer health insurance as compared with 43 percent of firms that have fewer than 50 workers.[14] Among small firms, the percentage offering health insurance peaked in 2001 and has been gradually declining since then.[15] On average, small firms face much higher premiums relative to large firms for a given level of coverage generosity.[16] This is primarily due to small firms facing higher administrative costs and insurers' concern about potential adverse selection risks.[17] Assuming that real growth in employer-sponsored insurance premiums does not slow from current rates, CEA projects that less than 20 percent of small employers will offer coverage by 2040.[18]

While the percentage of Americans with public insurance has been rising, it has not been sufficient to offset the decline in rates of private health insurance coverage.[19] Using historical changes in the percentage of non-elderly uninsured individuals to predict future trends, Figure 7 shows that 22 percent of the non-elderly population (roughly 72 million Americans) will be uninsured by 2040.[20]

As the number of uninsured rises, there is a corresponding increase in uncompensated care costs, which include costs incurred by hospitals and physicians for the charity care they provide to the uninsured as well as bad debt (for example, unpaid bills).[21] Both the Federal government and state governments use tax revenues to pay health care providers for a portion of these costs through Disproportionate Share Hospital (DSH) payments, grants to Community Health Centers, and other mechanisms.[22] In 2008, total government spending to reimburse uncompensated care costs incurred by medical providers was approximately $42.9 billion.[23] In the absence of reform to slow the real growth rate of health spending and a subsequent rise in the uninsured, we project that the real annual tax burden of uncompensated care for an average family of four will rise from $627 in 2008 to $1,652 (in 2008 dollars) by 2030.[24]

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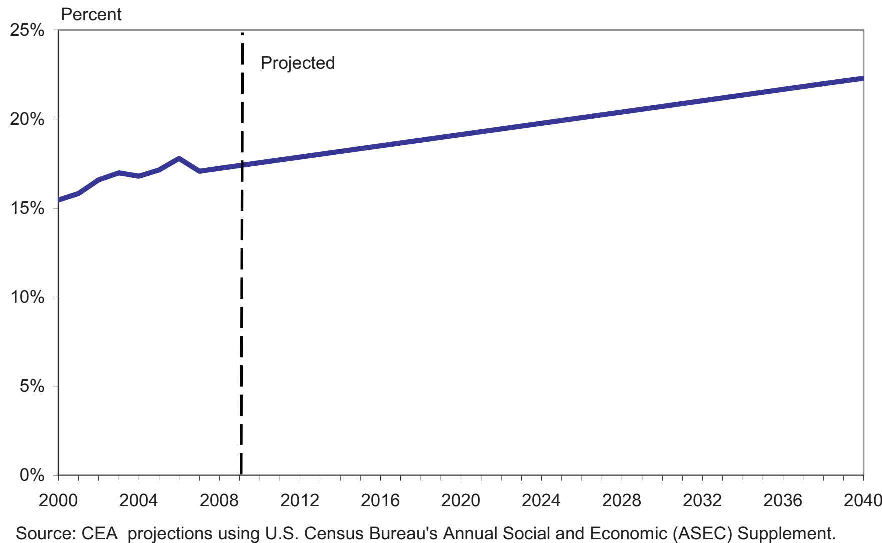
[14] U.S. Department of Health and Human Services, Medical Expenditure Panel Survey-Insurance Component (2006).
[15] Kaiser Family Foundation (2008).
[16] Gabel, McDevitt, and Gandolfo (2006).
[17] Lee (2002); Simon (2005).
[18] Projection was generated using the average annual change in small firm offer rates over the 2001 to 2006 period. For additional discussion of small firms' demand for health insurance, see Hadley and Reschovsky (2002) and Gruber and Lettau (2004).
[19] Cutler and Gelber (2009).
[20] The projection was generated using the historical average annual change in the percentage of the non-elderly population that is uninsured from 1999 to 2007, as reported by DeNavas-Walt et al. (2007). Given the lags in data availability on national health insurance coverage, our estimates do not fully incorporate the effect of the economic downturn on employer-sponsored coverage and its impact on future coverage rates. Moreover, the projection does not take into account other factors that may influence coverage rates, such as changes in public insurance eligibility or local labor market conditions.
[21] American Hospital Association (2005).
[22] Hadley et al. (2008).
[23] The precise amount of government spending used to finance uncompensated care is challenging to estimate since these resources may not be well targeted to providers who treat the uninsured. See Hadley et al. (2008) for more discussion.
[24] Current year per capita estimates were based on the ratio of total estimated uncompensated care costs paid for by the government to the estimated number of full-year uninsured. We then assume that per capita spending would grow at 4 percent per year in real terms.



Taken together, these facts and projections paint a compelling picture of the serious challenges facing the American health care system. Rapidly rising costs threaten to lead to stagnating take-home wages and devastating budget deficits. And, they are likely to greatly increase the number of people without health insurance over the next three decades.

III. Inefficiencies in the Current System

To understand what could be accomplished with health care reform, it is crucial to identify the inefficiencies present in the current system. This section details both the empirical evidence for such inefficiencies and the likely sources. It also describes the market failures leading to low rates of insurance coverage. The section then describes two key components of health care reform: genuine containment of the growth rate of health care costs and expansion of insurance coverage. Because genuine cost containment will be difficult, we describe some of the critical changes likely to be necessary to achieve success.

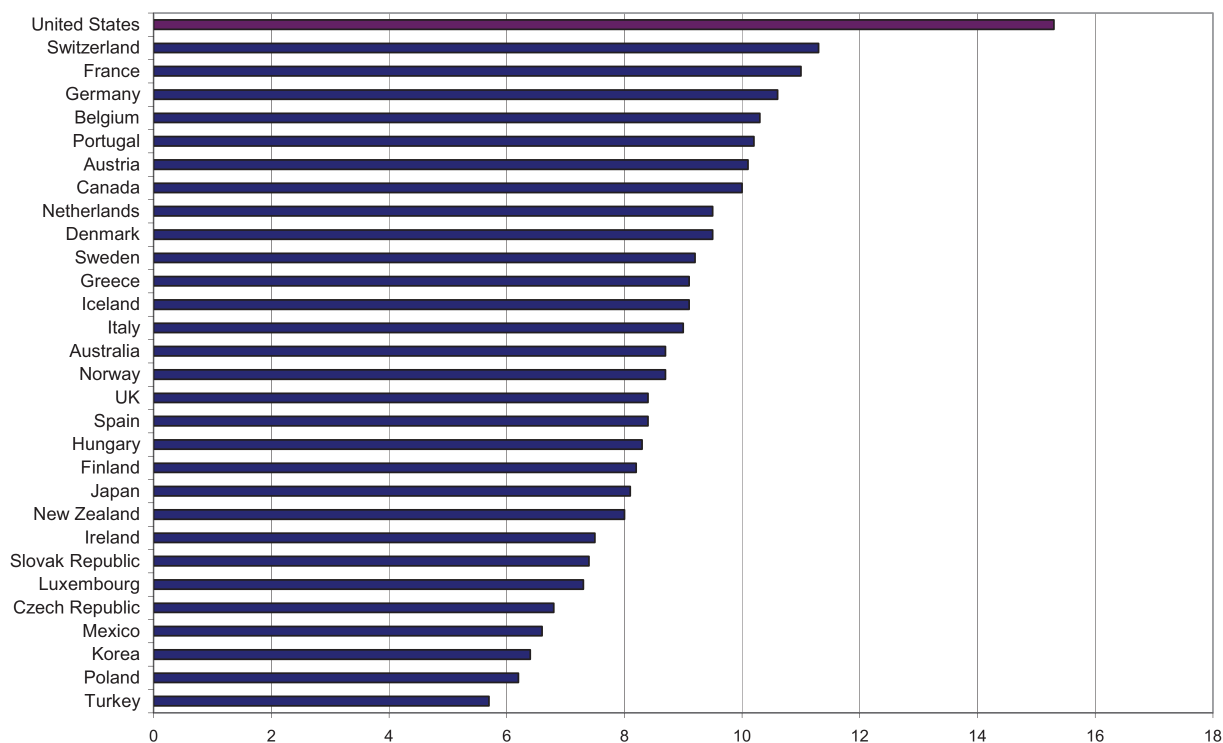
A. Quantifying the Amount of Inefficiency Using Comparisons

It is well known that the American health care system has many virtues. Over the past half century, American hospitals, physicians, pharmaceutical companies, and academic researchers have developed techniques and prescription drugs that permit the treatment of a host of previously untreatable conditions.[25] Nevertheless, two sets of comparisons strongly suggest that there are large inefficiencies in the American health care system.

[25] Cutler and McClellan (2001).

***International comparisons*.** The first set of comparisons is international. We devote a far larger share of our GDP to health care than other developed countries, but we do not achieve better health outcomes.[26] Figure 8 shows the fraction of GDP devoted to health care in a number of developed countries in 2006. According to the Organization for Economic Cooperation and Development (OECD), the United States spent 15.3 percent of its GDP on health care in 2006. The next highest country was Switzerland, with 11.3 percent. In most other high-income countries, the share was less than 10 percent.

Figure 8: International Comparison of Health Care Spending as a Share of GDP, 2006

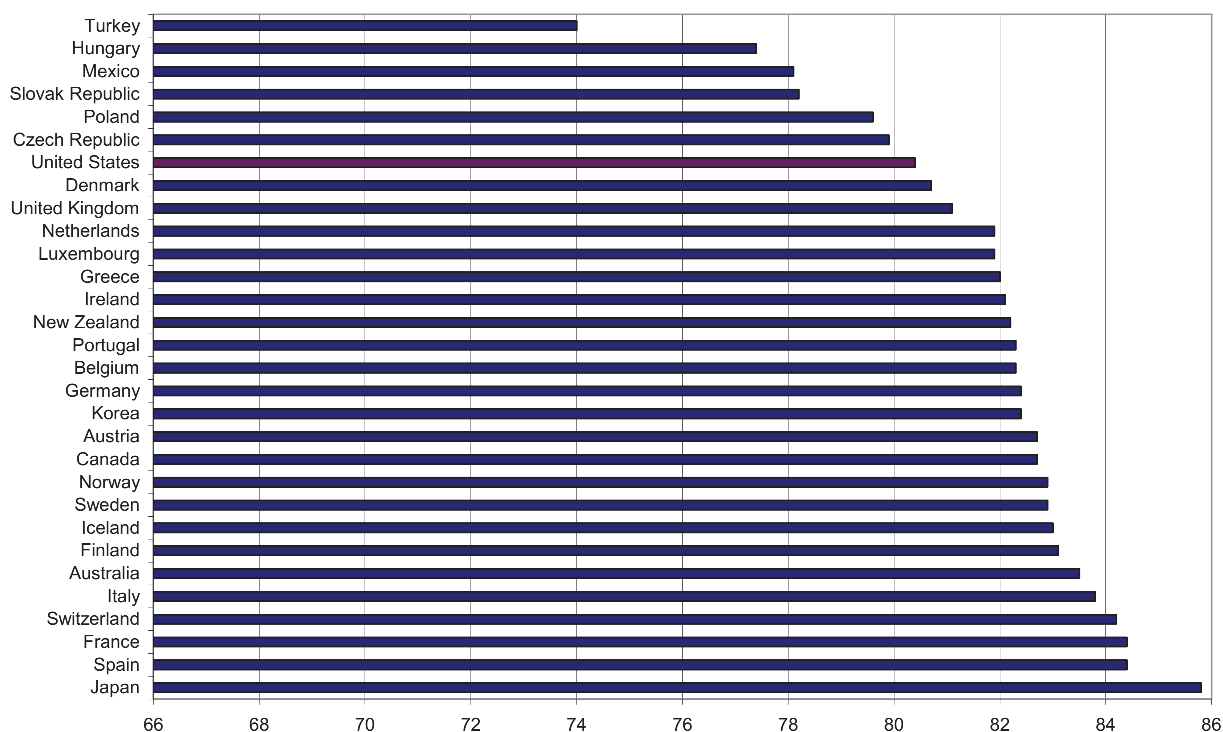


Source: Organization for Economic Cooperation and Development, OECD Health Data, 2008 (Paris: OECD, 2008).
Note: For countries not reporting 2006 data, data from previous years is substituted.

Figures 9a and 9b show female and male life expectancy in the same group of countries. The data show that life expectancy in the United States is lower than in any other high-income country—and many middle-income countries. The same result holds if one looks at infant mortality: despite the high share of health care expenditures in the United States, our infant mortality rate is substantially above that of other developed countries. Of course, many factors other than health care expenditures may affect life expectancy and infant mortality rates, including demographics, lifestyle behaviors, income inequality, non-health disparities, and measurement differences across countries.[27] But, the fact that the United States lags behind lower spending countries is strongly suggestive of substantial inefficiency in our current system.

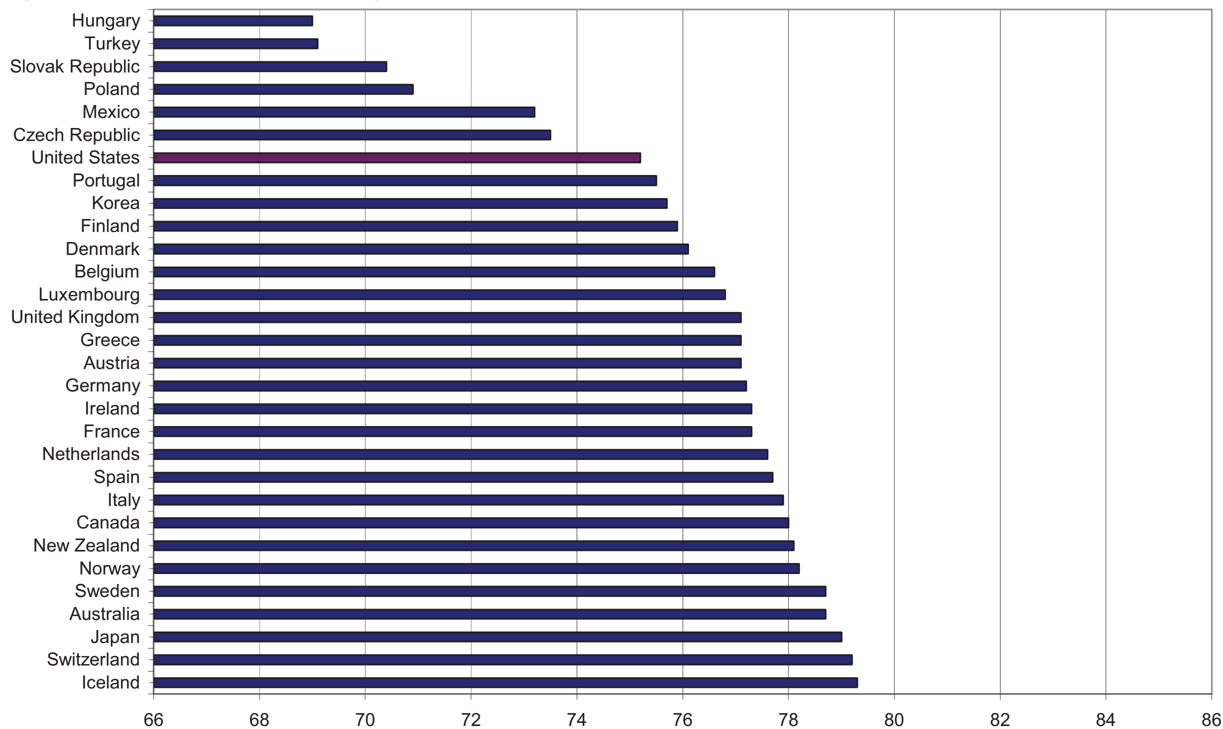
[26] Anderson and Frogner (2008).
[27] Robert Wood Johnson Foundation (2009). For more information on how differences in measurement and norms affect cross-country comparisons, see Congressional Budget Office (1992).

Figure 9a: Female Life Expectancy at Birth, 2006



Source: Organization for Economic Cooperation and Development. OECD Health Data, 2008 (Paris: OECD, 2008).
Note: For countries not reporting 2006 data, data from previous years is substituted.

Figure 9b: Male Life Expectancy at Birth, 2006



Source: Organization for Economic Cooperation and Development, OECD Health Data, 2008 (Paris: OECD, 2008).
Note: For countries not reporting 2006 data, data from previous years is substituted.

As a crude indicator, one can use the difference in health care's share of GDP between the United States and similar countries to gauge the magnitude of inefficiency. Looking at the average for Canada, Germany, Japan, Sweden, Britain, and France, it appears that the amount of resources devoted to health care in the United States that may be due to inefficiency is roughly 5 percent of GDP (15.3 percent in the United States in 2006, versus 9.6 percent, the average for the six comparison countries, all of which have better health outcomes).[28] Put another way, judging from the spending and outcomes in other countries, efficiency improvements in the U.S. health care system potentially could free up resources equal to 5 percent of U.S. GDP. This is, however, only a rough measure. It may well be that because of other differences between the various countries the true level is smaller. But, this estimate is a useful guidepost.[29]

Further evidence that the high level of spending in the United States reflects inefficiency comes from the behavior of spending over time. U.S. health care spending has risen dramatically in recent decades relative to spending in other countries, with no evident gains in relative outcomes. In 1970, we devoted only a moderately higher fraction of our GDP to health care than other high-income countries. As described above, today we spend dramatically more. Yet, during that period, life expectancy has actually risen less in the United States than in other countries.[30] Unless one believes that other influences on life expectancy have deteriorated dramatically in the United States relative to other countries, this suggests that much of the increased U.S. spending is inefficient.

***State comparisons*.** A second set of comparisons is within the United States. Because U.S. states are more similar on most dimensions than independent countries, this comparison is even more compelling. There is a large body of evidence, much of it assembled by researchers associated with the Dartmouth Atlas of Health Care, showing that utilization of specific procedures and per capita health care spending vary enormously by geographic region, and that in many cases these variations are not associated with any substantial differences in health outcomes.[31] Figure 10, for example, shows the wide variation in spending per Medicare enrollee across the United States. Large variation remains even after adjusting for differences in the age, sex, and race of enrollees across states.[32]

Analyses suggest that areas with high rates of per capita spending have higher intensity of services in an inpatient setting, higher rates of minor procedures, and greater use of specialists and hospitals ("supply-sensitive services"). Factors such as differences in medical care prices, patient demographics, health status, and income levels cannot fully explain this variation.[33]

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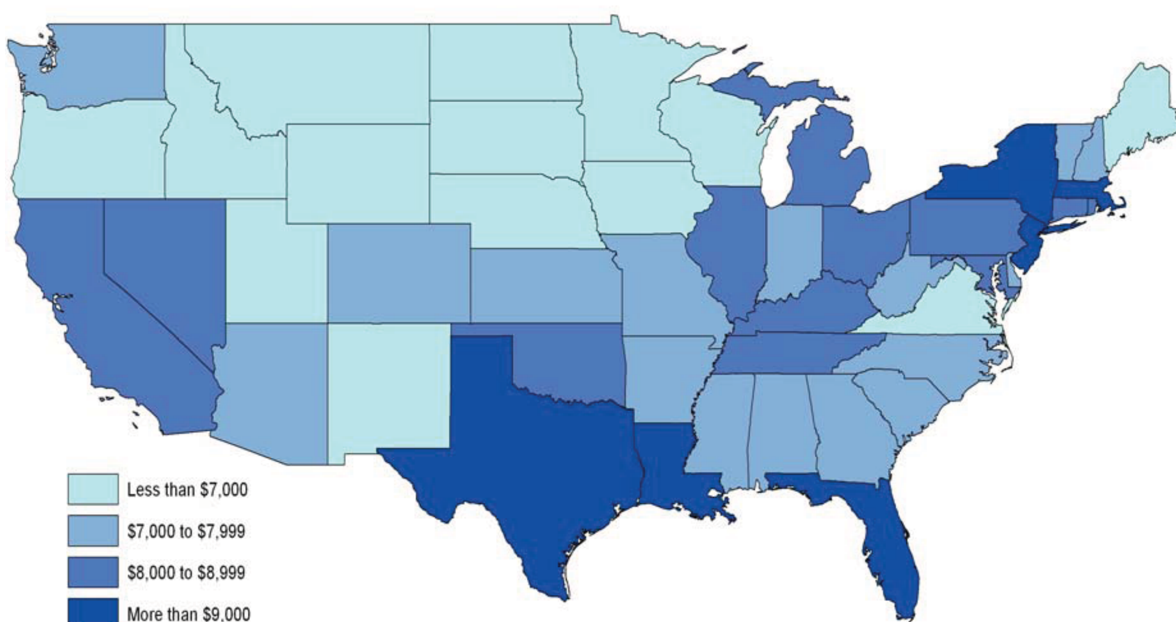
[28] OECD (2008).
[29] A recent report by McKinsey Global Institute (2008) concluded that the United States spends $630 billion more than expected on health care after adjusting for differences in wealth. This is over 4 percent of GDP in 2008.
[30] Garber and Skinner (2008).
[31] Wennberg, Fisher, and Skinner (2002).
[32] Fisher, Bynum, and Skinner (2009).
[33] Research suggests that there may be additional contributing factors, including workforce patterns and end-of-life care education. See Baicker and Chandra (2004) and Fisher et al. (2003) for additional discussion.



These large differences in spending suggest that nearly 30 percent of Medicare's costs could be saved without adverse health consequences.[34] If these patterns are consistent with the experience of other populations, such as Medicaid enrollees and the privately insured, then it should be possible to cut total health expenditures by about 30 percent without worsening outcomes. Since we currently spend approximately 18 percent of our GDP on health care, a 30 percent reduction in expenditures would again suggest that savings on the order of 5 percent of GDP could be feasible.

B. Sources of Inefficiency in the Health Care Delivery System

The inefficiencies behind the empirical estimates have been widely reported. Among the most frequently cited are:

- We spend a substantial amount on high cost, low-value treatments.
- Patients obtain too little of certain types of care that are effective and of high value.
- Patients frequently do not receive care in the most cost-effective setting.
- There is extensive variation in the quality of care provided to patients.
- There are many preventable medical errors that lead to worse outcomes and higher costs.
- Our system is complex and we have high administrative costs.

At a fundamental level, the inefficiencies stem from the fact that health care is very different from conventional goods and services. The markets for health insurance and medical

[34] Wennberg, Fisher, and Skinner (2002).

care are classic examples of markets in which asymmetric information is important—that is, where one party to a transaction is likely to have more information than another. In health insurance markets, asymmetric information can lead to adverse selection, whereby individuals who know they are likely to have high health care costs are more likely to seek health insurance. Information asymmetries also lead to moral hazard, where insurance coverage may insulate patients from cost consciousness and promote unnecessary care. In considerable part because of these market failures, government programs and policies play a large role in health care. This means that in many cases incentives are not determined by market forces.

These departures from the conditions that would lead to efficient outcomes manifest themselves in seven main drivers of inefficiency in the U.S. health care system.

***Provider incentives*.** Most provider payment systems are fee-for-service, which creates financial incentives for doctors and hospitals to focus on the volume of services that they deliver rather than the quality, cost, or efficiency of care delivery. In general, payment systems do not reward higher quality and value. In some cases, they reward poor quality of care by paying for the costs associated with additional medical care necessary to fix errors that could have been prevented.[35] Providers also have strong financial incentives to compete on the basis of technology adoption rather than price, leading to an excess supply of high technology equipment and services (for example, MRI machines and minimally invasive vascular diagnostic and procedure suites) and accelerated replacement of hospital beds in local markets. In turn, this can lead to higher rates of utilization and costs.[36] Also, current payment systems generally do not reward providers for effectively managing patients with chronic illnesses or educating patients about preventing disease through lifestyle changes such as exercise, improved nutrition, and smoking cessation. Finally, some academic research has suggested that some physicians practice "defensive medicine," that is, supply additional services that are of marginal or no medical value, including additional diagnostic tests and unnecessary referrals to specialists.[37]

***Limited financial incentives for consumers*.** While health insurance provides valuable financial protection against high costs associated with medical treatment, current benefit designs often blunt consumer sensitivity with respect to prices, quality, and choice of care setting.[38] There is well documented evidence that individuals respond to lower cost-sharing by using more care, as well as more expensive care, when they do not face the full price of their decisions at the point of utilization.[39] Additionally, most insurance benefit designs do not include direct

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[35] Preventable re-admissions are an example. According to Medicare Payment Advisory Commission (MEDPAC), about 18 percent of Medicare hospital admissions result in re-admissions within 30 days of discharge, which amounts to an extra $15 billion a year spent on re-admissions. About $12 billion of this amount is spent on potentially preventable re-admissions (Hackbarth, 2009). A second example is payment for drug-related injuries. In a recent Institute of Medicine study, researchers estimated that medication errors injure at least 1.5 million people each year and generate at least $3.5 billion in health care spending (Institute of Medicine, 2006).
[36] U.S. General Accounting Office (2008).
[37] Studdert et al. (2005).
[38] This source of inefficiency is driven in part by the tax treatment of health insurance, which over time has led to very generous health insurance products (e.g., low deductibles and coinsurance) being offered in the market, particularly in employer settings.
[39] The classic illustration of this relationship is from the RAND Health Insurance Experiment (Manning et al., 1987). Additional evidence can be found with respect to emergency room visits (Selby, Firemand, and Swain, 1996;

financial incentives to enrollees for choosing physicians, hospitals, and diagnostic testing facilities that are higher quality and lower cost.

***Pricing of medical treatment*.** There are relatively few forces in health care markets that lead to price reductions in the way that we observe price reductions in other sectors of the economy when new technologies are introduced and diffused. Many administered pricing systems, such as those used by Medicare and some private plans, are slow to adjust for productivity improvement or decreasing marginal costs of production that come as new medical procedures are routinized and providers acquire experience. One example of this is CT scan technology, whereby a procedure on an older 8- or 16-slice machine may be reimbursed at a similar rate as one on a newer 32- or 64-slice model. Even though the newer machine is faster, which can lead to greater throughput and a lower average cost per scan, prices are not adequately updated to reflect this, leading to potential overpayment.[40]

***Fragmentation*.** Within the United States, patients receive care from a variety of independent and often competing organizations. Poor information flows across provider organizations and misaligned incentives can lead to higher utilization and costs, as well as poorer health outcomes.[41] There is some evidence that vertically integrated provider systems (such as Kaiser Permanente, Geisinger, and Mayo Health System) can better manage costs and coordinate high-value treatment plans with patients, resulting in higher quality of care.[42] Fragmentation of the system also leads to higher administrative costs. Because there is a lack of standardization around billing systems, forms, and benefit designs, additional personnel are needed in hospitals and physicians offices to handle administrative functions for different payers. There is a wide range of estimates regarding just how much higher administrative costs are in the United States relative to other countries given our complex multiple-payer system. For example, a report by the McKinsey Global Institute estimates that the excess administrative costs associated with the U.S. multi-payer system are approximately $100 billion (in 2008 dollars) per year.[43]

***Lack of information for providers*.** Medical care has become increasingly specialized and complicated, and patients do not always receive care that fully complies with current clinical guidelines.[44] Often, it is exceedingly difficult for providers to keep up with the best available evidence regarding the clinical risks and potential health benefits of alternative treatments. In the United States, there are few coordinated efforts to objectively quantify the benefits of new devices, drugs, and procedures for diagnosing and treating diseases relative to their predecessors. This lack of information for providers is likely an important part of explaining the variation in treatment patterns, and may help to explain why the United States spends a great deal on procedures and treatments with little objective marginal value.

Wharam et al., 2007); and the effect of tiered cost-sharing for pharmaceuticals (see Gibson, Ozminkowski, and Goetzel, 2005, for a review).

[40] Competitive bidding systems would address some of these weaknesses, but have only been adopted in limited capacities by public insurance programs. See Dowd, Feldman, and Christianson (1996) for additional discussion of competitive bidding and Cutler (2009) for discussion of productivity improvement in health care.

[41] Cebul et al. (2008).

[42] For example, see Feachem, Sekhri, and White (2002).

[43] McKinsey Global Institute (2008).

[44] A study by McGlynn et al. (2003) found that only 54 percent of acute care and 56 percent of chronic care provided by physicians conformed to clinical recommendations in the medical literature.

Lack of comprehensive performance measurement and feedback. Performance measurement provides a way for physicians to determine how well or poorly they are doing with respect to delivering recommended care, using resources, and patient outcomes.[45] There is some evidence that when physicians receive data on their clinical performance, they change behavior in ways that can improve outcomes.[46] Currently, a large proportion of physicians do not get timely feedback on the quality of care they provide and their resource use relative to that of their peer group, making it difficult for them to know how they compare in order to modify their practice behavior.[47]

Lack of information for consumers. During the past several years, there have been important investments by government and private organizations to develop better information resources for consumers.[48] However, large gaps still exist with respect to the availability of information on the effectiveness of alternative treatment options, preventive care recommendations, physician quality, and transaction prices for specific medical services. Without this, consumers are not able to make informed decisions when they select providers and treatments—choices that may affect their out-of-pocket costs, the quality of care they receive, and their health outcomes. For example, when a patient lacks information on the number of times a provider has performed a particular procedure, he or she may choose to go to a low-volume hospital for a complex procedure, even though there is very good evidence that this choice will put him or her at higher risk of complications and death.[49]

C. Market Failures Leading to High Numbers of Uninsured

The preceding discussion focuses on the sources of unnecessarily high costs related to the delivery of medical care. But, the large number of individuals and families without health insurance represents another major inefficiency of our health care system. In a well-functioning market, individual choices lead to the desirable quantities of goods and services being purchased, and the fact that many individuals choose not to purchase some goods is not usually a cause for concern. The market for health insurance, however, is not a well-functioning market. There are several market failures—that is, factors that cause the costs and benefits that households face to differ from the true costs and benefits. These market failures result in too few individuals and households having insurance.

Asymmetric information and adverse selection. The most important market failure causing inefficiently low coverage is adverse selection. An insurance company will not price

[45] Institute of Medicine Report Brief (2005).
[46] The New York State Cardiac Surgery Reporting System provides one such example. Chassin (2002) reports some evidence that measurement and public reporting on cardiac surgeons' performance led to improved patient outcomes.
[47] A Commonwealth Fund study by Audet, Doty, Shamasdin, and Schoenbaum (2005a) found only one-third of physicians had any comparative performance data available to them, with health plans being the most common source. See also, Audet, Doty, Shamasdin, and Schoenbaum (2005b)
[48] Two examples of government information resources include Hospital Compare and Nursing Home Compare, which are found on the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services website. Other resources include the Leapfrog Group and HealthGrades.
[49] See for example, Birkmeyer et al. (2002), Gaynor, Seider, and Vogt (2005), and Huckman and Pisano (2006).

individual health insurance at the average cost of covering the uninsured. If it did, the individuals who purchased the policy would be disproportionately those who knew they were likely to have high health care costs, and so the company would lose money. To address adverse selection risks, most insurers use medical underwriting and incorporate a risk premium into the actual price of coverage. As a result, the price of health insurance that a typical person would face in the individual market greatly exceeds the average cost of covering him or her.[50] Moreover, a significant proportion of individuals may be uninsured because they are denied coverage as a result of medical underwriting. For example, a 2007 survey by America's Health Insurance Plans found that in a sample of about 1.5 million individual applicants underwritten for coverage, among those between 50 and 64 years of age, approximately 22 percent of applicants were denied coverage based on medical underwriting.[51]

***Liquidity constraints and uncompensated care*.** Imperfections in credit markets reduce the ability of households, especially low-income households, to obtain goods and services with immediate costs but long-term benefits. Health insurance is a classic example of such a good. Similarly, the uninsured obtain some free medical care through emergency rooms, free clinics, and hospitals, which reduces their incentives to obtain health insurance.[52]

***Positive externalities*.** When an uninsured person obtains health insurance and thus better access to care, there are benefits to others. For example, in the case of infectious diseases such as influenza or tuberculosis, appropriate diagnosis and care may prevent the spread of illness. This is the classic definition of a positive externality—a benefit that accrues to someone other than the decision-maker. This is another force that works in the direction of causing too few individuals and households to have health insurance.

IV. KEY ELEMENTS OF SUCCESSFUL HEALTH CARE REFORM

As discussed above, the key goals of health care reform are reducing the growth rate of costs, while maintaining choice of doctors and health plans, and assuring quality, affordable health care for all Americans. At this point, the specifics of reform are far from settled. In the analysis that follows, we therefore discuss relatively stylized versions of what successful reform could accomplish.

A. Slowing Cost Growth

On May 11, 2009, representatives from many facets of the health care system, including doctors, hospital administrators, health insurers, pharmaceutical firms, medical device manufacturers, and unions, met with the President and made clear their commitment to health care reform that lowers cost growth and covers all Americans. These representatives pledged to do their part to achieve the goal of reducing the annual growth rate of health care costs by 1.5

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[50] Similar adverse selection problems exist for the self-employed and small employer groups.
[51] America's Health Insurance Plans (2007).
[52] Herring (2005).

increasing at similar rates.[89] This suggests that the relationship between labor force participation and health insurance may not be a primary determinant of labor force participation of this segment of the population today.[90]

Similarly, the expansion of coverage will likely include subsidizing premiums for newly insured, low-income individuals and families. If subsidy levels decline as household income rises, this will increase the effective marginal tax rate for these households. As a result, workers could respond by reducing their labor supply. To consider the likely magnitude of this effect on aggregate labor supply, it is instructive to consider a policy that affected individuals across a relatively wide range of the incomes for which subsidized premiums may be relevant. Academic research explored the effect on labor supply of the earned income tax credit (EITC), which introduced a 10 percent tax rate for EITC beneficiaries with incomes slightly above the poverty line because of the phase-out of EITC benefits with additional earnings.[91] The results suggest that this tax had very little impact on labor supply, and the study concludes that the findings are consistent with previous research indicating that taxes such as these typically have very little effect on hours of work. It therefore seems likely that the effects of subsidized health insurance premiums on aggregate labor supply would be modest.

Overall effects. In light of the large number of individuals with disabilities and significant medical conditions, and the fact that the offsetting effects appear small, the net impact of health care reform would very likely be to increase effective labor supply. This would magnify the rise in GDP and improvement in the government's budgetary position discussed above. The magnitude of the effects would depend on the size of the effects on labor supply. For example, a one percent increase in overall labor supply would translate in the long run to a one percent increase in GDP beyond the effects described in Section V.

C. Health Care Reform would Improve the Functioning of the Labor Market

The provision of health insurance through workers' employers has significant advantages. It is, and will remain, the source of health insurance for many Americans. At the same time, some of the specific features of our employer-based system cause the labor market to function less effectively. Properly designed health care reform could reduce those inefficiencies. Here we discuss two ways that health care reform would improve efficiency in the labor market.

Reduce job lock. Because of limitations on coverage of pre-existing conditions, many workers who might change jobs do not do so out of fear of losing their access to insurance coverage or facing limitations on coverage offered by a new employer.[92] Health care reform would allow many of these workers to move to jobs where they would be more productive.

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[89] U.S Department of Labor.

[90] Additionally, greater access to health care insurance may increase the utilization of treatments that facilitate work. For example, Garthwaite (2008) finds that the use of certain new pharmaceutical treatments substantially increased the labor supply of near-elderly individuals with chronic pain. The author argues that new treatments may be partially responsible for the increase in labor supply among near-elderly and elderly men during the past decade.

[91] Eissa and Liebman (1996).

[92] Gruber (2000).

Again, it is possible to get a sense of the size of the potential gains involved. Although there is not complete agreement on the issue, many studies find substantial effects of employer-sponsored insurance on job mobility.[93] In particular, one study examines the effect of employer-sponsored health insurance on job turnover, and estimates the corresponding effect on wages.[94] To do this, it focuses on the short-term (one-year effect) by multiplying the estimate of the number of workers between the ages of 25 and 54 who do not move in the current year (1.04 million in 1987) because of employer-sponsored insurance by the estimate of the average wage gain that the workers would have enjoyed in their new jobs ($3,560 per year). The selectivity-adjusted wage gain of $3.7 billion represents 0.3 percent of wages for all workers between the ages of 25 to 54 and more than ten percent of wages for the affected workers. This estimate is a lower bound, however, as it focuses on the flow in each year rather than the stock over a longer time period.

While there appear to be no corresponding estimates for long-term wage effects in the literature (that consider not just the flow but the stock), a simple back-of-the-envelope calculation can be useful. One study estimates that 16 percent of workers ages 25 to 54 change jobs each year.[95] This suggests that on average, a worker will change jobs five times between ages 25 and 54. It further estimates that both men and women are approximately 25 percent less likely to change jobs if they are likely to lose health insurance coverage. This implies that a worker with employer-sponsored insurance throughout his working years would change jobs approximately four times during the years from 25 to 54, whereas his counterpart with health insurance from another source would change jobs five times. Assuming that these job transitions are equally spaced during the 30-year interval and that the wage gain is the same for each worker at each transition, the average wage effect during this thirty-year period would be at least three times larger than the short-term estimate reported above would suggest.[96] This represents approximately 1.0 percent of wages for all workers between the ages of 25 and 54 in the typical year, and more than 0.2 percent of GDP.[97] This estimate is necessarily more speculative than the short-term one, however.

***Promote small firm creation and competitiveness*.** Firms compete for workers by offering compensation packages that include wages as well as non-wage benefits such as health insurance. In a large majority of states, current insurance market practices disadvantage small employers (including the self-employed) relative to larger firms with respect to purchasing coverage. High administrative costs and concerns among insurers about adverse selection contribute to higher premiums for small employers, which can reduce their willingness to offer health insurance as part of total compensation. This, in turn, can affect the ability of small

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[93] See, for example, Madrian (1994), Monheit and Cooper (1994), and Currie and Madrian (1999). For a review of related literature, see Gruber and Madrian (2001).
[94] Monheit and Cooper (1994).
[95] Monheit and Cooper (1994).
[96] The short-term estimate essentially only considers the wage difference that is missed at the time of the extra transition. However, because the worker will spend more time in each job, there will be more than one year at the lower wage, with this becoming increasingly true over time. For example, while the worker without ESI would change to a third job around the age of 37, the worker with ESI would not transition to the third job until age 41. On average, the worker with ESI transitions to the next job almost four years later than the one without ESI, and this lag increases from just a year or two at the first transition to several years at the final transition.
[97] The estimated long-term effect of at least $11 billion in 1987 represents 0.24 percent of GDP in that year.

employers to attract and retain qualified workers. Moreover, if small employers choose not to offer health insurance, they are further disadvantaged given the preferential tax treatment associated with employer contributions toward health insurance.

In addition to the direct effect of higher premiums on the ability of small firms and the self-employed to purchase affordable health insurance, there are broader economic costs introduced by this market failure. Both economic theory and empirical evidence suggest that there are substantial benefits to society of individual risk-taking of the kind that entrepreneurs bear when starting up their own businesses.[98]

As discussed above, the creation of an exchange has the potential to improve access to affordable coverage for small employers and to help level the playing field with respect to their ability to compete for talented workers in the labor market.

VII. Conclusion

The American health care system is on an unsustainable path. Expenditures as a share of GDP are already substantially higher than in other developed countries, and are projected to grow rapidly in the next three decades. This growth threatens to have a devastating impact on the growth in workers' take-home pay and the government budget deficit. It is also likely to increase the number of Americans without health insurance from its already very high level and thus undermine the health of our population.

Successful health care reform will slow the growth rate of health care costs, maintain choices of doctors and health plans, and expand coverage. Slowing the growth rate of costs by 1.5 percentage points per year would have a dramatic impact on the trajectory of health care expenditures as a share of GDP over time. Slowing the growth rate of costs by a smaller amount (0.5 or 1.0 percentage point per year) would have smaller, but still important effects.

Our analysis shows that successful health care reform would have major benefits for the U.S. economy. Over time, the slowing of cost growth through increased efficiency would bring about substantial increases in Americans' standard of living. It will also prevent devastating increases in the budget deficit and raise capital formation. We estimate that slowing health care cost growth by 1.5 percentage points will increase real GDP in 2030 by nearly 8 percent relative to what would happen without reform. We also find that slowing cost growth is likely to lower the unemployment rate consistent with steady inflation by roughly one-quarter of a percentage point for an extended period.

The net welfare effects of expanding coverage to the uninsured are also likely to be very large—probably in the range of $100 billion each year. Genuine reform will also likely increase labor supply, reduce job lock, and aid small businesses.

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[98] van Praag and Versloot (2007) and Holtz-Eakin and Kao (2003); see also Lerner (1999).

The kind of reform that will bring about these economic rewards will not be easy. It will require truly game-changing innovations in many areas. But, if we can bring about such changes, there will be substantial benefits to American households, businesses, and the economy as a whole.

Exhibit 5

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Commentary

QJM

The moral foundations of health insurance

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Introduction

The US and numerous developing countries do not provide universal health insurance coverage to their populations. Academic approaches to health insurance[1] have typically adopted a neo-classical economic perspective, assuming that individuals make rational decisions to maximize their preferred outcomes, and businesses (including insurance companies) make rational decisions to maximize profits. In this approach, individuals who are risk-averse will purchase health insurance to reduce variation in the costs of health care between healthy and sick periods.[2] In empirical studies, however, individuals do not always make rational choices. They also find it difficult to assess their health risks and to know how much insurance they need.[3]

By contrast, medical ethics has focused on the issue of equal access to health care, but provided little in the way of philosophical justification for risk management through health insurance *per se*. Nor has it shown how the practice whereby many at-risk individuals pay premiums to cover one individual's expensive health outcome ('risk-pooling'), is ethically desirable, except insofar as it ensures equal access to health care and equal income to purchase it for all contributors.

This article offers an alternative moral framework for analysing health insurance: that universal health insurance is essential for human flourishing. The central ethical aims of universal health insurance coverage are to keep people healthy, and to enhance their security by protecting them from both ill health and its economic consequences, issues not adequately considered to date. Universal health insurance coverage requires redistribution through taxation, and so individuals in societies providing this entitlement must voluntarily embrace sharing these costs. This redistribution is another ethical aim of universal health insurance unaddressed by other frameworks. This article is part of an alternative approach to health and social justice,[4] offered here and elsewhere,[5,6] that builds on and integrates Aristotle's political theory and Amartya Sen's capability approach.

Theory of demand for health insurance

In neo-classical welfare economic theory, individuals make choices to maximize their preferences over time, and the goal of society is to maximize social welfare, or aggregate preferences. It assumes that individuals make rational choices based on cost-benefit calculations under varying conditions.[7]

This approach asserts that the free market is the best way to allocate resources, as it values efficiency over equity. Risk-averse individuals are predicted to choose insurance against large risks, leaving smaller risks uncovered, thereby improving their overall welfare.[8] As stated above, however, in empirical studies, individuals find it difficult to make such choices.[3]

Health insurance markets are also not entirely free. Insurance companies have an information advantage, which they can use to 'cherry pick'[9] both the kinds of consumers they insure, and

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the kinds of coverage they offer them, in order to increase their profits. In consequence, more comprehensive coverage tends to be confined to wealthier individuals, reducing the pooling of risk across the population. Conversely, poorer individuals often fail to choose coverage that meets their health needs.[10]

Behavioural economics and prospect theory

In health insurance markets, as in other areas of economics, people do not perfectly forecast their preferences or desires under different conditions, nor can they always estimate the consequences of changes in their circumstances.[11] They also have relatively little knowledge of individual health insurance plans when choosing between them.[12] Neo-classical theory predicts that consumers will insure against catastrophic medical events and cover lower-cost services themselves; in reality consumers typically choose policies with low deductibles and co-payments.

Economists explain this divergence as a matter of 'regret': individuals choose plans with no deductibles to avoid making trade-offs between medical care and money, trade-offs they might 'regret' after the fact.[13] Prospect theory[14] offers a different explanation for this behaviour. In empirical research, given equal cash amounts of loss and gain, consumers place a higher value on the amount lost than on the same amount gained. This strong aversion to loss may lead consumers to buy low-deductible policies to eliminate barriers to medical care. Such efforts to minimize regret, loss, and anxiety reflect a concern for overall well-being, rather than the preference maximization efforts described by the neo-classical model.

Medical ethics and equal access to health care

In medical ethics, several principles support a right to health care and equal access to health care. Space does not allow a thorough review of the literature, but approaches ranging from egalitarian to communitarian have been used to justify equal access to health care or health coverage. However, they have not provided an adequate analysis of health insurance in relation to risks, their consequences and management. Consequently, they do not adequately consider loss aversion, regret, anxiety, forecasting, discounting, and redistribution, all important issues for a theory of health insurance.

Economic theory, while often inconsistent with practice, recognizes these human characteristics, and can provide many helpful insights, both into people's behaviour and their underlying motives. We will now examine an alternative framework for understanding health insurance issues, and rationalizing universal health insurance to resolve them.

Welfare economics and the capability approach

Amartya Sen's capability approach is an alternative to the neo-classical economic model. It evaluates an individual's well-being and social welfare in terms of *functionings* and *capabilities*. Functionings are a person's achievements: what they are able to do or be, their activities and states of being. Capability is a person's freedom to achieve functionings that they value. Capabilities thus address both actual and potential functionings,[15] taking into account individuals' abilities to function even if they are not actually functioning at that level at a given time. For example, someone who is convalescing typically retains the capability for work (a functioning) even though they cannot work right now, whereas someone who is seriously injured may lose that capability, if the injury is serious enough.

From this perspective, the major premise of neo-classical economics, that welfare rests on an individual's willingness to pay for a commodity (e.g. health insurance), is flawed. Rather than resting on the individual's pursuit of maximum satisfaction, with priority given to satisfying individual and aggregate preferences, the capability approach gives moral significance to human capability and human flourishing. Moreover, welfare economics depends on the standard rational actor model. The capability approach does not make those assumptions: in the real world, individuals do not invariably make rational choices, according to the neo-classical model.

This approach focuses on individuals' *exposure* to risk and their ability to adequately *manage* it, rather than their *preferences* regarding it. When individuals lack access to means of reducing or mitigating risks, they become insecure. Vulnerability and insecurity diminish well-being and inhibit human flourishing.

Vulnerability and insecurity

Vulnerability and insecurity in health are an inescapable fact of life. However, because the risk

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of ill health is uncertain in frequency, timing and magnitude, it is difficult to insure against at the individual level. Most measures of risk give equal weight to both upward and downward variation in factors such as income, but downward changes both affect and concern most people far more than upward changes do.

Lack of health-care access increases risk exposure: failing to meet health needs when they occur can expose individuals to even greater risk of illness or injury later on. Illness itself brings vulnerabilities: a potential further decline in health, lost income due to medical expenses, and lost opportunities at work or school. The irreversibility of worst-case scenarios, such as severe disability or death, heightens individuals' insecurity and vulnerability.

Without health insurance, individuals and households must self-insure, use informal risk-sharing arrangements, diversify assets, draw down savings, sell assets, borrow, or go into debt to cover needed services, all of which offer moderate to little effective income smoothing over time. In many cases, individuals who lack health insurance must go without necessary medical care.

Moral foundations of health insurance

From this perspective, the moral foundations of health insurance build on the Aristotelian concept of 'human flourishing', the goal of all political activity. This is Aristotle's theory of the supreme good, the aim of 'every action and decision'.[16] If health policy is to promote human flourishing, its goal should be to enable individuals to function best, given their circumstances, and thus reduce the vulnerability and insecurity associated with ill health.[5] It is not enough simply to provide resources to individuals (for example, cash payouts or direct medical services).[17] Justice requires that individuals and households be protected against the vulnerabilities resulting from ill health,[18] and insurance offers this protection.

From this view, protective security[19] through health insurance is a necessary safety net that shields individuals from physical and mental harm and preventable death. This is both valuable in itself and also in providing the other opportunities that result from good health. Because protective security supports a person's overall health and general capability, public policies relating to health and health care should promote it. The way society finances health care thus has equity implications above and beyond health services delivery and health capability inequalities.

In this approach, universal health insurance is critical to protect individuals against deprivations resulting from illness or injury, and changes in material circumstances, such as exorbitant health care debt. Society must protect people from financial insecurity resulting from 'changes in the economic or other circumstances or from uncorrected mistakes of policy'[20] such as an economic downturn and rising unemployment. Protecting health, for example, and preventing 'sudden, severe destitution'[21] are thus major goals of public policy.

Universal health insurance is thus morally justified because it ensures (some of) the conditions for human flourishing, by reducing, mitigating and coping with the risks of ill health and the resulting financial insecurity. Major illness and/or disability cause significant economic costs both in income losses and medical expenses. Lack of insurance, underinsurance, self-insurance, informal insurance and discontinuous insurance not only provide insufficient protection, but are also barriers to receiving high-quality,[22,23] medically necessary and appropriate health care.[6]

Health care costs can also affect health directly by suppressing demand for necessary medical services. Direct out-of-pocket payments (co-payments, user fees, user charges, waiting periods, and deductibles) can discriminate against the sick and impede use of necessary health care. Attempts to exempt poorer individuals from user fees in public facilities and to use ability-to-pay sliding scales for user fees have had limited success.[24] Co-payments, deductibles, user fees, and other costs of health care thus create inequities and raise important moral concerns. Financial disincentives that discourage patients from using necessary health services leave people behind economic barriers and therefore fail to promote health capabilities.[25] Studies of small co-payments are necessary to assess their affect on the demand for needed health care and their ability to avoid unlimited demand for health care.

Health insurance can reduce risk by providing preventative medicine (immunizations, prenatal and maternity care, infant care, cancer screening, nutritional services, regular wellness exams and physical exams), as well as covering health-care costs in times of illness or injury. Insurance effectively pools risk across time and across individuals such that the financial risks of illness can be predicted and premiums (including actuarially fair premiums plus administrative costs) can be estimated with good reliability, given a sufficiently large pool. For all these reasons, formal,

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institutional and legally guaranteed health insurance is not only critical but also the rational choice in a just society.

An equitable health system requires protection of all individuals, especially the poor and most disadvantaged, against the monetary burdens associated with health risks. Experience-rated insurance premiums, which penalize those who have used more health care, violate this principle of provision. They can cause sicker individuals to avoid seeking care, by making them pay more than healthier individuals. In contrast, community-rated premiums require everyone to pay the same rate, regardless of health status. The equity implications of financing and of access are inseparable.

If universal health insurance is not to exacerbate other inequities, such as income, the population should share the health insurance tax burden justly, so that the poor or sick are not impoverished by insurance premiums. Financing systems can be classed as regressive (contributions consume a progressively smaller proportion of income as income rises), neutral (all income groups pay the same percentage of their income) or progressive (premiums represent a rising percentage of income as income rises). Health insurance financing needs to be progressive to improve health and overall capabilities. Risk pooling and wealth redistribution are essential for equitable and efficient health care financing.

The justification for progressive financing and community rating is based on the close relationship between income and reduced capability. Coupling disadvantages,[26] such as when a sick person cannot earn a decent income or pay for needed health care, compounds the problem. As Sen notes, 'Hardships such as age or disability, or illness, reduce one's ability to earn income. But they also make it harder to convert income into capability, since an older or more disabled, or more seriously ill person may need more income (for assistance, for prosthesis, for treatment) to achieve the same functionings'.[27]

Universal health insurance boosts the economic security of both individuals and communities. Good health can expand people's productivity and incomes, allowing them to support a more prosperous overall economy, which can then afford more and better health care and other social services. By contrast, uninsured health care costs can force a person into poverty through medical expenditures or the inability to access necessary health care. Aggregated over many individuals, these consequences can undermine the economy at large. Health security and economic security are interrelated, and promotion of human flourishing requires attention to both. Health policy must ensure universal health insurance to enhance human capabilities and promote individuals' ability to flourish, and it must do so efficiently. Health insurance helps create opportunities for both good health and protective security; these interrelated freedoms 'advance the general capability of a person'.[28]

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Exhibit 6

Myths And Misconceptions About U.S. Health Insurance

Health care reform is hindered by confusion about how health insurance works.

by Katherine Baicker and Amitabh Chandra

ABSTRACT: Several myths about health insurance interfere with the diagnosis of problems in the current system and impede the development of productive reforms. Although many are built on a kernel of truth, complicated issues are often simplified to the point of being false or misleading. Several stem from the conflation of health, health care, and health insurance, while others attempt to use economic arguments to justify normative preferences. We apply a combination of economic principles and lessons from empirical research to examine the policy problems that underlie the myths and focus attention on addressing these fundamental challenges. [*Health Affairs* 27, no. 6 (2008): w533–w543 (published online 21 October 2008; 10.1377/hlthaff.27.6.w533)]

Several common myths about the benefits and design of health insurance undermine the development of a productive conversation on reform efforts. These misunderstandings both interfere with the diagnosis of problems in the current system and impede the development of a much-needed bipartisan consensus on how to engineer reform. Although many of the myths are built on a kernel of truth, advocacy for addressing real problems often simplifies complicated issues to the point of being false or misleading. In this paper we evaluate these myths using a combination of economic principles and lessons from careful empirical research. The misconceptions often arise from genuine policy concerns, and we hope that stripping them away will promote reforms that focus on the underlying challenges facing the U.S. health system.

Our choice of which misconceptions about health insurance to address is idiosyncratic to our experience. These misconceptions are pervasive enough that pointing to specific instances may be counterproductive. Rather, we prefer to draw attention to the genuine underlying policy challenges. A common feature of several myths is the conflation of health, health care, and health insurance. The three are surely connected, but they are not the same. Others stem from attempts

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to use economic arguments to justify normative preferences. Our discussion is meant to give an economist's point of view, rather than to introduce new analysis or to provide a comprehensive treatment of any of these important topics. We begin by discussing what health insurance is and is not, and then discuss five myths about health insurance in the United States.

What Insurance Is, And Is Not

Insurance, in its simplest form, works by pooling risks: many pay a premium up front, and then those who face a bad outcome (getting sick, being in a car accident, having their home burn down) get paid out of those collected premiums. The premium for health insurance is the expected cost of treatment for everyone in the pool. The key insight is that not everyone will fall sick at the same time, so it is possible to pay for the care of the sick even though it costs more than their premiums. This is also why it is particularly important for people to get insured when they are healthy—to protect against the risk of needing extra resources to devote to health care if they fall ill.

Uncertainty about when we may fall sick and need more health care is the reason that we purchase insurance—not just because health care is expensive (which it is). Lots of other things are expensive, too, including housing and college tuition, but we don't have insurance to help us purchase them because they are not uncertain in the way that potentially needing very expensive medical care is. The more uncertainty there is, the more we value insurance.

Myth 1: The Problem With The Health Insurance System Is That Sick People Without Insurance Can't Find Affordable Policies

■ **Reality.** Insured sick people and uninsured sick people present very different public policy challenges. People who have already purchased insurance and then fall sick pose a particular policy problem: insurance is not just about protecting against unexpected high expenses this year, but is also about protecting against the risk of persistently higher future expenses in the case of chronic illness. With this kind of protection, enrollees' premiums would not rise just because they got sick, but this is not always the case today. In fact, insurers have an incentive to shed their sickest enrollees, which suggests a strong role for regulation in protecting such enrollees. Nor are insurers held responsible when inadequate coverage raises the costs for a future insurer, such as Medicare for those over age sixty-five. These problems highlight the limited availability of true long-run insurance offerings, a reform issue that is often glossed over in the confusion between health care and health insurance.

Uninsured Americans who are sick pose a very different set of problems. They need health care, not health insurance. Insurance is about reducing uncertainty in spending. It is impossible to "insure" against an adverse event that has already happened, for there is no longer any uncertainty about this event. (Insurance

could still cover the uncertainty of other changes to health, but not this preexisting condition.) Try purchasing insurance to cover your recent destruction of your neighbor's Porsche: the premium would be the cost of a new Porsche. You wouldn't need car insurance—you'd need a car. Similarly, uninsured people with known high health costs do not need health insurance—they need health care. Private health insurers will not charge uninsured sick people a premium lower than their expected costs. The policy problem posed by this group is how to ensure that low-income uninsured sick people have the resources they need to obtain what society deems an acceptable level of care—and ideally, as discussed below, how to minimize the number of people in this situation.

■ **Social insurance versus private insurance.** This highlights one of the many reasons that health insurance is different from car insurance: the underlying good, health care, is viewed by many as a right. Furthermore, we may want to redistribute money from the healthy to the (low-income) sick, in the same way that we redistribute money from the rich to the poor. This kind of redistribution is fundamentally different from private insurance—it is social insurance, and it is hard to achieve through private markets alone.[1] Private markets can pool risk among people starting out with similar health risks, and regulations can ensure that when some members of those risk pools fall ill, insurers cannot deny them care or raise their premiums. Transferring resources from lower-health-risk groups to higher-health-risk groups, however, requires social insurance. There is a distinction between the public provision of a good and the public production of a good: social insurance may or may not be "socialized." For example, providing subsidies for individuals to purchase private insurance or providing the insurance directly (as through Medicare) are both forms of social insurance.

■ **How to provide care for the sick and uninsured?** How then do we provide the sick and uninsured with socially acceptable care? For starters, it would help to understand that unregulated private health insurance markets are unlikely to deliver this goal: no insurer will be willing to charge a premium less than enrollees' likely health costs. Instead, they could be given health care directly or a premium subsidy equal to their expected health care costs. Alternatively, we could force sick people and healthy people to pool their risks, such as through community rating coupled with insurance mandates (to preclude healthy people from opting out of subsidizing sick ones). But such pooling implies a transfer from healthy people to sick people, and consequently is based on normative preferences about redistribution.

The advantage of social insurance programs, including a nationalized health care system, is that they can achieve redistribution that private markets alone cannot. They may also provide benefits with lower administrative costs (although, in the case of moving to a single-payer system, the size of administrative savings relative to overall health care cost growth is likely to be small).[2]

There are, of course, also costs associated with social insurance programs. First,

Exhibit 7

THIRD EDITION

PUBLIC FINANCE AND PUBLIC POLICY

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food.[2] This growth is not expected to stop: health care is forecast to consume 38% of U.S. GDP by 2075, which would represent a greater share than the United States currently spends on cars, fuel, furniture, food, clothing, housing, utilities, and recreational activities combined.[3]

Is such high and rapidly growing health care spending a problem? After all, what is more important than our health? And, by some measures, we are buying wonderful things with our health care dollars. Consider the treatment of knee injuries in the 1950s and today. Fifty years ago, if you tore the meniscus (the cartilage under the kneecap), the only option was to have open surgery, during which the surgeon cut open your knee and removed the entire meniscus. You would spend days in the hospital, months recovering, and 15 years down the road you'd have an increased chance of developing arthritis in that knee. If you tear your meniscus today, you can often have only a small piece of it removed by arthroscopic surgery, which allows the surgeon to make tiny incisions in your knee and repair the damage in an average of 30 minutes. You go home that same day, can do light work within a few days, and be up and running (or whatever other sport you enjoy) within three to six weeks.

Similarly, in 1950, 6 out of every 1,000 Americans died from a heart attack. Since then, that number has fallen by half.[4] In 1950, 29 out of every 1,000 infants born died in their first year of life; today, that figure is less than 7 out of 1,000.[5]

Despite the huge benefits reaped from the U.S. health care system, all is not completely well. First, there are enormous disparities in medical outcomes. For example, in 2003 the white infant *mortality rate* in the United States, the share of infants who die in their first year, was 0.7%, which was in line with other developed nations like the United Kingdom and Australia. The 2003 black infant mortality rate, however, was 1.4%, which was somewhat higher than the infant mortality rate in Barbados (1.1%) and twice as high as the rate in Malaysia (0.7%).[6]

Second, the United States is the only major industrialized nation that does not endeavor to provide universal access to health care for its citizens. Forty-six million persons, almost one-sixth of the U.S. population, are without health insurance, and this number has grown fairly steadily for the past 20 years despite a strong economy for much of that period.

Despite the perceived "private" nature of the U.S. health care system, governments account for almost half of all health spending in the United States. Health care spending is now nearly a quarter of the federal government budget and more than a fifth of state and local government budgets.[7]

Furthermore, growth in health spending is projected to account for most of the long-run fiscal problems faced by the U.S. government because of the aging

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[2] Historical health spending statistic comes from Cutler (2004, p. 4); 2004 spending from Centers for Medicare and Medicaid Services (2006c); comparisons to spending on other goods come from the Bureau of Economic Analysis's National Income and Product Accounts, Table 1.1.5 and Table 2.3.3.

[3] Chernew et al. (2003).

[4] See the technical appendix to Chapters 3 and 4 of Cutler (2004), located at http://post.economics.harvard.edu/faculty/dcutler/book/technical_appendix.pdf.

[5] Data from the Centers for Disease Control at http://www.cdc.gov/nchs/fastats/pdf/mortality/nvsr52_03t31.pdf.

[6] U.S. statistics come from Centers for Disease Control and Prevention (2006a). International statistics come from United Nations Development Programme (2005).

[7] See Figure 1-7.

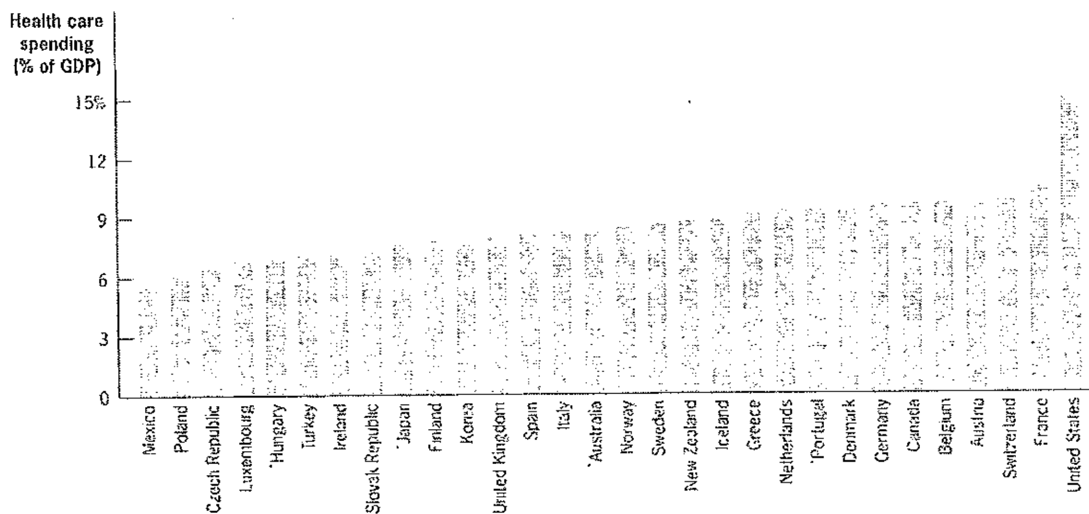
of the U.S. population and the rapid rise in medical care costs. Thus, there are clear public finance issues raised by this large and growing health economy.

In the next two chapters, we discuss many issues relative to health care and its importance to the economy and to government policy. In this chapter, we discuss the nature of health care and the set of general health insurance issues relevant to government involvement in the delivery of health insurance. This chapter provides the basis for understanding the health economy and allows us to contemplate reforms in the government role in the delivery of health care. In the next chapter, we examine the two largest public-sector interventions in health insurance markets, the Medicaid and Medicare programs, and the implications of past evidence for future directions in health care reform.

15.1 An Overview of Health Care in the United States

In 2008, the United States spent $2.24 trillion on health care, or 16.6% of GDP.[8] As noted earlier, this represents a dramatic increase from 50 years ago. This amount is also much higher than the amount spent in other industrialized nations. As Figure 15-1 shows, in 2007 the United States devoted nearly twice as large a share of our economy to health care as did Japan or the United Kingdom.

▪ FIGURE 15-1

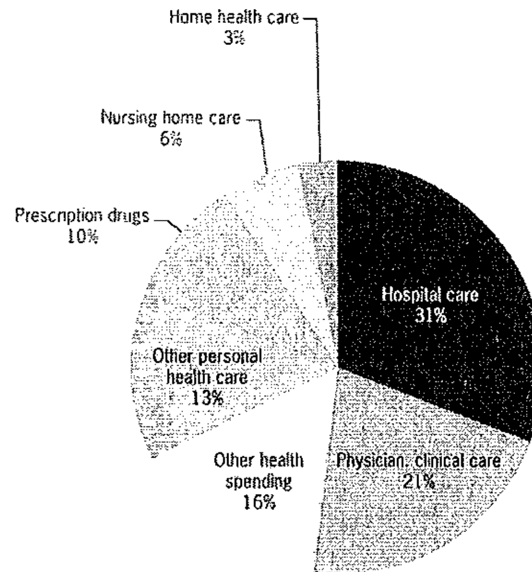


Health Care Spending in OECD Nations in 2007 ▪ Health care spending is much higher in the United States than in the typical industrialized nation.

Source: OECD Health Data 2009, "Total Expenditures on Health, % of GDP."
*Japan, Hungary, Australia, Portugal all based on 2006 figures.

[8] Centers for Medicare and Medicaid Services (2009a).

■ FIGURE 15-2



Distribution of National Health Expenditures, 2007 • Kaiser Commission on Medicaid and the Uninsured (2009)

Source: http://www.kff.org/insurance/upload/7692_02.pdf.

Health spending in the United States amounts to $7,225 on average for each man, woman, and child.[9]

Where do our health dollars go? Figure 15-2 shows the distribution of health spending across the major categories of expenditures. Over 30% of the typical health dollar is spent on hospital care, and about a fifth is spent on physician care. Prescription drug spending accounts for a tenth of health spending, while spending on nursing homes and care for the elderly in their homes accounts for almost another tenth.

Individuals typically fund these expenditures by purchasing insurance. As discussed in Chapter 12, risk-averse individuals generally prefer insurance as a means of financing uncertain expenditures, at least if that insurance is available on an actuarially fair basis. There are several major sources of health insurance in the United States: the distribution of the population across these sources in 2004 is illustrated in Table 15-1.

How Health Insurance Works: The Basics

Health insurance parallels the general structure of insurance discussed in Chapter 12. Individuals, or firms on their behalf, pay monthly premiums to insurance companies. In return, the insurance companies pay the providers of medical

[9] Information on medical spending comes from the Centers for Medicare and Medicaid Services (2009a), while information on the U.S. population comes from U.S. Bureau of the Census (2009c).

goods and services for most of the cost of goods and services used by the individual (the individual's medical claims). Under most health insurance plans, however, the patient also pays the provider for part of the costs of medical goods and services and the insurance company pays the remainder. There are three types of patient payments:

- *Deductibles:* Individuals face the full cost of their care, but only up to some limit; for example, a $100 deductible would mean that you pay the first $100 of your medical costs for the year, and the insurance company pays some or all of the costs thereafter.
- *Copayment:* Individuals make some fixed payment when they get a medical good or service; for example, a $10 copayment for a doctor's office visit or a new prescription.
- *Coinsurance:* The patient pays a percentage of each medical bill (the coinsurance rate, e.g., 20%), rather than a flat dollar amount (as with a copayment).

▪ TABLE 15-1

Americans' Source of Health Insurance Coverage, 2007

	People (millions)	Percentage of population
Total population	301.5	100.0%
Private	201.0	66.7%
Employment-based	176.3	58.5%
Direct purchase	26.8	8.9%
Public	87.4	29.0%
Medicare	43.0	14.3%
Medicaid	42.6	14.1%
TRICARE/CHAMPVA	11.6	3.8%
Uninsured	46.3	15.4%

Source: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. U.S. Government Printing Office, Washington, DC, 2008.

Note: Estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

More than two-thirds of insured Americans have private health insurance, largely through employers, while the remaining have public health insurance. Roughly one-sixth of Americans are uninsured.

Private Insurance

The most important source of health insurance in the United States is private insurance; in 2008, 66.7% of the population (78.8% of those with some kind of health insurance), or 201 million persons, had private health insurance. Within that group, the predominant source of private insurance is employer-provided health insurance. Only 13.3% of those with private insurance purchase insurance on their own, through the **nongroup insurance market**.

nongroup insurance market The market through which individuals or families buy insurance directly rather than through a group, such as the workplace.

Employers offer insurance to qualified employees in the firm, typically those who work full-time and have completed some minimal service requirement (such as six months of employment at the firm); employers also typically charge employees some share of the employers' premium payments for insurance. As a result of these employee premiums, some employees choose not to take up the insurance even if it is offered. In 2008, the typical employer-sponsored insurance plan cost $4,704 for singles and $12,680 for families; employees typically paid 16% of the costs of single coverage and 27% of the costs of family coverage.[10]

[10] Kaiser Family Foundation, 2009.

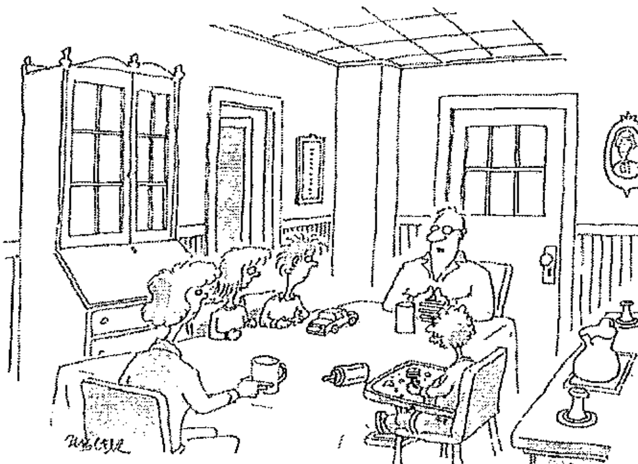
There are two reasons why employers are the predominant source of insurance.

Why Employers Provide Private Insurance, Part I: Risk Pooling The first reason that employers provide most private insurance is the nature of insurance risk pools. An insurance **risk pool** is the group of individuals who enroll in an insurance plan. When insurers sell an insurance plan to a group, they don't care about the medical experiences of any one member of the group. What matters to the insurer is the total premium collected from, and medical claims paid out on behalf of, that insurance pool as a whole. Recall our example from Chapter 12: actuarially fair pricing simply requires that the insurance company collect enough in premiums from the entire group to cover its costs for that group.

risk pool The group of individuals who enroll in an insurance plan.

As a result, the goal of all insurers is to create *large insurance pools with a predictable distribution of medical risk*. So long as the insurer can accurately predict the claims that it will pay out for that insurance pool, it can charge a premium to cover its claims costs (along with administrative costs and profits). If it can't make that prediction accurately, there is a risk that the premiums will not cover the pool's medical costs.

Two features increase the predictability of medical risk distributions for insurance risk pools. The first is the absence of adverse selection. Insurers predict medical risk based on the observable characteristics (such as age and sex) of the individuals in the risk pool, and such predictions will only be valid if those individuals have the average medical risk of their age and sex group. If individuals are forming a pool based on their (unobserved to the insurer) health status as well, then the insurer can't predict the expected costs of that pool very well. The second factor that increases predictability is group size. The statistical *law of large numbers* (introduced in Chapter 3) states that as the size of the pool grows, the odds that the insurer will be unable to predict the average health outcome of the pool falls.



"Kids, your mother and I have spent so much money on health insurance this year that instead of vacation we're all going to go in for elective surgery."

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Employees of firms, particularly large firms, constitute a risk pool that has a good chance of meeting these two conditions. Workers generally do not take their health status into account when choosing which firm to work for, so there is no reason to believe that there will be adverse selection in this risk pool. That is, there is no reason to suspect that particularly sick or healthy individuals band together to work in a firm (particularly a large firm), so that on average within a firm, workers of a given age and sex will have the expected medical expenditures for that age and sex. In addition, most employees work in firms that are sufficiently large that the law of large numbers can be employed in predicting medical risks.

For these reasons, firms provide an attractive risk-pooling mechanism for insurers. Individuals, on the other hand, do not. Large groups of individuals could be formed to deal with the second concern, group size, but the first concern, adverse selection, always remains: the individuals who band together to come to the insurer looking for coverage might be doing so simply because they are sick. Because of adverse selection, insurers would much rather sell insurance to large employer groups than to small groups or individuals.

The preference for large groups by insurers is reinforced by another aspect of insurance provision, administrative costs. Many of the costs of administering insurance are *fixed* at a certain level no matter the size of the pool (e.g., the costs of selling the insurance product). As a result, the larger the pool, the more widely per capita administrative costs can be spread. For individuals or small groups, these fixed administrative costs can amount to a large share of the premium, but the costs are a very small share of the premium for large firms.

These issues are reflected in the pattern of private insurance coverage in the United States. Large employers in the United States almost universally offer health insurance to their employees: 98% of firms with more than 200 employees offer health insurance. Among smaller firms, however, health insurance offering rates are much lower; only 47% of firms with fewer than 10 employees provide insurance, and only 72% of firms with 10–24 employees provide insurance.[11] This difference is partly because the insurer cannot appeal to the law of large numbers for these smaller pools: one cancer or AIDS patient in a small firm could cause medical claims costs to exceed the insurance company's projection and thus exceed premiums collected. As a result, insurers are more reluctant to insure small firms, since they can't predict with certainty the insurance costs that their premiums must cover. The difference is also due to the higher (fixed) administrative costs per worker at small firms. As discussed in Chapter 12, the demand for insurance will fall if administrative costs cause insurance premiums to rise above their actuarially fair level.

Why Employers Provide Private Insurance, Part II: The Tax Subsidy The second reason why employers are the predominant providers of health insurance is the **tax subsidy to employer-provided health insurance.** Under current U.S. tax law, employee compensation in the form of wages is subject to taxation, but employee compensation in the form of health insurance expenditures is not. If your employer pays you $1 in wages, you keep only $1 × (1 − τ) of those wages, where τ is your tax rate: if you have a 33% tax rate, you only keep $0.67 of each $1 you earn. If your employer pays you in health insurance, on the other hand, you keep the full $1 of health insurance. This tax subsidy is *only available* for employer-provided health insurance. Thus, there is a large subsidy to purchasing health insurance through your employer rather than on your own.

tax subsidy to employer-provided health insurance Workers are taxed on their wage compensation but not on compensation in the form of health insurance, leading to a subsidy to health insurance provided through employers.

For example, suppose that Jim and Peter are both working for the same employer (see Table 15-2). The labor market is perfectly competitive, so their wage is equal to their marginal product, which is $30,000 per year for each

[11] Kaiser Family Foundation (2009), Exhibit 2.4.

■ TABLE 15-2

Illustrating the Tax Subsidy to Employer-Provided Insurance

	Marginal Product, Wage	Employer Health Insurance Spending	Pre-Tax Wage	After-Tax Wage	Personal Health Insurance Spending	After-Tax, After-Health Insurance Income
Jim	$30,000	0	$30,000	$20,000	$4,000	$16,000
Peter	$30,000	$5,000	$25,000	$16,666	0	$16,666

Jim and Peter both have the same marginal product of labor, but Peter chooses to take insurance through his employer, accepting a $5,000 reduction in wages as a result, while Jim purchases it on his own for $4,000. Even though Jim's insurance is cheaper, Peter ends up with $666 more income after taxes than Jim due to the subsidy to employer-provided insurance.

employee. Assume that both employees face a flat tax rate of 33%, so that, without insurance, their after-tax income is $30,000 × (1 − 0.33) = $20,000. The employer now offers both employees the opportunity to have health insurance at a cost of $5,000, but the employer will reduce their wages by $5,000 if they take this insurance, so that their total compensation is still equal to their marginal product.

Jim can purchase insurance on his own for $4,000, so he turns down the employer. He has an after-tax income of $20,000, out of which he pays $4,000 for insurance, so that he ends up with $16,000 in after-tax, after-insurance income. Peter takes the health insurance. His earnings fall to $25,000, which is $25,000 × (1 − 0.33) = $16,666 after tax. But Peter now has a higher after-tax, after-insurance income than does Jim, even though his insurance is much more expensive ($5,000 rather than $4,000). This is because Peter has benefited from the tax advantage to employer-provided health insurance, lowering the taxes he has to pay by $1666 (33% of $5,000), which more than offsets the $1,000 higher cost of the employer-provided insurance.

Quick Hint The subsidy to employer-provided health insurance is generally not well understood. This is not a subsidy to *employers* but rather a subsidy to *employees* for insurance purchased in the employment setting. From the employer's perspective, whether she pays you in wages or health insurance is irrelevant; either way, a dollar of employer spending has the same effect on the firm's bottom line (since any type of employee compensation is deductible from corporate taxation). From the worker's perspective, however, there is a large difference: by being paid in health insurance rather than wages, the worker reduces her tax payments. If the government wanted to end the tax subsidy, it would not do so by increasing the corporate tax paid by the firm; it would instead include employer spending on health insurance as part of an employee's taxable income.

The Other Alternative: Nongroup Insurance Of the approximately 70 million individuals who are not covered by employer insurance (or public insurance

sources described later in this chapter), only around 37% (27.1 million) turn to the nongroup health insurance market. This relatively small percentage is explained partly by the problems we highlighted with the small group market (potential for adverse selection and high administrative costs per enrollee), which are even greater when the insured is a single individual or family. As a result, the nongroup insurance market is not a well-functioning market. Furthermore, nongroup insurance is not always available: those in the worst health are often unable to obtain coverage (or obtain it only at an incredibly high price). Often, nongroup policies will have "preexisting conditions exclusions," which state that the health insurance will refuse to pay for the expenditures associated with any illness that the purchaser has when he or she buys the insurance (e.g., recurrences of cancer would not be covered for those with past episodes of cancer).

Medicare

Medicare A federal program that provides health insurance to all people over age 65 and disabled persons under age 65.

The second major source of health insurance is the **Medicare** program, which provides health insurance for all people over age 65 and disabled persons under age 65. Medicare is financed by a payroll tax of 1.45% each on employees and employers.

Every citizen who has worked for ten years in Medicare-covered employment (and their spouse) is eligible for Medicare at age 65. (Unlike Social Security, individuals cannot access Medicare coverage before the age of 65.) In 2009, about 37 million elderly persons were eligible for Medicare. After a two-year waiting period, Medicare insurance is also available to those receiving disability insurance. Disabled persons under age 65 add another 7.3 million people to the Medicare program.[12]

Medicaid

Medicaid A federal and state program that provides health care for the poor.

The other major public health insurance program in the United States is the **Medicaid** program, which provides health care for the poor. The federal and state governments share the financing of this program, which is paid for out of general tax revenues.

Medicaid benefits are targeted at several groups:

- Those who qualify for cash welfare programs, mostly single mothers and their children
- Most low-income children in the United States (typically below 200% of the Federal poverty level)
- Most low-income pregnant women (typically below 200% of the poverty level, for the expenses associated with their pregnancies only)
- The low-income elderly and disabled (for non-Medicare health costs and long-term care costs for facilities such as nursing homes)

Medicaid is best known for its coverage of the young poor population, particularly mothers and children, who make up nearly 70% of program recipients.

[12] Social Security Administration (2009), Tables 8.B4 and 8.B5.

However, over two-thirds of the costs of the program are accounted for by disabled and elderly program recipients. Expenses for this group include those for long-term care, either from providers visiting their homes or from institutions such as nursing homes, which account for 20% of total Medicaid spending.[13]

TRICARE/CHAMPVA

Another large source of insurance in the United States is health insurance for those currently or formerly in the military and their dependents. TRICARE is a program administered by the Department of Defense for military retirees and the families of active-duty, retired, or deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans. Together, these two programs provide health coverage for about 11 million Americans.

The Uninsured

Finally, there are the 46.3 million in the United States without any insurance coverage at all. Who are they?[14]

- The uninsured have lower-than-average incomes: one-half of the uninsured are in families with incomes below $30,000 per year. Not all the uninsured are poor, however: 15% of the uninsured are in families with incomes above $75,000.
- In 2007, nearly two-thirds of the uninsured came from families where one or more members were full-term workers, but were either not offered health insurance by their employer, or were offered insurance by their employer but did not enroll in that insurance to cover themselves or their family members.
- Almost one-fifth of the uninsured are children.

Why Are Individuals Uninsured? Why are so many individuals without health insurance coverage? One reason is that even risk-averse individuals may be unwilling to purchase insurance if it is not available at an actuarially fair price. Private insurance in the United States has administrative costs that average roughly 12% of premiums paid. In the expected utility model developed in Chapter 12, such a deviation from actuarial fairness can cause individuals with a low level of risk aversion to forgo insurance.

A second reason is adverse selection in the health insurance market. Health insurers operate with less than full information about those seeking insurance. This lack of information raises the cost of insurance in two ways. First, some share of the administrative costs of private insurance is made up of the costs devoted to screening potential applicants to identify the costliest cases. The second way that adverse selection raises the cost of insurance is through the

[13] Social Security Administration (2009), Table 8.E1 and 8.E2.
[14] EBRI (2008).

standard lemons-pricing effect discussed in Chapter 12: Prices will be higher to reflect the (presumably sickest) subset of individuals who choose to insure. Moreover, insurers may be simply unwilling to insure the worst risks because of fears of adverse selection.

A third reason is that individuals may be rationally forgoing insurance because the odds of illness are low, and if they become ill, they can receive care for free from medical providers. Under federal law, any hospital that accepts reimbursement from Medicare must treat individuals who arrive in an emergency condition, regardless of their ability to pay. Hospitals can try to collect the costs of such care from uninsured patients, but they often remain unpaid, becoming **uncompensated care** costs to the hospital and providing a form of "implicit insurance" for the patient.

uncompensated care The costs of delivering health care for which providers are not reimbursed.

A fourth reason is that individuals may be uninsured because they simply can't afford the high costs of health insurance. Individuals not offered insurance by their employer, or for whom the employer pays only a small share of the costs, may simply not have the available funds to pay the remaining costs.

A fifth reason is that individuals are making mistakes and not appropriately valuing insurance coverage. This situation could arise because young and healthy individuals do not fully appreciate the health risks they face. Or it could be because individuals face the type of self-control problems discussed in Chapter 6, overvaluing the short-run costs of insurance relative to long-run medical risk.

Why Care About the Uninsured? What does it matter if there are people without health insurance? There are several possible answers to this question. First, there are physical externalities associated with communicable diseases; uninsured people are less likely to receive vaccinations and care for communicable diseases. (Recall the measles example in Chapter 1.) Second, there is a significant financial externality imposed by the uninsured on the insured through uncompensated care. When the uninsured get served by medical providers and don't pay their bills, those costs are passed on to other users of the medical system through high medical prices, a practice called *cost-shifting*. The latest estimates suggest that the amount of uncompensated care delivered in the United States is $56 billion each year.[15] This is a classic negative financial externality because the uninsured are raising medical costs for others without bearing the full costs themselves.

The third reason we might care whether individuals are uninsured is that care is not delivered appropriately to the uninsured, thus jeopardizing their health and further raising the costs of uncompensated care that are paid by those who are insured. A classic example is the uninsured's use of the emergency room (which is designed for acute medical emergencies) for primary care, such as treatment of the common cold. There is enormous anecdotal evidence of such inefficient use of medical services; for example, a recent survey of individuals in a Los Angeles emergency room revealed that 38% of those surveyed would trade their current emergency room visit for a doctor's office visit within three days![16] This misuse of services is a problem because the

[15] Hadley, Jack, John Holahan, Theresa Coughlin and Dawn Miller (2008). Covering the Uninsured in 2008: Current Costs, Sources of Payment and Incremental Costs. *Health Affairs Web Exclusive*.
[16] Hadley et al., 2008.

EMPIRICAL EVIDENCE

HEALTH INSURANCE AND MOBILITY

Is job lock an important problem in reality? A large literature has investigated this question and concluded that it is. Initially, this literature compared the mobility rate of those who have and do not have health insurance, and showed that those who have health insurance are less likely to leave their jobs than those who do not, suggesting job lock. However, these groups do not form sensible treatments and controls, since they are likely to be dissimilar in at least two ways. First, those who choose to enter jobs that offer health insurance may be quite different from those who do not; for example, they may be in worse health. If worse health is associated with less job mobility, then this may be the reason for the observed correlation of health insurance and mobility. (Those with insurance are less likely to leave jobs because they are most ill, not because of insurance coverage.) Second, jobs that provide health insurance are typically "better jobs" along many dimensions, such as higher wages and other benefits (such as pension plans or vacation). Individuals may be reluctant to leave these jobs not because they fear losing health insurance coverage but because these jobs are too good to leave! As a result of this lack of comparability between treatment groups (those with health insurance) and control groups (those without), these estimates are biased.

A more sophisticated literature in the 1990s surmounted this problem in two different ways.[17] First, studies used a difference-in-difference strategy that compared a treatment group of those who valued health insurance particularly highly with a control group of those who did not. These studies asked, for example: Does having health insurance lower the mobility rate among those who don't have any other source of insurance coverage (treatments), relative to those who do have coverage from their spouses or some other source (controls)? If job lock is an important problem, it should be found most prominently among those who don't have coverage from a spouse; other reasons for the correlation of insurance with mobility (bias that does not represent true health insurance effects) are captured by the control group of those who don't have spousal coverage.

Second, studies examined the impact of state laws that allowed workers to continue to purchase their employer-provided health insurance for some period of time after leaving their jobs. These laws mitigated the problem of job lock to some extent because workers could be sure to have coverage for a period of time even if they left a job with health insurance for one without health insurance. These laws were passed in some U.S. states in the 1970s and 1980s, so that a quasi-experimental analysis was possible: individuals in states passing laws were the treatment group (since job lock should be loosened) and those in states without laws were the control group, and any difference in mobility was due to a loosening of job lock through these laws. Federal legislation in 1986 (part of the Consolidated Omnibus Reconciliation Act, or COBRA) then made continuation coverage available nationally (which is why it is often known as COBRA coverage). The passage of COBRA provided another opportunity for quasi-experimental analysis in which those workers in states that did not already have laws were the treatment group, and those in states that already had laws (and were thus unaffected by the federal law) were the control group.

The results from these studies support the notion that job lock is quantitatively important. Madrian's (1994) estimates, for example, suggest that it reduces mobility across jobs among those with health insurance by as much as 25%. Subsequent studies in this same vein have found that a lack of health insurance coverage for retirees reduces the odds that someone will retire before age 65 from his or her job, since older persons do not want to risk being uninsured before they become entitled to Medicare at age 65.

emergency room is a very expensive place to treat a minor illness; the efficiency of the medical system would be improved by sending these individuals to physicians' offices instead.

Fourth, there are paternalism and equity motivations for caring about the uninsured. In particular, individuals may irrationally underinsure themselves because they do not appreciate the risks they face, and governments may view

[17] For a review of this literature, see Gruber and Madrian (2004).

such irrational underinsurance as justifying intervention in insurance markets. In addition, many feel that health care is a basic right, like food or shelter, and since the uninsured are generally poorer than average, they may be a group to whom we want to redistribute health care resources.

The final reason for caring about the uninsured is that *becoming uninsured* is a concern for millions of individuals who currently have insurance. Many individuals are afraid to search for or move to jobs where they may be more productive because they are afraid of losing their health insurance coverage. This reluctance to change can lead to a mismatch between workers and jobs that can lower overall U.S. productivity. This is often referred to as **job lock,** the unwillingness to change to a better job for fear of losing health insurance.

job lock The unwillingness to move to a better job for fear of losing health insurance.

To illustrate this problem, suppose that Brigitte has utility over only two goods, health insurance and consumption, so that her utility function is of the form $U = U(C, HI)$, where C is consumption, and HI is a variable equal to 1 if she is covered by health insurance and to 0 otherwise. Suppose that she works in a well-functioning labor market so that the wage that she is paid is equal to her marginal product, net of the cost of providing health insurance, and that she consumes her net income.

Suppose that Brigitte is currently on job 1 (an accountant), but has an offer to move to job 2 (a start-up software firm), where she has a higher marginal product ($MP_1 < MP_2$). This move would be an efficiency improvement from society's perspective. Suppose, however, that job 1 is at a large firm where health insurance is relatively cheap and is therefore provided at a cost P, while job 2 is at a small firm where health insurance is very expensive and is therefore not provided. Brigitte enrolls in health insurance in job 1, so that she earns a wage $MP_1 - P$. Consumption is equal to net compensation, so Brigitte has utility $U(MP_1 - P, 1)$ if she stays on job 1, and utility $U(MP_2, 0)$ if she moves to job 2. On job 1 she has a lower marginal product, from which is subtracted the cost of health insurance, but she gets health insurance; on job 2, she has a higher marginal product and doesn't have to pay the costs of health insurance, but she doesn't get insurance.

In this case, if Brigitte values health insurance at above its cost (if there is a lot of weight on the second term in her utility function relative to the first), she might stay at her old job, even though $MP_2 > MP_1$, because of her disutility of losing insurance. *Health insurance availability may inhibit productivity-increasing job switches.*[18] In fact, as we review in the Empirical Evidence box, it appears that job lock is an important phenomenon in the United States: workers with health insurance are about 25% less likely to change jobs because of that insurance.

[18] This conclusion assumes that (a) firms can't offer health insurance only to some workers, or (b) firms can't set worker-specific wages to address their valuation of health insurance. If firms could do these two things, then firm 2 could lure Brigitte away from firm 1 by offering health insurance just to her, and reducing wages accordingly. But assumption (a) is legally justified; firms cannot restrict eligibility for health insurance based on characteristics other than hours of work or tenure with the firm. Assumption (b) is trickier; we'll discuss this point in Chapter 18.

15.2 How Generous Should Insurance Be to Patients?

In considering government intervention in health insurance markets, the first question is: How generous should health insurance be? As with other insurance discussed in Chapters 12–14, the optimal generosity of health insurance will be determined by trading off the consumption-smoothing benefits and moral hazard costs of insurance. Yet generosity is measured in a very different way with health insurance than with the other programs we have studied. For Social Security or unemployment insurance, generosity reflects the share of pre-event wages replaced, or perhaps the duration of benefits. In the context of health insurance, generosity reflects the share of medical spending that will be reimbursed by the health insurer.

The generosity of health insurance is therefore measured along two dimensions. The first is generosity to *patients:* what share of the bill for medical services should be paid by the insurer, and what share by the patient, through deductibles, copayments, and coinsurance? The most generous health insurance plan is one that provides **first-dollar coverage,** reimbursing providers fully with no cost to the patients themselves. Plans can be less generous to consumers either by refusing to reimburse some services, so that patients pay the full cost, or by raising the amount that patients need to pay when they get the service. So the question we discuss in this section is: What share of a patient's medical spending should be reimbursed by the insurer, and what share should be paid by the patients themselves?

first-dollar coverage Insurance plans that cover all medical spending, with little or no patient payment.

The second dimension of insurance generosity is generosity to *providers:* How should insurers reimburse providers for the services they deliver? Should insurers just pay the amount billed by the provider for medical services, or should the insurer limit in some way how much the provider will be reimbursed? In the next section, we discuss this alternative dimension of generosity.

Consumption-Smoothing Benefits of Health Insurance for Patients

Applying what we learned in Chapter 12, the benefits of health insurance to individuals are clear. Risk-averse individuals will value health insurance as a means of smoothing their consumption with respect to the cost of medical events. Not all types of medical events are created equal, however. Some are minor and predictable, such as a quick physician visit for a checkup. Others are more extensive and unpredictable, such as hospitalization for a heart attack. The key insight of expected utility theory is that insurance is much more valuable for the latter types of medical events, and that there is relatively little consumption-smoothing benefit from covering the former type of (minor) events. Thus, first-dollar coverage does not provide much more consumption smoothing than does health insurance that makes patients pay the minor costs of medical care and has insurance pay only the higher costs of major medical events (what is often called "catastrophic care").

Exhibit 8

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The effect of the availability of charity care to the uninsured on the demand for private health insurance

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Abstract

The economic reasons why some people do not obtain health insurance are unclear. In this paper, I test the hypothesis that the availability of charity care to the uninsured reduces the likelihood of obtaining private coverage. I utilize variation in the availability of charity care across the different markets in the Community Tracking Study's Household Survey (CTS-HS) using an "access to care" measure of the uninsured's cost-related difficulties in obtaining medical care, to both aggregate across the various "safety net" providers and control for its potentially endogenous supply. I find evidence supporting this hypothesis for low-income people, in both the individual market and the employment-based group market. I also estimate a joint model of offer and take-up decisions for the group market sample and find that the availability of charity care reduces low-income workers' offer rates but not their take-up rates.
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1. Introduction

Why do the uninsured in the United States fail to obtain private health insurance? There were almost 44 million people without health insurance in 2002, and various policies are currently under consideration to expand coverage. Despite the significant policy interest in the uninsured, there exists a fair amount of uncertainty about the economic determinants of whether people ineligible for public insurance purchase private insurance. What *is* known is that large subsidies for private health insurance premiums will likely be needed to induce a large number of the uninsured to obtain coverage (Gruber and Levitt, 2000; Pauly and Herring, 2001). Most policymakers focus on issues related to the magnitude of premiums and ways to reduce the net prices for insurance that people face, but an interesting underlying question is *why* is the willingness-to-pay for private coverage of the uninsured so low.

In this paper, I argue that it is not necessarily the *absolute* cost of health insurance that is prohibitive for many of the uninsured; instead, it is the cost of health insurance *relative* to the costs associated with remaining uninsured that is important for one to consider. Various "safety net" providers supply free or subsidized care to the uninsured due to altruistic concerns, which lowers the uninsured's expected out-of-pocket expenses considerably. Rational economic actors will realize that the availability of charity care lowers the value of obtaining private health insurance coverage, and thus the relative likelihood of purchasing private coverage should decrease.

I present an empirical test of this hypothesis in this paper.[1] Testing this relationship between insurance coverage and the availability of charity care, however, is not clear-cut for two main reasons: there are many different safety net providers of charity care, and these providers may increase their supply of charity care in response to larger numbers of uninsured. To address these issues, I use a local-level "access to care" measure of the absence of cost-related difficulties in obtaining care reported by the area's uninsured. I argue below that such a measure both appropriately aggregates across the different safety net providers (which serve as substitutes in different areas) and is not subject to reverse causality. I examine the likelihood of obtaining private coverage in the individual market and the employment-based group market separately. Since one must be offered coverage and take up offered coverage to be insured in the employment-based group market, I estimate a simultaneous model of offer and take-up decisions for people in the group market.

Section 2 of the paper reviews some theory regarding the demand for insurance and presents a simple theoretical model to illustrate my hypothesis. Section 3 of the paper details the amount of charity care available to the uninsured by examining medical expenditure data. Section 4 of the paper presents the empirical model and its results for the demand for private insurance as influenced by the availability of char-

[1] In the context of this paper, I consider "charity care" from the patient's perspective rather than the provider's perspective, and I define charity care as any medical care for which an uninsured person is not required to pay the full cost. Providers of such care may be reimbursed from other direct or indirect sources, so this medical care may not necessarily be considered "charity" from their perspective. Moreover, I examine the provision of charity care to those who are uninsured and not the provision of public insurance such as Medicaid or SCHIP.

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ity care; the beginning of Section 4 describes the access measure that I use and verifies that it well-specified, while the latter portion of Section 4 estimates various empirical models for insurance coverage. Section 5 of the paper discusses my findings.

2. What does theory predict?

2.1. *Standard models of insurance*

Individuals face a great deal of uncertainty regarding the random financial losses associated with medical utilization. The theoretical implication of this is quite clear: risk-averse individuals facing uncertain levels of future-period wealth prefer the certainty associated with the purchase of insurance (Arrow, 1963). More complex models of insurance demand generally predict a decrease in the generosity of insurance obtained rather than predict the non-purchase of insurance. Faced with moral hazard, consumers will demand a level of coinsurance so that the marginal benefits of reducing inefficient consumption are offset by the marginal costs of decreased risk reduction (Pauly, 1968). Faced with adverse selection resulting from private consumer information about one's risk level, the equilibrium (if it exists) is characterized (not by low-risks being uninsured but instead) by low-risk individuals separating into insurance plans with less generous coverage (Rothschild and Stiglitz, 1976).[2] Faced with high administrative loading, consumers will generally decrease the generosity of coverage rather than forego obtaining any coverage at all. Only when the load is excessively high will individuals fail to obtain any coverage at all; however, the group market's relatively-low administrative loading coupled with the tax subsidy implies that the amount that most Americans would be required to pay for health insurance is not far in excess of expected benefits.

The discussion of the theory to this point has assumed that the uninsured are at full financial risk for the costs associated with their medical utilization. However, it is generally thought that many of the uninsured receive charitable medical care at no or a reduced cost. Buchanan (1975) noted early that the rich face the "Samaritan's dilemma" in which they are not able to commit to not providing ex post transfers of wealth to the unfortunate poor enduring a financial loss. Coate (1995) formalizes this idea in a theoretical model showing that even ex ante unconditional transfers of wealth from the government do not necessarily cause the poor to purchase private insurance; instead, the poor will still rely on additional ex post charitable transfers of wealth from rich Samaritans if a loss is realized. He also shows that ex ante in-kind transfers of insurance are more efficient than ex post transfers of wealth.

[2] An extension of the Rothschild–Stiglitz model in which insurers are constrained to earn zero profits over all plans offered (instead of each individual plan) results in an equilibrium with one moderate coverage plan in which low-risk people subsidize high-risk people (Wilson, 1977). Low-risk people still obtain coverage because their willingness-to-pay for the reduction in risk exceeds the amount of their subsidization of the high risks.

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2.2. *Insurance purchasing when charity care exists*

I present a simple theoretical model formalizing this idea that a person's incentive to purchase private insurance is diminished due to the presence of charity care. Consider the following expression for the expected indirect utility of a risk-averse person i facing an uncertain total cost of medical care:

$$\mathrm{EU}_i \equiv I_i - EX_i - R_i \qquad (1)$$

where I_i is person i's income, X_i the total amount paid for medical care, and R_i is i's ex ante valuation of the risk due to variation in the realization of X_i. Let R_i equal to $\frac{1}{2}\mathrm{AP}_i\,\mathrm{var}(X)$, where AP_i is the traditional Arrow–Pratt relative risk-aversion coefficient and var(X) is the variance of X. Finally, assume that i faces a random distribution of total medical expenditures independent of cost-sharing with a mean equal to M_i and a standard deviation equal to σ_i.

Suppose that if uninsured, i expects to receive an amount of charity care from medical providers equal to a proportion, C, of the total expense, and that there are no supply-side limits on the availability of charity care from providers. I assume that the magnitude of C is known with certainty but discuss relaxing this assumption below. Expected uninsured out-of-pocket expense therefore equals $(1 - C)M_i$. For simplicity, I assume that a competitive market for full insurance exists, that the premiums insurers charge are proportional to individual risk level, and that administrative loading equal a fixed percentage of expected benefits; if L_i is the net loading that i faces, i's premium therefore equals L_iM_i.[3]

Now consider i's choice of whether to purchase insurance. This choice is a matter of maximizing expected utility: i will purchase private health insurance if $\mathrm{EU}_{I,i} > \mathrm{EU}_{U,i}$. Person i's "propensity" for purchasing private insurance—defined as the difference between person i's expected utilities—can be expressed as

$$Y^*_{I,i}(C) \equiv \mathrm{EU}_{I,i} - \mathrm{EU}_{U,i}(C) = (1 - C)M_i + \tfrac{1}{2}\mathrm{AP}_i((1 - C)(\sigma_i)^2) - L_iM_i, \qquad (2)$$

given the assumptions made above. This expression implies that individuals will purchase insurance if their reservation price exceeds the premium; the reservation price is the sum of expected uninsured out-of-pocket expense and the valuation of risk associated with fluctuations in this expense.

Differentiating Eq. (2) with respect to C produces the testable hypothesis that $\mathrm{d}Y^*_{I,i}/\mathrm{d}C < 0$; i.e., as the availability of charity care increases, the propensity for purchasing insurance decreases. Because both the absolute magnitude of uninsured out-of-pocket expense and the variation in uninsured out-of-pocket expense decrease with increases in charity care, expected uninsured utility increases with increases in charity care. Interestingly though, the marginal effect of the amount of charity care C on the propensity for purchasing insurance will be smaller in magnitude for larger values of C. Mathematically, this is because the second derivative of Eq. (2) with respect to C is positive. Intuitively, this is

[3] Since this model assumes non-zero loading, the optimal insured state would actually not be full insurance, but instead include some level of cost-sharing; this would add an expected insured out-of-pocket expense term. For simplicity, however, I assume here that the insurance chosen is full insurance.

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driven by the increasingly negative effect that charity care has on the variance of uninsured out-of-pocket expense. (The relevance of this point will be more apparent later in the paper.)

Although the simplicity of this model makes this intuitive relationship rather apparent, the effect of extending this model to incorporate uncertainty about the availability of charity care is noteworthy.[4] While the amount of charity care that is made available may not be uncertain from the provider's perspective, patients will likely have imperfect knowledge about the actual magnitude of charity care they will receive—either because a known provider's subsidy policy is unknown or because the actual availability of a specific provider is unknown. This uncertainty will increase the propensity for insurance. While expected out-of-pocket expense remains the same, the variance of out-of-pocket expense increases when C is uncertain, thereby decreasing uninsured expected utility; this result is shown mathematically in Herring (2000). Intuitively, diminishing marginal utility of wealth makes the downside of receiving a less-than-anticipated amount of charity care worse than the upside of receiving a greater-than-anticipated amount of charity care. This implies that, all else equal, people who are less uncertain about the availability of charity care (e.g., from their family, friends, and neighbors) will be relatively less likely to purchase private health insurance. (The relevance of this point will be more apparent later in the paper, as well.)

I present an empirical test of the hypothesis that the availability of charity care has a negative effect on the demand for private health insurance in Section 4 below. However, such an analysis would be moot if the uninsured only receive trivial amounts of charity care. For this reason, I first examine data regarding the magnitude of charity care provided to the uninsured—analogous to the term C above. These results are shown in Section 3 below.

3. How much charitable medical care do the uninsured receive?

I examine the magnitude of charitable medical care provided to the uninsured using the household survey data from the Medical Expenditure Panel Survey (MEPS) for years 1996–2000. The data include annual dollar amounts classified both by the type of medical care and by the source of the payment. Since the MEPS expenditure data are annualized, I limit my sample to those under 65 who were uninsured for the entire survey year by using the monthly insurance status information.[5] I present mean values for both total utilization and total out-of-pocket spending for a sample of 17,725 year-long uninsured individuals; all expenses are inflated to year 2000 US dollars. The total utilization variable represents

[4] Two other extensions of this model would be to include a valuation of the difference in quality between charity care and insured medical care and to include a measure of the "stigma" from being a charity case.

[5] Many of the uninsured at any point in time lack private health insurance for only a few months. For instance, only 69.7% of people in the MEPS who were uninsured in January of 1996 were uninsured for the each of the eleven subsequent months. More detail about short "spells" of uninsurance can be found in Swartz et al. (1993). A caveat that one should keep in mind here is that the amount of charity care a "year-long" uninsured person receives (observed in the MEPS data that I present) may be somewhat higher than that received by a person during a shorter spell.

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Table 1
Uninsured out-of-pocket expenses: by income and by utilization[a]

Utilization	Percent of the uninsured (%)	Total utilization[b]	Out-of-pocket expense[b]	*Percent out-of-pocket* (%)
All income levels ($N = 17{,}725$)				
Mean value	n/a	923	336	36.4
Low income[c] ($N = 13{,}830$)				
Mean value	n/a	923	305	33.1
With no utilization	48.1	0	0	n/a
With US$ 0–250 utilization	24.7	99	76	76.7
With US$ 250–2500 utilization	20.6	809	525	64.9
With US$ 2500–10,000 utilization	5.0	5059	2313	45.7
With US$ >10,000 utilization	1.6	29638	3880	13.1
High income[c] ($N = 3895$)				
Mean value	n/a	923	412	44.7
With no utilization	44.6	0	0	n/a
With US$ 0–250 utilization	25.2	107	89	83.4
With US$ 250–2500 utilization	23.6	787	610	77.6
With US$ 2500–10,000 utilization	4.7	5061	3000	59.3
With US$ >10,000 utilization	1.9	24902	5483	22.0

Source: 1996–2000 Medical Expenditure Panel Survey household components.
[a] The sample includes all people under age 65 without private or public insurance for the entire year. Observations are weighted to be nationally representative.
[b] Amounts are in year 2000 US dollars.
[c] Low and high income are defined as having total family income below or above 300% of the federal poverty level.

the dollar value of all medical care consumed regardless of whether the provider received an actual payment.[6]

The first row of Table 1 shows results for total "insurable" expenditures of the uninsured using this MEPS data.[7] Somewhat surprisingly, the results indicate that the uninsured paid out-of-pocket only US$ 336 per year in year 2000 US dollars; this amount averages 36.4% of the total medical care they received.[8] I also split this sample to examine the effect of income on the provision of charity care to the uninsured. I express total family income as a

[6] For instance, an office visit provided to a low-income uninsured patient in which the physician did not actually bill the patient is also included in this definition of utilization. Likewise, the "full" value of a visit to a community health center offering a discounted fee to the uninsured is included, as well. However, "discounts" are relevant for a second reason, since the "list price" for most healthcare providers is in excess of what any patient would pay. Thus, I want to express this total utilization measure as the full payment that would be expected in the absence of any provision of charity care. I therefore define total utilization as 75% of the AHRQ-defined charge, making the assumption that the discount for individual patients is slightly smaller than the average group discount of 68% observed in the MEPS data for the insured sample.

[7] I examine only expenditures that are traditionally covered by private health insurance to focus on the difference in medical care if uninsured. Total expenditures in the MEPS data already exclude over-the-counter medicine and alternative care. I also exclude dental, vision, and chiropractor expenses.

[8] There is a large difference between the total utilization of the uninsured and the privately insured. While the annual utilization of the uninsured averages US$ 923, the annual utilization of the insured averages US$ 1416. While some of this discrepancy may be attributed to both adverse selection and moral hazard, this disparity between

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percentage of the U.S. Census poverty threshold by family size and split the sample below and above 300% of poverty; the median income for all household in the U.S. is roughly 300% of poverty, and the poverty threshold was US$ 13,738 for a family of three in 2000. Results for the low-income sub-sample are shown in the middle panel of Table 1, and results for the high-income sub-sample are shown in the bottom panel. As one might expect, both the magnitude of out-of-pocket expense and its proportion of total utilization are lower for the low-income uninsured—demonstrating that relatively more charity care is available to low-income people. The low-income uninsured on average pay for about one-third of the total medical care they received, while the high-income uninsured on average pay for almost one-half of the care they received.[9]

Table 1 also shows these values for low-income and high-income uninsured out-of-pocket spending, broken down by the magnitude of total utilization. These results indicate that while the *magnitude* of out-of-pocket expense increases as total utilization increases, the *proportion* paid out-of-pocket decreases considerably as utilization rises. For example, the low-income uninsured with non-zero utilization less than US$ 250 paid 76.7% out-of-pocket, while those with utilization between US$ 2500 and US$ 10,000 paid 45.7% out-of-pocket. For all levels of utilization, out-of-pocket expenses are lower for low-income uninsured than for high-income uninsured, with the biggest difference for those with the highest utilization; the low-income uninsured pay 13.1% out-of-pocket while these high-income uninsured pay 22.0%. Although less than 2% of the uninsured face such high utilization in a given year, an out-of-pocket expense of US$ 3880 is hardly trivial to a low-income person. Income for a single person at twice the poverty line would be about US$ 17,500, so this out-of-pocket expense would equal 22% of income. The purchase of private health insurance with an upper limit on out-of-pocket spending would lower this amount considerably. Nevertheless, this substantial amount of charity care available to the uninsured (relative to paying all out-of-pocket) is expected to provide a strong disincentive towards the purchase of private health insurance coverage.

I present the empirical test of this hypothesis in the following section. In Section 4.1, I review some related empirical studies. In Section 4.2, I outline my empirical framework, detailing the specification I use to measure the availability of charity care. In Section 4.3, I show the results from the model of the demand for insurance—particularly for four relevant sub-samples described below.

4. Estimating private insurance coverage

4.1. Related studies

Kunreuther et al. (1978) provide anecdotal evidence that the availability of charity reduces private insurance coverage; they observe that 30% of Americans lacking insurance

average total utilization implies that there probably exists some level of disutility associated with obtaining charity care such as stigma and queues, or perhaps an outright refusal of providers to supply care.

[9] More detail regarding the different types of medical providers supplying charity care to the uninsured and the type of reimbursement these providers do receive can be found in Herring (2000).

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Exhibit 9

Risks And Benefits In Health Care: The View From Economics

A model that gives clarity to the discussion of risk and can be relevant to designing social institutions to deal with risk.

by Mark V. Pauly

ABSTRACT: This paper discusses the meaning of the term *risk* from the economic perspective. It argues that some consumer decisions about insurance and the use of medical care are consistent with the economic model, but many are not. When decisions are inconsistent, real-world democratic governments' ability to intervene is limited by politicians' desire to please voters. The choice of incomplete insurance coverage in private markets is often said to present a case for governmental intervention, but the choice of insurance design in the Medicare drug benefit shows that the political process also may fail to select insurance that is optimal from an economic viewpoint. [*Health Affairs* 26, no. 3 (2007): 653–662; 10.1377/hlthaff.26.3.653]

The language we have come to use in describing health, health care, and medical spending sometimes gets in the way of clear thinking and sometimes reflects (without being explicit) quite different ways of thinking. There is no better example of this than the use of the term *risk*. Policy discussions talk about "trade-offs between the risks and benefits" of medical interventions, "pooling risk" through insurance, and "analyzing risk" in clinical decisions, often as if there were consensus on the meaning of the term *risk* but in reality using that single short word in a variety of ways.

It is probably fair to say that the most rigorous and careful analysis of risk in its multiplicity of meanings has been the province of economics and the associated disciplines of decision analysis and actuarial science. But policymakers and voters do not necessarily use the term in the same way as the experts do. Some of the difference is attributable to confusion or imprecision, which (in my judgment) has adversely affected policy making as people argue in different languages. Because economic models and theories cannot capture all that is relevant to human preferences and behavior, some of the differences reflect substantive contrasts in how choices and policies are viewed—psychologically, subjectively, but validly.

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In this paper I set out the economic views of risk, and I discuss where there is confusion and where we are uncertain—both because the analysis is complex and because a definitive model of actual or ideal behavior has yet to emerge. One obvious but important conclusion is that if people think and behave in ways different from the economic model, the outcome will, to some extent, be suboptimal from an economic perspective. What that would mean for practical public policy, however, is far from clear. I emphasize the approach most common in economics but most emphatically do not argue for its universal applicability, and I mention some other views.

The most fundamental characteristic of situations involving "risk" or "risks," in economics as in the dictionary, is the absence of certainty: when what will happen is not known beforehand for sure. In the achievement of health and the use of health care, risk is ubiquitous. I do not know what my health state will be in the future—what accident or illness might occur. If I am sick, I do not know for certain the outcome of treatments or medications; I hope for the best but realize that adverse side effects can happen. And from a financial perspective, I do not know what my medical bills will be.

Risks about health state, about the health outcomes of treatment, and about health care cost all usually bother middle-class people. It is not just that they do not like bad outcomes; rather, they do not like not knowing what the outcome will be. In a general sense, people prefer a surer thing to a "maybe"; they are "risk-averse." Uncertainty about health states and medical bills motivates the voluntary purchase of insurance that delivers money when bad events occur and takes money (in the form of premiums) when they do not. The risk of adverse treatment effects (which might also trigger medical bills) prompts demand for information about the trade-offs between these effects and benefits. Either situation also prompts a demand for regulation to ensure that insurance works properly and that trade-offs are appropriate.

There are three aspects of medical decisions under risk that are often misperceived: trade-offs in choices among procedures or medicines, opportunities for the voluntary purchase of market insurance, and proper decision making about both care and coverage.[1] In this paper I define *risk* or *risks* as necessarily involving uncertainty.

The Economic Model Of Actual And Ideal Decision Making

How do people generally make decisions in risky situations? How should they do so? The model that economists and decision theorists have traditionally used to answer these questions is the "expected utility" (EU) model.[2] It is important to recognize that like all theoretical models, this is at best a useful caricature describing general tendencies; it does not imply that literally everybody, every day, in every case uses this approach, that people even recognize that they think this way, or that it captures all of the influences on decisions. Its value is really comparative:

Does it do a better job of explaining or evaluating decisions in general than some other model, including the null hypothesis that people make choices at random?

There is considerable controversy about the EU hypothesis. It should not be regarded as the perfect truth, or the universal truth, but it is a place to start. Moreover, even when actual decisions are found not to fit this model, the judgment of whether that behavior is appropriate from a policy perspective is almost always made using this model as the normative benchmark.

Consider two different kinds of risky prospects. One has health status as the outcome (for example, future life-years); the other, money in the form of income minus health spending. We imagine that a typical person has a utility function that evaluates well-being depending on what actually happens: The outcome or "state of the world" with more life-years or more money left over after health expenses has more utility. The person also in some fashion attaches probabilities to each state; these estimates might come from statistics (50/50 for flipping a fair coin) or might just be a subjective guess.

The expected utility from a prospect of two outcome states is a weighted average of the utility in the two states, where the weights are the probabilities. So, for example, if one treatment would give a moderate level of life expectancy for sure while the other has the possibility of either complete cure or an unintended but serious adverse outcome (such as death), the person would decide what to do by comparing the sure utility from the first choice with the expected utility from the second and would select whichever is higher.

One other assumption that is usually made is that of diminishing marginal utility: The gain in utility from more life expectancy or more money to spend on things other than medical care is always positive but is larger if health is low or medical expenses are high. Given this assumption, we can conclude that people will prefer the certain prospect to the one with an equal expected or average value. For example, if under one treatment the chance of death (zero additional life-years) is 0.1 and that of normal life expectancy is 0.9, the person will prefer an alternative treatment that offers 90 percent of normal life expectancy with certainty. Uncertainty about treatment outcomes also translates into uncertainty about financial consequences. If the risky treatment has the higher expected utility, the person will prefer to fully insure the cost if the premium is 0.9 times the (probably low) cost of successful treatment plus 0.1 times the (probably very high) cost of treatment in case of an adverse outcome. How much more than this "average health" or "average cost" the person might be willing to experience and still prefer the same thing depends on how risk-averse the person is. There are differences on this preference parameter across people; some people are more willing to take chances for health or money than others are.

What does this model, highly simplified, tell us about choices and possibly about policy? As a general case, I discuss what are called "extreme events": low-probability, high-consequence events. Such an outcome might be the rare but se-

vere life-threatening side effect of a drug or device, or it might be the equally rare but spectacularly expensive treatment for an uncommon or uncommonly severe illness. Catastrophic treatment failures and catastrophic medical bills are things for which, in principle, correct decisions about risk are important, but they also are difficult for people to make and for policymakers to understand and control.

A Medical Treatment With Rare Side Effects

If the EU model is applied to a new treatment that has the potential for major improvement in life expectancy but also the chance of a fatal side effect, the person should choose the innovation, despite the chance of the catastrophic outcome, if the utility for the good outcome offsets the (negative) utility of the bad outcome by enough to make that choice better than the "moderately good" sure thing. But implementing this advice is difficult; knowing and understanding the probability of the bad effect and, even more, "appreciating" it can be a challenge. Even when probabilities are known statistically, people have problems understanding small probabilities and often set a near-zero probability to zero, thus ignoring it. Or sometimes they fixate on the adverse consequence and ignore the fact that it almost surely will not happen. The problem is even more severe when all anyone knows is that the bad outcome, although unlikely, could happen, but with what probability is anyone's guess. To the point, however, the decisionmaker will have to guess about some "subjective probability." The decisionmaker may, in a deviation from the EU model, attach an extra amount of disutility just because the probability is ambiguous.

It is obvious that there are values of benefits and probabilities that will make the innovative treatment the preferred one. Policy issues then are of two contrasting types: there may be concerns if the adverse outcome actually happens, but there may also be concerns that fixation on the adverse outcome causes people to choose the "safer" alternative, despite the very much greater average benefits from the riskier one.

In the first instance, it will be human nature, after the fact, to look for a cause on which to blame the bad outcome, even if its possibility and uncertainty were well known in advance. Of course, if such an explanation opens up a strategy to reduce the probability in a way that has more benefit than cost, this reaction will be salutary. But if not, it will be an understandable but undesirable waste of time. In the other case, excessive caution may lead to worse population health outcomes.

The policy goal here is the proper balancing of benefits and (true) risks. The approval process followed by the Food and Drug Administration (FDA) attempts to do this based on scientific evidence and scientific principles. But, according to the economic model, the former is necessarily incomplete, and the latter do not exist. The first part has some substance: Good information is better; better information (for example, from larger or longer trials) is best. The scientific way to compare risks and benefits is, to be charitable, quite unclear: How are risks and benefits to

be balanced, given the dependence of this balance, in the EU model, on the estimated probability of adverse outcomes, the dependence of the ideal choice on each person's utility function, and the likely interaction of probabilistic side effects and type of insurance? The utility function's form influences both the person's valuation of the adverse outcome and the degree of risk-aversion, neither of which are obvious subjects of scientific expertise at the FDA.

Criticisms of actual public policy or private decision patterns in this area can be interpreted as coming from the EU model. Some criticisms reflect the fact that citizens have different utilities for benefits, adverse outcomes, and the risk of both; there can be no judgment that is scientifically correct for all. Sellers of products, whether drug firms or health professionals, would be expected to take an optimistic view of net benefits of what they sell or do. Some consumer representatives think that the FDA has not been sufficiently appreciative of the possibility of adverse outcomes (a too-low subjective probability or a too-low valuation of the consequences), while others (primarily patient advocacy groups) think that it attaches excessively high values to adverse effects relative to the utility from positive health benefits made available as quickly as possible to those who have few alternatives. "Sufficiently" and "excessive" are the nonscientific, preference-related words here (even more elusive of meaning than "risk"). In the EU model, decisions cannot be based only on clinical or medical knowledge but depend in part on patients' preferences, about which the FDA has no great expertise. The real question is which (or whose) preferences should dominate.

Virtually any product will be too risky for the most risk-averse people, but any delay will be too long for many more willing to take a chance for a better average outcome. Some suggest that the regulatory process tends to overvalue avoiding adverse effects relative to delaying or preventing the emergence of beneficial outcomes.[3] The tendency to be politically cautious and to avoid the recriminations from bad outcomes (even ones based on a gamble with good prior odds) could further widen the deviation from the EU model.

But beyond predicting these general and unavoidable criticisms in a country in which people have different values, the EU model can do little more than offer a framework for classifying the things on which people may differ. It might suggest more explicit specification of that framework and more precise quantification of the parameters (of value and risk aversion) as a way of improving transparency and consistency.

Buying Insurance

The other application of EU theory is in choice of insurance coverage. A fundamental implication of the theory is that considering potential insurance coverage of two risky prospects with the same expected value, the person should attach more value to coverage of the lower-probability, higher-loss event. The intuitive reason: Sacrificing the premium to transfer dollars to the state in which the no-

insurance wealth would have been lower is to be preferred because then dollars will have higher marginal utility—"mean more to the unlucky person"—in that state than in the other. If we characterize these extreme events as those associated with catastrophic levels of expense, and if insurance comes with a premium that is close to the expected value, we can conclude that the person should prefer catastrophic coverage above all.

Do consumers seem to follow this model and its advice? To some extent they do. Inpatient hospitalization is a costly event, but it is a low-probability or rare event for "average risks" at any age. The proportion of such expense people have to pay out of pocket in the United States, even with a sizable uninsured minority, is only about 3 percent. By way of contrast, expense for dental care is lower on average but more likely (and also subject to some moral hazard). Here people have made choices that result in a much larger 44 percent paid out of pocket. Moreover, the great bulk of private insurance plans have good coverage of catastrophic costs, with upper limits in the hundreds of thousands or even millions of dollars.

In short, despite the complexity, confusion, and lack of confidence that are intrinsic to insurance choices, the pattern of coverage Americans choose seems quite consistent with the EU model. But there are different views than those based on this model, and those views sometimes lead to different perceptions and different choices. A good example, and one relevant to the specific policy question I discuss below, relates to efforts to design insurance coverage with lower premiums for lower-middle-income workers. The HR Policy Association, comprising benefits experts at major corporations, has designed some basic health insurance policies that can be offered at moderate premiums to currently uncovered workers (often new, temporary, or part-time workers). The hope is that these plans will be more attractive than being uninsured and will not require large employer contributions.

Focus groups were convened to provide information about what kinds of plans would be popular offerings. Consumers were asked, among a variety of plans with given premiums, what they most preferred. Catastrophic coverage (full coverage above a deductible) was not always the most preferred option. Based on this advice, the National Health Access Program offers a catastrophic option (major medical) but also other options that, after a modest deductible, cover the more likely ambulatory care services, while leaving the less likely (but much more expensive) hospital costs uncovered or moderately covered.[4] One rationale for a preference for the latter option, as suggested by research, is that people look at insurance as an investment, with the premium as the initial investment and benefits as the return.[5] In this view, a good investment would be one that a person would probably collect on (get a return from), whereas catastrophic coverage is not a good investment because it would rarely pay off.

This perspective is not consistent with the EU model, which actually views the best outcome as one where the person paid premiums but then was lucky enough almost never to get sick and so almost never to collect benefits, while still having

good protection should illness occur. More to the point, the expected utility under simple catastrophic coverage would be higher than that under the other kind of policy. It would therefore be common among analysts to suggest to policymakers that they attempt to correct these mistaken preferences, at least through guidance if not through regulation, and direct consumers toward the catastrophic plans that are better for them.

Example: Medicare Part D

Although the EU model says that people would prefer to use a given premium for catastrophic coverage, real people and real politics appear to have combined to frustrate the application of this advice in the public sector as well. In particular, the stylized form for the new middle-class Medicare drug benefit is not full (catastrophic) coverage above a deductible but rather is so-called doughnut coverage, with a modest deductible, then 75 percent coverage over a range of expenses, then 100 percent cost sharing (the "doughnut hole"), and finally a return to virtually complete catastrophic coverage.

Compared to traditional catastrophic coverage with a deductible, the politician-designers of Part D reduced coverage for people with high expenses (where, in theory, people would have gotten the most utility value from coverage) to offer rather generous coverage for people who happened to have low expenses (where, in theory, coverage should be less valuable), to provide most beneficiaries with a return on their premium. What was the attitude toward risk here, and what does it tell us about the relevance of the EU model? The simple answer to this question is that the comparative attractiveness of this design was the result of political catering to consumers' misperceptions.

The government did not play—or even try to play—the role of rational corrector of illogical consumer decisions. Rather, because of the need to please voters in a democracy, political leaders went along with and even endorsed a fundamentally incorrect view of insurance. This experience, in my mind, raises grave doubts about the general ability of democratically elected governments to intervene to prevent widespread mistakes about risk by consumers. The fundamental problem is that as long as consumers still think they are right, when they vote they will favor politicians who take positions that cater to their mistaken judgments. Government can limit things that most citizens agree are mistaken, but it cannot so easily limit things that most citizens are mistaken about.

Is there any way to explain the Part D design? One response is to surrender and accept citizens' preferences as given and legitimate: While the doughnut design does not fit the EU model, perhaps voters genuinely have different preferences about insurance—preferences that, as adults, they have a right to hold and to support politicians who hold them, too.

This is a logically consistent argument, but it is destructive to traditional policy analysis. It weakens the basis for judging large-scale choices of consumers as mis-

taken. If people can validly prefer insurance that exposes them to greater financial vulnerability, why not regard their other decisions, such as avoiding flu shots, as also fully rational reflections of special preferences involving some unusual likes and dislikes?

The argument that the Part D design is inconsistent with EU maximization is not completely bulletproof. In designing Part D, Congress set for itself a limit on total budgetary cost and the intent that beneficiary premiums should cover a quarter of this cost. If all Medicare beneficiaries had been of the same risk, the EU-maximizing design for the nonpoor would have been to buy catastrophic coverage with a deductible no larger than what the total premium (75 percent federal and 25 percent beneficiary) would buy.

But in reality, people are not of the same risk of outpatient drug expense. The existence of multiyear chronic illness treated with expensive drugs means that some people can confidently expect to get much more benefit than average from a given catastrophic policy, while others will expect much less. If the premium is the same for those high risks as for those who know themselves to be average or low risks, then low risks might decline catastrophic coverage even with a subsidy. One possibility—although not one advanced as part of the policy discussion—was that by offering some more up-front coverage that lower risks might expect to use, the plan might attract them.

An alternative and probably better way to prevent adverse selection would have been to provide catastrophic coverage for free. The budgeted subsidy would probably have been enough to offer a plan with a catastrophic threshold lower than that in the current plan. But perhaps the main rationale for the beneficiary premiums was itself political: to give the impression, despite the enormous subsidy, that the elderly were paying for their benefits and to maximize participation as evidence of support for the new benefit.

Whatever the precise political motivation, it is clear that the desire to offer insurance viewed as a profitable investment for many people shaped the design of this program. Finding the plan that maximized expected utility for the average beneficiary did not.

What Social Criteria?

Given the difficulty people have in understanding risk, much less dealing with it optimally, there might be a role for public policy. But it is far from clear how the objectives of that policy ought to be defined.

One possible definition is what we might call the "Man of the People" strategy. The policymaker should determine what strategy citizens would prefer—given their preferences for risk, their perception of the relevant probabilities, and their tastes and foibles—and then try to achieve that outcome. One problem with this approach is that citizens in unregulated markets could do this much as well as or better than government. The other problem is that these preferences might be

simply illogical, or wrong-headed, or harmful in the long run, and extending democracy to endorse reflection of citizens' mistakes might be hard to explain (much less to justify) as a policy goal.

Another perspective is frank paternalism, as advocated most recently by Richard Thaler and Cass Sunstein.[6] One problem here is that paternalists might well adopt a maximization of expected outcomes (for example, years of survival per capita) without regard to citizens' utilities and the values they imply for risk-aversion and the like.

The third approach is to force EU-maximizing outcomes on a reluctant public, based on the view that when outcomes are realized, this will maximize average utility after the fact (even if it might disappoint those unlucky enough to sustain no losses and therefore collect no benefits). A politician who is trusted might be able to pull this off, but it is a tall order.

Some Remedies

If citizens are confused by risk and have confused preferences that they try to foist on politicians, is policy condemned to an inefficient and unstable fate? Perhaps not. There might be strategies that even people with distorted or unusual preferences will support and yet represent a better outcome than simply doing what voters think they seem to want.

One example of such a strategy is the National Vaccine Injury Compensation Program. This program arose in part because different groups had very different views on the risks posed by pediatric vaccines. Some people believed that there was a high risk of side effects; others, that it was low. The strategy then was to levy what effectively was an excise tax on vaccine sales, use the proceeds to set up a trust fund, and pay claims for actual damages (on a no-fault basis). After an initial flurry of payments for previous injuries, the level of payments fell dramatically, and the trust-fund balance grew. Those who thought that adverse effects would be common turned out to be wrong. But the point is that those who thought side effects unlikely expected to get money back, and those who thought them likely felt that they were protected; both groups could agree with the proposal.

The second application is mutual insurance.[7] Suppose that consumers differ with actuaries or policymakers on their subjective judgment about the probability of loss. (If expected expenses vary across people, they must still all agree on who belongs in each expected expense category, but not on the expected loss in that category.) For example, many young people (especially males) now think that they will not need medical care, while actuaries see higher probabilities. These consumers will refuse to pay the actuarially based premiums; this group actually is the group most likely to decline to have insurance. But they might agree to contribute a payment to a young people's mutual insurance plan, in return for the promise that if they are right and are all low users, premiums will be refunded. Such a plan would agree to pay back "dividends" to policyholders if benefits pay-

outs are low; usually these payments are used to lower future premiums. Thus, young people who think that they rarely get sick should still be willing to join this plan as long as they know that the other insured people are like themselves and have the same risk as they—whatever that risk "really" is.

The EU economic model of private and public decision making under risk is far from perfect, either as a predictor of behavior or as a normative model. Yet it still seems to give some clarity in the discussion of risk and can be relevant to designing social institutions to deal with risk. Paradoxically, the more behavioral economics discovers cases where people act differently than the model would suggest, the more it might be called upon as a normative criterion for public policy. Even here there are limits in world of democratic public choice. Sometimes there are alternative designs that might not be as perfect as those from a perfect world of EU-maximizers but that can still be an improvement over muddling through with confused language and euphemistic slogans. The economic view might still help in dealing with risk in complex and complicated settings.

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NOTES

1. One source of error is in the language used to describe choices of medical therapies: "the trade-off between benefits and risks." The confusion arises because sometimes the word *risk* is really used as a synonym for adverse or undesired effects. Suppose a drug I might take for my allergies always and unequivocally in all patients does two things: It alleviates the symptoms of allergy, and it causes an unsightly rash. There is no uncertainty, no variation. The appropriate decision might still be ambiguous since it involves a trade-off between alleviated symptoms (for sure) and a red rash (for sure), and different people might value these outcomes differently. But there is no issue of risk.

2. C.E. Phelps, "Health Insurance," chap. 10 in *Health Economics*, 3d ed. (Boston: Addison Wesley, 2003), 318–365.
3. See S. Peltzman, "An Evaluation of Consumer Protection Legislation: The 1962 Drug Amendments," *Journal of Political Economy* 81, no. 5 (1973): 1049–1091, for a classic early statement of this view; see C.R. Sunstein, *Laws of Fear: Beyond the Precautionary Principle* (Cambridge, U.K., and New York: Cambridge University Press, 2005), for a more recent version.
4. National Health Access, "Limited Health Benefits" (table), http://www.nationalhealthaccess.com/ParticLM.aspx (accessed 9 February 2007).
5. H. Kunreuther, "Risk Analysis and Risk Management in an Uncertain World," *Risk Analysis* 22, no. 4 (2002): 655–664.
6. R.H. Thaler and C.R. Sunstein, "Libertarian Paternalism," *American Economic Review* 93, no. 2 (2003): 175–179.
7. M. Pauly, H. Kunreuther, and J. Vaupel, "Public Protection against Misperceived Risks: Insights from Positive Political Economy," *Public Choice* 43, no. 1 (1984): 45–64.

Exhibit 10

How Many People Lack Health Insurance and For How Long?

May 2003

The Congress of the United States ■ Congressional Budget Office

How Many People Lack Health Insurance and For How Long?

More than 240 million people in the United States have health insurance coverage today, through a variety of sources. The vast majority—about 63 percent—are covered through their, or a family member's, employer.[1] Government programs provide coverage to millions more people: about 14 percent have coverage through Medicare, 11 percent through Medicaid and the State Children's Health Insurance Program (SCHIP), and about 3 percent through military programs. Roughly 8 percent of people purchase coverage from private individual health insurers.[2]

Yet millions of people do not have health insurance coverage. For those people, extended periods without insurance could lead to insufficient access to medical care and exposure to significant financial risk. From a broader perspective, a lack of coverage could lead to less efficient use of health care services and facilities, including emergency rooms, and to higher public spending for health programs.

Policymakers have proposed alternatives for expanding health insurance coverage, including providing tax inducements to individuals or employers, expanding Medicaid and SCHIP, reforming rules regulating private insurance, and requiring employers to offer coverage.[3] Designing cost-effective policies to expand health coverage requires information on the size and characteristics of the uninsured population. Because many people gain and lose coverage over time, an important feature of uninsured spells is their duration.

This paper presents estimates of the size, demographic characteristics, and dynamics of the uninsured population, using data from four federally sponsored national surveys: the Current Population Survey (CPS), the Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), and the National Health Interview Survey (NHIS). Both the CPS and SIPP are sponsored by the Census Bureau, MEPS by the Agency for Healthcare Research and Quality, and NHIS by the Centers for Disease Control and Prevention. Each survey's strengths and limitations are described in Appendix A.

The Congressional Budget Office's (CBO's) analysis focuses on the nonelderly population because nearly all Americans age 65 and older are covered by Medicare. It excludes people in institutions (such as nursing homes and prisons) because they are not counted in the surveys. Active-duty military personnel are not included in the CPS, MEPS, and NHIS and thus are excluded from CBO's analysis of the data in those surveys, but the analy-

1. The federal government exempts employment-based health insurance, among other noncash benefits, from taxation, providing an incentive for the provision of employment-based insurance.

2. See Bureau of the Census, *Health Insurance Coverage: 2001*, Current Population Reports, Series P60-220 (September 2002). The estimates, based on self-reported data from the civilian noninstitutionalized population, are not mutually exclusive; people can be covered by more than one type of insurance in a year.

3. For a discussion of policy options for expanding health insurance coverage, see Congressional Budget Office, *Budget Options* (February 2001), pp. 40-52.

sis of SIPP includes active-duty military personnel, who are counted unless they live in military barracks.

Size of the Uninsured Population

In recent years, the number of uninsured people in the United States has been pegged at approximately 40 million, or about 16 percent of the nonelderly population. By CBO's analysis, that estimate overstates the number of people who are uninsured all year and more closely approximates the number who are uninsured at a point in time during the year. A more accurate estimate of the number of people who were uninsured for all of 1998—the most recent year for which reliable comparative data are available—is 21 million to 31 million, or 9 percent to 13 percent of nonelderly Americans.

The CPS is the source of that widely cited estimate of about 40 million uninsured. By interviewing people in March about their insurance coverage the previous calendar year, the CPS is intended to yield an estimate of the number of people who are uninsured all year. However, comparisons with estimates from other surveys indicate that the CPS estimate overstates that number. Some analysts believe the overstatement stems from an underreporting of insurance coverage by CPS respondents, who are asked to recall their coverage over a longer period than other surveys require.[4] Other analysts have concluded that the similarity of the CPS estimates to the point-in-time estimates from other surveys suggests that many CPS respondents report their insurance status as of the time of the interview rather than for the previous calendar year, as requested.[5]

In this paper, CBO uses three measures—the number of people who are continuously uninsured for an entire year, the number who are uninsured at any time during the year, and the number who are uninsured at a point in time—to gauge the size of the uninsured population. Because estimates based on the first two measures use survey data in which people are asked to remember their insurance coverage over a specified period, those data are more prone to reporting error. Point-in-time estimates are subject to less error because people are asked to report their insurance coverage at the time of the interview; however, those estimates do not distinguish between people who are uninsured for a long time and other uninsured people, and they do not reveal how fluid the uninsured population is. Together, the three ways of measuring the uninsured population give a more complete picture than any single measure could.

The Number of People Who Are Uninsured All Year

CBO estimated the number of people who are uninsured all year using data from SIPP and MEPS, two surveys in which respondents are interviewed multiple times over the life of the survey. (Such longitudinal surveys allow researchers to repeatedly observe a set of subjects over time.) SIPP interviews people every four months about their insurance coverage during the preceding four months (called a "wave"), while MEPS interviews people every four to five months, on average. By asking people to remember their insurance status over a shorter period of time than the CPS requires, SIPP and MEPS should yield more accurate estimates of the number of people who are uninsured all year.[6]

According to the most recent SIPP data, 9.1 percent of the nonelderly population (or 21.1 million people) were continuously uninsured throughout 1998 (*see Table 1*).[7] According to MEPS, the corresponding figures were 13.3 percent (or 31.1 million people). The discrepancy between those estimates could be due to various factors, including differences in the wording and sequencing of

4. Robert L. Bennefield, "A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP" (paper presented at the Joint Statistical Meetings, American Statistical Association, Chicago, Ill., August 6, 1996).

5. Katherine Swartz, "Interpreting the Estimates from Four National Surveys of the Number of People Without Health Insurance," *Journal of Economic and Social Measurement*, vol. 14 (1986), pp. 233-242.

6. SIPP and MEPS also have certain limitations, which are discussed in Appendix A.

7. These figures are based on analysis of data from the 1996 panel of the Survey of Income and Program Participation, which followed all respondents through July 1999. Because only a limited amount of data from the 2001 SIPP is now available, CBO's analysis does not rely on that version of the survey.

Table 1.

Percentage and Number of Nonelderly People Without Health Insurance in 1998 and 1999, Estimated from Four National Surveys

	Uninsured Nonelderly People			
	In percent		In millions	
	1998	1999	1998	1999
Uninsured All Year				
SIPP	9.1	n.a.	21.1	n.a.
MEPS	13.3	12.2	31.1	28.9
Uninsured at Any Time During the Year				
SIPP	24.5	n.a.	56.8	n.a.
MEPS	25.3	25.1	59.0	59.2
Uninsured at a Point in Time				
SIPP	16.6	15.7	40.5	38.5
MEPS	18.3	17.4	42.6	41.0
NHIS	16.5	16.0	39.0	38.3
CPS[a]	18.4	16.2	43.9	39.0

Source: Congressional Budget Office based on data from the 1996 panel of the Survey of Income and Program Participation (SIPP), the 1998 and 1999 Medical Expenditure Panel Survey (MEPS), and the March 1999 and March 2000 Current Population Survey (CPS). Estimates from the National Health Interview Survey (NHIS) are from the Centers for Disease Control and Prevention, "Early Release of Selected Estimates Based on Data from the 2001 NHIS," available at www.cdc.gov/nchs.

Note: n.a. = not available.

a. The CPS estimate is intended to measure the number of people who are uninsured for the entire year. However, there is considerable evidence that the CPS estimate overstates the number of people who are uninsured all year and is closer to the number of people who are uninsured at a point in time. About two-thirds of the reduction in the CPS estimate of the number of uninsured from 1998 to 1999 was due to the inclusion of an additional question in the survey that was designed to yield more-accurate estimates.

questions on health insurance coverage, data editing procedures, interviewers' training and knowledge about health insurance, and the period of time over which people were asked to recall their coverage.

Data from MEPS also indicate that the number of people who were uninsured all year fell from 31.1 million in 1998 to 28.9 million in 1999 (estimates from MEPS of the full-year uninsured are not available for more recent years). But recent trends in the CPS estimates—which are similar to the point-in-time estimates from SIPP, MEPS, and NHIS—suggest that the number of people who were uninsured all year probably remained relatively stable from 1999 to 2000 and then increased somewhat in 2001.[8] That conclusion is based on the fact that the full-year and point-in-time estimates of the uninsured are likely to move in a similar manner over time. More recently, the number who are uninsured all year probably has not changed substantially, given historical trends.

The Number of People Who Are Uninsured at Any Time During the Year

CBO's analysis of data from SIPP and MEPS indicates that about a quarter of the nonelderly population (or

8. According to the CPS, the number of nonelderly people who lacked health insurance rose from 39.6 million in 2000 to 40.9 million in 2001, after falling slightly the previous year.

about 57 million to 59 million Americans) was uninsured at any time during 1998 (*see Table 1*). According to MEPS, that measure remained essentially unchanged from 1998 to 1999. If the elderly were included in the analysis, the percentage of the population that was uninsured at any time during the year would have fallen to 22 percent.[9]

Analysis of SIPP and MEPS data also shows that the uninsured population is very fluid. According to data from SIPP, roughly 63 percent of the people who were uninsured at any time in 1998 lost coverage or gained coverage (or did both) at some point during the year.[10] The corresponding figure from MEPS was 47 percent, increasing to 51 percent in 1999.

The Number of People Who Are Uninsured at a Point in Time

Data from SIPP, MEPS, and NHIS yield similar estimates of the number of people who are uninsured at a given point in time.[11] The point-in-time estimates from those surveys, which are very similar to the CPS estimates, ranged from 39.0 million to 42.6 million uninsured in 1998, or from 16.5 percent to 18.3 percent of the nonelderly population (*see Table 1*). That range of estimates fell slightly in 1999, according to all four surveys. Taken altogether, the point-in-time estimates from SIPP, MEPS, and NHIS provide compelling evidence that the CPS overstates the number of people who are uninsured all year.

Although analyses of the uninsured typically focus on individual-level data, analyses at the family level provide a measure of the total number of families that are potential targets of policymakers' efforts to expand coverage. According to data from SIPP, approximately 26 million families had at least one person who was uninsured at a given point in time in 1998.[12] In 27 percent of those families, however, at least one person was insured. Such families represent a variety of circumstances, including those in which children are covered under Medicaid or SCHIP but parents are not or only some members are covered by an employment-based (or private nongroup) policy.

The relationship between the number of people who are uninsured at a particular point in time and the number who are uninsured all year appears to have not changed significantly—at least since 1992—although the evidence supporting that conclusion is limited. The most direct comparison of the two measures comes from a study of SIPP data that found that 14.8 percent of Americans (including the elderly) were uninsured at a point in time in 1992, while 7.6 percent were uninsured all year.[13] That nearly two-to-one ratio is echoed in the 1998 figures from SIPP,16.6 percent versus 9.1 percent. Indirect evidence that a similar relationship probably held in earlier years comes from studies (discussed below) showing that the duration of uninsured spells among the nonelderly population had a distribution similar to that found in this analysis.

9. Including military personnel and the institutionalized—all of whom are either insured or have access to medical care—would also reduce the percentage of the population that was uninsured at any time during the year, but by a much smaller amount than would be obtained by including the elderly. The magnitude of the reduction cannot be determined from available data; information is not available on the insurance status of people who spend part of a year in the military or an institution. However, such an analysis is possible when measuring insurance coverage at a point in time. Using data from SIPP, CBO estimates that including the military and the institutionalized in the analysis would reduce the percentage of nonelderly who were uninsured at a point in time in 1999 by about 0.1 percentage point.

10. Some 15.4 percent of the nonelderly population was uninsured for part, but not all, of 1998. Such people constitute 62.9 percent of the total nonelderly population that was uninsured at any time in 1998.

11. NHIS estimates are from Centers for Disease Control and Prevention, National Center for Health Statistics, "Early Release of Selected Estimates Based on Data from the 2001 NHIS" (released July 15, 2002).

12. Families are defined in this analysis as health insurance eligibility units, on the basis of eligibility rules of most private insurance plans. In households with two or more people, those rules were applied to identify all individuals who would be eligible for coverage under a family policy. This definition of families also includes single adults.

13. Bennefield, "A Comparative Analysis of Health Insurance Coverage Estimates."

The Implications of the Medicaid Undercount

The number of people who report that they have Medicaid coverage in population surveys is smaller than the number indicated by the program's administrative data. Less clear than the fact of the undercount itself, however, are its size and its implications for estimates of the uninsured.

Underreporting of Medicaid coverage could occur for various reasons. Some people might not report their coverage in a survey because of the stigma associated with participating in a public assistance program. Also, some people covered by Medicaid may mistakenly believe that they have another type of coverage, such as private insurance. That confusion may be most common among people enrolled in Medicaid managed care because such programs often use names designated by private plans or by a state's Medicaid agency that do not include the term "Medicaid."

According to one study, SIPP undercounts Medicaid enrollment relative to the administrative data maintained by the Centers for Medicare and Medicaid Services by about 12 percent to 15 percent.[14] CBO's analysis of data from MEPS indicates that that survey undercounts Medicaid enrollment by a similar amount. Those findings may imply that the number of nonelderly people who are enrolled in Medicaid at any time during the year could be undercounted in population surveys by about 4 million to 5 million.

Estimates of the size of the Medicaid undercount must be viewed with caution, however, because of limitations of the administrative data that are used as the benchmark.[15] Even if those estimates are correct, they do not necessarily imply a corresponding error in the count of the uninsured, because some Medicaid enrollees who do not report having Medicaid coverage may report another type of coverage. One study that matched Medicaid administrative records in Minnesota with a population survey conducted in that state found that the vast majority of Medicaid enrollees who did not report being covered by Medicaid reported another source of insurance.[16] As a result, the measured uninsurance rate was overstated by only about 0.3 percentage points. It is not known how those findings may be generalized to other states or other surveys.

Because of uncertainties about the size of the Medicaid undercount and its implications for estimates of the uninsured, CBO did not adjust its analysis to compensate for the undercount.

The Implications of Less-Than-Full Participation in Medicaid

Many people who are eligible for Medicaid do not participate in the program. Research estimates that about half of eligible nonparticipants have private coverage and half are uninsured.[17] For uninsured people who are eligible but not enrolled, Medicaid provides a form of conditional coverage. Such people can apply for Medicaid at the time they obtain care and receive retroactive coverage for their expenses.[18] Because of that provision, some policymakers view those people as insured. Others view them as uninsured because they may not realize that they are eligible for Medicaid and therefore may delay or avoid seeking medical care.

An estimated 2.9 million children were uninsured but eligible for Medicaid at a given point in time in 1994 (the most recent year for which estimates are available). That figure represents about one-third of uninsured children

14. John L. Czajka, *Analysis of Children's Health Insurance Patterns: Findings from the SIPP* (report submitted by Mathematica Policy Research, Inc., to the Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, May 1999).

15. The administrative data maintained by the Centers for Medicare and Medicaid Services are reported separately by each state and are subject to reporting errors. The "ever enrolled" estimates are intended to represent an unduplicated count of the number of people enrolled in Medicaid at any time during the fiscal year.

16. Kathleen Thiede Call and others, "Uncovering the Missing Medicaid Cases and Assessing Their Bias for Estimates of the Uninsured," *Inquiry*, vol. 38, no. 4 (Winter 2001/2002), pp. 396-408.

17. All estimates reported in this section are from Czajka, *Analysis of Children's Health Insurance Patterns*.

18. Jonathan Gruber, *Medicaid*, Working Paper No. 7829 (Cambridge, Mass: National Bureau of Economic Research, August 2000).

and about 17 percent of all children who were eligible for Medicaid. For many children, being eligible for Medicaid while uninsured is a short-term phenomenon. Many such children are in transition from one source of coverage to another (for example, from private insurance to Medicaid), and others are eligible for Medicaid for a short period because of a temporary decline in family income. Even so, an estimated 1 million children remained uninsured all year in 1994 even though they were eligible for Medicaid.

Demographic Characteristics of the Uninsured Population

Education and income level are closely tied to the likelihood of being uninsured. According to data from SIPP, 25 percent of people in families in which no one had a high school diploma were uninsured all year in 1998, and 50 percent were uninsured at any time during the year (*see Table 2*). Similar percentages of people in families with income below 200 percent of the poverty level were uninsured in 1998. Hispanics had a higher rate of being uninsured all year in 1998 than other racial and ethnic groups (23 percent), and young adults ages 19 to 24 were more likely than people in other age groups to be uninsured all year (14 percent).

The likelihood of being uninsured does not vary greatly by self-reported health status. According to SIPP data, about 10 percent of people who said they were in poor health were uninsured all year in 1998; that figure is similar to the percentages of people in excellent or very good health who lacked insurance coverage all year.[19] Because individuals in poor health constitute a relatively small proportion of the total nonelderly population, they accounted for only 5 percent of the full-year uninsured in 1998. As a group, however, they may be of particular concern to policymakers because they are likely to be the greatest users of health care services.

Nearly 90 percent of the people who were uninsured all year in 1998 were in families in which at least one person worked, either part time or full time (*see Table 2, column 3*). Research has found that about 75 percent of the uninsured in working families do not have access to insurance through their employer, the dominant form of coverage among the nonelderly, while the other 25 percent have access to employment-based insurance but do not accept it.[20] Lower-wage workers are less likely than higher earners to have access to employment-based insurance and are less likely to accept it where it is offered.[21]

Dynamics of the Uninsured Population

CBO's analysis of SIPP data reveals that although many uninsured spells are relatively short, some are quite long. Many people who become uninsured are in transition from one source of coverage to another (for example, because of a waiting period for coverage at a new job), so their uninsured spells are relatively brief.

The Duration of Uninsured Spells

CBO measured the duration of uninsured spells in two ways. First, it estimated the duration of spells that began during the 12-month period from July 1996 through June 1997.[22] Because new spells closely approximate a representative sample of all uninsured spells, they provide the most reliable basis for estimating durations.[23] Second, because policy discussions often refer to the uninsured

19. Information on health status was collected in interviews between August 1997 and November 1997. Survey respondents were at least 15 years of age.

20. Sherry Glied, "Challenges and Options for Increasing the Number of Americans with Health Insurance," *Inquiry*, vol. 38, no. 2 (Summer 2001), pp. 90-105.

21. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, vol.16, no. 6 (November/December 1997), pp.142-149.

22. CBO also estimated the duration of uninsured spells that began during other periods—for example, during each month within the July 1996-June 1997 period and during the 24-month span from July 1996 through June 1998. Similar results were obtained for all of those periods.

23. Katherine Swartz, John Marcotte, and Timothy D. McBride, "Spells Without Health Insurance: The Distribution of Durations When Left-Censored Spells Are Included," *Inquiry*, vol. 30 (Spring 1993), pp. 77-83.

Table 2.

Nonelderly People Without Health Insurance in 1998, by Selected Characteristics

(In percent)

Characteristic	Nonelderly People: Uninsured at Any Time During the Year	Nonelderly People: Uninsured All Year	Distribution of the Population Uninsured All Year
Age			
Less than 19	26.8	7.3	24.9
19 to 24	41.9	14.4	13.7
25 to 34	31.1	12.3	21.9
35 to 44	20.2	9.3	19.7
45 to 54	15.1	7.6	12.6
55 to 64	14.0	6.7	7.2
Race/Ethnicity			
White, Non-Hispanic	18.4	6.3	48.4
Black, Non-Hispanic	33.4	10.7	15.3
Hispanic	47.4	22.5	30.8
Other	31.1	10.9	5.5
Family Income Relative to the Poverty Level[a]			
Less than 200 percent	47.9	19.5	74.9
200 percent to 399 percent	17.4	5.3	19.8
400 percent or more	6.0	1.6	5.3
Education[a,b]			
No high school diploma	50.4	24.6	28.4
High school graduate	33.1	12.7	36.4
Some college coursework	22.1	7.3	26.6
Bachelor's degree or higher	9.9	2.6	8.7
Family Employment Status[a]			
At least one full-time worker all year	15.0	5.9	42.9
Part-time or part-year work only	46.1	16.1	46.6
No work	32.8	13.1	10.6
Health Status[c]			
Excellent	23.7	8.9	28.8
Very good	25.1	9.3	32.8
Good	24.6	9.1	24.5
Fair	25.1	8.7	8.9
Poor	25.3	10.3	5.1
Memorandum:			
Total Nonelderly Population	24.5	9.1	100.0

Source: Congressional Budget Office based on data from the 1996 panel of the Survey of Income and Program Participation.

a. For family-level variables, families are defined as health insurance eligibility units, which are composed of individuals who could be covered as a family under most private health insurance plans.

b. Education is defined as the highest education level among all adults in the family.

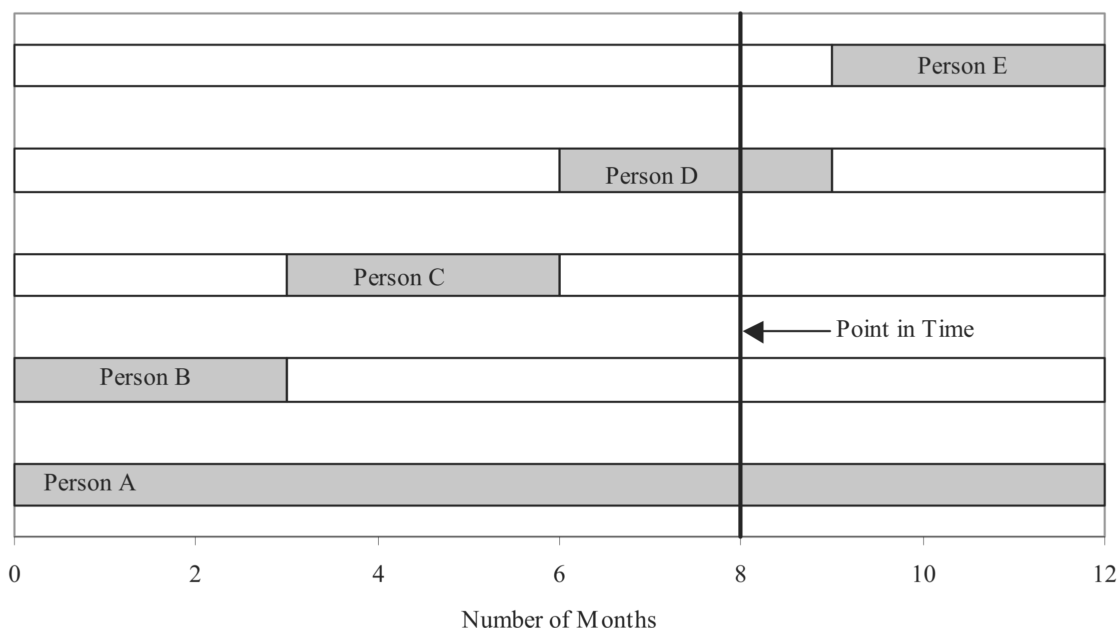
c. Information on health status was collected only for survey respondents who were at least 15 years of age.

Box 1.

Two Approaches to Measuring Uninsured Spells

Consider five people who become uninsured at some time during a year. Person A becomes uninsured in January and is uninsured for the entire year. The other four people are each uninsured for three months, the first from January through March, the second from April through June, and so on (*see figure, below*). If the duration of uninsured spells is measured by including all spells that begin during the year, 20 percent (one of five) last 12 months and 80 percent (four of five) last three months. If, instead, durations are measured by including only spells that are in progress at a particular point in time, 50 percent (one of two) last 12 months and 50 percent last three months. The first approach measures the duration of all uninsured spells that begin during the year, while the second approach characterizes spells at a given point in time.

Duration of Uninsured Spells



population at a given point in time, CBO estimated the duration of spells among people who were uninsured in a given month. The first measure captures the *flow* of uninsured spells over time, while the second captures the *stock* of uninsured spells at a point in time. The two measures yield very different estimates of durations (*see Box 1*).

New Spells. Forty-five percent of the uninsured spells that began between July 1996 and June 1997 lasted four months or less, whereas about 16 percent lasted more than 24 months (*see the top panel of Table 3*). Those figures correspond to estimates obtained by other researchers using SIPP data from 1983 to 1986 and 1992 to 1994.[24] Children under 19 were more likely than

24. Katherine Swartz and Timothy D. McBride, "Spells Without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry*, vol. 27 (Fall 1990), pp. 281-288; and Czajka, *Analysis of Children's Health Insurance Patterns*. The unemployment rate was much higher during the years covered by those studies, indicating that the duration of uninsured spells has not varied much with changes in economic conditions.

Table 3.

Distribution of Uninsured Spells by Duration and Age

(In percent)

Duration of Uninsured Spell	Total Nonelderly Population	Children	Adults
Spells That Began Between July 1996 and June 1997			
Four Months or Less	44.5	49.3	41.0
Five to 12 Months	26.2	25.2	26.9
13 to 24 Months	13.4	11.8	14.5
More Than 24 Months	15.9	13.7	17.6
Spells in Progress in March 1998[a]			
Four Months or Less	7.9	12.9	5.6
Five to 12 Months	14.4	19.3	12.3
More Than 12 Months	77.8	67.8	82.0

Source: Congressional Budget Office based on data from the 1996 panel of the Survey of Income and Program Participation.

Notes: Children are defined as people under 19 years of age, adults as people ages 19 through 64.

Appendix B explains the consistency of the two sets of estimates given in this table.

a. The estimates for spells in progress in March 1998 measure the total duration of such spells, looking backward and forward in time (the observation period extended through July 1999). Similar estimates were obtained for other months.

adults to have short uninsured spells. Forty-nine percent of the spells experienced by children lasted four months or less, compared with 41 percent for adults.

A potential limitation of measuring durations from a sample of new spells is that people who are uninsured for a long time may be underrepresented. By definition, analyses of new spells focus on spells for which a starting point can be observed. Spells that were in progress at the start of SIPP's observation period (so-called left-censored spells) are excluded, so individuals who were uninsured throughout the entire period are excluded from the calculation of durations.[25] Previous research suggests, however, that excluding left-censored spells does not dramatically alter the results of the analysis.[26]

Spells in Progress at a Point in Time. Compared with the duration of new spells, the duration of those in progress at a given point in time is much more likely to be relatively long. More than three-quarters of the uninsured spells in progress in March 1998 exceeded 12 months, whereas only about 8 percent lasted four months or less (*see the bottom panel of Table 3*). Those estimates measure the total length of the spells in progress in March 1998, looking backward and forward in time. Similar estimates were obtained for other months.

Although estimates of the duration of new spells and spells in progress in a particular month differ dramatically, they simply represent alternative ways of looking at the uninsured population. Nearly half of all new spells end within four months; over time, as those shorter spells end and longer spells remain in effect, the stock of uninsured spells at a given point in time has a relatively high proportion of long spells. Looked at another way, a par-

25. Four percent of the people in SIPP's sample were uninsured throughout the entire 41-month observation period.

26. See Swartz, Marcotte, and McBride, "Spells Without Health Insurance." Using sophisticated econometric methods in an analysis of data from the 1984 SIPP panel, the authors estimated that including left-censored spells reduced the share of spells that lasted five months or less from 50 percent to 48 percent and increased the share of spells that lasted more than 24 months from 15 percent to 19 percent. The median duration increased from six months to seven months. Those findings indicate that long-term uninsured people are underrepresented among new spells, but not by enough to invalidate the basic conclusions of analyses that focus solely on new spells.

ticular long spell is more likely to be in progress at a given point in time than a particular short spell. (Appendix B demonstrates the consistency of the two sets of estimates in Table 3.) The analysis in the rest of this paper focuses on new spells, because they more accurately represent all uninsured spells.

Characteristics Associated with the Duration of Uninsured Spells

The duration of spells varies with education level, race/ethnicity, and income of the uninsured. People with less education are more likely than higher-educated people to experience long uninsured spells. Some 23 percent of spells among people in families in which no one graduated from high school last more than two years, compared with a figure of only 8 percent among people in families in which at least one person has a bachelor's degree (*see Table 4*). That relationship probably reflects, at least in part, the fact that college-educated people are more likely than those with less education to have access to employment-based insurance.[27] Long uninsured spells are also more common among Hispanics and people with low income.[28] For example, 23 percent of uninsured spells among Hispanics last more than two years, compared with 14 percent of spells among non-Hispanic whites and 15 percent among non-Hispanic blacks. Eighteen percent of uninsured spells among people with annual income of less than 200 percent of the federal poverty level exceed two years, about two-thirds higher than the figure for people whose income is 400 percent or more of the poverty level.

The duration of uninsured spells does not vary much with self-reported health status. For instance, 14 percent of uninsured spells among people in poor health last more than two years, nearly the same percentage of spells as among people reporting very good health. By keeping some people from working full time, however, poor health may contribute to long uninsured spells. Those spells may be of particular concern from a policy perspective because such people are likely to be intensive users of health care services.

As noted previously, adults are more likely than children to experience long uninsured spells. The availability of Medicaid coverage may explain some of that discrepancy: coverage is available to many children in low-income families, but the great majority of low-income adults are not eligible for the program. In addition, single adults without children may be less inclined to seek insurance, on average, than other adults are, which may lead them to experience long spells without insurance.[29]

Multiple Spells and Total Uninsured Months

While the preceding analysis looked only at people who had one uninsured spell, to obtain a more complete picture of the uninsured this section looks at whether many uninsured people have multiple spells. The subsequent experience of people whose initial uninsured spell was relatively short is of particular interest. Did most of those people have a single uninsured spell? Or did many of them have additional spells, perhaps experiencing substantial periods without coverage?

To investigate those issues, CBO analyzed data from the 1996 SIPP panel, following people who had one unin-

27. Higher-wage workers are more likely to be offered employment-based insurance, and wages are highly correlated with education. For evidence of the relationship between wages and the likelihood of being offered employment-based insurance, see Cooper and Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance."

28. For this analysis, family income relative to the poverty level was defined as the mean value during the four months before the uninsured spell began. The intent was to classify families on the basis of their income before they experienced any reduction in income that may have accompanied the uninsured spell. Such an income reduction may have been temporary for many families but longer-lasting for others. The income measure was intended to reflect, for many families, their longer-term economic circumstances. The analysis was also conducted using a second income measure, defined as the mean family income relative to the poverty level during the first four months of the uninsured spell (or during the entire spell if it ended within four months). The second measure captures any changes in families' economic circumstances that occurred around the time the uninsured spell began. Estimates using the second measure (which this paper does not present) are similar to the estimates in Table 4.

29. That conclusion is supported by analysis conducted for this study (but not reported in detail here), which found that after controlling for differences in age, race/ethnicity, education, and income relative to the poverty level, single adults without children were much more likely than other adults to experience long uninsured spells.

Exhibit 11

WHO ARE THE UNINSURED?

An Analysis of America's Uninsured Population, Their Characteristics and Their Health

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premium costs and in the immigrant population will lead to an increase in the uninsured. Long term planning for increasing insurance coverage should take these trends into account.

Regarding the responsiveness of the purchase of private insurance to the cost of an insurance premium, either by the individual directly or through his or her employer, we find a significant demand elasticity for individuals who are not married and have no children, but not for married couples with children, who tend to have a higher level of private insurance and respond less to changes in its cost. With regard to non-cost factors, we find that educational attainment and immigrant status are the two most important determinants, other than income, of the probability a family or individual has private insurance coverage.

We now turn to the issue of the extent to which uninsured persons use medical care resources.

Health Resources Obtained by The Uninsured

Two types of measures are available for estimating the amount of healthcare resources obtained by the uninsured. One is based on answers to specialized health surveys that ask questions about the types of medical care services received over particular time periods. Answers to those questions can be derived for the insured and separately for the involuntarily and voluntarily uninsured. A second type of measure is based on estimates of the dollar cost of all types of medical care services received by the uninsured that are either paid for by the uninsured ("out of pocket") or are provided without charge by what has come to be called the "safety net"—various public and private charities as well as uncompensated care provided by hospitals and physicians. The data concerning the "safety net" that we use here are available for the uninsured as a whole, but some inferences can be drawn about the differences between the voluntarily and the involuntarily uninsured.

Medical Services Received by the Uninsured

We use data from the 2005 Medical Expenditure Panel Survey (MEPS) to measure the receipt of various medical services by adults classified according to insurance status. The MEPS concept of the uninsured is similar to that used by the CPS—namely, individuals who were not covered by insurance at any time in the year before they were interviewed. A summary of the results is shown in Table 9. We show the results by age and specify the time periods when the service was received.

There are large differences between the insured and uninsured in the percent receiving particular services when the comparison is restricted to services received in the past two years. However, the differentials become smaller when the receipt period is measured within the past five years (the sum of the past two years and prior 3–5 years) and are smaller still when the comparison is for those who have "ever received" the service. Thus, 78 percent of the insured population had a routine check-up in the past two years compared to 50 percent of the uninsured, and the comparison narrows to 88 percent versus 68 percent when the period of receipt is within 5 years and 95 percent versus 84 percent when it is extended to "ever received". (Of course, for many procedures "ever" may be too long ago to be meaningful.)

When it comes to cancer screening, 80 percent of insured women ages 40–64 had a mammogram within two years of the interview; and 87 percent when the period of receipt is extended to 5 years. That compares to 49 percent of uninsured women who had a mammogram within two years and

[10] See Table 8 in O'Neill and O'Neill (2007), which provides comparisons of cancer screening in Canada and the U.S.

65 percent when the period is within 5 years. However, those screening rates are relatively high even for uninsured women when compared with screening rates in Canada, a country with universal health coverage. The Canadian health survey reports that 65 percent of Canadian women ages 40–69 had a mammogram within the past 5 years, the same percentage as uninsured women in the U.S.[10] When it comes to Pap Smears, Canadian women also have about the same rate of screening over the past five years as uninsured women in the U.S. (80 percent), although those rates are below those of insured American women, among whom 92 percent were screened. Among U.S. men ages 40–64, 52 percent of those with insurance were screened for prostate cancer with a PSA test within the past 5 years, compared to 31 percent for men who are uninsured. (In Canada, the comparable percent is 16 percent.)

TABLE 9. Percent Received Selected Medical Services by Insurance Status and Age, MEPS 2005

	Insured all 12 months	Uninsured all 12 months		
		Total	*Involun.*	*Volun.*
Ages 18-64				
Routine Check-Up				
% ever received routine check-up	95.08	84.08	83.74	84.47
Past 2 years	78.40	50.43	48.54	52.62
3–5 years ago	9.42	17.16	18.28	15.86
Blood Pressure Check				
% ever received blood pressure check	99.29	93.78	94.69	92.74
Past 2 years	93.17	71.79	72.36	71.14
3–5 years ago	4.33	14.39	14.91	13.78
Flu Shot				
% ever received flu shot	48.52	29.79	29.25	30.42
Past 2 years	34.96	17.05	15.29	19.07
3–5 years ago	7.25	5.31	5.86	4.69
Ages 20-64				
PAPSMEAR TEST ***(Women only)***				
% ever received PapSmear Test	97.69	93.14	92.41	94.14
Past 2 years	83.84	62.81	58.95	68.04
3–5 years	8.04	17.23	17.45	16.95
Ages 40-64				
PSA TEST ***(Men only)***				
% ever received PSA Test	55.00	35.99	34.23	37.71
Past 2 years	46.32	24.02	23.72	24.32
3–5 years	5.41	6.71	6.12	7.29
MAMMOGRAM ***(Women only)***				
% ever received mammogram	91.26	76.15	66.66	86.86
Past 2 years	79.83	49.25	38.03	61.94
3–5 years	7.32	15.96	16.76	15.04

Note: Calculation excludes the small percentage that did not report whether they received the service or not.
Source: MEPS 2005

Table 9 also shows the same statistics on service receipt separately for the involuntarily and voluntarily uninsured. Generally speaking, we find no significant differences in the percent receiving the service between the two groups. The main exception is the higher rate of recent receipt of mammograms and pap smears by voluntarily uninsured women. As we show in (Table 12), the voluntarily uninsured not only have higher incomes than the involuntarily uninsured, but also have more education and other characteristics associated with good health, all of which may account for that difference.

Early detection of cancer is important for cancer survival. In international comparisons of 5-year relative survival rates for specific cancers, the U.S. comes out at the top, and undoubtedly, the generally high rate of screening in the U.S. helps to account for that ranking.[11] It is important to determine the extent to which the lower rates of screening of the uninsured, particularly of the involuntarily uninsured, are due to inability to pay, or if other factors, such as lack of information about available free services are more significant.

To summarize, the results in Table 9 show that for the services detailed, the uninsured receive about 50 to 60 percent of the amount of services received by those who are insured.

Estimates of the Total Cost of Resources Obtained by the Uninsured

Table 9 compared discrete types of health services received by persons with and without health insurance and also compared the services received by the involuntarily and voluntarily uninsured. In Table 10, we provide estimates of the per capita dollar costs of all medical care resources received in 2008 by the uninsured using the estimates of Hadley, and Holahan, et al. (2008a, 2008b) (hereafter "Hadley and Holahan"). This is a more comprehensive metric than the comparison of discrete types of care presented above. Table 10 is based on data from the MEPS survey. An alternative approach to measuring uncompensated care uses reports of costs incurred by various public and private organizations that target the uninsured—components of the so-called "safety net" and we discuss that as well.

Hadley and Holahan have estimated the total cost of medical resources utilized by the uninsured in 2008 using pooled data from the MEPS surveys of 2002 and 2004 and then inflating these estimates to 2008 dollars.[12] MEPS reports data on medical services consumed by individuals collected both from the individuals and from the doctors and hospitals from which they obtained the services. The doctors and hospitals also provide MEPS with data on their charges for various services. Doctors and hospitals are reimbursed by out-of-pocket expenditures from patients and by payments from insurance companies. Data on these reimbursement payments are also provided to MEPS.

As shown in Table 10, the estimated per capita amount paid out-of-pocket by those uninsured for a full year was projected to be $644 in 2008. In addition, the uninsured received care that was paid for by private and public sources. Those amounts on a per capita basis were estimated to be $276 from public sources and $317 from private sourc-

[11] See O'Neill and O'Neill (2007) for comparison of the U.S. and Canada and a summary of results of the EUROCARE-4 Working Group, comparing cancer survival in Europe and the U.S. and showing the higher ranking of the U.S. Also see Verdeccia et al., 2007–for a detailed account of the EUROCARE-4 Working Group's results on cancer survival in the U.S. compared to European countries.

[12] The estimates reported here are based on a major study of medical costs and sources of reimbursement conducted by Hadley, and Holahan, et al. for the Kaiser Family Foundation (2008a). Their complete results for 2008 are provided in their report to the Foundation in August 2008.

es per capita. The uninsured also received medical services that were "implicitly subsidized" and were estimated to add another $589 per capita. (Implicitly subsidized care is care received by the uninsured from indirect revenue sources that MEPS could not identify.) When we add up the cost of care received by the uninsured from all sources other than their own out-of-pocket payments, we get a total of $1,182 per capita for 2008. When out-of-pocket spending is included, the total dollar amount of care received by the uninsured from all sources comes to $1,825.

Medical spending on those who were privately insured for a full year is also shown in Table 10 and we can see that the total amount per capita was estimated to be $4,639 for 2008, about $2,800 more than the amount received by the uninsured. Thus, the uninsured receive about 40 percent of the health resources received by those with private insurance. The uninsured spend out-of-pocket about 80 percent as much as the privately insured, but subsidies and uncompensated care accounts for the majority of their health spending.

In the same study, Hadley and Holahan also provide alternative estimates of the uncompensated care component of medical resources obtained by the uninsured from data on individual components of the "safety net." They report on uncompensated care for the uninsured that flows through hospitals and physicians' offices, and through a variety of types of clinics and direct care programs. The largest direct care program is the Federally Funded Health Centers operated by the Health Resources and Services Administration of the Department of Health and Human Services. They find that the estimate of total uncompensated care based on expenditure data from those sources nearly equals the estimate based almost fully on MEPS data.

Although Hadley and Holahan do not distinguish between the voluntarily and involuntarily uninsured, it is likely that the per capita amounts received by the involuntarily uninsured, especially of uncompensated care, are significantly higher than those received by the voluntarily uninsured. Most of the safety net providers target their assistance not only by insurance status, but also by

TABLE 10. Estimated Medical Spending Per Capita by Insurance Status and Source of Payment, Projected to 2008, for Persons Ages 19–64

	Uninsured *(Full-Year)*	Privately Insured *(Full-Year)*
Per capita spending	1,825	4,639
Source of payment		
Out-of-pocket	644	777
Private insurance	0	3,551
Medicare	0	23
Medicaid	0	28
Other Public[1)]	276	224
Other Private[2)]	317	36
Implicitly Subsidized[3)]	589	0

[1)] Includes Veterans Health Administration, TriCare, other federal, other state, and local, other public, and workers' compensation.

[2)] Includes other private and other sources.

[3)] Implicitly subsidized care is care received by the uninsured that is subsidized by indirect revenue sources not measured by MEPS and imputed by Hadley, et al. (August 2008).

Source: Estimates are based on projections by Hadley, et al., in *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage*. Prepared for the Kaiser Commission, Henry J. Kaiser Family Foudation, August 2008, see Table 1c.

Exhibit 12

Health, United States, 2009

With Special Feature on Medical Technology

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

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Table 80 (page 1 of 3). Health care visits to doctor offices, emergency departments, and home visits within the past 12 months, by selected characteristics: United States, 1997, 2006, and 2007

[Data are based on household interviews of a sample of the civilian noninstitutionalized population]

	Number of health care visits[1]											
	None			*1–3 visits*			*4–9 visits*			*10 or more visits*		
Characteristic	*1997*	*2006*	*2007*	*1997*	*2006*	*2007*	*1997*	*2006*	*2007*	*1997*	*2006*	*2007*
	Percent distribution											
Total, age-adjusted[2,3]	16.5	17.2	16.4	46.2	46.9	47.2	23.6	23.1	23.6	13.7	12.8	12.8
Total, crude[2]	16.5	17.2	16.3	46.5	46.8	47.1	23.5	23.1	23.7	13.5	12.9	12.9
Age												
Under 18 years	11.8	10.9	10.3	54.1	57.2	57.0	25.2	24.6	25.5	8.9	7.3	7.2
Under 6 years	5.0	4.9	6.2	44.9	50.6	48.3	37.0	34.8	35.8	13.0	9.7	9.7
6–17 years	15.3	13.8	12.4	58.7	60.5	61.4	19.3	19.6	20.3	6.8	6.1	6.0
18–44 years	21.7	25.3	24.1	46.7	45.8	46.3	19.0	17.8	18.4	12.6	11.0	11.2
18–24 years	22.0	25.3	24.9	46.8	47.2	46.9	20.0	17.4	18.1	11.2	10.2	10.1
25–44 years	21.6	25.4	23.9	46.7	45.3	46.1	18.7	17.9	18.5	13.0	11.4	11.6
45–64 years	16.9	16.4	14.9	42.9	44.3	45.3	24.7	23.6	23.9	15.5	15.7	15.9
45–54 years	17.9	18.5	16.8	43.9	46.1	47.1	23.4	21.8	21.2	14.8	13.6	14.9
55–64 years	15.3	13.5	12.3	41.3	41.9	43.0	26.7	26.1	27.6	16.7	18.5	17.2
65 years and over	8.9	6.0	7.0	34.7	33.2	33.1	32.5	36.2	36.2	23.8	24.6	23.6
65–74 years	9.8	6.7	8.4	36.9	34.6	35.4	31.6	36.6	36.0	21.6	22.1	20.3
75 years and over	7.7	5.3	5.5	31.8	31.5	30.6	33.8	35.7	36.4	26.6	27.6	27.5
Sex[3]												
Male	21.3	22.8	21.3	47.1	46.8	47.3	20.6	20.0	20.9	11.0	10.4	10.5
Female	11.8	11.8	11.5	45.4	46.8	47.1	26.5	26.2	26.3	16.3	15.2	15.1
Race[3,4]												
White only	16.0	17.2	16.2	46.1	46.2	46.8	23.9	23.4	24.0	14.0	13.2	13.0
Black or African American only	16.8	16.0	15.5	46.1	49.2	48.4	23.2	23.3	23.4	13.9	11.5	12.7
American Indian or Alaska Native only	17.1	13.5	21.5	38.0	44.2	43.1	24.2	27.6	21.5	20.7	14.7	13.9
Asian only	22.8	21.9	22.0	49.1	51.3	48.9	19.7	18.1	19.9	8.3	8.7	9.2
Native Hawaiian or Other Pacific Islander only	- - -	*	*	- - -	*	*	- - -	*	*	- - -	*	*
2 or more races	- - -	16.3	13.0	- - -	44.8	45.4	- - -	21.3	24.1	- - -	17.6	17.5
Hispanic origin and race[3,4]												
Hispanic or Latino	24.9	27.1	25.2	42.3	43.0	44.6	20.3	19.6	20.3	12.5	10.3	9.9
Mexican	28.9	31.1	28.0	40.8	40.8	42.9	18.5	18.3	19.5	11.8	9.8	9.6
Not Hispanic or Latino	15.4	15.4	14.7	46.7	47.6	47.7	24.0	23.7	24.2	13.9	13.2	13.4
White only	14.7	15.0	14.1	46.6	46.9	47.4	24.4	24.2	24.8	14.3	13.9	13.7
Black or African American only	16.9	15.7	15.1	46.1	49.5	48.6	23.1	23.4	23.5	13.8	11.4	12.8
Respondent-assessed health status[3]												
Fair or poor	7.8	12.2	9.4	23.3	21.2	25.4	29.0	28.1	29.5	39.9	38.6	35.7
Good to excellent	17.2	17.8	17.1	48.4	49.3	49.6	23.3	22.8	23.2	11.1	10.1	10.1
Percent of poverty level[3,5]												
Below 100%	20.6	21.0	19.3	37.8	39.5	39.5	22.7	22.3	23.3	18.9	17.2	18.0
100%–less than 200%	20.1	21.6	20.5	43.3	43.5	42.1	21.7	21.5	23.3	14.9	13.3	14.0
200% or more	14.5	15.2	14.6	48.7	49.3	50.0	24.2	23.7	23.7	12.6	11.9	11.7

See footnotes at end of table.

Click here for spreadsheet version

Table 80 (page 2 of 3). Health care visits to doctor offices, emergency departments, and home visits within the past 12 months, by selected characteristics: United States, 1997, 2006, and 2007

[Data are based on household interviews of a sample of the civilian noninstitutionalized population]

	Number of health care visits[1]											
	None			1–3 visits			4–9 visits			10 or more visits		
Characteristic	1997	2006	2007	1997	2006	2007	1997	2006	2007	1997	2006	2007
Hispanic origin and race and percent of poverty level[3,4,5]	Percent distribution											
Hispanic or Latino:												
Below 100%	30.2	32.8	30.5	34.8	35.3	36.9	19.9	19.2	19.3	15.0	12.7	13.3
100%–less than 200%	28.7	29.9	30.0	39.7	42.0	39.6	20.4	19.3	21.2	11.2	8.8	9.1
200% or more	18.9	22.2	19.7	48.8	47.4	51.6	20.4	20.4	19.6	11.9	10.1	9.1
Not Hispanic or Latino:												
White only:												
Below 100%	17.0	16.3	15.4	38.3	38.7	38.1	23.9	24.2	25.5	20.9	20.8	21.0
100%–less than 200%	17.3	18.8	16.2	44.1	43.7	42.0	22.2	22.2	25.5	16.3	15.4	16.3
200% or more	13.8	14.0	13.5	48.2	48.6	49.5	24.9	24.6	24.5	13.1	12.7	12.5
Black or African American only:												
Below 100%	17.4	18.1	15.2	38.5	45.0	43.2	23.4	21.9	24.9	20.7	15.0	16.7
100%–less than 200%	18.8	17.9	17.6	43.7	45.5	46.3	22.9	24.2	21.7	14.5	12.5	14.5
200% or more	15.6	13.5	14.4	51.7	53.6	52.0	22.7	23.5	23.5	10.0	9.3	10.2
Health insurance status at the time of interview[6,7]												
Under 65 years:												
Insured	14.3	14.3	13.5	49.0	50.4	50.7	23.6	23.1	23.5	13.1	12.3	12.3
Private	14.7	14.7	13.9	50.6	52.6	52.8	23.1	22.4	22.6	11.6	10.3	10.7
Medicaid	9.8	11.3	11.4	35.5	37.4	38.2	26.5	25.5	26.2	28.2	25.8	24.3
Uninsured	33.7	39.2	37.4	42.8	42.2	42.8	15.3	12.5	13.6	8.2	6.1	6.2
Health insurance status prior to interview[6,7]												
Under 65 years:												
Insured continuously all 12 months	14.1	14.3	13.4	49.2	50.8	51.0	23.6	23.1	23.5	13.0	11.9	12.1
Uninsured for any period up to 12 months	18.9	19.1	19.8	46.0	46.3	46.0	20.8	20.9	21.4	14.4	13.7	12.8
Uninsured more than 12 months	39.0	45.6	42.9	41.4	40.2	40.7	13.2	9.6	11.5	6.4	4.5	4.9
Percent of poverty level and health insurance status prior to interview[5,6,7]												
Under 65 years:												
Below 100%:												
Insured continuously all 12 months	13.8	12.6	12.4	39.7	43.1	41.8	25.2	24.2	26.0	21.4	20.1	19.8
Uninsured for any period up to 12 months	19.7	17.8	20.7	37.6	39.3	38.1	21.9	23.4	22.1	20.9	19.5	19.1
Uninsured more than 12 months	41.2	50.1	44.3	39.9	35.3	39.4	12.2	9.9	11.0	6.6	4.8	5.3
100%–less than 200%:												
Insured continuously all 12 months	16.0	16.3	15.1	46.4	45.9	44.5	21.9	23.0	24.6	15.8	14.8	15.8
Uninsured for any period up to 12 months	18.8	20.6	17.4	45.1	49.8	45.8	21.0	18.7	22.2	15.0	10.9	14.6
Uninsured more than 12 months	38.7	44.3	42.3	41.0	42.1	39.5	14.0	10.2	13.7	6.3	3.4	4.4
200% or more:												
Insured continuously all 12 months	13.7	14.1	13.2	51.0	52.6	53.3	23.6	22.9	22.8	11.7	10.4	10.7
Uninsured for any period up to 12 months	17.8	18.6	20.2	50.3	48.0	49.9	20.4	20.7	20.3	11.5	12.7	9.5
Uninsured more than 12 months	36.6	42.8	41.8	43.8	42.4	43.3	13.2	9.3	9.6	6.4	*5.5	5.3
Geographic region[3]												
Northeast	13.2	12.1	13.0	45.9	47.6	47.7	26.0	25.1	26.2	14.9	15.2	13.2
Midwest	15.9	15.2	15.5	47.7	48.4	48.8	22.8	23.6	22.4	13.6	12.7	13.3
South	17.2	18.3	16.9	46.1	45.6	45.3	23.3	23.5	24.8	13.5	12.6	13.0
West	19.1	21.7	19.1	44.8	46.7	48.2	22.8	20.2	21.1	13.3	11.3	11.7

See footnotes at end of table.

Click here for spreadsheet version

Table 80 (page 3 of 3). Health care visits to doctor offices, emergency departments, and home visits within the past 12 months, by selected characteristics: United States, 1997, 2006, and 2007

[Data are based on household interviews of a sample of the civilian noninstitutionalized population]

Characteristic	Number of health care visits[1]											
	None			1–3 visits			4–9 visits			10 or more visits		
	1997	2006	2007	1997	2006	2007	1997	2006	2007	1997	2006	2007
Location of residence[3]	Percent distribution											
Within MSA[8]	16.2	16.8	16.5	46.4	47.5	47.7	23.7	23.1	23.5	13.7	12.6	12.4
Outside MSA[8]	17.3	19.2	15.9	45.4	43.7	44.7	23.3	23.3	24.4	13.9	13.8	15.0

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error (RSE) of 20%–30%. Data not shown have an RSE greater than 30%.
- - - Data not available.
[1]This table presents a summary measure of health care visits to doctor offices, emergency departments, and home visits during a 12-month period. See Appendix II, Emergency department visit; Health care contact; Home visit.
[2]Includes all other races not shown separately and unknown health insurance status.
[3]Estimates are age-adjusted to the year 2000 standard population using six age groups: Under 18 years, 18–44 years, 45–54 years, 55–64 years, 65–74 years, and 75 years and over. See Appendix II, Age adjustment.
[4]The race groups, white, black, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, and 2 or more races, include persons of Hispanic and non-Hispanic origin. Persons of Hispanic origin may be of any race. Starting with 1999 data, race-specific estimates are tabulated according to the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity and are not strictly comparable with estimates for earlier years. The five single-race categories plus multiple-race categories shown in the table conform to the 1997 Standards. Starting with 1999 data, race-specific estimates are for persons who reported only one racial group; the category 2 or more races includes persons who reported more than one racial group. Prior to 1999, data were tabulated according to the 1977 Standards with four racial groups and the Asian only category included Native Hawaiian or Other Pacific Islander. Estimates for single-race categories prior to 1999 included persons who reported one race or, if they reported more than one race, identified one race as best representing their race. Starting with 2003 data, race responses of other race and unspecified multiple race were treated as missing, and then race was imputed if these were the only race responses. Almost all persons with a race response of other race were of Hispanic origin. See Appendix II, Hispanic origin; Race.
[5]Percent of poverty level is based on family income and family size and composition using U.S. Census Bureau poverty thresholds. Missing family income data were imputed for 24%–29% of persons in 1997–1998 and 31%–34% in 1999–2007. See Appendix II, Family income; Poverty.
[6]Estimates for persons under 65 years of age are age-adjusted to the year 2000 standard population using four age groups: Under 18 years, 18–44 years, 45–54 years, and 55–64 years of age. See Appendix II, Age adjustment.
[7]Health insurance categories are mutually exclusive. Persons who reported both Medicaid and private coverage are classified as having private coverage. Starting with 1997 data, state-sponsored health plan coverage is included as Medicaid coverage. Starting with 1999 data, coverage by the Children's Health Insurance Program (CHIP) is included with Medicaid coverage. In addition to private and Medicaid, the insured category also includes military plans, other government-sponsored health plans, and Medicare, not shown separately. Persons not covered by private insurance, Medicaid, CHIP, state-sponsored or other government-sponsored health plans (starting in 1997), Medicare, or military plans are considered to have no health insurance coverage. Persons with only Indian Health Service coverage are considered to have no health insurance coverage. See Appendix II, Health insurance coverage.
[8]MSA is metropolitan statistical area. Starting with 2006 data, MSA status is determined using 2000 census data and the 2000 standards for defining MSAs. For data prior to 2006, see Appendix II, Metropolitan statistical area (MSA) for the applicable standards.

NOTES: In 1997, the National Health Interview Survey questionnaire was redesigned. See Appendix I, National Health Interview Survey. Standard errors are available in the spreadsheet version of this table. See http://www.cdc.gov/nchs/hus.htm. Data for additional years are available. See Appendix III.

SOURCE: CDC/NCHS, National Health Interview Survey, family core and sample adult questionnaires.

Exhibit 13

S. HRG. 110–1052

47 MILLION AND COUNTING: WHY THE HEALTH CARE MARKETPLACE IS BROKEN

HEARING

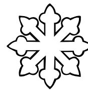
BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

JUNE 10, 2008



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APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Testimony from

Raymond Arth, Phoenix Products, Inc.

On behalf of
THE NATIONAL SMALL BUSINESS ASSOCIATION

For the hearing

"47 Million & Counting: Why the Health Care Marketplace is Broken"

Senate Finance Committee

June 10, 2008

Good morning. I would like to thank Chairman Baucus, Ranking Member Grassley and the committee for inviting me here today. I am honored to testify before a committee recognized for its hard work and for its bipartisan cooperation. Each of us testifying today will provide you with a different story, a diverse perspective and I expect one, common conclusion—small businesses are being crushed by the burden of the increasing cost of health care.

I am here today in two capacities, as a small business owner and as a past Chair of the National Small Business Association and so have two parts to my testimony. The first is an overview of the challenges I have faced in providing affordable, quality health insurance to my employees; the second to briefly describe NSBA's position and policy recommendations for reform. I am not an authority on health insurance but I have had a lot of experience as a consumer, and participated in developing NSBA's policy recommendations.

Before I get into my health insurance adventures, it is important that we understand how broad this issue is, and why dealing with the problems facing small business are important. According to data from the U.S. Census and Small Business Administration Office of Advocacy, there are approximately 70 million people in the U.S. who work for or run a small business – that is more than half of the private U.S. workforce. For the past 15 years, small business has created on average 93.5 percent of all net new jobs—resulting in an average of 4,000 new jobs EVERY day. The small-business community's role in creating jobs and stimulating economic growth cannot be underestimated or made merely into a talking point. Neither can the extreme time and financial drain the current health care system poses for small-business owners.

In nationwide surveys, small-business owners consistently rank health care among their top concerns. According to the recently-released NSBA Survey of Small and Mid-Sized Business, only 38 percent of respondents—nearly 90 percent of whom employ less than 19 workers—offer their employees health insurance. That is down 3 percent from one year ago, down 11 percent from 2000, and down 29 percent from 1995. Despite the low-rate of offering health insurance, 69 percent of respondents rated health insurance as the top benefit they WANT to offer.

The cost of health care disproportionately hurts the smallest businesses, with only 25 percent of companies with fewer than 5 employees offering health insurance to their employees. Furthermore, the Kaiser Family Foundation estimates that 60 percent of small businesses shop for a new health insurance plan every year, but of those, less than half actually make any changes. These statistics tell us one very important, and far too bleak fact: small businesses have very few viable options. Unfortunately, that is where I find myself today.

Experience of Phoenix Products, Inc.

From the day we started our company, providing affordable, comprehensive health insurance has been a primary priority. My partner was a cancer survivor who had a variety of chronic health problems that were the result of the severity of his illness and the extreme measures taken to battle it. For over 30 years I have had to confront the challenge of finding suitable health insurance plans during which period the health insurance landscape has changed dramatically.

During that time we moved through a progression of coverage options; going from 100 percent, company paid indemnity plans with low deductibles through Preferred Provider Organizations (PPOs), to an HMO plan with a Point of Service option to high deductible coverage. In our discussion this morning I will focus on changes over the last few years.

My company also has gone through substantial changes, growing from a youthful start-up into a fairly large, small business with nearly 100 employees. Today, due to fundamental changes in the size of our core market and fierce foreign competition we are a much smaller and mature organization.

Phoenix Products is now 31 years old, and our employee group has gotten older with the company. Today our "average" employee is over 52 years old and has been with the company nearly 16 years. As the group has aged,

our health expenses have grown significantly and we have had to dramatically change the benefit structure of our plans to offset rising costs.

As recently as 2003 we still could afford to provide a plan with a $250/$500 deductible which included a $15 co-pay for office visits and modest co-pays for prescription drugs. The monthly premium for this plan was $218 for a single employee and ranged up to $677 for full family coverage. But our group was shrinking, growing older and consuming more health care. At the same time, the cost of health care was increasingly rapidly, out of step with the rate of cost increases in other market segments. So my plan demographics and the dynamic increase in cost for health care were working against my group.

By moving away from what was a pre-paid health care plan that covered almost everything to an insurance plan that protects our employees from catastrophic events we have been able to control the premium increases which have grown by only about 10 percent from 2003 to 2007. Last year alone we avoided a 22 percent increase by moving to a very high deductible level. We were forced to pay a little more to cover much less.

Today we have a plan with a $3,000 deductible for a single employee and $5,900 for a family. The insurance company does not pay a thing until that deductible is met. Prescription drugs and office visits are treated like any other medical expense and are included in the same deductible limits. However, our company self-insures a part of the deductible so the actual exposure is limited to $1,750/$3,500 per employee.

Following our renewal last year I learned that we had a covered participant who had been diagnosed with Gaucher's disease, a very rare enzyme deficiency. While not immediately life threatening its long term effects can be devastating. Treatment consists of bi-weekly enzyme replacement therapy. Because the condition is so rare the cost of the drug is extremely high. As a result we have had extremely high utilization this last year and our renewal rates reflect that.

Our 2008 renewal rates are 35 percent above last year; the maximum allowed under Ohio insurance regulations. Quotes from other carriers were two to two-and-a-half times higher than our current rates. At this point we have exhausted all of the plan design options that could minimize our increase. Neither the company nor our employees are in a position to absorb an increase of almost $40,000 in premiums.

The company pays a variable percentage of the premium based on the employee coverage, but in total we bear over 80 percent of the total cost. The increase in the cost of our health insurance has affected our employees over the last few years. The employee contributions have grown with the premiums. Wage rates have been frozen since 2001, though we do make occasional lump sum distributions of profits as conditions permit. The market is brutal so let me emphasize the word "occasional. "

We have not yet figured out exactly what we are going to do about this renewal. We provide life insurance plus short-term and long-term disability coverage at the company's expense. Our average employee is now eligible for four weeks of paid vacation in addition to nine paid holidays. We are a family-run business and our employees are part of our family. As much as I do not want to resort to reducing some of these benefits, there are few other viable alternatives to offset the cost of health insurance.

Our situation has been aggravated because we have a single case that has such a dramatic effect on the total group. But last year, before this case emerged, we were confronted with a 22 percent increase that we averted by substantially increasing the deductible and self-insuring part of that risk. Despite countless hours working to redesign our plan to ensure its affordability, the rapid inflation in health care costs and our aging group are catching up with us.

As this committee rightly focuses on how to help small businesses afford health insurance, I urge you not to lose sight of the indirect costs our health care system imposes upon entrepreneurs. Often overlooked in the policy discussion is the time required to create and sustain a health insurance group plan. There are plan policies, procedures and documents that must be created and maintained, along with filing requirements for larger plans.

Annual shopping for new carriers or the evaluation of other plan design options also consume countless hours. In most small companies this means that the owner or other key employees are devoting their limited time to this effort. I can not begin to describe the exasperation and frustration that I experience trying to select the best plan option while lacking basic information about the actual utilization of the plan benefits; this information being "protected" under the HIPAA confidentiality shroud or otherwise unavailable. Each hour I spend struggling to find a way to continue offering health insurance to my employees is an hour NOT spent working to hire more employees.

Our group has experienced many challenges over the years and we have been fortunate to be able to find ways to continue providing our employees with a quality insurance plan that was affordable. But now we are squeezed between our group's demographics, the huge expense of a single case and the explosive increase in health care costs. After 31 years we may have finally found the limit of our ability to provide this benefit to our employees.

Broad Reform Proposal

My story is not unique. Small businesses are nearing a cliff, and we cannot continue down this path that creates such a significant competitive disadvantage globally and among larger businesses in our industry. When I was Chair of NSBA in 2004, the small-business community had been experiencing year-after-year double-digit increases in the cost of health insurance, and we decided it was time to come to the table with more than our horror-stories and criticisms. We spent a year working with myriad business owners, insurers and consumers, and crafted a proposal for reform that would fix not only our dilemma, but address the overall failures of the U.S. health care system.

While the need for reform is clearly urgent, and while there are a number of more short-term reforms that can improve on the system, what small businesses deserve is broad, comprehensive reform that will not only address the symptoms of a failing health care system, but cure the underlying illness plaguing the entire system.

The Realities of the Insurance Market

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within it. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. But such is not the case in the health arena, where the costs of treating uninsured are split and shifted onto those with insurance in the form of increased costs. Moreover, individuals' ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased (which, of course, further decreases the likelihood of the healthy purchasing insurance).

Small businesses must function within the insurance markets created by their states. States have developed rules on rating and underwriting that attempt to establish the subsidies between the healthy and the sick. Most states require insurers operating in the small group market to take all comers and limit their ability to set rates based on health status and other factors. However, there is extensive variability among the states on these rules. Some states allow great latitude on rates, thereby limiting the cross-subsidies, but this makes insurance much more affordable for the relatively young and healthy. Other states severely limit rate variation, which often helps keep costs in check for many older, sicker workers, but drives up average premiums and puts insurance out of financial reach for many. These tight rating rules (known as "community rating" or "modified community rating") also can cause some insurers to leave certain markets they deem to be unprofitable. Problems in those states are then compounded by a lack of competitive pressures.

It is important to note the interplay between the small group and individual insurance markets, particularly in some states. In general, insurers in the individual market are not required to take all comers (at least not those not "continually insured") for all services and are allowed much greater discretion to underwrite and rate policies based on health history and a series of other factors. Individuals also can see their rates skyrocket if they get sick, usually to a much greater degree than in the small group market. In other words, there is far less of a cross subsidy in the

individual market than the small group market. That means that relatively young and healthy individuals can get much cheaper insurance in the individual market (at least initially) than they can get through an employer—particularly in states that have community rating in the small group market. In many of our smallest companies (under 10 employees but especially under five), it makes financial sense to increase wages to allow for the purchase of individual coverage. If the workforce becomes sicker, it may make sense to convert to the now-more-reasonably-priced small group market. This dynamic (and others) means that the "moribidity" of the under-ten market is much higher than the group market as a whole. Naturally, insurers often will seek ways to avoid serving an undue share of this market.

So long as we have in place a voluntary system of insurance, where individuals and businesses—at any given point in time—can choose whether or not to purchase insurance, this quest for the insurance rating "golden mean" will continue. While there has been endless debate about what the right set of rating rules should be, it is imperative that there be only one set of rules. Insurance markets where different players operate under different sets of rules are doomed to failure. Even in the interplay between the group and individual markets—which are different markets—we see the consequences of different rules. When two sets of rules operate within the same market, the self-interested gamesmanship that occurs among both insurers and consumers ultimately leads to dysfunction and paralysis.

Solution Principles

Any solution to the problem should abide by the following, most important principle - primum non nocere: first, do no harm. Often, legislation passed has hidden, unintended consequences that can create a larger problem than the bill initially sought to fix. Lawmakers must use a keen eye when considering any solution, no matter how incremental or sweeping, to ensure that the fix doesn't unearth an even bigger problem.

The second principle when discussing a health care fix for small business is to understand the real problems small businesses face. The biggest problem small businesses face is cost and competitiveness. Health insurance in the United States has transformed from a "fringe benefit" to a central component of compensation. The realities of the small group market make it much more difficult for a small firm to secure quality, affordable insurance than it is for a large business. The ebb and flow of workforce in a large company can be compensated for in their insurance pool simply due to the large number of workers. Whereas in a small business, that natural shift in workers can lead to extraordinary fluctuations in health premiums. Given these costs and general level of instability in the insurance market, the ability for a small business to effectively compete for good workers against large companies is exponentially more difficult.

There exists another competitiveness issue, and that is a global one. The U.S. boasts a unique entrepreneurial spirit and has been a leader in technological advances. A great deal of that innovation and creation comes from small businesses. According to the U.S. Small Business Administration's Office of Advocacy, small firms represented 40 percent of the highly-innovative firms in 2002, a 21 percent increase in just two years. Unfortunately, health insurance costs can serve as the deciding factor whether or not an individual will opt to continue with his or her business. A report released earlier this week by that same Office of Advocacy states that the presence of the health insurance deduction decreases the rate of exit from entrepreneurship for self-employed individuals by 10.8 percent for single filers, and 64.9 percent for married filers. What this tells us is that we are losing potential new advances and innovations due to the cost of health insurance, which holds serious implications to our overall global competitiveness.

The third principle is equity and common sense. While competitiveness does touch on fairness between large and small companies, equity in our mind is a different animal altogether. Any health care solution ought to provide the same benefits to a business owner as they do an employee. Tax benefits should be extended fairly to whichever party is paying for the health insurance, be it employers or individuals. Continually providing tax benefits to companies and employment and not individuals perpetuates the current system where employers are practically forced into providing insurance to their employees.

NSBA's Comprehensive Solution
In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of a larger pool with shared costs, the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that—to bring meaningful affordability, access, and equity in health care to small businesses and their employees—a broad reform of the health care system is necessary. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

There is no hope of correcting these inequities until the U.S. has something close to universal participation of all individuals in some form of health care coverage. NSBA's plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Individual Responsibility
Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of "uncompensated care." These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance.

Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker). Almost four million individuals aged 18-34 making more than $50,000 per year are uninsured. The absence of these relatively-healthy individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups of individuals onto the insurance rolls would bring consequential premium reductions to current small business premiums.

Of course, the decision to require individuals to carry insurance coverage would mean that there must be some definition of the insurance package that would satisfy this requirement. Such a package must be truly basic. The required basic package should include only necessary benefits and should recognize the need for higher deductibles for those able to afford them. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for all expenses. More robust consumer behavior will surely follow.

Incumbent on any requirement to obtain coverage is the need to ensure that appropriate coverage is available to all. A coverage requirement would make insurers less risk averse, making broader insurance reform possible. Insurance standards should limit the ability of insurance companies to charge radically different prices to different populations and should eliminate the ability of insurers to deny or price coverage based upon health conditions, in both the group and individual markets. Further, individuals and families would receive federal financial assistance for health premiums, based upon income. The subsidies would be borne by society-at-large, rather than in the arbitrary way that cost-shifting currently allocates these expenses for those without insurance.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program all would be acceptable means of demonstrating coverage. More and more health care policy leaders are realizing the need for universal coverage through individual responsibility and a requirement on each person to have health insurance.

Reshaping Incentives
There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of

Statement of Mark A. Hall, J.D.

Fred D. and Elizabeth L. Turnage Professor of Law and Public Health

Wake Forest University
Winston-Salem NC

U.S. Senate Committee on Finance, Hearing on
"47 Million and Counting: Why the Health Care Marketplace is Broken"

June 10, 2008

Chairman Baucus, Ranking Member Grassley, and esteemed Senators, it is a distinct honor to appear before this distinguished committee as it begins the monumental undertaking of reforming our health care system. My name is Mark A. Hall, and I am a Professor of Law and Public Health at Wake Forest University, where I specialize in health care finance and regulation.

My testimony addresses problems in the structure and functioning of private health insurance markets. I have studied these markets for almost two decades, starting with a Fellowship at the Health Insurance Association of America in 1991, and continuing through fifteen years of empirical studies with insurers, agents, employers, and regulators.

Health policy analysts are fond of invoking medical metaphors, and I too cannot resist. Some might say that the private health insurance market is crippled, severely wounded or on life support. I am not quite that gloomy, but no one can deny that the market is far from a picture of rosy health. Some parts are functional, other parts are in steady decline from chronic ailments, and yet others are fairly stable but show ominous precursors of acute illness. I will describe these critical indicators and diagnose the underlying conditions that afflict different parts of the market organism.

The Numbers

Since 2000, insurance premiums have doubled, increasing four times faster than earnings or general inflation (Figure 2). Today, the average cost of family coverage is over $12,000 a year, which is about one-quarter of median household income. Single coverage averages about $4500 a year, which is almost half the income of someone at the federal poverty line.

These averages reflect employer-based coverage. For individual insurance, the industry reports average rates that are about half these amounts ($2600 single coverage and $5800 family), but this is for coverage that tends to be much less generous and more difficult to obtain than employer-based insurance.

Premium increases are driving people out of the insurance market. Since 2000, both the percentage of employers offering coverage and the percentage of people covered by employers have dropped more than five points, to around 60 percent (Figure 3 and Exhibit 1). This decline in employer coverage has not been accompanied by any increase in individual coverage. Therefore, the portion of the non-Medicare population covered by private insurance has slipped from about 3/4 to about 2/3 in the past six years.

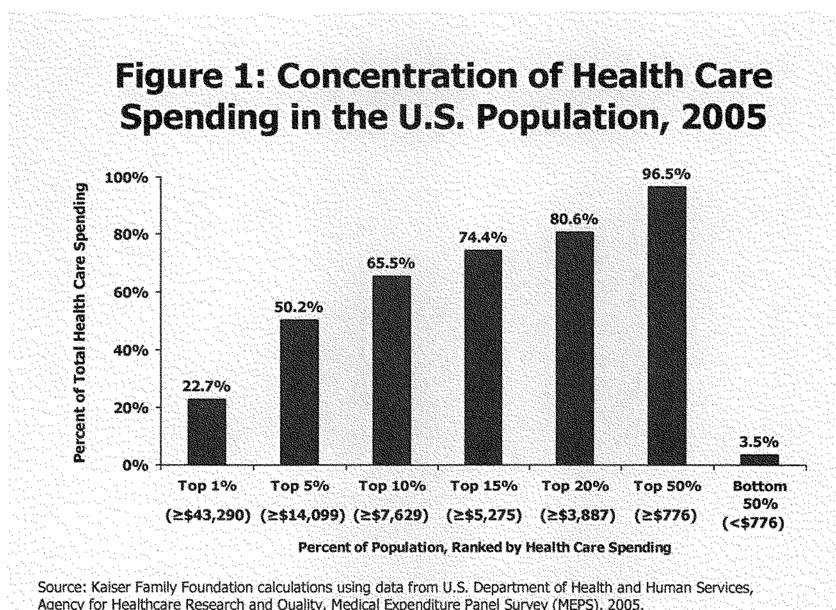
These disturbing declines have occurred despite strenuous efforts to shore up the market's erosion through legislation. For instance, federal reforms expand tax benefits for purchasing insurance (HSAs) and restrict insurers' from rejecting group applicants (HIPAA). These laws have been vitally important. Without them, conditions would only have worsened much more than they have. But, we must keep in mind that it will take

considerable additional effort simply to keep things from getting worse, let alone to substantially improve or to fix this market.

Things have gotten worse despite corrective efforts because the basic market conditions that cause the problems are still very much in place. Indeed, they are elemental. These market conditions will always plague us to some extent because they derive from a fundamental fact of the human condition – that the need for medical care is highly skewed throughout the population. This point is the main focus of my testimony.

The Highly Concentrated Burden of Medical Costs

The high concentration of most medical costs in a relative few people is the single most important fact for understanding the private insurance market. It is hard to find the right words to describe this foundational statistical phenomenon in terms that are sufficiently compelling, so I will start with a graphic depiction.



Arraying the population by health care spending in a year, this chart shows that

- the top 1% (those who spent more than $43,000) accounted for almost one-fourth of total spending
- the top 5% (who spent more than $14,000) accounted for half of all spending
- and the top 20% (who spent more than about $4000) accounted for 80% of spending.

The bottom half of the population distribution (who spent less than $800 that year) incurred less than 4% of total costs.

For convenience, I refer to this as "the 80/20 rule." I call it a rule because the pattern is remarkably universal. This pattern has a fractal geometry that appears wherever one looks. It holds true both for the population at large and for just about any subpopulation of any size one might choose to examine (see Exhibit 3). Medicare spending is essentially just as concentrated as that for people in their 40s, or that in just about any larger employer group. The extreme concentration of health care costs is an economic law of nature that has been observed as early as the 1930s and that will be with us for as long as anyone can foresee – regardless of how we deliver and pay for health care.

There is no easy way to reduce or eliminate the effects of concentrated medical costs because the extremes are so great. Various techniques such as high-risk pools, reinsurance, and risk adjustment have been tried or proposed. These measures can certainly help somewhat, but the amount of money involved is too large to eliminate the basic underlying phenomenon. For instance, if even the top half of expenditures (which are concentrated in 5% of the population) were removed from the market, we would still have a market in which some people's expenses were ten times greater than the *middle* of the distribution. Removing half the costs would cut the total costs in half, but this would not alter the basic dynamics created by the fact that the remaining costs would still be concentrated in a relatively small portion of people.

Market Dynamics: Risk Segmentation, Adverse Selection, and Medical Underwriting

I stress the 80/20 rule because it is the most elemental fact of health insurance. It is as fundamental as gravity, and as pervasive as the weather. It is the endemic First Cause that reaches everywhere and explains just about everything of importance in the market for insurance.

The high concentration of medical costs is why we need and have insurance in the first place. Pooling expenses across a population keeps them affordable for everyone, but the extreme costs at the high end also explain why insurance is so expensive, especially for those who anticipate no real need.

The extreme magnitude of differences in health risks also explains the private insurance market's most perplexing dynamics. I will describe several troubling phenomena, each of which derives from the basic fact that insurers stand to gain a great deal by avoiding or appropriately pricing people with higher risks. They also stand to lose a great deal if they

do not attract a good number of lower risks. Therefore, competitive forces in health insurance markets inevitably focus on risk selection (or risk segmentation). Other points of competitive focus – such as product design, benefit coverage, sales vehicles, and care management – either have much less impact on profitability or are themselves surrogates for risk selection or segmentation.

The most visible form of risk selection is *medical underwriting*. This consists of evaluating the health risks specific to each subscriber in order to assign an actuarially fair price. According to industry figures, about 70% of people who apply for health insurance receive an offer of coverage at standard rates or better. The rest are either declined (12%), offered higher rates (6%), or offered coverage that excludes one or more particular pre-existing conditions (13%). In field studies, market testers found that conditions as common as asthma, ear infections, and high blood pressure can create problems obtaining coverage.

Medical underwriting is necessary because of *adverse selection* – the tendency of people to avoid the purchase of insurance unless they expect to need it, and for those with more need to buy more insurance. A health insurance market could never survive or even form if people could buy their insurance on the way to the hospital. Therefore, medical underwriting rewards people who purchase while they are still young and healthy, and imposes pre-existing condition exclusions or charges higher rates, for those who are not.

An especially aggressive form of risk screening is called "post-claims underwriting" – namely, waiting to assess pre-existing conditions until a paying subscriber submits large claims. If, after more scrutiny, insurers find that applicants were not completely forthcoming, they have been known to *rescind coverage retroactively*, even after people have paid premiums and received authorized treatment. State insurance regulators monitor such practices and determine when they are excessive or inappropriate, but it is a constant tension between public-minded regulators and competing insurers to determine the boundary of proper underwriting and claims adjudication.

The mirror image of adverse *selection* is adverse *retention*. A newly underwritten insurance pool will tend to deteriorate over time, meaning that the pool's health costs will increase fairly steeply relative to marketwide averages. This *durational effect* is pronounced because people are free to shop around for cheaper or better insurance – but only if they are still healthy. To remain competitive, insurers target these shoppers by offering them their most attractive rates. To compensate, they must increase the rates of renewing subscribers – which is one reason people experience rate hikes that are much steeper than their increases in wages.

Existing subscribers who no longer can pass medical underwriting, or who would be subjected to new pre-existing condition exclusion periods, are stuck with the insurance they have. Although they are guaranteed to be able to keep this coverage forever, at some point mounting medical costs in the pool make it no longer economical for the insurer to sell that particular policy. And, once no new healthier subscribers are entering the pool, the costs skyrocket into what is called a "death spiral." Some insurers exploit

this dynamic by *churning* risk pools. They frequently close off existing policies to any new subscribers and instead market new policies that are very similar but that are available only to freshly underwritten subscribers. This practice results in more hermetically separating lower versus higher risk subscribers into differently-priced policies.

Medical underwriting, plus constantly searching for a better price, adds additional costs to the system. These transaction costs account for a sizeable portion of the premiums people pay – on the order of roughly 20-25% for individual insurance and 10-15% for small groups. Constant turnover in coverage also undercuts the inherent efficiency of insurance markets. Insurers have little incentive to invest in life-long health prevention measures because the typical policyholder remains with a plan for an average of only about three years.

The natural dynamics of risk segmentation are so strong that risk selection occurs even without overt medical underwriting. Subscribers naturally sort themselves by risk to some extent, according to the covered benefits and plan features they find most attractive. Insurers and employers have learned that features such as deductibles, managed care, and particular benefits that are covered or excluded appeal differently to people with lesser versus greater health care needs. This is one reason many health policy analysts favor uniform benefits and why most employers limit their workers' choice of health plans.

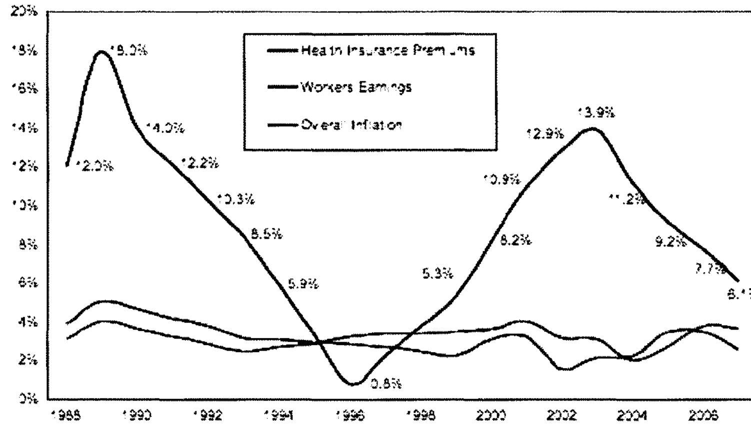
Necessary Reforms

Various insurance market reforms have worked well to mitigate the worst excesses of these market-driven competitive practices, but these counteractive measures are not capable of eliminating these effects. Risk selection practices flow directly from the very nature of how competitive markets should and must respond to highly concentrated health risks. Therefore, these effects will never be eliminated unless the market is fundamentally restructured.

The basic requirement is to place people into large groups whose membership is not tied to health risk, and to limit the choice of plans within the group. This is currently how large employer groups work, which is why they remain the best-functioning part of the market. These conditions also fit subsidized insurance pools such as the Massachusetts Connector. To meet these essential conditions, everyone (or almost everyone) who is eligible must agree to purchase insurance from their assigned group, and the insurers must not have a great deal to lose or gain according to how healthy or sick each subscriber is. This is easy enough to state in the abstract, but exceedingly difficult to achieve in practice.

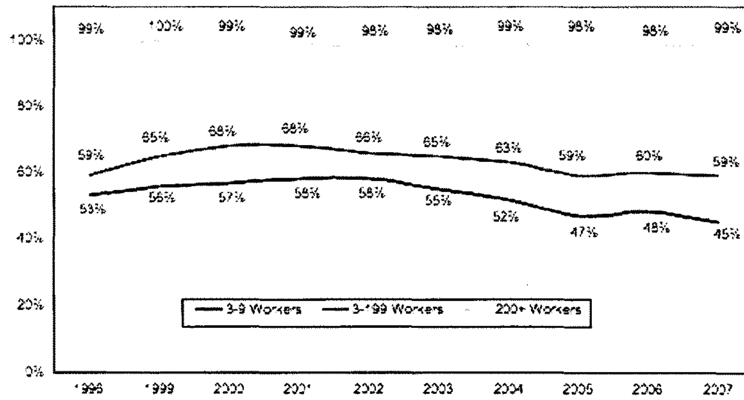
I wish this Committee and the Senate Godspeed and wisdom in pursing this formidable challenge.

Figure 2: Annual Growth Rates for Health Insurance Premiums, Workers Earnings, and Overall Inflation, 1988-2007



Source: Kaiser Family Foundation/Health Research and Educational Trust.

Figure 3: Percentage of Employers Offering Health Benefits by Firm Size, 1996-2007



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

EXHIBIT 1

Health Insurance Coverage Among Nonelderly Americans, By Age And Source Of Coverage, 2000–2004 And 2004–2006

	All nonelderly			Adults			Children		
	Coverage distribution		Change (millions of people)	Coverage distribution		Change (millions of people)	Coverage distribution		Change (millions of people)
2000–2004	2000	2004	2000–04	2000	2004	2000–04	2000	2004	2000–04
All incomes (millions of people)	245.1	255.1	10.0[c]	168.8	177.3	8.5[c]	76.3	77.8	1.5[c]
Employer	67.8%	63.3%[a]	-4.9[c]	68.9%	64.4%[a]	-2.2[c]	65.4%	60.7%[a]	-2.6[c]
Medicaid/state	8.6	11.2[a]	6.9[c]	5.3	6.5[a]	2.6[c]	16.7	21.9[a]	4.3[c]
TRICARE/Medicare	2.1	2.3[a]	0.7[c]	2.3	2.7[a]	1.0[c]	1.7	1.3[a]	-0.3[c]
Private nongroup	5.1	5.4[a]	1.3[c]	5.6	5.8[b]	0.9[c]	3.9	4.4[a]	0.4[c]
Uninsured	16.1	17.8[a]	6.0[c]	17.9	20.6[a]	6.3[c]	12.3	11.6[a]	-0.4
2004–2006	**2004**	**2006**	**2004–06**	**2004**	**2006**	**2004–06**	**2004**	**2006**	**2004–06**
All incomes (millions of people)	255.1	260.0	4.9[c]	177.3	181.8	4.5[c]	77.8	78.2	0.4
Employer	64.0%	63.0%[a]	0.5	65.2%	64.4%[a]	1.5[c]	61.4%	59.7%[a]	-1.0[c]
Medicaid/state	11.2	11.3	0.7[c]	6.6	6.6	0.3	21.9	22.4	0.5[c]
TRICARE/Medicare	2.3	2.3	0.3	2.7	2.8	0.3[d]	1.4	1.4	0.0
Private nongroup	5.6	5.5	0.0	6.0	5.9	0.1	4.5	4.5	0.0
Uninsured	16.9	17.9[a]	3.4[c]	19.5	20.4[a]	2.4[c]	10.9	12.1[a]	1.0[c]

SOURCE: Urban Institute, 2007, based on data from the 2001, 2005, and 2007 March Supplements of the Current Population Survey.

NOTE: Excludes those age sixty-five and older and those in the Armed Forces.

[a] Change in percentage of people is statistically significant (at the 95% confidence level).

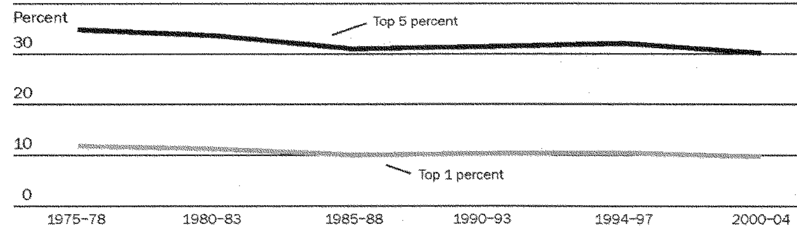
[b] Change in percentage of people is statistically significant (at the 90% confidence level).

[c] Change in numbers of people is statistically significant (at the 95% confidence level).

[d] Change in numbers of people is statistically significant (at the 90% confidence level).

EXHIBIT 4

Percentage Of Medicare Spending Attributable To The Most Expensive 5 Percent And 1 Percent Of Beneficiaries, Aggregated Over Four-Year Periods, 1975–2004



SOURCE: Claims and enrollment data from the Continuous Medicare History Sample, various years.

NOTES: Data are for beneficiaries entitled to Part A and Part B and in fee-for-service in each year they were alive. Data have been inflation adjusted to the last year in the period using the Consumer Price Index–All Urban Consumers.

Exhibit 14

HEALTH REFORM IN THE 21ST CENTURY: INSURANCE MARKET REFORMS

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
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ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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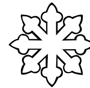

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Prepared Statement of Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy and Professor of Economics and Public Affairs, Princeton University, Princeton, New Jersey

My name is Uwe E. Reinhardt. I am Professor of Economics and Public Affairs at Princeton University, Princeton, New Jersey. My research work during the past several decades has been focused primarily on health-care economics and policy.

I would like to thank you, Chairman and your colleagues on this Committee for inviting me to present a statement on the problems of structuring a market for individually purchased health insurance in the United States.

After some remarks on the interface between social ethics and health reform, my statement will focus for the most part of ways of reforming the market for health insurance.

I. INTRODUCTION

Any modern health system, regardless of its structure, must perform the following five major functions:

1. **FINANCING** health care, that is, extracting the requisite funds for the health system from individuals and households, who ultimately pay for all of health care. (Government, employers and private insurers are merely pumping stations in the flow of funds from individuals and households to the providers of health care).
2. **POOLING RISKS** for the purpose of protecting individuals and households from the uncertain financial cost of needed health care.
3. **PURCHASING** health care from its providers (doctors, hospitals, and so on), which includes negotiating or setting the prices to be paid for health care and determining the set of goods and services actually needed for the efficient, evidence-based best treatment of given medical conditions (including disease management and chronic care).
4. **PRODUCING** the goods and services required for the proper treatment of given medical conditions, including their diagnosis.
5. **REGULATING** the various clinical and economic activities involved in the operation of the nation's health system so that it works consistently towards socially desired ends.

As I understand it, this hearing is about the allocation of the first three functions between the private and the public sectors. The fifth function, of course, is the natural preserve of government, especially after the financial markets have demonstrated at such great cost to the rest of the world that private markets cannot be trusted to be self-regulating and working in society's interest, a point now grasped even by economists, including libertarian Alan Greenspan.

The allocation of the first three functions between government and the private sector, however, is not so clear-cut. It depends crucially on the social goals society wishes to posit for its health system, including how the financial burden of ill health is to be allocated to members of society and how care is to be distributed among them. I shall therefore offer a few remarks on that facet of a health system.

II. THE SOCIAL GOALS OF HEALTH SYSTEMS

Most industrialized nations in the OECD, along with Taiwan, seek to operate their health systems on the *Principle of Social Solidarity.* It means to them that health care is to be viewed as a so-called "social good," like elementary and secondary education in the United States. That perspective, in turn, implies that the financial burden of health care for the nation as a whole should be allocated to individual members of society roughly in accordance with the individual's ability to pay, and that needed health care should be available to all members of society on toughly equal terms.

If the health system is to operated subject to this distributive social ethic, it requires that government either operate the financing, risk-pooling and purchasing functions directly (as is the case in Canada, Taiwan and the UK, for example) or that government tightly regulate all three functions, even if they are actually performed by private institutions outside of government proper (as is the case in Germany, the Netherlands and Switzerland).

Unfortunately, the United States never has been able to evolve a widely shared consensus on the distributive social ethic that ought to govern the U.S. health system. The bewildering American health system reflects that lack of consensus.

At one end of the ideological spectrum, many Americans appear to believe that health care ought to be treated as a private consumer good that should be distributed on the basis market principles. This means that the financing of health care ought to be viewed primarily as the responsibility of the individual, and only the

poorest members of society ought to be given public assistance in procuring a bare-bones package of health care. In other words, these Americans believe that, for the most part, health care should be rationed among members of American society on the basis of price and ability to pay, like other basic consumer goods, such as housing, clothing and food.

At the other end of the ideological, just as many other Americans share the ethical precepts of other nations in the OECD. These Americans, too, believe that our health system ought to be operated on the *Principle of Social Solidarity*, that is, that health care should be viewed a social good. If rationing of health care there must be, then it ought to be on principles other than price and ability to pay.

In between these distinct but coherent views reigns massive intellectual confusion.

To illustrate, the same citizens and politicians who look askance at "socialized medicine"[1] reserve the purest form of socialized medicine—the VA health system—for the nation's allegedly much admired veterans. A foreigner may be forgiven for finding this cognitive dissonance bizarre.

Similarly, there are many Americans, who believe that government does not have the right to impose on them a mandate to have health insurance, all the while considering it their moral right as Americans to receive even horrendously expensive tertiary health care in case of critical need, even if the recipients have no hope of financing that care with their own resources. Foreigners may be forgiven for shaking their heads at this immature and asocial entitlements mentality, which would be rare in their home countries.

Finally, a good many citizens and politicians who accept with equanimity the rationing of health care by price and ability in this country openly deplore the rationing of health by administrative means in other countries, perhaps not realizing that textbooks in economics explicitly ascribe to market prices the role of rationing scarce resources among unlimited want[2] Why the latter form of rationing is superior to the former is not obvious.

A much mouthed mantra in our debate on health policy is that "we all want the same thing in health care, but merely quibble over the means to get there." Nothing could be further from the truth. That debate has been and continues to be a tenacious ideological fight over the social ethic that ought to govern American health care; but we camouflage it as a technical debate strictly over means.

My plea before this Committee and to the Congress is that any health reform proposal put before the American people be preceded with a preamble that clearly articulates the social goals our health system is supposed to pursue and the social ethic it is to observe. Policy makers in other nations routinely do so and accept the constraints that this preamble imposes on their design of health reform. It would be helpful to have a clearly articulated statement on the social ethics for American health care as well.

With these preliminary remarks, I would now like to turn to the structure of the market for health insurance.

III. THE MARKET FOR PRIVATE HEALTH INSURANCE

The value a health insurance system offers society is the ability to pool the financial risks faced by individuals in order to protect members of that risk pool from uncertainty over the financial inroads of high medical bills in case of illness. In return for receiving that value, individuals make a financial contribution to the risk pool, in the form of taxes (e.g., payroll taxes) or premiums.

Many economists view this risk pooling as the sole proper function of health insurance *per se*. To them, for example, the segmentation of a free market for private health insurance by risk class, with relatively higher insurance premiums charged to patients expected to be relatively sicker over the insured future period, is not only an inevitable outcome of such a market, but is viewed perfectly acceptable. Such

[1] The formal definition of "socialism," according to my American Heritage Desk Dictionary, is a system in which *government owns the means of production*. "Socialized medicine" thus is a system in which government owns, operates and finances health care, as in the VA health system. It is not the same as "social insurance," which merely is an arrangement under which individuals transfer financial risks they face to a larger collective body, often the government. The limited liability shareholders of corporations enjoy, for example, is one of the oldest forms of social insurance, as is the Federal Government's assistance to states struck by natural disasters, as is the many guarantees government extends to the financial sector and as is, of course, Medicare and Medicaid.

[2] As two well-known authors put it: "*Bread must be rationed somehow; and the price system accomplishes this in the following way: Everyone who is willing to pay the equilibrium price gets the good, and everyone who is not, does not.*" See Michael L. Katz and Harvey S. Rosen, *Microeconomics*, (1991): 15.

premiums are called “actuarially fair.” On this view, if society wants greater equity in the financing of health care, then government should provide risk-adjusted subsidies toward the purchase of actuarially priced private insurance.

As a practical matter, however, most people seem to believe that both private and public insurers should not only protect individuals from the variance of their own health spending likely to be incurred by that individual over time, but also incorporate in its premium structure hidden cross subsidies from chronically healthy to chronically sick members of society. Most health insurance systems in the world actually do that, including the Medicare and Medicaid programs in the United States and the private employment-based health insurance system.

A. Employment-Based Insurance

In the market for employment-based group health-insurance, the insurance premium paid the insurer by the employer typically is “experienced rated” over the group of employees being insured. It means that the premium reflects the *average expected (actuarial) cost* of the health care likely to be used collectively by all of that employer’s employees, plus a markup-up for the cost of marketing and administration and profits.

In effect, then, the bulk of the risk pooling for employment-based health insurance actually is performed by the employer, not the insurer. The insurer bears only a small fraction of the total risk, a fraction that varies inversely with the size of the insured group.

This is even clearer when the employer overtly self-insures, as most large employers in the United States now do. In that case, the employer bears all of the financial risk of the employees’ illness, and private insurance carriers are engaged by the employer merely perform the purchasing function (the third function above) on behalf of the employer-run risk pool, including claims processing.

Economists are persuaded by both theory and empirical evidence that, over the longer run, the full cost of the employer’s contribution to the employees’ group health insurance is shifted back somehow to employees in the form of lower take-home pay or a reduction in other fringe benefits. The arrangement typically does force chronically healthier employees to cross-subsidize chronically sicker employees, because the reduction in take-home pay within a given skill level is independent of the individual employee’s health status.

In a sense, then, employment-based insurance is a form of “social insurance.” One may call it “private social insurance,” especially for larger employers, as distinct from government-run social insurance. It is one reason that the employment-based system has such strong support among people who would like to see American health care governed by the *Principle of Social Solidarity*. The feature of employment-based insurance that attracts them is the pooling of risks in that system.

A problem, of course, is that this principle is vastly eroded, the smaller the number of employees is over which premiums are experience-rated. For very small firms, employment-based insurance approximates individually purchased insurance.

B. The Market for Individual Insurance

In the market for individually purchased insurance, risk pooling necessarily must take place at the level of the insurance company.

As is well known from a distinguished literature in economics, a price-competitive market of individually sold health insurance will naturally segment itself by risk class. By economic necessity—and not a mean spirit—insurers in such a market have no choice but to engage in “medical underwriting” if they want to survive.

This means that private insurers must (a) determine as best they can the health status and likely future cost to the risk pool that an individual prospective customer will cause and (b) charge the individual a premium that covers that anticipated cost (the “actuarially fair premium”) plus a mark-up for the risk pool’s cost of marketing and administration and for desired profits. The size of this mark-up is constrained through price competition. As the Lewin Group estimated in a recent report, this mark-up averages 31.7% for private insurers in the individual market.[3]

The general public and the media that informs the public seem insufficiently cognizant of the horrendously complex product insurers sell. A health insurance policy is a so-called “contingent contract” under which the insurer is obligated to pay the insured a specified amount of money—or, alternatively, to purchase for the insured specified medical benefits—should that contingency arise.

The problem has always been to define that “contingency” so that it does not trigger disputes on whether or not the contingency has occurred—e.g., whether a med-

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[3] The Lewin group, *The Cost and Coverage Impacts of a Public Plan: Alternative Design Options,* Staff Working Paper # 44, April 6, 2009.

ical procedure was called for on clinical grounds. Furthermore, it should be clear that *both* sides to the contract—the insured and the insurer—have the opportunity to cheat on the contract, if they are so inclined. It is the reason why these types of contingent contracts typically are subject to penetrating government regulation and oversight.

There is a tendency among the critics on the private health insurance industry to vilify it. I find that unfair and unproductive. The important question is whether that industry, as it is currently structured, can serve the social objectives American society may wish to posit for it and, if not, what regulation of the industry would be required to make it march toward the desired social goal.

C. Marrying a Purely Private Insurance Sector to the Principle of Social Solidarity

If the social objective of our health reform is to make health insurance available to all Americans on equal terms—as President Obama's campaign statements clearly imply—then the current private market for individual insurance has three major shortcomings.

The first is the practice of *medical underwriting,* that is, the practice of inquiring deeply into the personal health status of individual applicants for insurance and basing the quoted premium on the individual's health status. This practice could be eliminated by forcing every insurance company to charge the same premium to every one of its customers, with the possible exception of age. Every insurer would charge so-called *community-rated premiums*, although these could vary competitively among insurers.

A second practice at odds with the President's stated social goal for American health care is the practice of denying health insurance to anyone whose expected future medical bills exceed the premium that can be charged the individual, or to rescind insurance *ex post* when medical claims have piled up and he insurer cancels the policy over some flaw belatedly found in the original application for insurance. This practice can be eliminated by imposing *"guaranteed issue"* on the industry. It means every insurer must accept all applicants seeking to buy coverage at the insurer's quoted community-rated premium and may not cancel policies *ex post*.

But as both the theoretical and the empirical literature on this market clearly demonstrate, imposition of *community-rated premiums* and *guaranteed* issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with a third, highly controversial requirement, namely, a *mandate on individual to be insured* for a at lest a specified minimum package of health benefits.[4]

A mandate upon the individual to be insured, however, is likely to be disobeyed by large numbers of low-income individuals unless the government is willing and able to grant those individuals sufficient public subsidies toward the purchase of health insurance. One way to assess the adequacy of these subsides is to reach a political consensus on the maximum percentage X that the individual's (or family's) total outlay for health insurance premiums and out-of-pocket health-care spending takes out of the unit's discretionary income (disposable income minus outlays for other basic necessities, such as food, housing, clothing, etc.). That maximum percentage X probably would have to rise with income. Its proper size is a political call. It would be helpful if Congress could agree on such a number.

With these four features—*(1) community rating, (2) guaranteed issue, (3) mandated insurance* and *(4) adequate public subsidies*—a private, strictly monitored health insurance market for individually purchased health insurance probably could be made to march fairly closely in step with the distributive social ethic professed by the President and by many Members of Congress. It would require very tight regulations and supervision of the industry, however, most likely through the National Health Insurance Exchange provided for in the President's health-reform proposal. Within their ranks of enrollees, both the Medicare Advantage program and the Medicaid Managed Care program are tightly regulated and supervised in roughly this fashion.

IV. THE POTENTIAL ROLE OF A NEW PUBLIC HEALTH PLAN

During his presidential campaign, President Obama firmly and quite explicitly promised not only to reform the market for private, individually sold health insur-

[4] For a report on how private insurance markets implode when the mandate to be insured is not imposed in a community-rated market with guaranteed issue, see Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox, "**Community Rating And Sustainable Individual Health Insurance Markets In New Jersey:** Trends in **New Jersey** 's Individual Health Coverage Program reveal troubled times for the program," *Health Affairs*, July/August 2004; 23(4): 167–175.

ance—along the lines outlined above—but to include among the insurance options in this market a new public plan for non-elderly Americans. This public plan would have to compete with private health insurers for enrollees.

A. Why might a Public Plan be attractive to Americans?

One could imagine a sizeable latent demand among the American public for such a public health plan, even in the absence of any significant cost advantage that such a public plan might have.

In recent years, Americans have seen retiree health benefits once promised them by private corporations melt away. They have seen their 401(k) savings in the private sector similarly melt down severely and the value of any other private pension plan vastly eroded. They have lost their employer-based health insurance with their job or, if they have not yet lost it, they fear of losing it. They have seen once revered and seemingly indestructible American corporations stumble toward bankruptcy and extinction, either at the hand of global competition or as a result of mismanagement. Finally, they have seen the once revered leaders of the financial sector behave in so irrational and destructive a manner as to make a mockery of received economic theory, with its instinctive belief in the economic superiority of private markets[5].

After all of this turbulence, destruction and self-immolation in the once hallowed private sector of the economy, many Americans may now seek the comfort of permanence that a fully portable, reliable and permanent government-run health insurance plan would offer them, side by side with the possibility of choosing a private health insurance plan instead. To deny them that opportunity would require a compelling justification.

Advantages of a Public Plan: A public health insurance plan for non-elderly Americans could offer society a number of advantages.

First, it would be likely to have the advantage of large economies of scale. Therefore, it could economically use expensive and powerful health-information technology to simplify claims processing, lower the cost of prudent purchasing ad quality monitoring, and engage in disease management, if it were allowed to do so.

Although a few large private insurers dominate the market in many areas, overall the market for private health insurance remains remarkably splintered, with many insurers carrying on somehow with very small enrollments, often below 20,000 insured[6] It is not clear how such small insurers can harvest the economies of scale of marketing and administration, and especially the benefits of health information technology. One must wonder what features in this market have allowed them to survive to this point. Presumably, the market for private insurance would have to consolidate significantly in a reformed insurance market.

Second, a public plan would not have to include in its premiums an allowance for profits and probably have low or no marketing costs. The previously cited Lewin Group sees that as a significant cost advantage of the public plan, reducing administrative costs as a percent of medical claims to about 13%, relative to 31% for private insurers. That advantage, however, may be exaggerated if private insurers offered their policies through a formal insurance exchange, reducing the cost of commissions to insurance brokers.

A third advantage could be the ability of a public plan to innovate in paying the providers of health care. Medicare already has been remarkably innovative on that front. The case-based DRG system for hospital payment, now being copied around the world, is Medicare's creation, and so is the development of the Resource-Based-Relative-Value Scale (RBRVS) which now forms the basis of negotiations over fees between physicians and private health insurers.

The next step in payment reform has to be a move away from the time-honored but inefficient fee-for-service system that dominates in both the private and public insurance sectors, and round the world, towards bundled, case-based payments for evidence based, clinically integrated care[7] Along with Medicare, a new public plan for non-elderly Americans could play a role in the development of this payment method as, of course, could private insurance plans.

Finally, government has already contributed substantially to the measurement of the quality of health care and websites that disseminate such information to the

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[5] See, for example, George A. Akerlof and Robert J. Shiller, *How human Psychology Drives the Economy, and Why it Matters for Global Capitalism,* Princeton University Press, 2009.

[6] See, for example, Allan Baumgarten, *Texas Managed Care Review* 2006 (available at http://www.allanbaumgarten.com/images/presentations/TX_ManagedCareReview_2006.pdf) and similar reports by that author for other states.

[7] See, for example, the website of Prometheus Payment® Inc., http://www.prometheuspayment.org/

market place and has fielded demonstration projects for disease management, once again side by side with the private sector.

Problems with a Public Plan: As I see it, the main problems with the addition of a public health insurance plan to a menu of competing private insurance options are political, rather than technical.

There is in the realm of politics the overarching question whether government should perform functions that the private sector could also perform, even if the private-sector would use more resources—be more costly—to achieve the same end. We see that question debated now in connection with student loans [8] which, according to the Congressional Budget Office [9], cost taxpayers considerably more when channeled through the private banking sector than when loans are made directly by government to students. The outcome of the current debate over student loans may be an augury for the course of health reform.

But even if the answer to the previous question were "Yes"—that government may indeed intrude as a competitor on economic turf traditionally held by the private sector—there is the question of what would constitute a level playing field in a proposed competition of private insurers with a new public plan.

Private insurers argue that if they are forced to compete with a public plan that can piggy-back its payment system onto the administratively set Medicare fees, they are forced to play on an uneven playing field tilted unfavorably in their direction. This suggests a scenario in which the private insurance plans would be pushed to the wall until eventually the U.S. ends up with a single-payer system. The long queues in Canada for certain types of health care, the low fees paid doctors and tight budgets for hospitals there, along with and the much sparser endowment of Canada's health system with certain high-tech equipment are cited as the inevitable destination of a single-payer system.

At this stage, this scenario is mere conjecture, and I have some difficulties following it.

In Canada, private insurance for services covered by the government-run system is prohibited. It would not be in the United States. Thus, if a public health insurance plan for non-elderly Americans really began to deprive American patients of what they desire in health care, the private insurance industry offering superior benefits at higher premiums would not melt away or, if it had, it would quickly be reborn, just as we now see providers starting to refuse the allegedly low fees paid by large private insurer and resorting again to the indemnity insurance model. Markets work that way.

There does, however, remain the issue of the level playing field, which I would not brush aside so easily. In what follows, I shall offer some comments on that issue.

V. DEFINING A LEVEL PLAYING FIELD

Two major facets define the evenness of the playing field on which insurance companies compete with one another: (1) the risk pool with which the insurer ends up and (2) the level of fees at which the insurer can procure health care from its providers.

Risk Pool: At this time roughly two thirds of the American population obtains health insurance from private insurance carries; but collectively private insurers account for only slightly more than one third of total national health spending. It is so because through its Medicare and Medicaid programs, government covers much higher risks on average than do private carriers.

It is not clear how the allocation of risks to private carriers and a new public plan would work out in a market for individual insurance. Chances are that a somewhat sicker risk pool would gravitate toward the public plan, which by itself would put it at a competitive disadvantage *vis a vis* the private plans, other things being equal.

Whatever the case may turn out to be, this facet of the playing field should be recognized in the debate on health reform. To mitigate any tilting of the playing field by that factor, one would ultimately have to install a differential-risk compensation mechanism, such as those operated in Germany, the Netherlands and Switzerland.

Payment Levels: The previously cited report by the Lewin Group projects that, if a new public health plan for non-elderly American paid Medicare fees, and if the overhead of such a plan were less than half of that experienced by private competi-

[8] http://www.washington monthly.com/archives/individual/2009_04/017728.php
[9] http://studentlending analytics.typepad.com/student_lending_analytics/2009/03/cbo-significantly-ups-cost-savings-estimate-from-eliminating-ffelp-.html

tors, then the premiums of the public plan would be 21% below those charged by the private plans.

Assuming a premium-elasticity of the demand for health insurance of −2.47 (meaning a 1% decrease in the premium of the public plan vis a vis the premium of private insurers would trigger a 2.47% migration from private to public insurance), the Lewin Group simulates that some 119 million Americans would shift from private insurance to the public plan, a large fraction of whom would be Americans hitherto covered by employment-based insurance in smaller firms. In fact, the Lewin Group estimates that if the public plan were forced to pay at what it calls "private payer levels," enrollment in private insurance would decline only by 12.5 million, rather than 119 million."

Any such simulation, however, is merely the product of a computer algorithm into which researchers feed assumptions that largely drive the predictions. I, for one, believe that the assumed differential of administrative overhead may be too large, if private insurers sold their policies through an organized exchange, rather than through brokers. Furthermore, research based on the Dutch and Swiss experience suggests considerable stickiness of insurance choices, suggesting that the premium-elasticity assumed by the Lewin Group may be too high. In Switzerland, in particular, very large differences in insurance premiums charged by private insurers for the same package in the same Canton exist with only minimal switching by consumers among plans in response to such differentials. A similar experience has been observed in the Netherlands.[10]

Be that as it may, there is the question what the Lewin Group means by "private payment level." Is there actually such a thing? If so, how is it defined and measured?

Table 6.3 below, taken directly from the *Final Report of the New Jersey Commission on Rationalizing Health Care Resources* (2008),[11] illustrates the variance of actual payments made by one large health insurer to different providers for a standard colonoscopy. Table 6.4 exhibits the variation in actual payments made to different New Jersey hospitals for identical hospital services. Finally, table 6.5 below exhibits similar variances for the same procedures paid by a different, large insurer to different hospitals in California.

Table 6.3:

Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	$178 to $431
Hospital	$716 to $3,717
ASC	$443 to $1,395

[10] See http://www.commonwealthfund.org/~/media/Files/ Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf

[11] http://www.nj.gov/health/rhc/finalreport/index.shtml

Table 6.4:
Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007[47]

	Normal Delivery[1]	CABG[2]	Appendectomy[3]	Hip Replacement[4]
Hospital A	$2,178	$26,342	$2,708	$3,330
Hospital B	$2,787	$32,127	$2,852	$3,444
Hospital C	$2,906	$34,277	$3,320	$4,200
Hospital D	$3,187	$36,792	$3,412	$4,230
Hospital E	$3,276	$37,019	$3,524	$5,028
Hospital F	$3,629	$45,343	$4,230	$5,787

[1] Mother only, case rate.
[2] Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.
[3] Surgical per diem (DRG 167) with average length of stay of 2 days
[4] Surgical per diem for Total Hip replacement, average length of stay 3 days.

Table 6.5:
Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy[1]	CABG[2]
Hospital A	$1,800	$33,000
Hospital B	$2,900	$54,600
Hospital C	$4,700	$64,500
Hospital D	$9,500	$72,300
Hospital E	$13,700	$99,800

[1] Cost per case (DRG 167)
[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

Cost Shifting: Medicare and Medicaid stand accused of shifting costs to private insurers by paying providers, especially hospitals, low prices, often below costs. In a study commissioned by the insurance industry, published in December of 2008, Milliman Inc. estimated the size of this cost shift for 2007 at $51 billion for hospitals and $37.8 billion for physicians, for a total of $88.8 billion.[12]

Although the phenomenon of the cost shift seems real to hospital—and insurance executives, it is less obvious to many economists who have debated the existence of the cost shift for decades among themselves. Indeed, with appeal to empirical data bearing on the issue, Congress' own Medicare Payment Advisory Commission (MedPAC) has cast doubt on the existence of a cost shift before this very Committee in a *Statement for the Record* dated March 2009.[13]

But even if one agreed that there actually were such a cost shift from the public to the private insurance sectors, Tables 6.3 to 6.5 presented above that there must be an even larger cost shift within the private insurance sector among private insurers. It raises the question whether the playing field is level even within that sector.

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[12] Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," (December, 2008) http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf

[13] See also MedPAC, Medicare Payment Policy: MedPAC's March 2009 Report to Congress: 57–67 available at www.medpac.gov.

As Michael A. Porter and Elizabeth Olmsted Teisberg rightly observe on this point in their book *Redefining Health Care*: [14]

"Within the private sector, patients enrolled in large health plans are perversely subsidized by members of smaller groups, the uninsured and out-of-network patients. . . . The dysfunctional competition that has been created by price discrimination far outweighs any short term advantages that individual system participants gain from it, even for those participants who currently enjoy the biggest discounts." [15]

What, then, is the Private Payer Level?: Any proposal to force a new public health plan for non-elderly Americans to pay providers at "private payer levels"—the words used by the Lewin Group—would immediately run into the problem of the rampant price discrimination within the private sector, that is, and the huge variation in fees this price discrimination begets. Every insurer pays vastly different fees to different providers for the same service, and every provider bills different insurers different fees for the same service.

What in the chaos begotten by this system would the "private payer level" be to which a new public health plan should adjust. Would it be the average or the median of the prices paid by private insurers? Would they be simple or weighted averages and medians? If the latter, weighted by what? Over what geographic areas would these averages or medians be calculated?

Finally, if the public plan would have to pay such average or median fees, would it not by sheer arithmetic endow private insurers below that average or median with playing field tilted in its favor?

VI. MAKING THE PUBLIC PLAN FUNCTION LIKE A PRIVATE PLAN

In a recent position paper, Len Nichols and John A. Bertko of the New America Foundation have gone to some length to design a level playing field for private insurers and a new public plan.[16]

Nichols' and Bertko's proposal is inspired by the thirty or so state governments that offer their employees a choice between (a) traditional private insurance plans and (b) and a self-insured public plan operated by the state. The authors would subject the competing private and the public plans to exactly the same rules, monitored by an entity other than the government itself. The public plan would have to be actuarially independent and not get any public subsidies not also available to the private plans. Like the private plans, the public plan would have to negotiate its own fees with providers.

Presumably, unlike Medicare, it would be allowed to exclude particular providers from its network of providers and would be allowed to engage in disease management and other strategies designed to enhance value for the dollar.

The advantage the authors can claim for that proposal is that it might find bipartisan approval. A drawback, however, would be the high administrative cost of forcing the new public plan to negotiate fees with each and every provider.

Furthermore, this approach would perpetuate the rampant price discrimination that should, at some time in the future, be replaced with a more efficient and fairer payment system—perhaps even an all-payer system, such as those used in Germany and Switzerland. As Michael Porter and Elizabeth Olmsted Teisberg [17] and others have argued, it is hard to detect any social value in the chaotic price-discrimination that now characterizes the private health insurance market in the United States.

VII. A MARKET COMPOSED SOLELY OF PRIVATE INSURERS

In the end, the idea of the promised new public plan may be sacrificed on the altar of bipartisan political horse trading. In that case, if one wanted to offer Americans the stability and permanence they are likely to crave and run the market for health insurance on the *Principle of Social Solidarity*, one might structure the market for individually purchased insurance along the lines now used in Germany [18],

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[14] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 66.

[15] For a proposal to begin to reduce this price discrimination see Uwe E. Reinhardt, "A More Rational Approach to Hospital pricing," http://economix.blogs.nytimes.com/2009/01/30/a-more-rational-approach-to-hospital-pricing/ and Uwe E. Reinhardt, "**The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy,**" *Health Affairs*, January/February 2006; 25(1): 57–69.

[16] Len Nichols and John M. Bertko, "A Modest proposal for a Competing Public Health Plan, The New America Foundation, (March 11, 2009) http://www.newamerica.net/files/CompetingPublicHealthPlan.pdf

[17] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 66.

[18] See http://www.commonwealthfund.org/~/media/Files/Resources/2008/Health%20Care%20System%20Profiles/Germany_Country_Profile_2008_2%20pdf.pdf and http://content.

the Netherlands and Switzerland [19], all of whom seek to marry the Principle of Social Solidarity with a system of private, non-profit insurance carriers (Germany and Switzerland) or a mixture of non-profit and for-profit insurers (the Netherlands).

As already noted in the introduction, in these systems the first two functions of a health system—financing and risk pooling—is basically under the control of government, either directly or through tight regulation. The purchasing function, however, is delegated to private, competing entities, albeit under tight regulation as well.

In Germany and Switzerland these systems operate on the basis of an all-payer system, in which fees are negotiated, at the regional level of the state (*Land*) between associations of insurers and associations of providers, where after the negotiated fees apply to all payers and providers within the region. In the Netherlands, fees paid can vary among insurers; but the variance across plans is relatively small by American standards.

VIII. CONCLUSION

Even the opponents of a new public health plan for non-elderly Americans will probably concede that the private market for individually purchased health insurance remains underdeveloped and needs a restructuring before it can serve the needs of the American people better than it has heretofore.

As was argued in Sections III and VII above, even if Congress in the end decided not to permit the establishment of a new public health plan, a rather daunting set of new regulations would have to be imposed on that market to meet the social goals posited for our health system by President Obama. It would also require a mandate on individuals to have basic coverage, a proposal eschewed by the President during the election campaign, albeit not by his Democratic rivals.

Chairman RANGEL. Thank you, Doctor.

We would now like to hear from Bill Vaughan. I join with Chairman Stark in congratulating you and Consumers Union for the contribution you have made to our Congress over the years. And we would like to hear you.

STATEMENT OF WILLIAM VAUGHAN, SENIOR POLICY ANALYST, CONSUMERS UNION

Mr. VAUGHAN. Well, thank you very much, sir, and thank you for inviting us to testify. Consumers Union is the independent, nonprofit publisher of Consumer Reports, and we don't just test toasters. We try to help people with health issues, and we are big, big fans of comparative effectiveness research, which we are using to save people, we think, millions of dollars in getting the most effective, safest, best buy drugs out there.

If Dante were alive writing about the independent health insurance market, it would be in the eighth circle just above where the uninsured are stuck. And it is exhibit number one for what is wrong with American health care.

I was going to go into that, but I think the opening statements of Mr. Camp, Mr. Stark, that is coals to Newcastle. Our statement documents why it is all goofed up, and has some very moving,

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healthaffairs.org/cgi/content/abstract/27/3/771?ijkey=DsTX9syExLZLc&keytype=ref&siteid=healthaff

[19] See http://content.healthaffairs.org/cgi/content/full/27/3/w204) and (http://www.commonwealthfund.org/~E/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swiss dutchhltinssystems_1220%20pdf.pdf and http://www.allhealth.org/BriefingMaterials/JAMA-Uwe-1183.pdfhttp://content.healthaffairs.org/cgi/content/full/27/3/w204) (http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/ The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pd and http://www.allhealth.org/Briefing Materials/JAMA-Uwe-1183.pdf

Thank you very much, and I am happy to answer any questions that you might have.

[The prepared statement of Ms. Blumberg follows:]

Improving Health Insurance Markets
and Promoting Competition
Under Health Care Reform

Statement of

Linda J. Blumberg, Ph.D.

Senior Fellow
The Urban Institute

Committee on Ways and Means
United States House of Representatives

April 22, 2009

Sections of this testimony are taken from John Holahan and Linda Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reforms?" Urban Institute Health Policy Center Issue Brief, 2008, available at http://www.healthpolicycenter.org, and Linda J. Blumberg and Karen Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals," Timely Analysis of Immediate Health Policy Issues brief, forthcoming, 2009.

Mr. Chairman and distinguished Members of the Committee: Thank you for inviting me to share my views on health insurance markets and health care reform. The views I express are mine alone and should not be attributed to the Urban Institute, its trustees, or its funders.

Current health insurance markets suffer from many shortcomings. I'm going to focus my remarks on three that I believe are central, and what I think we might be able to do under reform to address them. First the private insurance system is a voluntarily one for both employers and insurers, but too often those who would like to buy coverage face significant barriers to doing so, including lack of affordability and discrimination based on health status. These barriers contribute to the growing population of uninsured. Second, private health insurance markets are not very organized, making it difficult for individuals and employers to effectively compare options based on price, benefits, and quality of service. The lack of cohesive information on comparability of plan options limits the ability of purchasers to make cost-effective choices for their coverage.

Third, there is little competition between insurers, a consequence of a substantial amount of consolidation among insurers and health care providers in recent years. With little incentive on the part of large consolidated providers to negotiate over price with insurers, and insurers with large market shares being able to pass on these costs to purchasers while continuing to increase their own profits, rapid growth in insurance premiums is fueled.

I believe that comprehensive health care reform will be necessary to address these problems. Insurance market reforms and subsidies to make coverage affordable for the modest-income population within the context of a more organized health insurance

market are essential strategies. A health insurance exchange can be developed to organize the insurance market and to provide guidance and oversight in achieving reform goals. Making a public health insurance plan option available to purchasers can further promote competition in insurance markets and could be an effective strategy for slowing health care cost growth.

Spreading Health Care Risk

Competition in private health insurance markets today focuses largely on obtaining the lowest-risk enrollees. With a highly skewed distribution of health expenditures—the top 10 percent of spenders account for nearly two-thirds of total health expenditures[1]—the gains to insurers from excluding high-cost enrollees is tremendous. Insurance market regulations are required to prevent risk-selecting behavior by insurers. However, states allow insurers to risk select to varying degrees today so that they can protect themselves from the inherent nature of a voluntary insurance market, where individuals who expect to use significant health care services are those who are most likely to seek coverage. Without such leeway on the part of insurers, individuals may wait to purchase coverage until they know they need medical care, creating strong disincentives for the healthy to enroll. This dynamic would lead to very high premiums, reflecting a high-cost group of enrollees, and compromising the long-run stability of insurance pools. However, the consequences of allowing insurers to use such strategies are that many who need coverage cannot obtain it, and many more who have some type of insurance may not have adequate coverage to meet their health care needs.

[1] Samuel Zuvekas and Joel Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, vol. 26, no. 1 (2007): 249-57.

In the context of a health care system that is universal—where everyone is insured all of the time—there is no longer any reason to allow discrimination by health status. Consequently, coverage denials, benefit riders, pre-existing condition exclusions, and medical underwriting can be prohibited, and the costs of those with high medical needs can be spread broadly across the population. Without universal coverage, insurer discrimination by health status can only be eliminated in tandem with broad-based subsidization of the high medical need population, ideally using a source of revenue that is unrelated to the decision to purchase insurance coverage.[3]

In a context of universal or near-universal coverage that includes subsidies for the low-income population and possibly for the high-risk population and prohibits insurer discrimination by health status, an exchange can play an important role related to ensuring the broad-based spreading of health care risk. An exchange can penalize or exclude from participation companies that violate insurance market regulations, establishing market conduct rules to prevent evasion of regulations through informal means. Requiring enrollment through a centralized place, for example, can prevent carriers from denying coverage to particular groups with poor risk profiles or actively marketing only to the healthy. An exchange can also provide for risk adjustment to account for any uneven distribution of enrollee risks across insurers, requiring participating insurers to provide sufficient data on their health plan enrollees. With more accurate risk adjusters, exchanges can maintain a more diverse group of plan options, including highly managed and less tightly managed plans.

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[3] See for example, John Holahan, Len Nichols, and Linda Blumberg, "Expanding Health Insurance Coverage: A New Federal/State Approach," in *Covering America – Real Remedies for the Uninsured*, Jack Meyer and Elliot Wicks, eds., Economic and Social Research Institute, 2001, *available at* http://www.urban.org/UploadedPDF/1000224_holahanuninsuredproposal.pdf.

If the exchange is the exclusive health insurance marketplace for some portion of the population (e.g., individual purchasers and some small groups), then opportunities for steering risks to alternative markets are eliminated. However, if insurers and purchasers can choose whether to participate in the exchange or whether to purchase coverage elsewhere, some risk segmentation potential will remain. In such a case, careful monitoring of the health risks of the enrolling and disenrolling populations will be important for the exchange to maintain, as risk adjustment between the exchange and non-exchange markets may be necessary to maintain the stability of all pools.

Delivering Health Insurance Subsidies

Exchanges can also be designed to efficiently deliver health insurance subsidies, an essential element of a reform intended to make coverage affordable for all incomes. Centralizing the subsidy determination and the process by which subsidy payments are made to insurers into a single agency, such as an exchange, would be a much more efficient approach to administration than that under the Health Coverage Tax Credit (HCTC) experience. Under the HCTC, a non-means-tested program that subsidizes coverage in the existing varied private insurance markets, roughly 34 percent of total spending for the program is attributable to the costs of administering the subsidy.[3] Processes for determining eligibility and for making appropriate payments to hundreds of different health plans require many separate transactions that are performed by multiple agencies under that program.

Having all of these processes centralized in one place could appreciably increase the efficiency of delivering subsidies. This one-stop-shopping approach has been taken

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[3] Stan Dorn, "Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons," Urban Institute Health Policy Center issue brief, 2008, http://www.urban.org/url.cfm?ID=411608.

Mr. STARK. Let's see. Mr. Pascrell, would you like to inquire?

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Sperling, I read your—listened to your testimony and read your testimony, and I agree with a lot of what your testimony is, and even though you're supposed to be one of many, but you made a lot of sense in what you're talking about.

One thing you made sense, I believe, in is you said on Page 5 that, "Our health care system rewards physicians when they provide more services for sick care, rather than rewarding them equally for spending time to help patients avoid the 80 percent of illnesses that are lifestyle related."

I think that's a mouthful. I would agree with you. Much of the debate on health care over the past 15 years has gone to finding money to cover people, rather than getting folks to understand what they're paying for and how we could prevent these kinds of situations. And if that's at the basis of our health care system in the future, we will not be on this one-path that my good friend, Congressman Boustany, talked about very briefly.

I don't agree with you at all on your ERISA comments. I believe they need not only renovation and review, but revamping. A tremendous amount of changes need to happen in those ERISA laws, for us to get on equal footing.

Dr. Reinhardt, there's no debate that the current market for health insurance is failing folks looking to buy health insurance on their own, and small businesses.

Back in 1992, in New Jersey—you're very familiar with New Jersey—New Jersey adopted sweeping health insurance market reforms. We standardized the standardization plan options for small businesses and individuals. We ended discrimination against sick people. And we provided subsidies to people who could not afford to purchase individual coverage. We did a lot of other things, but I think they were the main things that happened in that so-called reform.

These are some of the most progressive policies, supposedly, in the nation. However, healthier individuals disproportionately enrolled in the cheaper, more bare bones options, or dropped coverage altogether. That's a fact. I'm not making this up. It's not conjecture. The numbers indicate that that's exactly what happened. You tell me if I'm missing something.

The premiums quickly began to increase. The subsidies disappeared. And overall enrollment declined.

So I think there's an important lesson here, and if you could define that New Jersey thing very quickly, because that's not my question. Two questions, besides the questions of affordability.

With the experiences of Jersey in mind, and I think it's a good basis here to get off on our discussion about how we're going to change health policy in the country, what are the key pieces of health reform that ensures that healthy and sick people are optimally pooled together and that long-term affordability is sustained; and could you explain to us clearly and concisely the economic need for more standardization and a minimum benefit in terms of risk spreading and adverse selection? But give us a very brief point about why the plan in New Jersey, I think, failed.

Mr. REINHARDT. It failed because it wasn't accompanied by a mandate to be insured for a defined package. It doesn't have to be Cadillac. It should, however, cover what is necessary.

There was an initial study of it by Cathy Schwartz of Harvard, who reported that the New Jersey system worked well, but we, her colleagues argued, "This cannot be true, this will unravel." And sure enough, it did unravel, and I quote a paper here by Monheit et al and others that showed what happened to the New Jersey scheme. It imploded.

Mr. PASCRELL. I'm very proud of the fact that I'm the only legislator that voted against it in New Jersey at the time, and my worst analysis came true, unfortunately.

Mr. REINHARDT. You must be an economist, thought like one, because if those three things don't go together, markets will unravel. It's simply predictable. Young people will not insure, and wait until they can throw themselves on the mercy of a community-rated product.

That's why I favor a mandate, and there are various ways to rig this. One could tell people, "Look, if you postpone insurance and then want to join, you have to have a long waiting period, or your premiums will be higher."

In this country, we invite people to play games with adverse risk selection, because we allow people to change every year or even more frequently. If I had my druthers, I would not allow Medicare beneficiaries to join the private plan and come back within a year. I would say, "You have to do this for five-year periods," somehow to eliminate these games.

But that is what happened in New Jersey, so this is why, in my testimony, I stress those three things do have to go together: guaranteed issue, community rating, and a mandate to be insured, which of course, means you're forcing healthy young people to subsidize older, sicker people.

Mr. PASCRELL. Can I just continue, just for a second?

Mr. Sperling, what would your reaction be to Dr. Reinhardt on the three basic points that this reform of health care must have within it as ingredients, in order to—in Italian we say [Italian word]—in order for this stew to work?

Mr. SPERLING. Congressman, I've been in this business for 30 years. One of the first things I learned is never to argue with Dr. Reinhardt.

[Laughter.]

Mr. SPERLING. The concept of having everybody in, in order to have risk pooling, is something that is unassailable. He's absolutely right.

Mr. PASCRELL. So you agree with that?

Mr. SPERLING. He's absolutely right.

Mr. PASCRELL. You agree with that point?

Mr. SPERLING. Yes.

Mr. PASCRELL. Go ahead. What else?

Mr. SPERLING. Well, I think there's several aspects of the self-insured marketplace that work and can be applied as we try to expand access to——

would negotiate standard, reasonable and timely payments with all health care providers. No exclusions, no denials, no hassle. Everyone would have access to guaranteed health care. Instead of wasting time arguing with insurance companies about payments, doctors and nurses could focus on providing services to patients. A publicly financed, privately delivered system would also make the real costs of our system more visible and make true accountability possible.

Caring for each other. It is time for the American health care system to return to its roots—driven by mission rather than money. There are proposals in the Congress that would begin to move us toward that goal and rescue our failing health care system. They are the Conyers bill, H.R. 676 in the House, and the Sanders bill, S. 703 in the Senate. Congresswoman Pingree is already a co-sponsor of HR 676. We urge you to contact Congressman Michaud and ask him to join her as a co-sponsor of H.R. 676, and Senators Snowe and Collins to urge them to cosponsor S. 703.

In that way, we can join every other industrial country in the world in making access to affordable health care a right.

Phil Caper, M.D.
Joe Lendvai
Brooklin, Maine

This commentary appeared in the Bangor Daily News on April 17, 2009.

The American Academy of Actuaries, Statement

The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

As Congress considers various proposals to reform the individual health insurance market, the American Academy of Actuaries'[1] Health Practice Council appreciates this opportunity to submit written testimony outlining an actuarial perspective on market reforms. According to the latest estimates from the U.S. Census Bureau, about 45 million Americans under age 65, or 17 percent of the nonelderly population, lacked health insurance in 2007. The economic downturn has most likely led to an increase in the number of uninsured. Increasing access to health insurance coverage depends on making insurance more affordable, to individuals as well as to states and the Federal Government. Instituting health insurance market reforms are increasingly viewed as a method of increasing the availability of affordable insurance coverage. Although the potential impact of any given reform will depend on its specific details, actuarial considerations will be vital when determining whether particular proposals will lead to improved markets with increased access to affordable coverage. In particular:

- For insurance markets to be viable, they must attract a broad cross section of risks.
- Market competition requires a level playing field.
- For long-term sustainability, health spending growth must be reduced.

Insurance markets must attract a broad cross section of risks

For health insurance markets to be viable, they must attract a broad cross section of risks. In other words, they must not enroll only high risks; they must enroll low risks as well. If an insurance plan draws only those with high expected health care spending, otherwise known as adverse selection, then premiums will be higher than average to reflect this higher risk. Adverse selection is a byproduct of a voluntary health insurance market. People can choose whether or not to purchase insurance coverage, depending in part on how their expectations for health care needs compare to the insurance premium charged. The higher premiums that result from adverse selection, in turn, may lead to more low risks opting out of coverage, which would result in even higher premiums. This process is typically referred to as a premium spiral. Avoiding such spirals requires minimizing adverse selection and instead at-

[1] The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

tracting a broad base of low-risk individuals, over which the costs of high-risk individuals can be spread. Attracting healthier individuals will ultimately help keep premiums more affordable and stable.

How the various rules and regulations that apply to health insurance markets are defined can affect the degree of adverse selection. For instance, guaranteed-issue provisions can exacerbate adverse selection concerns, by giving individuals the ability and incentive to delay purchasing insurance until they have health care needs.[2] Likewise, pure community rating and adjusted community rating rules can raise the premiums for healthy individuals, relative to what they would pay if health status could be used as a rating factor.[3] This could cause healthy individuals to opt out of coverage, leaving a higher-risk insured population. Allowing insurers to deny coverage or to charge higher premiums to high-risk individuals can help reduce adverse selection by making insurance more attractive to healthy risks, but at the cost of reduced access to coverage and higher premiums for the higher-risk population.

Increasing overall participation in health insurance plans could be an effective way to minimize adverse selection. Requiring individuals to have insurance coverage is one way to increase participation rates, especially among low-risk individuals, and thereby reduce adverse selection risk. Other types of incentives are also available to increase participation, including: limiting open-enrollment periods with penalties for delayed enrollment, subsidizing premiums, and instituting automatic enrollment (i.e., opt-out rather than opt-in provisions). Medicare Parts B and D include some of these incentives. Nevertheless, an effective and enforceable individual mandate would likely achieve higher participation rates than these types of voluntary incentives.

In the absence of universal coverage, some degree of adverse selection is inevitable. And even with universal coverage, some insurance plans could end up with a disproportionate share of high-risk individuals. If plan premiums do not reflect this, the plan could be at risk for large losses. As a result, plans could develop strategies to avoid enrolling less healthy individuals. Risk adjustment could be used to adjust plan payments to take into account the health status of plan participants. This would reduce the incentive an insurer might have to avoid enrolling higher-risk individuals. In addition, some type of reinsurance mechanism could limit insurers' downside risk by protecting against unexpected high-cost claims.

Market competition requires a level playing field

For health insurance markets to be viable, plans trying to enroll the same participants must operate under the same rules. If one set of plans or insurers operate under rules that are more advantageous to high-risk individuals, then they will migrate to those plans; low-risk individuals will migrate to the plans more advantageous to them. In other words, the plans that have rules more amenable to high-risk individuals will suffer from adverse selection. Over time, the premiums for these plans will increase to reflect this, leading to more adverse selection and threatening the viability of those plans.

For example, if a regional health exchange or connector is created, and plans are offered inside and outside the exchange, the rules governing plans inside and outside of the exchange need to be the same. Otherwise either the plans inside the exchange or outside the exchange could get a disproportionate share of high-risk individuals, depending on which set of plans is subject to rules that are more advantageous to those in poorer health.

Similarly, adverse selection can occur when insurance is allowed to be purchased across state lines. High-risk individuals will purchase plans from states with stricter regulations (e.g., those mandating guaranteed issue and community rating), and low-risk individuals will purchase plans from states with looser regulations (e.g., allowing underwriting and premium variations by health status). Premiums for the plans in states with stricter regulations will increase accordingly, which could lead to even fewer insurance purchases among the low-risk population.

For long-term sustainability, health spending growth must be reduced

According to National Health Expenditure data, health care spending increased 6.1 percent in 2007. Although this is the lowest growth rate in a decade, it far exceeds the rate of inflation, and exceeds the growth in the overall economy as well.

[2] Guaranteed issue provisions require that all health insurance applicants must be offered coverage, regardless of their health status or likelihood of large medical expenditures.

[3] Under pure community rating, every insured under a particular insurance plan pays the same premium; premiums cannot vary by factors such as age, gender, and health status. Under modified (or adjusted) community rating, premiums are allowed to vary, often within limits, by certain characteristics, such as age and gender. However, premiums are not allowed to vary by health status.

If health spending continues to grow at this pace, as projected, health insurance premiums will continue to increase as well. Unless health care costs are controlled, efforts to achieve universal coverage may be in vain. Reining in health insurance premiums in the near term will be for naught if rising health spending means that premiums will return to their original levels within a few years, and continue to rise rapidly thereafter. Therefore, to have the potential for sustainable success, health reform proposals need to focus on controlling the rate of health spending growth. And because there is mounting evidence that the money being spent for health care is not providing enough value and that the vast variations in health spending across the country aren't correlated with variations in health care outcomes, spending growth should be addressed within the context of quality and value reforms.

Several factors contribute to the growth in health spending, and there are options to address many of them, each offering promising opportunities to improve quality while reducing costs. The introduction of new technology and treatments can increase health care spending by increasing utilization, particularly of higher-intensity services. More comparative effectiveness research should be conducted to better ensure that new technologies and treatments add value, not just costs. Another driver of health spending growth is that current provider payment systems do not align provider financial incentives with the goal of maximizing the quality and value of health care provided. Instead, the most common provider payment mechanisms reward more care, and more intense care. Restructuring provider payment systems could result in more coordinated, cost-effective, and quality care.

Comprehensive insurance benefits, by lowering the cost of care to the insured, can also result in increased utilization of health care services. Although some of the utilization increases are for necessary care, some are not. Benefit design features such as cost-sharing requirements can be used to encourage more effective use of health care services. However, any incentives to make the insured, particularly those with chronic conditions, more sensitive to benefit costs should be balanced so that individuals are not discouraged from seeking needed care. Value Based Insurance Design (VBID), a relatively new concept in insurance benefit design, attempts to better target cost-shsaring requirements so they more effectively encourage needed care, yet discourage unnecessary care.

Conclusion

Health insurance market reforms have the potential to increase the availability of affordable health insurance coverage and, thereby reduce the number of uninsured Americans. However, for reforms to be viable, they must adhere to actuarial principles. In particular, insurance markets must attract a broad cross section of risks, especially low-risk individuals. Otherwise, adverse selection will result, potentially leading to a premium spiral. In addition, market competition requires a level playing field. Subjecting market competition to the same rules and regulations will help minimize adverse selection between plans and markets. And finally, health spending growth must be curtailed in order to ensure long-term sustainability.

The American Medical Association, Statement

The American Medical Association (AMA) appreciates the opportunity to present the views of our physician and medical student members regarding reforming the health insurance market to ensure greater accessibility and affordability. We commend Chairman Rangel, Ranking Member Camp, and members of the Ways and Means Committee for your leadership in recognizing the need to examine the problems in the health insurance market. The AMA agrees that major reforms are required to make the health insurance market work better for both physicians and their patients.

Covering the uninsured is a top priority of the AMA. The AMA believes that we must enact comprehensive health system reform that will cover the uninsured, improve our health care delivery system, and place affordable, high quality care within reach of all Americans. As advocates for patients, physicians have a particular stake in finding viable, effective approaches to these issues, especially the challenge of covering the uninsured. The AMA's comprehensive proposal to expand health insurance coverage and choice addresses the needs of all patients, regardless of income, and builds on the current employer-based system to promote individual choice and ownership of health insurance coverage.

The AMA proposal allows for the continuation of employment-based insurance in the private sector, while encouraging new sources of health insurance that would

be available to both the uninsured and the currently insured. Under our proposal, individuals who are satisfied with their existing coverage will be able to maintain that coverage. Those who are uninsured or dissatisfied with their current coverage will be able to purchase the coverage they want. One of the goals of our proposal is to give patients more control over their choice of health coverage and their own care and to preserve and improve the patient-physician relationship.

The AMA proposal is based on three pillars designed to expand health insurance coverage and choice: 1) helping people buy health insurance through tax credits or vouchers; 2) choice for individuals and families in what health plan to join; and 3) fostering insurance market reforms that establish fair ground rules and encourage the creation of innovative and affordable health insurance options. In addition, the AMA supports individual responsibility for Americans who have incomes of more than 500 percent of the Federal poverty level and can afford to purchase coverage. Those who cannot afford it and do not qualify for public programs should receive tax credits for the purchase of health insurance. Once affordable, everyone should have the responsibility to obtain health insurance.

The AMA proposes streamlined, more uniform health insurance market regulation, in tandem with targeted government subsidies for coverage of high-risk patients. Market regulations must establish fair ground rules in order for the private insurance market to function properly while also protecting high-risk patients without driving up health insurance premiums for the rest of the population. The sheer number and variety of state and Federal market regulations make it unnecessarily costly to provide health insurance in many markets. There should be greater national uniformity of market regulation across health insurance markets, regardless of type of submarket (i.e., large group, small group, individual), geographic location, or type of health plan. Appropriate regulations would permit market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing, and premiums. Limited state variation in market regulation should be permitted as long as it does not drive up the number of uninsured, unduly hamper the development of multi-state group purchasing alliances or create adverse selection across states.

Health Insurance Exchanges

The AMA supports the creation of new opportunities to buy health insurance individually or as part of a group, such as health insurance exchanges modeled after the Federal Employees Health Benefits Program (FEHBP), small employer purchasing alliances, or health plans offered through professional, trade, religious, or alumni organizations. Insurance must be portable and individuals must have a choice among insurance options that best suit their needs. For those individuals who do not have access to or do not select employer-based insurance, the AMA supports establishing a health insurance purchasing exchange to increase choice, facilitate plan comparisons, and streamline enrollment that will assist individuals in choosing coverage that best suits their needs. Insurers should provide understandable and comparable information about their policies, benefits, and costs to empower patients, employers, and other purchasers and consumers to make more informed decisions about plan choice.

Modified Community Rating

Strict community rating should be replaced with modified community rating. By allowing some degree of premium variation based on individual risk factors, but limiting premium differences within specified risk bands, modified community rating strikes a balance between protecting high-risk individuals and the rest of the population. Some degree of age rating is acceptable, as are lower premiums for nonsmokers, but an individual's genetic information should not be used to determine premiums or eligibility for coverage.

Guaranteed Renewability

The AMA supports the replacement of guaranteed issue regulations with guaranteed renewability. Guaranteed issue requires insurers to accept all applicants regardless of pre-existing conditions, even if they are uninsured. Similarly, prohibiting insurers from imposing pre-existing condition limitations means that insurers must offer the same level of benefits coverage to all applicants. In the context of the current market, which does not have an individual mandate, these regulations permit people to "free-ride" by waiting until they need medical attention to buy health insurance, exposing insurers and all those who have maintained their insurance coverage to unfair risk (once everyone has coverage through individual responsibility or an individual mandate, the concern about guaranteed issue is resolved). As an alternative, the AMA supports guaranteed renewability. Guaranteed renewability would protect individuals from losing coverage or being singled out for premium

hikes due to changes in health status, rewarding people for obtaining and maintaining coverage. Similarly, people who wish to switch health plans should face limited underwriting and pre-existing condition limitations, compared with those who are newly seeking coverage.

Individual Responsibility

The AMA supports requiring individuals and families who can afford coverage to obtain health insurance. Those earning greater than 500 percent of the Federal poverty level should be required to obtain at least catastrophic and preventive coverage, or face adverse tax consequences. The requirement would extend to people of all incomes only after implementation of subsidies for those who need financial assistance obtaining coverage (i.e., sliding-scale, refundable tax credits or vouchers to buy insurance). A requirement to have insurance would enable insurers to move toward community rating. Simplified, automated underwriting would result in de facto modified community rating, as the natural byproduct of market function rather than as a result of market regulation.

Targeted Subsidies for High-Risk Individuals

The AMA believes that insurance market reform must include protections for high-risk patients. The AMA advocates explicit, targeted government subsidies to help high-risk people obtain coverage without paying prohibitively high premiums. Risk-based subsidies make high-risk patients more attractive to insurers without driving up premiums for the general population. Such subsidies can take the form of high-risk pools, reinsurance, and risk adjustment. For example, providing subsidized coverage through high-risk pools gives insurers reassurance that they are unlikely to insure an unfavorable selection of high-cost enrollees in the regular market, allowing them to offer lower premiums and making coverage attractive to the young and healthy. Financing risk-based subsidies with general tax revenues rather than through premiums avoids the unintended consequences of driving up premiums and distorting health insurance markets.

Health Insurer Transparency

We believe that health insurance market reform must include efforts to improve transparency for patients and physicians. The AMA has long supported efforts to promote transparency in health care. We believe that empowering patients with understandable price information and incentives to make prudent choices will strengthen the health care market. To that end, we believe that all methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service. Disclosure of price information, however, can only be meaningful if, in addition to disclosure of physician fees, there is disclosure of insurance claims processing and payment practices. Without transparency on the part of health plans and insurers, both patients and physicians suffer.

Insurers must make available to enrollees and prospective enrollees information, in a standard format, about the amount of payment provided toward each type of service identified as a covered benefit. In addition, health plans and insurers should make medical payment policies, claim edits, and benefit plan provisions embedded in their fee schedules or "negotiated rates" available to patients. Physicians must also have access to health plan pricing information. Without this information, it is impossible for patients to know what their costs will be.

It is critical that employers and consumers have a clear understanding of how health care premiums are allocated by health insurance companies, and in particular how much of their premium dollar is spent on health care services as opposed to administration, profit, or other purposes. Full transparency of how health care insurance premiums are spent will empower patients, employers, and other health insurance purchasers to make more informed decisions, foster competition, and reward companies that minimize administrative waste.

Clarifying and illuminating health care claims payment and adjudication is the only way to ensure that patients will have accurate, current information at their disposal. Such information will enable them to make informed decisions about the most priceless thing in life—their health. Moreover, bringing health care pricing information out of the dark will allow physicians to regain some control over their practices and focus on what they were trained for—treating and healing their patients.

There are a number of claims processing and payment issues that have contributed to the incredibly difficult climate for physicians attempting to be paid promptly, accurately, and fairly by insurers. Failure to comply with state prompt payment claims and attempts to delay and improperly discount physician payments can financially debilitating effects on small physician practices and can severely limit pa-

tient access. Yet often, patients and physicians have little, if any, recourse to challenge health plan actions.

Efforts should be made to deal with prompt payment and other critical insurer payment practices. One-sided contract terms, lack of transparency or conformity in payer payment rules, repricing of physician claims, refusal to accept valid assignments of benefits, and other manipulative payment practices represent egregious business practices. These practices would be unacceptable in any other business context and should not be permitted to continue and flourish in the health insurance industry.

In conclusion, the AMA looks forward to working with you and your colleagues in Congress as you develop health system reform legislation. Thank you again for your strong leadership in this important endeavor.

The National Association of Health Underwriters, Statement

The National Association of Health Underwriters (NAHU) is a professional trade association representing more than 20,000 health insurance agents, brokers and employee benefit specialists all across America. Our members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. They also help their clients use their coverage effectively and make sure they get the right coverage at the most affordable price.

All of this experience gives our membership a unique perspective on the health insurance market place. Our members are intimately familiar with the needs and challenges of health insurance consumers, and they also have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes. They have had the chance to observe the health insurance market reform experiments that have been tried by the states and private enterprise, and are in a unique position to report on which of these efforts have worked the best.

NAHU strongly feels that any health reform effort should be centered around employer sponsored plans, which efficiently provide comprehensive coverage to over 160 million Americans. However, employer-sponsored coverage is not the right choice for everyone; approximately 14.5 million Americans have private health insurance coverage that is not connected with an employer-sponsored plan.[1]

In terms of needed health insurance market reforms, NAHU believes the current individual health insurance marketplace is not always serving consumers in the most effective manner. In our work helping consumers from all over the country obtain private health coverage, we have observed that problems relating to access, preexisting conditions and affordability are prevalent nationwide. Since each state's individual market is uniquely regulated, consumers in some states are faring better than in others, but no state's individual health insurance market is problem-free.

Coverage for Everyone

One of the greatest problems with individual health insurance today is that not all Americans are able to purchase coverage. In some states, people with serious medical conditions who do not have access to employer-sponsored plans cannot buy individual coverage at any price.

One of the simplest ways to address the access issue in the individual market would be to require that all individual health insurance policies be issued on a guaranteed issue basis, without regard to pre-existing medical history. However, in addition to being accessible to all Americans, individual coverage also must be affordable. It would be unwise to require insurers to guarantee issue individual coverage to all applicants unless a system where nearly all Americans have coverage and full participation in the insurance risk pool has been achieved. Due to their small size and the propensity towards adverse selection, state individual health insurance markets are very fragile and price sensitive. Also, there currently is no controlled means of entry and exit into the individual health insurance market independent of health status, like there is with employer-group coverage. Without near universal participation, a guaranteed-issue requirement in this market would have the perverse effect of encouraging individuals to forgo buying coverage until they are sick or require sudden and significant medical care. This, in turn, would undermine the core principle of insurance—spreading risk amongst a large population. The result

[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements) http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3

Exhibit 15

S. HRG. 111–344

CONSUMER CHOICES AND TRANSPARENCY IN THE HEALTH INSURANCE INDUSTRY

HEARING

BEFORE THE

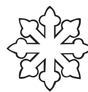
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

JUNE 24, 2009

Printed for the use of the Committee on Commerce, Science, and Transportation



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And then show people in a very detailed way, here's what the policy would cover. Here's what the policy wouldn't cover and you would have to pay and give them a bottom line. So that when they are shopping and comparing the price of policies they can actually see what it would cover.

Transparency is going to be important. But accountability is also going to be very, very important because again of the strong financial incentives we just can't run the health insurance system on the honor system. There's going to need to be strong oversight and strong enforcement of the rules that are there to protect consumers.

In particular it's going to be very important for there to be resources to monitor the health insurance industry and to enforce the rules, resources that are sadly lacking today. At a hearing last summer, over on the House side, the Committee on Oversight and Government Reform, a Representative of the Administration testified that at HHS there were four part-time people whose job it was to monitor all of the HIPAA protections for private health insurance in Federal law. Four, part-time people, that's it.

And despite, this was a hearing on rescissions, despite press reports about abusive rescission practices, no one at HHS had looked into it. No one had asked any questions. No one had even checked to see if the state laws were up to speed and were protecting people in these ways.

Over at the Department of Labor which has oversight over employer sponsored health plans, where most of us get our coverage, testimony has been given that there are resources for that department to review each employer sponsored health plan under its jurisdiction once every 300 years.

And at the state level, regulatory resources are also very limited. I think the states are trying very hard. But state insurance departments have to oversee all lines of insurance, not just health insurance. They have seen staffing cuts, significant staffing cuts in recent years.

And most of them also oversee other things, banking, insurance, commerce, real estate. In four states the Insurance Commissioner is also the Fire Marshall. And they do not have the resources to have, in most states, a dedicated team that just keeps an eye on health insurance all the time doing regular monitoring, regular audits, to make sure that consumers are protected. They have to operate in response to complaints.

So in conclusion, Mr. Chairman, I want to congratulate you for introducing the Informed Consumer Choices in Health Care Act. That bill would provide for the transparency and accountability that we need and the resources to make that happen. I hope that will be part of health reform. And I'm very happy to take your questions.

[The prepared statement of Ms. Pollitz follows:]

PREPARED STATEMENT OF KAREN POLLITZ, RESEARCH PROFESSOR, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

Good afternoon, Mr. Chairman and Members of the Committee.

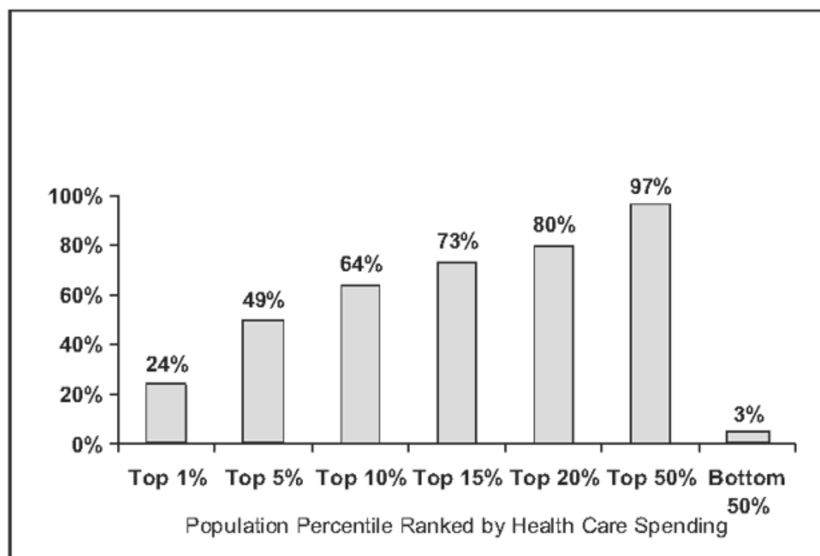
My name is Karen Pollitz. I am a Research Professor at the Georgetown University Health Policy Institute where I study the regulation of private health insurance.

Thank you for holding this hearing today on transparency and accountability in health insurance. These characteristics are lacking in private health insurance today and must be strengthened as part of health care reform.

The Paradox of Risk Spreading

It has long been true that a small proportion of the population accounts for the majority of medical care spending. (See Figure 1) Most of us are healthy most of the time, but when serious or chronic illness or injury strikes, our medical care needs quickly become extensive and expensive.

Figure 1. Concentration of Health Spending in the U.S. Population



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2003. Population includes those without any health care spending. Health spending defined as total payments, or the sum of spending by all payer sources.

Because of this distribution, we buy health insurance to spread risks and protect our access to health care in case we get sick. However, the same distribution creates a powerful financial incentive for insurers to *avoid* risk. In a competitive market, if an insurer can manage to avoid enrolling or paying claims for even a small share of the sickest patients, it can offer coverage at lower premiums and earn higher profits.

Today, insurance companies employ many methods to discriminate against consumers when they are sick. Medical underwriting may be the best known—a process used to assess the risk of applicants. People who have health problems may be denied health insurance when they apply. Or they may be offered a policy with a surcharged premium and/or limits on covered benefits including pre-existing condition exclusions.

However, underwriting is not confined just to the application process. New policyholders (both individuals and small groups) who make large claims during the first year or two of coverage will likely be subject to post-claims underwriting. During this process insurers will re-investigate the applicant's health status and history prior to the coverage effective date. Any discrepancy or omission, even if unintentional and unrelated to the current claim, can result in coverage being rescinded or canceled. At a hearing of the House Energy and Commerce Committee last week, patients testified about having their health insurance policies rescinded soon after making claims for serious health conditions. One woman who is currently battling breast cancer testified that her coverage was revoked for failure to disclose a visit to a dermatologist for acne. At this hearing, when asked whether they would cease

the practice of rescission except in cases of fraud, executives of leading private health insurance companies testified that they would not.[1]

Health care reform legislation will likely include rules to prohibit these practices—guaranteed issue, modified community rating, and prohibition on rescissions and preexisting condition exclusions. These rules are important, but alone, will not put an end to competition based on risk selection. The incentive to compete based on risk selection will not go away.

Insurers can use other formal and informal methods to discriminate based on health status. For example, they can make strategic decisions about where and to whom to market coverage, avoiding areas and populations associated with higher costs and risk. So-called "street underwriting" can be used to size up the health status of applicants before deciding whether to continue with the sales pitch. Insurers can also design covered benefits and provider networks to effectively attract healthy consumers and deter sicker patients from enrolling or remaining enrolled. Claims payment practices and care authorization protocols can also create hassles for patients that discourage coverage retention. Fine print in policy contracts may limit coverage or reimbursement for covered services, leaving consumers to pay out-of-pocket for medical bills they thought would be covered.

Therefore, rules will not be enough. To ensure health coverage is meaningful and secure, greater transparency and accountability must also be required of private health insurance.

Transparency in Health Insurance

Transparency in health insurance will involve three key elements:

- reporting to regulators of data on health insurance company products and practices;
- greater disclosure to consumers of how their coverage works and what it will pay; and
- standardization of health insurance terms, definitions, and practices so that consumers can have a choice of good coverage options without having to worry about falling into traps.

Data—Insurers should report information to health insurance regulators on an ongoing basis about their marketing practices. Data on the number of applications received and new enrollments, as well as data on enrollment retention, renewals, non-renewals, cancellations, and rescissions will be needed. In addition, data must be reported on health insurance rating practices at issue and at renewal. Regulators should know what policies are being sold, what they cover, and who is covered by them. Measures of coverage effectiveness will also be needed to track what medical bills insured consumers are left to pay on their own. Tracking of provider participation, fees, and insurer reimbursement levels is essential. Health insurance policy loss ratios (the share of premium that pays claims, vs. administrative costs) must be monitored. So must be insurer practices regarding claims payment and utilization review. If regulators have access to this kind of information, patterns of problems that affect the sickest consumers won't be easy to hide.

Disclosure—Consumers need much more information about their coverage and health plan choices. Adequate disclosure to consumers begins by ensuring that complete information about how coverage works is readily available. Policy contract language should be posted on insurance company websites so that it can always be inspected by consumers and their advocates. Current provider network directories and prescription drug formularies should also be open to public inspection at all times.

In addition, for each policy marketed, insurers should be required to provide "Coverage facts labels that illustrate how the policy will work to cover standard illustrative patient care scenarios. Recently we issued two reports on the adequacy and transparency of coverage sold in Massachusetts and California. Our reports found substantial differences in coverage protection provided by policies that might otherwise appear similar to consumers. Even in Massachusetts, with its extensive health care reforms and market regulation, significant variation in policy features persists and could leave patients to pay medical bills they did not expect and cannot afford. For example, under two so-called "bronze" policies that have the same actuarial value and cover the same benefits, we found a breast cancer patient might pay

[1] Lisa Girion, "Health insurers refuse to limit rescission of coverage," *Los Angeles Times,* June 17, 2009.

$7,600 out-of-pocket for her treatment under one policy, but $13,000 out-of-pocket for the same treatment under the other policy.[2]

To make coverage differences more obvious to consumers, a series of "Coverage Facts" labels could be developed that simulate the medical care claims patients might have under several expensive conditions, such as breast cancer, heart attack, diabetes, or pregnancy. Insurers would be required to take these standardized scenarios, "process" the simulated claims under policies they sell, and then, for each policy, present a detailed summary of what would be covered and would be left for patients to pay. The format for these labels could be patterned after the Nutrition Facts label that help consumers understand the ingredients and nutritional value of packaged foods. See Figure 2.

Figure 2. Sample "Coverage Facts" Label for Health Insurance

Coverage Facts

Individually Purchased Health Insurance, 2008

Plan C (Bronze)

Monthly Premium (age 55)	**$596**
Annual deductible	**$2,000, $100 for Rx**
Annual OOP limit	**$5,000**
Cost sharing not subject to annual OOP	**Medical, prescription, mental health co-pays**
Significant exclusions, benefit limits	**none**

Breast Cancer Scenario ‡

(May 1 diagnosis, 87 weeks active treatment)

Estimated allowed charges for all treatment	$143,180
Estimated paid by patient	**$12,907 (9%)**

Care type	# billed	Total allowed charges ($)	$ paid by patient	% paid by patient
Office Visit	48	4,387	1,200	38%
Office Procedure	47	466	202	43%
Radiology	12	5,789	898	6%
Laboratory	40	2,924	472	10%
Surgery	1	3,386	1,683	34%
Hospital	1	3,293	659	0
Inpat Med Care	1	174	35	0
Rx Drugs	36	5,473	1,185	19%
Prostheses	1	360	72	0
Chemotherapy	36	98,124	3,967	*
Mental Health	36	2,894	900	33%
Radiation Therapy	35	15,911	1,635	10%

* signifies less than 1/2 of 1%

Source of expense	Number encountered	Amount
Annual deductibles	3	$4,300
Co-pays	120	$3,160
Co-insurance	-	$5,447
Non-covered care	n/a	$0

‡Breast Cancer Scenario includes outpatient lumpectomy, 4 two-week cycles each of two chemotherapy regimens, 7 weeks of daily radiation therapy, one year of Herceptin therapy, short term mental health counseling, various diagnostic lab and imaging services and prescription drugs. Scenario based on treatment guidelines published by NCCN. ***Individual patient care needs may vary.***

All care assumed to be received from in-network providers following all plan rules for prior authorization. Receipt of care by non-plan providers or without required authorizations can result in substantially higher out-of-pocket costs.

Active treatment over 87 weeks beginning in May assumes patient faces annual deductibles and other cost sharing in three plan years. Diagnosis at different time during calendar year could produce different cost sharing results.

[2] Karen Pollitz, *et. al.,* "Coverage When It Counts: What Does Health Insurance in Massachusetts Cover and How Can Consumers Know?" May 2009. Available at *http://www.rwjf.org/pr/product.jsp?id=42248.*

Consumers will need to know other information about how health insurers operate, including rates of prompt payment of claims and claims denials, loss ratios, and the number and nature of complaints and enforcement actions taken against an insurer. Health plan report cards should be developed to provide this information. As people shop for coverage, they must be able to compare differences in efficiency and the level of customer service that insurers provide.

Standardization—People clearly value choice in health coverage, but so many dimensions of coverage vary in so many ways that choices can become overwhelming and even sometimes hide features that will later limit or prevent coverage for needed care. An important goal of health care reform must be to adopt a minimum benefit standard so consumers can be confident that all health plan choices will deliver at least a basic level of protection. Key health insurance terms and definitions must also be standardized. For example, the "out-of-pocket limit" on cost sharing should be defined to limit *all* patient cost sharing, not just some of it. If a plan says it covers hospital care, that should mean the entire hospitalization is covered, not all but the first day.[3] Further, when consumer choice of plans includes low-, medium- and high-option plans, standardized tiers should be developed so people can be confident they are comparing like policies.

Accountability in Health Insurance

Finally, Mr. Chairman, accountability in health insurance requires strong rules and the capacity to monitor and enforce compliance.

Strong rules must be clear, with few exceptions, so they are harder to evade. Weaker rules and exceptions create opportunities for current problems to persist. For example, health care reform legislation pending in the Senate will prohibit discrimination based on health status in premium rates, covered benefits, and eligibility. At the same time, however, Senate Committees are considering an exception to this rule that would allow premiums to vary based on health status in the context of so-called wellness programs. Some employers today offer wellness programs with pointed financial incentives for employees to not only participate, but actually change their health status. Under one popular program, all employee costs are increased by $2,000 at the outset. Workers then have the opportunity to reduce costs by $2,000, but only if they enroll in the incentive program and pass four health status tests, including normal readings for blood pressure, blood cholesterol, body mass index, and tobacco use. On the website for this wellness program, under "Frequently Asked Questions for Employers" it is acknowledged that employer savings are achieved when some employees "choose other health care options."[4]

Because this program discourages some sicker employees from taking coverage, it operates very similarly to other insurer practices of charging higher premiums to people with high blood pressure or high cholesterol in order to deter their enrollment. If discrimination like this is prohibited in one context but allowed in another, holding private health insurance to a nondiscrimination standard will be a challenge.

Regulatory resources—Finally, accountability in health insurance requires resources. Private health insurance regulatory resources at the Federal level are particularly lacking and must be increased. At a hearing last summer of the House Committee on Oversight and Government Reform, a representative of the Bush Administration testified that the Centers for Medicare and Medicaid Services (CMS), which is responsible for oversight of HIPAA private health insurance protections, then dedicated only four part-time staff to HIPAA health insurance issues. Further, despite press reports alleging abusive rescission practices, the agency did not investigate or even make inquiries as to whether Federal law guaranteed renewability protections were being adequately enforced.[5]

Additional resources will also be needed at the U.S. Department of Labor (DOL). After the enactment of HIPAA, a witness for DOL testified the Department had resources to review each employer-sponsored health plan under its jurisdiction once every 300 years.[6]

At the state level, limited regulatory resources are also an issue. In addition to health coverage, state commissioners oversee all other lines of insurance. In several states the Insurance Commissioner also regulates banking, commerce, securities, or

[3] A discussion of plans that include these kinds of features is available in "Hazardous health plans: Coverage gaps can leave you in big trouble," *Consumer Reports,* May 2009.

[4] See *http://www.benicompadvantage.com/products/faq__employers.htm.*

[5] Testimony of Abby Block, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.

[6] Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.

real estate. In four states, the Insurance Commissioner is also the fire marshal. State insurance departments collectively experienced an 11 percent staffing reduction in 2007 while the premium volume they oversaw increased 12 percent.[7] State regulators necessarily focus primarily on licensing and solvency. Dedicated staff to oversee health insurance—and in particular, insurer compliance with HIPAA rules—are limited.

Informed Consumer Choices in Health Care Act of 2009

Mr. Chairman, I want to congratulate you for introducing S. 1050, The Informed Consumer Choices in Health Care Act of 2009. And I commend Congresswoman Rosa DeLauro for authoring companion legislation in the House of Representatives, H.R. 2427. This bill would create a framework to assure greater transparency and accountability in health insurance. It would establish a new Federal agency within HHS tasked specifically with private health insurance oversight. This agency would develop new consumer information and disclosure tools, including a Coverage Facts label for health insurance. It would require regular reporting by insurers on industry products and practices. The bill provides resources for HHS to hire expert staff to carry out these functions and coordinate with state regulators. And it creates a grant program for state insurance departments so they, too, can have resources to better enforce market rules and protect consumers. This legislation and it deserves to be included in health care reform.

In conclusion, starting with the financial industry bailout this year and continuing with the economic stimulus package, transparency and accountability have become the watchwords of this Congress, as taxpayers demand to know how their money is spent and whether stated goals have been achieved. As Congress prepares to make another significant and critically important investment, this time in our health care system, transparency and accountability must also guide your way.

The CHAIRMAN. Thank you very much, Karen Pollitz. I will lead with the questions, will be followed by Senator Johanns and then Senator Klobuchar.

The focus of today's hearing and there are several focuses. But why is it so hard for consumers to get clear, reliable information? I don't always think so much in terms of insurance policies.

But if I get a prescription for something if I'm not well and then you take that little thing out of the bottom of the bag, and I have to get out magnifying glasses and things that Galileo invented in order to find out, you know, what's actually written there. And there's a reason for that, that I won't read it, which of course, I never do. Therefore whatever they want to have happen, can happen.

I'd like to start this discussion on this document which I'm holding up and which will be to some degree passed out, called Examples of Benefits Documents. And it's not very pretty either in appearance or in substance. It's called an Explanation of Benefits or Explanation of Benefits statement.

Every time a consumer goes to see a doctor or receives medical service he or she receives one of these Explanation of Benefits statements. And the health insurance companies send tens of millions of these statements to their policyholders every year. Now the Explanation of Benefits is supposed to "explain to the consumer how much the doctor charged for the service and how much the insurance company pays as a reimbursement for the service." And it sounds pretty simple, pretty straight forward, I would guess.

But it's not, when you start trying to read these statements. Each insurance company has its own specific terminology. And I want to emphasize that each one has its own specific terminology.

[7] National Association of Insurance Commissioners, *2007 Insurance Department Resources Report,* 2008.

Exhibit 16

Health Reform:
Help for Americans with Pre-Existing Conditions

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Introduction

In March, the President signed an historic package of health reforms into law. The new law offers critical protections for the millions of Americans who have pre-existing conditions today—as well as for those who are healthy now but who may develop a health problem as they grow older. As a result of health reform, no American with a pre-existing condition will be denied coverage, charged a higher premium, or sold a policy that excludes coverage of essential health benefits simply because he or she has a pre-existing condition.

This report takes a closer look at the number of Americans with *diagnosed* pre-existing conditions who, absent reform, would be at risk of being denied coverage in the individual insurance market. The uninsured and those who do not have access to job-based coverage are at greatest risk, but even those who now have coverage at work could be at risk if they lose or leave their jobs and have to find coverage in the individual market. To better understand the effect that health reform will have on these people, Families USA commissioned The Lewin Group to quantify the number of Americans who are diagnosed with conditions that commonly lead to denials of coverage.

Looking only at those serious conditions that are commonly linked to coverage denials, we found that 57.2 million non-elderly Americans have a pre-existing condition that could lead to a denial of coverage in today's individual insurance market. That's more than one out of every five people under the age of 65, or 22.4 percent. No group is immune to the effects of this pervasive problem: It affects people in all age groups, every racial and ethnic group, and every income group. All of these people with diagnosed pre-existing conditions are at risk for being denied coverage.

Our analysis does not include every condition that may lead to a denial of coverage, nor does it capture every person with a pre-existing condition that would likely result in higher premiums or excluded benefits. Further, this analysis cannot capture the uninsured and underinsured Americans who, lacking a way to pay for care, do not seek treatment and whose health conditions, therefore, remain undiagnosed. Because people with low incomes and racial and ethnic minorities are disproportionately represented among the uninsured and underinsured, they are likely to be undercounted in our analysis.

The protections that health reform offers mean that every American will now have greater security and peace of mind, knowing that insurance companies will be required to sell health insurance to all individuals regardless of their health status, to charge them the same premiums rather than making them pay more, and to cover all benefits. These new protections mean that every American will always be able to purchase quality, affordable coverage.

Summary of Methodology

This report examines the number of Americans with diagnosed pre-existing conditions who, absent reform, would be at risk of being denied coverage in the individual insurance market. To better understand the magnitude of this problem, Families USA commissioned The Lewin Group to analyze data relating to pre-existing conditions. As described more fully in the Technical Appendix on page 15, The Lewin Group quantified the number of Americans who are diagnosed with health conditions that commonly lead to denials of coverage in today's marketplace. This study's findings are based on data on health conditions from the U.S. Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS) and demographic data from the U.S. Census Bureau's Current Population Survey (CPS). This analysis presents the total number of non-elderly, non-institutionalized, non-Medicare-eligible Americans who are diagnosed with pre-existing conditions that commonly lead to a denial of coverage, including those who currently have health insurance but would be at risk if they needed to seek coverage on their own in the individual insurance market.

Key Findings

One in Five Americans Is at Risk of a Denial of Coverage

- Approximately 57.2 million Americans under the age of 65 have a pre-existing condition that, absent reform, could lead to a denial of coverage by an insurance company (see Table 1).
- This means that, without health reform, more than one in every five non-elderly Americans (22.4 percent) is at risk of being denied coverage.

Table 1.

People under Age 65 Diagnosed with a Pre-Existing Condition that Could Result in a Denial of Coverage

Population Under 65*	Population under 65 with a Pre-Existing Condition	Percent of Population under 65 With a Pre-Existing Condition
255,103,000	57,152,000	22.4%

* Data are for the non-institutionalized, non-Medicare-eligible population.

Source: Estimates based on pre-existing conditions diagnosed or treated in 2007, prepared by The Lewin Group for Families USA (see the Technical Appendix for details).

Pre-Existing Conditions: A Problem that Grows with Age

- Individuals in every age group are affected by pre-existing conditions that, absent reform, could lead to a denial of coverage (see Figure 1 and Table 2). However, those who are older are much more likely to have such a condition, as follows:
  - Nearly one in six young adults aged 18 to 24 (15.9 percent) has a pre-existing condition that could lead to a denial of coverage.
  - More than one-third of adults aged 45 to 54 (35.3 percent) have a pre-existing condition that could lead to a denial of coverage.
  - More than two in five adults aged 55 to 64 (45.5 percent) have a pre-existing condition that could lead to a denial of coverage.

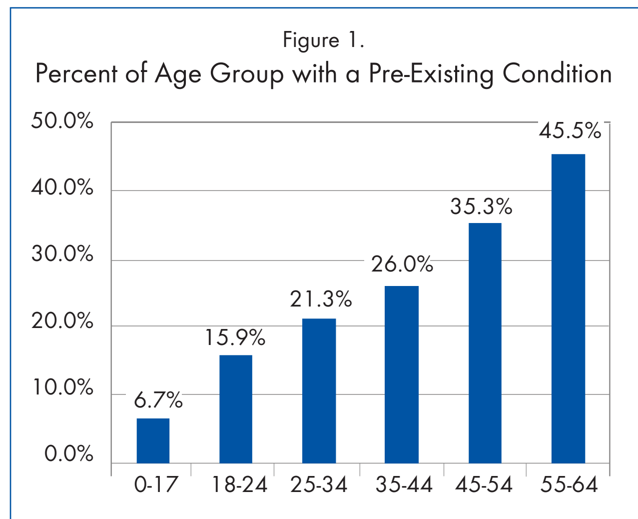


Table 2.

People under Age 65 Diagnosed with a Pre-Existing Condition that Could Result in a Denial of Coverage, by Age

Age Group	Number in Age Group*	Number in Age Group with a Pre-Existing Condition	Percent of Age Group with a Pre-Existing Condition	As a Percent of Non-Elderly People with a Pre-Existing Condition
0-17	73,793,000	4,952,000	6.7%	8.7%
18-24	28,298,000	4,486,000	15.9%	7.8%
25-34	39,667,000	8,460,000	21.3%	14.8%
35-44	41,167,000	10,696,000	26.0%	18.7%
45-54	42,085,000	14,863,000	35.3%	26.0%
55-64	30,092,000	13,695,000	45.5%	24.0%
Total**	**255,103,000**	**57,152,000**	**22.4%**	**100.0%**

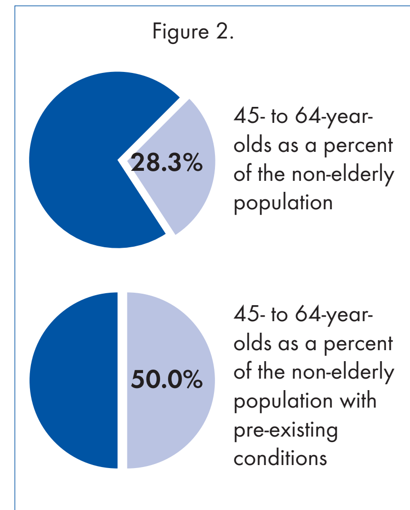
* Data are for the non-institutionalized, non-Medicare-eligible population.

** Numbers do not add to total because of rounding.

Source: Estimates based on pre-existing conditions diagnosed or treated in 2007, prepared by The Lewin Group for Families USA (see the Technical Appendix for details).

- Adults aged 45 to 64 account for only 28.3 percent of the non-elderly U.S. population, but they make up fully half (50.0 percent) of those with pre-existing conditions (see Figure 2).
  - This phenomenon is most pronounced among adults aged 55 to 64. Adults in this age group account for only 11.8 percent of the non-elderly U.S. population, but they make up nearly a quarter (24.0 percent) of those with pre-existing conditions.

Figure 2.



Children and Young Adults with Pre-Existing Conditions

- While the percentage of American children and young adults who have a pre-existing condition that could lead to a denial of coverage is low relative to older Americans, a substantial number of children and young adults are affected.
  - Nearly 5.0 million children under the age of 18, and 4.5 million young adults aged 18 to 24, have a pre-existing condition that could lead to a denial of coverage.

Every Income Group Is Affected

- People of every income group have pre-existing conditions that, without health reform, could lead to a denial of coverage (see Table 3). By income group, we see the following trend:
  - The lowest-income Americans are the most likely to have such a condition, with nearly one-quarter (24.2 percent) of individuals in families with incomes below 100 percent of the federal poverty level (less than $22,050 for a family of four in 2010) affected.
  - Approximately 21.9 percent of individuals in families with incomes between 100 and 199 percent of poverty ($22,050-$44,100 for a family of four in 2010) have such a condition.
  - Approximately 22.2 percent of individuals in families with incomes at or above 200 percent of poverty (more than $44,100 for a family of four in 2010) have such a condition.
  - While the lowest-income Americans are slightly more likely to be affected by pre-existing conditions, middle-income and higher-income Americans (those in families earning more than 200 percent of poverty, or $44,100 for a family of four in 2010) make up more than two-thirds (69.8 percent) of those with pre-existing conditions that could lead to a denial of coverage.

Table 3.

People under Age 65 Diagnosed with a Pre-Existing Condition that Could Result in a Denial of Coverage, by Income

Family Income Relative to the Federal Poverty Level	Number in Income Group*	Number in Income Group with a Pre-Existing Condition	Percent of Income Group with a Pre-Existing Condition	As a Percent of Non-Elderly People with a Pre-Existing Condition
<100%	32,832,000	7,932,000	24.2%	13.9%
100-199%	42,653,000	9,336,000	21.9%	16.3%
≥ 200%	179,618,000	39,884,000	22.2%	69.8%
200-399%	78,291,000	17,408,000	22.2%	30.5%
≥ 400%	101,326,000	22,476,000	22.2%	39.3%
Total**	**255,103,000**	**57,152,000**	**22.4%**	**100.0%**

* Data are for the non-institutionalized, non-Medicare-eligible population.

** Numbers do not add to total because of rounding.

Source: Estimates based on pre-existing conditions diagnosed or treated in 2007, prepared by The Lewin Group for Families USA (see the Technical Appendix for details).

Every Racial and Ethnic Group Is Affected

- People of every racial and ethnic group have pre-existing conditions that, absent reform, could lead to a denial of coverage (see Table 4 on page 6). By race and ethnic group, we see the following trend:
  - American Indians and Alaska Natives are the most likely to be affected, with more than one-quarter (25.9 percent) having a pre-existing condition that could lead to a denial of coverage.
  - Approximately one-quarter (24.4 percent) of whites (non-Hispanic) have such a condition.
  - Nearly one-quarter (23.4 percent) of African Americans (non-Hispanic) have such a condition.
  - More than one in six Hispanics (16.9 percent) is affected.
  - Slightly fewer than one in six Native Hawaiians and other Pacific Islanders (14.5 percent), and just over one in 10 Asian Americans (11.7 percent), have a pre-existing condition that could lead to a denial of coverage.

Table 4.

People under Age 65 Diagnosed with a Pre-Existing Condition that Could Result in a Denial of Coverage, by Race or Hispanic Origin

Racial or Ethnic Group	Number in Group*	Number in Group With a Pre-Existing Condition	Percent of Group With a Pre-Existing Condition	As a Percent of Non-Elderly People with a Pre-Existing Condition
American Indian/Alaska Native	3,400,000	880,000	25.9%	1.5%
Asian	12,433,000	1,454,000	11.7%	2.5%
Black, non-Hispanic	31,851,000	7,452,000	23.4%	13.0%
Hawaiian/Pacific Islander	910,000	132,000	14.5%	0.2%
Hispanic	42,809,000	7,221,000	16.9%	12.6%
White, non-Hispanic	163,699,000	40,012,000	24.4%	70.0%
Total**	**255,103,000**	**57,152,000**	**22.4%**	**100.0%**

* Data are for the non-institutionalized, non-Medicare-eligible population.

** Numbers do not add to total because of rounding.

Source: Estimates based on pre-existing conditions diagnosed or treated in 2007, prepared by The Lewin Group for Families USA (see the Technical Appendix for details).

Our analysis is based on the number of Americans who are *diagnosed* with a pre-existing condition that could lead to a denial of coverage. The analysis did not control for disparities in access to care and in the delivery of care that may result in lower rates of diagnosed disease among certain racial and ethnic minority groups. For a more in-depth examination of this point, please see the Discussion below.

Discussion

Millions of Americans have pre-existing conditions, such as diabetes, heart disease, and cancer. These people will be substantially helped by the new health reform law. Under health reform, insurance companies will no longer be allowed to deny people coverage based on their health status. Equally important, insurance companies will no longer be allowed to charge higher premiums for this coverage or to sell policies that exclude coverage for certain benefits based on a person's pre-existing condition.

This study was designed to improve our understanding of how many Americans have pre-existing conditions that could lead to a denial of coverage by an insurance company if there were no protections for people with pre-existing conditions. Our report looks at people who are diagnosed with health conditions that commonly lead to denials of coverage. Denials, however, are just the tip of the iceberg. Our analysis presents a conservative estimate of the number of people who are affected by pre-existing conditions for the following three reasons:

- First, the data capture only the number of people who were *diagnosed* with one of a list of specific pre-existing conditions; it does not count people who had an undiagnosed condition.
- Second, the data count only those people who were diagnosed with or treated for one of a list of pre-existing conditions within the one-year period of 2007 (the latest year for which data are available).
- Third, we count only people who had at least one health condition on the list of specific conditions that are likely to lead to a denial of coverage. We do not count people who had conditions that are not on this list but that may also lead to a denial of coverage or to higher premiums or coverage exclusions.

The findings of our analysis are alarming: 57.2 million non-elderly Americans—more than one out of every five people under the age of 65 (22.4 percent)—have a pre-existing condition that, absent reform, could lead to a denial of coverage.

A Shared Problem

Our findings demonstrate that every group of Americans—people from every age group, income group, and racial and ethnic group—have pre-existing conditions. While people of all ages are affected, our analysis found that the likelihood of having a pre-existing condition grows with age. Older adults are more likely than children and younger adults to have a pre-existing condition that could lead to a denial of coverage in today's marketplace. For example, fewer than one in five young adults aged 18 to 24 (15.9 percent) has a pre-existing condition that could lead to a denial of coverage, while more than two in five adults aged 55 to 64 (45.5 percent) have such a condition. In addition, adults aged 45 to 64 account for only 28.3 percent of the non-elderly U.S. population, but they make up half (50.0 percent) of those with pre-existing conditions.

Our findings also reveal that every income group experiences the effects of this widespread problem. For instance, the lowest-income Americans are the most likely to have such a condition, with nearly one-quarter (24.2 percent) of individuals in families with incomes below 100 percent of the federal poverty level (less than $22,050 for a family of four in 2010) affected, but middle- and higher-income Americans face pre-existing conditions nearly as frequently. More than one in five Americans (22.2 percent) in families earning more than 200 percent of poverty (more than $44,100 for a family of four in 2010) has a pre-existing condition that could lead to a denial of coverage.

Finally, the findings show that every racial and ethnic group has pre-existing conditions that could lead to a denial of coverage. In fact, approximately one-quarter (24.4 percent) of whites (non-Hispanic) and 23.4 percent of African Americans (non-Hispanic) have such a condition, while slightly more than one in six Hispanics (16.9 percent) is affected.

While these findings may seem somewhat counterintuitive, our analysis looks only at those people who have been *diagnosed* with a pre-existing condition. Research indicates, however, that there are substantial disparities in access to care and the delivery of care across racial and ethnic groups, which may in turn lead to differing rates of diagnosis. For example, Hispanic adults are more than twice as likely as non-Hispanic adults (34.3 percent versus 15.9 percent) to lack a usual source of care, and more than a quarter (25.2 percent) of Hispanic adults had no health care visits in 2007, compared to 14.7 percent of non-Hispanic adults.[1] Similar trends can be seen in the delivery of cancer screenings: Only 37.3 percent of Hispanic adults over age 50 and 48.6 percent of African American adults over age 50 received colorectal cancer screening in 2005, compared to 58.5 percent of white (non-Hispanic) adults over age 50.[2]

Current Insurance Company Practices

Until now, health insurers have generally been free to treat individuals with pre-existing conditions unfairly. In most states, insurers have been able to refuse to sell individuals policies due to a variety of factors, including their medical history, health status, and health risks. For instance, a person with a health condition such as diabetes could be denied coverage in the individual market because of his or her pre-existing condition.[3] While our analysis looks only at those who are at risk of being denied coverage due to a diagnosed pre-existing condition, still more people may be denied coverage because they are at risk for developing such a condition. For example, people may be denied coverage if they take common drugs for arthritis, cholesterol, or other health conditions, even if they are taking them to *prevent* a disease from developing and have not actually been diagnosed.[4]

If people with pre-existing conditions find an insurer that is willing to sell them a policy, in most states, insurers can charge them exorbitant premiums based on their pre-existing conditions.[5] Currently, in the majority of states, there are no limits on how much an insurance company can vary premiums based on an individual's health status.[6] This means that insurance companies have free rein to set premiums at whatever level they claim is "necessary." Practices like these make health insurance unaffordable for millions of Americans.

Even if people with pre-existing conditions pay these very high premiums for coverage, the insurance policy they get still might not cover their most important health problems. In every state, most insurance companies can exclude coverage for care related to enrollees' pre-existing conditions, at least for a certain period of time.[7] For example, an insurer may be willing to sell a policy to a person with asthma, but it can exclude any treatment or services related to asthma from the person's coverage.[8] In a survey of adults who attempted to purchase policies in the private individual market in a three-year period, more than half (57 percent) found it very difficult or impossible to find a plan that they thought was affordable, and nearly half (47 percent) found it very difficult or impossible to find a plan that offered the coverage they needed.[9]

Currently, five states have laws that require insurance companies in the individual market to accept all individuals who apply for coverage, regardless of their health status or other factors.[10] However, even people in states that offer the greatest protections for those with pre-existing conditions aren't fully protected: If an individual in one of these states tries to buy a policy after being uninsured for at least 63 days, the insurer is still free to exclude coverage of his or her pre-existing conditions for a period of time, just like in every other state.[11]

Once health reform is fully implemented and strong consumer protections are put in place, all insurance companies will be required to sell coverage to all Americans and will not be allowed to deny coverage, charge people higher premiums based on their health status, or sell them policies that exclude coverage for certain health problems.

The Consequences of Coverage Denials

In our current system, a denial of coverage can lead to a broad range of adverse consequences. Many people who are denied coverage are forced to go without health insurance, which puts them at risk both physically and financially. Those who are uninsured are less likely to get the care that they need when they need it and are more likely to delay seeking care—often until a condition becomes so serious that treatment can no longer be put off. Quite often, the uninsured also suffer devastating financial consequences as a result of paying for this care. In addition, the fear of going without health coverage negatively affects productivity and the labor market because many Americans make decisions about which job to choose, or whether to stay in a job, based on whether the job provides health coverage—a phenomenon known as "job lock." By ensuring that everyone, regardless of health status, has an offer of coverage, health reform will help diminish these adverse consequences.

Poorer Health

The health consequences of going without coverage form a vicious circle. Those who do not have coverage often do not receive care when they need it. For example:

- Uninsured adults are six times more likely than those who are privately insured to go without needed care due to its cost (24 percent versus 4 percent).[12]
- Uninsured adults are seven times more likely than insured adults to have gone without preventive care in the last year (42 percent versus 6 percent).[13]
- Uninsured adults with chronic conditions are particularly at risk. Among uninsured adults with chronic conditions
  - nearly one-third (32 percent) went without needed medical care,
  - approximately 59 percent delayed care, and
  - three out of five (60 percent) did not fill a prescription due to cost.[14]

People who go without coverage are less likely to have a usual source of care outside of the emergency room, often go without screenings and preventive care, are more likely to delay or forgo necessary medical care, and end up sicker when they do get care. When uninsured adults put off seeing a doctor, illnesses that could have been prevented or treated easily often become much more serious, and people can end up with worse outcomes and have more troublesome diagnoses when they do seek care. The uninsured are therefore more likely to need intensive interventions. For example, it is important that individuals with diabetes monitor their blood sugar. Poor management of diabetes can lead to devastating consequences, such as kidney failure, blindness, and amputation, all of which can be prevented through good diabetes control.[15]

Of course, the worst consequence of being uninsured is premature death: Studies have shown that uninsured adults are at least 25 percent more likely to die prematurely than privately insured adults.[16]

Financial Burdens

When uninsured individuals do seek care, they often have to pay more for it. One reason for this is because uninsured individuals lack the buying power to negotiate discounts on medical services like insurance companies do for their customers. As a result, uninsured patients are often charged more than 2.5 times what insured patients are charged for the same hospital services.[17]

Another reason that people without insurance often pay more for care is because they delay getting the care they need. When people delay care, their health conditions often worsen and become more costly to treat. For example, uninsured women are substantially more likely than women with private insurance to be diagnosed with breast cancer in a later stage and to require more intensive treatment.[18] Accordingly, their recommended treatment is likely to be more expensive, and they may suffer economically because of this. For example, more than two-thirds (68 percent) of people who were uninsured during cancer treatment say that the costs were a burden on their families.[19]

When people cannot afford to pay for their medical care, they often find themselves with medical debt. In order to pay their debt, uninsured people may use up all of their savings, charge credit cards for bills that will take years to repay, or take out a loan or mortgage on their home. When those resources have been exhausted, people with medical debt may struggle to pay for basic necessities such as food, heat, clothing, and other basic necessities.[20]

Medical debt is strongly linked to bankruptcy. In 2007, illness or medical bills were two key contributing factors to nearly two-thirds (62.1 percent) of all personal bankruptices filed.[21] In addition, medical debt can lead to the loss of a home. One study found that nearly half of home foreclosures (49 percent) in four states were caused, at least in part, by financial issues stemming from a medical problem, such as illness or injury, medical bills that were beyond the person's ability to pay, or lost work because of their own medical problems or those of a family member.[22]

■ Labor Market Inefficiency

In our current system, people with health conditions have a difficult time finding coverage in the individual market. Uncertainty about whether they'll be able to find affordable coverage leads many Americans to make decisions about which job to choose or whether to stay in a job based on whether the job provides health coverage. This phenomenon is known as "job lock."[23]

Job lock primarily affects individuals with health conditions who are considering leaving their current job for another job that does not offer health insurance. Workers who have health problems are less likely to leave a job that offers health coverage. One study found that chronically ill workers who rely on their employer for health coverage are about 40 percent less likely to leave their job than chronically ill workers who do not rely on their employer for coverage.[24] Another study found that workers with a history of health problems such as diabetes, cancer, or heart attack, and those who have substantial medical expenses, stay at their jobs significantly longer because of their job-based health coverage.[25]

Job lock has a particularly strong effect on people who have family members with chronic illnesses. Research has shown, for example, that workers who rely on their employer to provide insurance for chronically ill family members stay in jobs that they might otherwise leave. One study found that women with job-based coverage who have a chronically ill family member that depends on that coverage are 65 percent less likely to leave their job than women with job-based coverage who have a chronically ill family member that does not depend on that employer coverage.[26]

The fear of going without health coverage discourages individuals from leaving their existing jobs and starting new businesses of their own, especially if they have pre-existing conditions or if they have a family member with a health condition. Productivity is hurt when the new ideas, new products, and competitiveness that new businesses bring to the economy are lost. Health reform has the potential to significantly reduce the problem of job lock: Thanks to reform, individuals will no longer have to base their employment decisions on whether a job offers health coverage.

Conclusion

With the passage of health reform, all Americans, including those with pre-existing conditions, can be confident that they will be able to purchase insurance today and in the future. The newly passed legislation will have a profound effect on the millions of Americans who have pre-existing conditions. Because of health reform, insurance companies will no longer be allowed to deny people coverage based on health status, and 57.2 million non-elderly Americans who have a diagnosed pre-existing condition will no longer be at risk of being denied coverage. Nor will they face higher premiums or policies that exclude the very benefits they need. These new protections mean that every person will have access to high-quality, affordable coverage.

Exhibit 17

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Can States Pick Up the Health Reform Torch?

Sara Rosenbaum, J.D.

It is impossible to recall another time when a single incident — in this case, the off-cycle election of a U.S. senator — so thoroughly implicated the long-term direction of U.S. health policy. Washington is still taking the full measure of Senator Scott Brown's victory in Massachusetts, but among seasoned observers, the election's potential fallout for health reform was evident even before the first votes were cast.[1]

The political narrative of the Brown victory is the stuff of legend: the loss of a Senate seat held by an iconic figure who devoted his half-century political career to the very issue now at the center of events. The policy narrative is just as astounding, since Massachusetts' health care reform plan (for which Brown voted) provided the basic template for federal reform.

Even as the White House and Congress struggle to move forward, some observers have once again focused on the states. To be sure, the Senate bill, unlike its House counterpart, uses a state-based approach to the operation of health insurance exchanges, the purchasing marts through which eligible individuals and small businesses would gain access to affordable coverage. But unlike independent state reforms, the House and Senate bills offer a national solution for the residents of all states, not just those who live in jurisdictions with the political and financial means to pursue change.

Why Congress has reached a moment of national action is not hard to grasp. The insurance crisis has been with us a long time: only its magnitude has changed, with health care costs now exceeding 17% of the gross domestic product and with 17 states in which 15% or more of the nonelderly population is uninsured.[2] States have had decades to enact broad reforms, yet the record has been one of futility despite enormous effort. Massachusetts, the one standout in this regard, found itself in 2006 remarkably positioned to move. The state's social culture favored government involvement; its Republican governor and Democratic legislature aligned on a coverage mandate, greater insurance regulation, and strong Medicaid restructuring. A relatively low proportion of the population was uninsured, and the state enjoyed a seemingly healthy economy and the financial wherewithal to act (chiefly as a result of the Medicaid restructuring that was the basis of reform). As its financial

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picture continues to erode, Massachusetts now depends on a national solution to hold on to its gains, which makes particularly ironic the assertion of then-candidate Brown that national health care reform should be rejected because it would divert funds away from the state that it needs to maintain its program.

Massachusetts must be understood as the rarity rather than the norm. In the best of times, most states could not repeat the experience in Massachusetts. Today, between surging numbers of uninsured, collapsing state economies (see table), and a decided shift in the culture and politics of government intervention, another Massachusetts is out of the question. Putting aside the immediate financial crisis, proponents of state action overlook the vast legal, political, operational, and economic barriers to sweeping state reform.

The first hurdle is fiscal reality; health care reform rests on an infusion of federal resources, given the reduced income of most uninsured Americans. No matter how health insurance reform is structured (subsidized private coverage, a single payer, or a combination of approaches), insurance is astoundingly expensive. Cost estimates for employer group coverage (the most efficient market) in 2009 were $4,824 for an individual plan and $13,375 for a family plan.[3] Making coverage affordable means a real investment in the population. This is especially true in states whose unin-

State Budget Cuts Made during Fiscal Year 2009 and Proposed for Fiscal Year 2010.*

State	Fiscal Year 2009		Fiscal Year 2010	
	Size of Cuts	Cuts to Medicaid	Size of Cuts	Cuts to Medicaid
	millions of $		*millions of $*	
Alabama	697.4			
Alaska	11.7		1,053.4	
Arizona	554.0	X	111.0	X
Arkansas	64.9			
California	10,654.5	X	20,363.5	X
Colorado	144.0	X	926.5	X
Connecticut	341.4	X	52.8	X
Delaware	247.0		751.0	
Florida	887.4	X		
Georgia	2,262.2	X	2,596.0	X
Hawaii	86.2	X	315.4	X
Idaho	241.0		99.7	
Illinois	600.0		500.0	
Indiana	529.7		672.2	X
Iowa	108.8	X	564.4	X
Kansas	155.3		733.4	
Kentucky	163.2		273.8	
Louisiana	341.0	X		X
Maine	74.1	X	232.3	X
Maryland	470.9	X	448.0	X
Massachusetts	1,271.0		2,424.0	
Michigan	438.0	X	1,832.0	X
Minnesota	426.3	X	2,280.3	X
Mississippi	199.9	X		
Missouri	430.0		480.0	
Nebraska				X
Nevada	136.0	X	182.4	
New Hampshire	81.1			
New Jersey	2,000.0	X	3,284.0	X
New Mexico	282.1	X	539.1	X
New York	413.0	X	6,047.0	X
North Carolina	1,221.0	X		X
Ohio	1,093.0	X		
Oklahoma			471.7	
Oregon	764.0	X	988.0	X
Pennsylvania	470.4		1,172.8	
Rhode Island	214.0	X	415.6	X
South Carolina	1,106.4	X	328.3	X
South Dakota	0.4			
Tennessee	127.2		808.3	X
Utah	571.3		318.6	X
Vermont	68.0	X	98.0	X
Virginia	480.3	X	854.6	X
Washington	255.0	X	1,335.0	X
West Virginia			184.0	X
Wisconsin	635.0	X	1,917.7	X
Total	**31,318.1**	**27**	**55,654.8**	**28**

* Budgets for fiscal year 2010 are currently ongoing. Data are not available for Montana, North Dakota, Texas, and Wyoming. An X indicates cuts to Medicaid. Courtesy of the National Association of State Budget Officers.

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sured populations are staggeringly large. (Texas and California together accounted for 12.7 million uninsured persons in 2008, more than one quarter of the uninsured.)

A second hurdle is practical. If accessible private insurance is the goal, then states need to tackle the discriminatory tactics, such as price gouging and exclusion, that insurers use to deny enrollment or provide coverage that is grossly inadequate in relation to medical need. Even if individual states are willing to intervene, insurers are free to evade state regulation simply by pulling up stakes in any jurisdiction with an unappealing political and regulatory climate. State crackdowns make little headway; even California, the largest state, struggled to delay a proposed 39% rate increase by Anthem Blue Cross until the federal government intervened.

The law represents a third hurdle. Even states that are willing to intervene find themselves powerless to reach more than half the group market as a result of the Employee Retirement Income Security Act (ERISA), which exempts from state regulation self-funded employer plans that use large insurers only as plan administrators. Self-funding is not only for jumbo employers anymore; thousands of smaller firms now self-insure to avoid state insurance laws and liability for premium tax payments.

The final hurdle is the reality of health care today. The modern health care system is highly interdependent and operates across state boundaries. For example, health care providers in Washington, D.C., a place that has made a heroic effort to insure all residents, treat thousands of residents from Maryland and Virginia, whose public insurance programs are far less generous. Strategies for health care cost containment cannot be launched in individual states, because health care markets cross jurisdictional boundaries. Furthermore, in a modern economy, people need to be able to move interstate in order to pursue economic opportunities and participate in a changing labor market. Affordable health care is a national problem that demands a national solution.

The House and Senate bills recognize that to succeed, health insurance reform must be undertaken on a nationwide scale. Both measures foster local innovation in health care delivery, pumping billions of dollars into the development of local capacity and improvements in quality and efficiency. But the legislative proposals correctly frame health care as too large, complex, and essential to the nation's well-being to relegate adequate coverage levels to the individual states any longer. To this end, pending proposals aim to build a uniform foundation of affordable health insurance resting on combined federal and state oversight to ensure fair practices: fair enrollment and pricing that does not discriminate on the basis of sex, age, or health status; fairness in the quality of coverage; fair information and disclosure practices; and fair treatment of members, patients, and health care providers.

Despite the obvious need for national action, recent weeks have seen a revival of the notion of independent state action (even as more than half of all states either are considering or have enacted legislation to nullify federal reforms).[4] A few states, such as California and Missouri, have considered more ambitious state plans, although Missouri officials have been frank in admitting that they are unable to address the affordability problem. Indeed, every state is now trying simply to hold the line against deep erosion in Medicaid coverage, with nearly all states contemplating terrible reductions in the number of people insured, the range of essential services provided, and already desperately low provider payment rates.

Proposals from Congressional Republicans would considerably worsen matters for states. The most highly visible proposal can be found in *A Roadmap for America's Future*.[5] Mirroring the Democratic proposals in its framing of health care reform as part of a more extensive strategy to deal with "America's long-term economic and financial crisis," the *Roadmap* acknowledges the rising cost of health care, the financial burden that it places on families and businesses, and the economic consequences for the nation. With rhetorical flourish, the *Roadmap* characterizes the Democratic reform legislation as a "job-killing" government intrusion on the health care system, asserting that the Republican approach would play a key role in "rejuvenating America's vibrant market economy; and restoring an American character rooted in individual initiative, entrepreneurship, and opportunity."

But it does not take long to see the *Roadmap*'s real purpose: to shift the political and financial burdens of health care reform squarely back onto the states. A careful read of the *Roadmap* reveals a strategy in which a heavily deregulated insurance industry, operating with minimal federal

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oversight, would be free to market national plans aimed at the general population. Premium subsidies — financed by ending the favorable tax treatment given to employer-sponsored plans — would be limited to $2,300 for individual policies and $5,700 for family coverage, about 48% and 41%, respectively, of the 2009 cost of an employer group premium. This means, of course, that the products marketed interstate would be bare bones and targeted to low-volume, healthy users.

Under the plan, states would be expected to establish insurance exchanges, but since coverage of the young and healthy would be heavily tilted toward a stripped-down interstate insurance offering, the real purpose of the exchanges — made clear by the *Roadmap* — is to sponsor high-risk pools for uninsurable persons. As for subsidies for this enormously costly population, the *Roadmap* states outright that "states may offer direct assistance with health insurance premiums and cost-sharing" for this group, meaning that states are on their own. How the sponsors of the *Roadmap* think states will fund this is a mystery: the proposal would replace Medicaid for the poorest families with vouchers and cap federal payments for long-term care for the disabled and elderly at the general rate of inflation (although more than two thirds of state Medicaid budgets are spent on the sickest beneficiaries). Rather than position states for innovation, the proposal would drive their health care systems to the brink.

The United States has a strong tradition of federalism. Where health care is concerned, federalism has a central role to play, given the very local way in which health care is organized and delivered. But what does not vary — from town to town, metropolitan region to metropolitan region, or state to state — is the need for affordable, decent health care coverage, and it is a matter of vital national concern not to conflate the two. States may be health system innovators, but innovation in health care can happen only if it rests on a solid financial base. As in banking and other matters of national economic security, only the President and Congress — acting on behalf of an electorate possessed of the political will to move forward — can create the financial conditions on which a 21st-century health care system necessarily rests.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Exhibit 18

PATIENTS AS CONSUMERS: COURTS, CONTRACTS, AND THE NEW MEDICAL MARKETPLACE

*Mark A. Hall**
*Carl E. Schneider***

The persistent riddle of health-care policy is how to control the costs while improving the quality of care. The riddle's once-promising answer—managed care—has been politically ravaged, and consumerist solutions are now winning favor. This Article examines the legal condition of the patient-as-consumer in today's health-care market. It finds that insurers bargain with some success for rates for the people they insure. The uninsured, however, must contract to pay whatever a provider charges and then are regularly charged prices that are several times insurers' prices and providers' actual costs. Perhaps because they do not understand the health-care market, courts generally enforce these contracts. This Article proposes legal solutions to the plight of the patient-as-consumer and asks what that plight tells us about market solutions to the health-care quandary.

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> *[Professionals] may, as in the case of a successful doctor, grow rich; but the meaning of their profession, both for themselves and for the public, is not that they make money but that they make health, or safety, or knowledge, or good government or good law. . . . . [Professions uphold] as the criterion of success the end for which the profession, whatever it may be, is carried on, and [subordinate] the inclination, appetites and ambition of individuals to the rules of an organization which has as its object to promote the performance of function.*
>
> —R. H. Tawney
> *The Acquisitive Society*

INTRODUCTION: PATIENTS AS CONSUMERS IN A NEW MARKETPLACE

Patients have always been consumers.[1] Before health insurance was common, they shopped in a market for medical services just as they shopped in a market for toasters and tailors. The fifteen percent of us who lack health insurance still shop that way. Even insured patients shop: they make copayments and have coinsurance; they pay extra for doctors and hospitals outside the insurer's network and for drugs outside the insurer's formulary.[2]

Patients have always been consumers, but, today, America's battle to restrain rocketing costs of health care has transformed the world of patients as consumers: Crucially, two recent reforms have (1) pushed more patients into the medical market and (2) made that market a more parlous place.

In one of those reforms—managed care—insurers bargain with doctors and hospitals and give providers incentives to cabin costs. This helps plan members get care less expensively, which is its intent. Unintentionally, how-

1. *See generally* Nancy Tomes, *Patients or Health-Care Consumers?*, *in* HISTORY AND HEALTH POLICY IN THE UNITED STATES 83 (Rosemary A. Stevens et al. eds., 2006).

2. *See generally* Dahlia K. Remler & Sherry A. Glied, *How Much More Cost Sharing Will Health Savings Accounts Bring?*, 25 HEALTH AFF. 1070 (2006); James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, 2002 HEALTH AFF. W139, http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.139v1 (web exclusive).

times what insurers pay.[100] In contrast, before aggressive managed care discounts, physicians' markups over Medicare and private insurance were roughly 25%–50% for both primary care and specialty procedures.[101]

These striking figures reveal the impressive market power that doctors can and do wield. However, doctors' fees are rational and moderate compared with hospitals' magnificently baroque and extravagant charges. To them we now turn.

E. *Hospital Prices*

We have already said that hospital prices for uninsured patients are incomprehensible. We now will show that those prices are little disciplined by the market and often unfair. Before managed care, hospitals billed insured and uninsured patients similarly. In 1960, "[t]here were no discounts; everyone paid the same rates"—usually cost plus ten percent.[102] But as some insurers demanded deep discounting, hospitals vigorously shifted costs to patients with less clout.[103] Since uninsured patients are protected in this Darwinian marketplace by neither insurers nor regulators, hospitals are loosed to charge what they will.

The egregious failure of the hospital market is revealed by the astonishing differences between what hospitals nominally charge and what insured patients pay.[104] Insurers pay about forty cents per dollar of listed charges.[105] Thus hospitals bill uninsured patients 250% more than insured patients. This disparity has exploded over the past decade: since the early 1990s, list prices have increased almost three times more than costs, and markups over costs have more than doubled, from 74% to 164%.[106]

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100. *See* Pennachio, *supra* note 99. These averages conceal wide variations. A recent physician's narrative on medical fees, for instance, described one surgeon who charged more than ten times Medicare rates for some procedures. Gawande, *supra* note 56, at 48.

101. *See* Cromwell & Burstein, *supra* note 15, at 53, 58.

102. Anderson Testimony 2004, *supra* note 70, at 18.

103. *See* Jason S. Lee et al., *Medicare Payment Policy: Does Cost Shifting Matter?*, 2003 HEALTH AFF. W3-480, http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.480v1.pdf (web exclusive) (reporting broad consensus that hospitals are able to shift costs to private insurers); Michael A. Morrisey, *Cost Shifting: New Myths, Old Confusion, and Enduring Reality*, 2003 HEALTH AFF. W3-489, W3-490, http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.489v1.pdf (web exclusive) (explaining that cost-shifting behavior indicates both ability to exercise market power and previous restraint in doing so); *supra* note 14.

104. The absence of meaningful price competition can also be seen in the extreme differences in the list prices for the same service among hospitals in the same market. Among California hospitals, for instance, a *Wall Street Journal* reporter found that a basic chest x-ray with two views ranged from $120 to $1,519; a comprehensive metabolic panel ranged from $97 to $1,733; a CT scan of the head (without contrast) went from $882 to $6,599; a single tablet of Tylenol could be no charge or $7. Lucette Lagnado, *Medical Markup: California Hospitals Open Books, Showing Huge Price Differences*, WALL ST. J., Dec. 27, 2004, at A1.

105. Anderson, *Soak the Rich*, *supra* note 64, at 780; Reinhardt, *supra* note 64, at 57.

106. MEDICARE PAYMENT ADVISORY COMMISSION, A DATA BOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM, JUNE 2004, at 103, *available at* http://www.medpac.gov/

At some hospitals the disparities are smaller, but at others they are larger still.[107] Undiscounted charges are often three or four times the rates given insurers, and there are "contracts where the discount from list price was over [ninety] percent."[108] Charges alleged or found in recent lawsuits include $20,000 for two nights' hospitalization for pregnancy complications,[109] $12,863 for a day's treatment for shortness of breath,[110] "$52 for a single tablet of Tylenol with codeine,"[111] and a half million dollars for twenty-three days of treatment—twice what Medicare insurance allowed.[112] The *Wall Street Journal* described a patient treated two days for a suspected heart attack, for whom the "bill for the hospital stay totaled $29,500. That bill did not include an additional $6800 from the cardiologist, $1000 for the ambulance ride, and $7500" for a stent.[113] Had the patient qualified for "state-sponsored healthcare through Medicaid, the hospital would have accepted a payment of only $6000 for the twenty-one hour hospital stay, $1000 for the cardiologist, and $165 for the ambulance ride. The list price for the stent was $3195, less than fifty percent of what [the patient] was charged."[114]

Rational markets do not produce such bizarre prices.[115] Surveying "the chaos that now reigns behind the opaque curtain of proprietary prices in the U.S. hospital system," Uwe Reinhardt laments hospital price-setting that

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publications/congressional_reports/Jun04DataBook_Entire_report_links.pdf; MEDICARE PAYMENT ADVISORY COMMISSION, A DATA BOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM, JUNE 2006, at 101, *available at* http://www.medpac.gov/publications/congressional_reports/Jun06DataBook_Entire_report.pdf.

107. In Ohio, for instance, hospital markups over costs in 2003 ranged by metro region averages from 83% to 217%, SEIU DISTRICT 1199 CARE FOR OHIO, TWICE THE PRICE 5 (2005), http://s57.advocateoffice.com (follow "Twice the Price" hyperlink) (last visited Oct. 6, 2007), and across all hospitals from 37% to 279%, *id.* at 18–20.

108. Anderson Testimony 2006, *supra* note 64, at 106. For instance, in 2002, the average charge among Philadelphia-area hospitals for medical management of a heart attack was over $30,000, whereas "[m]ost insurers paid less than $10,000." Anderson Testimony 2004, *supra* note 70, at 20. A website that tracks hospital prices reported that a Philadelphia hospital charged $15,000 for a cornea transplant that private insurers reimburse $4,700 for. Michael Mason, *Bargaining Down that CT Scan is Suddenly Possible*, N.Y. TIMES, Feb. 27, 2007, at F5.

109. Kolari v. N.Y.-Presbyterian Hosp., 382 F. Supp. 2d 562, 569 (S.D.N.Y. 2005).

110. Colomar v. Mercy Hosp., Inc., 461 F. Supp. 2d 1265, 1267–68 (S.D. Fla. 2006).

111. Hall v. Humana Hosp. Daytona Beach, 686 So. 2d 653, 655 (Fla. Dist. Ct. App. 1996).

112. Valley Hosp. v. Kroll, 847 A.2d 636, 639 (N.J. Super. Ct. Law Div. 2003); *cf.* Burdette Tomlin Mem'l Hosp. v. Estate of Malone, 845 A.2d 615, 616 (N.J. Super. Ct. App. Div. 2003) (describing how hospital charged patient over three times what Medicare would have allowed).

113. Leah Snyder Batchis, Comment, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 493 (2005) (footnotes omitted) (summarizing the story reported by Lucette Lagnado, *Anatomy of a Hospital Bill: Uninsured Patients Often Face Big Markups on Small Items*, WALL ST. J., Sept. 21, 2004, at B1).

114. Batchis, *supra* note 113, at 493.

115. Hospital pricing is partly driven by the way Medicare pays hospitals—typically a fixed amount per visit. For patients who stay much longer than normal, Medicare pays an extra amount based on how the hospital sets its standard charges, but only if the hospital actually bills and collects its full "list prices" from non-Medicare patients. Anderson, *Soak the Rich*, *supra* note 64, at 785; Nation, *supra* note 8, at 121–23.

"appears to be ad hoc, without any external constraints."[116] Hospital executives confess that "the vast majority of [charges] have no relation to anything, and certainly not to cost,"[117] and see "no method to this madness."[118] If there is a method, it is perverse and destructive, because competition spurs higher prices.[119] In short, "effectively, there [is] market failure" in pricing uninsured hospital services.[120]

Weird pricing *might* not matter if hospitals charged the rich more so they could charge the poor less.[121] Hardly. *All* uninsured patients—rich and poor alike—face staggering markups. When patients don't pay, hospitals rush their accounts to collection agencies that belligerently exploit their legal weapons, including home foreclosures and personal bankruptcies.[122]

Perhaps this is changing. Faced with congressional hearings and class-action litigation, some hospitals advertise "patient-friendly" pricing they claim is clearer, saner, and fairer.[123] Some hospitals give uninsured patients discounts[124] in reaction to criticism of charging the most vulnerable patients

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116. Reinhardt, *supra* note 64, at 59, 66.

117. DOBSON ET AL., *supra* note 64, at 7.

118. Reinhardt, *supra* note 64, at 57.

119. *See supra* text accompanying notes 43–44. Thus, hospitals' markups of charges over costs and over insurers' payments are much higher in urban areas with a greater concentration of hospitals than in rural areas. Anderson, *Soak the Rich*, *supra* note 64, at 782 ex.1. For instance, the states with the greatest markups are California, New Jersey and Pennsylvania, and those with the lowest are Idaho, Montana, Vermont and Wyoming. In high markup states, hospitals' charges average more than 4 times their costs, or 3.5 times their net receipts. In low markup states, charges average less than 2 times their costs, or less than 1.7 times their gross receipts. *Id.* at 783 ex.2. (Maryland is also among the group of low-markup states, but that is because it is the only state in the country with strict regulation of hospital charges. *See* Gerard F. Anderson, *All-payer Rate Setting: Down But Not Out*, HEALTH CARE FINANCING REV., SUPP. 1991, at 35, 37 [hereinafter Anderson, *All-payer Rate Setting*].)

120. Anderson Testimony 2004, *supra* note 70, at 20.

121. Arguably, higher charges to uninsured patients might be fair if richer patients paid them in full and hospitals used the surplus from very high markups to offset losses from uninsured patients who can pay little or nothing. Hospital administrators report that they collect only about ten percent of their charges to uninsured patients. E-mail from Terry Rappuhn, Project Leader, Patient Friendly Billing Project, to Mark A. Hall, Professor of Law and Public Health, Wake Forest University (Feb. 16, 2007 11:59:00 EST) (on file with authors); *see also* Joel S. Weissman et al., *Bad Debt and Free Care in Massachusetts Hospitals*, 11 HEALTH AFF. 148, 154 ex.2 (1992) (reporting that Massachusetts hospitals in 1988 wrote off as bad debt nintey-three percent of their charges to self-pay (uninsured) patients). This suggests that hospitals forgive much of what uninsured patients owe, but usually only after billing these patients in full and sending bills to collection, sometimes causing bankruptcy.

122. *See supra* text accompanying note 7.

123. Andrea B. Staiti et al., *Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices for Uninsured Patients*, CENTER FOR STUDYING HEALTH SYS. CHANGE ISSUE BRIEF, Oct. 2005, *available at* http://www.hschange.com/CONTENT/788/788.pdf.

124. *Id.* A few states require these discounts in order for hospitals to maintain their charitable, tax-exempt status. *See* John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U. L.J. 1, 4 (2007); Jacoby & Warren, *supra* note 7, at 541–42.

the highest fees.[125] The American Hospital Association advises hospitals to "offer discounts to patients who do not qualify under a charity care policy for free . . . care,"[126] and it reports that some hospitals "have developed a sliding-fee scale that specifies different percentage discounts from gross charges depending on patients' household incomes."[127] But such pricing is hardly ubiquitous, is unproved, and perhaps appeals less to for-profit than non-profit hospitals. In any event, as long as some hospitals have patients sign open-ended contracts, bill them multiples of competitive prices, and hound them for money they don't have, courts need to protect them.

F. *Summary*

Adequate markets permit—indeed, help—consumers shop for good services at good prices. Even in such markets, however, consumers often stumble when buying unfamiliar products. Furthermore, several features of illness and its treatment prevent prudent shopping in medical markets.[128] First, the debilitation of illness and the urgency of medical care make patients lax consumers and inhibit them from switching providers. Second, patients often cannot really choose treatment or provider, since options are often few and since patients depend on doctors in selecting hospitals and specialists. Third, doctors dislike telling patients about costs and patients dislike asking. Fourth, patients' treatments are often unpredictable. Fifth, doctors' and especially hospitals' prices are so complex and arbitrary that patients could not hope to understand them were they revealed. Sixth, providers protect themselves by presenting patients with form contracts obliging them to pay whatever the provider eventually asks. In sum, patients regularly begin treatment not knowing their needs, their alternatives, or their costs. Almost helplessly, they agree to pay whatever providers charge for whatever services they supply. This is a desperate market in which consumers can only struggle as flies to wanton boys.

No one should dream that the market's failure can easily be fixed or that the failure is due to a remediable cause, like the presence of insurance. The failure's roots go deep into the nature of medical care. In a simpler world half a century ago, "it was assumed that competitive market forces had a role in determining pre-insurance prices for medical services, including physician's fees and hospital rates as well as the price of drugs, devices, and ancillary services."[129] Even in that simpler world, however,

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125. Beverly Cohen, *The Controversy Over Hospital Charges To The Uninsured—No Villains, No Heroes*, 51 VILL. L. REV. 95 (2006); Batchis, *supra* note 114.

126. AM. HOSP. ASS'N, HOSPITAL BILLING AND COLLECTION PRACTICES 3 (2003), http://www.aha.org/aha/content/2004/pdf/guidelinesfinalweb.pdf.

127. HEALTHCARE FIN. MGMT. ASS'N & AM. HOSP. ASS'N, HOSPITALS SHARE INSIGHTS TO IMPROVE FINANCIAL POLICIES FOR UNINSURED AND UNDERINSURED PATIENTS (2005), http://www.hfma.org/NR/rdonlyres/1D57ACA0-0AA1-43DA-8E7B-8A604DDEE664/0/2005_pfb_report.pdf.

128. *See* Ginsburg, *supra* note 70.

129. Roe, *supra* note 89, at 43.

> few patients either knew or tried to discover whether their health care could be purchased at different prices; prices were never published or advertised. Patients generally had faith in their physicians and assumed the fees were fair and valid—whether or not they could afford to pay them. They obediently entered whatever hospital they were sent to and took their prescriptions to the pharmacy or provider that the physician suggested. Experience indicates that few patients, even those who complained about the costs, did any shopping around for better prices.[130]

These enduring features of therapeutic relationships give rise to monopolistic market power that is ripe for exploitation. To be sure, exploitation is not pervasive. Doctors, on average, apparently are more restrained than hospitals,[131] perhaps because they have longer relationships with patients, have a stronger sense of professional obligation, or feel fewer of the pressures that distort hospital pricing.[132] Nevertheless, many physicians and most hospitals exploit their market power to induce patients to agree to pay what they are asked and then charge the uninsured fabulously more than the insured.

II. Judicial Protection of the Patient

How ought courts respond to the plight of the hapless patient charged predatory prices in a dysfunctional market? Should courts treat medical contracts like ordinary commercial contracts and leave patients to their bargain? If not, what can courts do for patients?

A. *Should Courts Protect Patients?*

As we have shown, the very disabilities that make people patients make them poor consumers. The relationships among patients, doctors, and hospitals make ordinary commercial relations uneasy and undesirable. And providers can compel patients to sign blank checks which providers can complete in dismaying ways. The law already recognizes consumers' susceptibility, patients' vulnerability, and doctors' power in numerous ways; protecting patients when they must be consumers logically extends that recognition.

The law responds to patients' exceptional vulnerability by altering several assumptions about commercial relationships. For example, the law spurns caveat emptor and the presumption that parties contract at arm's length and instead makes the doctor a fiduciary:

> [T]here is more between a patient and his physician than a mere contract under which the physician promises to heal and the patient promises to

130. *Id.*

131. They may also have less inherent market power than hospitals.

132. Also, hospitals tend to provide more public goods in the form of undercompensated essential services than do physicians. *Cf.* Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 Yale J. on Reg. 139 (2007) (documenting unprofitable services provided by hospitals).

Exhibit 19

Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs

The cost of expanding coverage to the 16 percent of Americans who are uninsured would add 5 percent to national health spending.

by Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller

ABSTRACT: People uninsured for any part of 2008 spend about $30 billion out of pocket and receive approximately $56 billion in uncompensated care while uninsured. Government programs finance about 75 percent of uncompensated care. If all uninsured people were fully covered, their medical spending would increase by $122.6 billion. The increase represents 5 percent of current national health spending and 0.8 percent of gross domestic product. However, it is neither the cost of a specific plan nor necessarily the same as the government's costs, which could be higher, depending on plans' financing structures and the extent of crowd-out. [*Health Affairs* 27, no. 5 (2008): w399–w415 (published online 25 August 2008; 10.1377/hlthaff.27.5.w399)]

Expanding health insurance coverage is a major issue in the 2008 presidential campaign. This study addresses three sets of questions that are critical to the policy debate. First, how much care do the uninsured receive? Second, how much of their care is "uncompensated," and who pays for that care? Third, if the uninsured were covered, what would be the cost of the additional medical care they would use? The first two questions set the baseline for the policy debate and identify payment sources that might be tapped to help fund expanded insurance coverage. The third question focuses on the additional resource cost to society. Importantly, this cost is not the cost of a specific plan to expand coverage, nor is it a measure of the cost to government.

■ **Study data and methods.** Following earlier studies, we used two distinct and independent methodologies to develop estimates of the uninsured's current medical

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care use and financing.[1] The first analyzes household data on more than 102,000 people interviewed as part of the 2002–2004 Medical Expenditure Panel Surveys (MEPS), a nationally representative survey of the civilian, noninstitutionalized population. The second approach draws on data from government budgets and health care provider surveys, including the 2007 American Hospital Association (AHA) Annual Survey of Hospitals; surveys of office-based private physicians; and budget and program data from Medicare, Medicaid, and other government programs that serve the uninsured.

We adjusted the MEPS data to make 2008 projections that are consistent with spending estimates from the National Health Expenditure Accounts (NHEA). Briefly, we inflated the 2002–2004 MEPS spending data to 2008 dollars using NHEA projections of personal health care spending per capita and projected the numbers of insured and uninsured people, by age, to 2008 from the 2004–2006 Current Population Surveys (CPS).[2] We calibrated the MEPS spending data to the NHEA by source of payment, using a detailed reconciliation of the differences between MEPS and the NHEA.[3]

MEPS does not measure indirect payments to providers, such as Medicare and Medicaid disproportionate-share hospital (DSH) payments, tax appropriations, public and private grant programs, or providers' profits from treating privately insured patients. Since these sources implicitly subsidize some of uninsured people's care, we estimated their contribution to uncompensated care as the difference between the payments providers would expect to receive if the person were covered by private insurance and actual payments received from explicit private sources (out-of-pocket payments from the uninsured and payments from other private sources and other unidentified sources) measured by MEPS.

We added the amount of implicitly subsidized care to the MEPS data on total spending and estimated two-part medical spending models for children and adults on samples of all people uninsured for any portion of the year plus insured people with incomes under 400 percent of poverty.[4] We restricted the insured sample to lower- and lower-middle-income people because their behavior is more likely to reflect the uninsured's medical care use if insured.

■ **Analysis.** The key independent variable measures the percentage of the year the person is insured. Its coefficients indicate how the probability of using any care and the amount of care received increase as insurance status varies from being uninsured all year to being fully insured. Because the insurance coverage variable does not measure individual plans' specific benefits, it reflects the average experience of people with different types of private and public coverage. Consequently, our estimates of the incremental resource cost of full coverage assume that the uninsured person's new benefits would be similar to the distribution of benefits now held by lower- and lower-middle-income people with either private or public coverage.

Other independent variables control for the effects of demographic characteristics (age, sex, and race/ethnicity); socioeconomic characteristics (education, mari-

tal status, family income relative to the federal poverty level, metropolitan residence, and census region); and self-reported health characteristics (general health status, measures of various types of limitations, indicators of the presence of specific health conditions, and an indicator of whether the person died or was institutionalized during the year).[5]

MEPS Estimates Of Medical Care Received By The Uninsured

Compared to people with full-year private coverage, the full-year uninsured receive less than half as much care but pay a larger share out of pocket (35 percent versus 17 percent). Implicitly subsidized care (the difference between the amount a privately insured person would be expected to pay for the same care and an uninsured person's actual payment) amounts to $536 per capita for the full-year uninsured, and care provided by other public and private sources adds $567 per capita (Exhibit 1). The total amount of uncompensated care, defined as all care not paid for out of pocket by the uninsured, comes to $1,103 per person.

The part-year uninsured receive $2,983 in care—31 percent less care than the privately insured. However, more than 85 percent of their care is received during

EXHIBIT 1
Medical Spending Per Capita, By Insurance Status And Source Of Payment, All Nonelderly Americans, Projected, 2008

	Full-year insured				Part-year insured			
	All	Private only	Medicaid only	Other[a]	All	Insured spending	Uninsured spending[b]	Full-year uninsured
2008 population (est.)	188,186,419	156,230,252	24,220,209	7,735,958	35,757,579	–[c]	–[c]	41,128,621
Total spending per capita	$4,463	$3,915	$4,813	$14,439	$2,983	$2,601	$382	$1,686
Source of payment								
Out of pocket	$ 654	$ 681	$ 175	$1,611	$ 550	$ 394	$156	$583
Private insurance	2,677	2,976	462	3,573	1,126	1,126	0	0
Medicare	205	17	59	4,463	45	45	0	0
Medicaid	681	25	3,880	3,908	859	859	0	0
Other public[d]	193	183	141	555	161	115	46	233
Other private[e]	53	32	96	328	99	63	36	334
Implicitly subsidized[f]	0	0	0	0	145	0	145	536

SOURCE: Authors' tabulations using data from the Medical Expenditure Panel Surveys (MEPS), 2002–2004.
[a] Includes Medicare only, Medicare plus Medicaid, and other combinations of full-year coverage.
[b] Uninsured spending is for care received during months when the person is uninsured.
[c] Not applicable.
[d] Includes Veterans Health Administration, TriCare, other federal, other state and local, other public, and workers' compensation.
[e] Includes other private and other sources.
[f] Implicitly subsidized care is care received by the uninsured that is subsidized by indirect revenue sources not measured by MEPS. For details of the imputation methodology, see J. Hadley et al., *Covering the Uninsured in 2008* (Washington: Henry J. Kaiser Family Foundation, August 2008).

months they report having insurance coverage. Private insurance and Medicaid are the two largest sources of third-party payments, with relatively small amounts paid for by Medicare, other public sources, and other private sources. Care received while uninsured is $382 per person, with out-of-pocket payments and implicitly subsidized care responsible for very similar amounts (about $150 per person). In the aggregate, out-of-pocket payments while uninsured by the full- and part-year uninsured total almost $30 billion.

Among people with full-year insurance coverage, those with private insurance spend the least ($3,915); Medicaid recipients spend about 23 percent more; and those with Medicare only or various combinations of coverage spend the most for care (Exhibit 1). These differences presumably reflect differences in health conditions across groups, especially for the "other" category, which includes Medicare-covered people with end-stage renal disease (ESRD) or disabilities.

Uncompensated Care Estimates From MEPS

People uninsured any time during the year receive $54.3 billion of uncompensated care (care received but not paid for by either the uninsured themselves or by a health insurer), with just over half ($27.8 billion) paid for by implicit subsidies (Exhibit 2). Payments from explicitly identified public and private sources are $11.4 billion and $15.1 billion, respectively. Adults, who constitute more than 80 percent of the uninsured, account for 87 percent of the uncompensated care received. Not surprisingly, the full-year uninsured receive 85 percent of all uncompensated care and 81 percent of all implicitly subsidized care.

EXHIBIT 2
Total Uncompensated Care Received By The Uninsured, By Sources Of Financing, Projected, Billions Of 2008 Dollars

Population	Total uncompensated care[a]	By sources of financing: Other public[b]	Other private[b]	Implicitly subsidized[c]
All uninsured	54.3	11.4	15.1	27.8
Children	7.2	0.4	3.4	3.3
Adults[d]	47.2	11.0	11.7	24.5
Full-year uninsured	46.1	9.8	13.8	22.6
Part-year uninsured	8.2	1.7	1.4	5.2

SOURCE: Authors' tabulations using data from the Medical Expenditure Panel Surveys (MEPS), 2002–2004.
[a] Uncompensated care is defined as care received by the uninsured, but not paid for either out of pocket or by a traditional public or private insurance plan.
[b] Explicitly measured payment sources reported in MEPS.
[c] Implicitly subsidized care is care received by the uninsured that is subsidized by indirect revenue sources not measured by MEPS. For details of the imputation methodology, see J. Hadley et al., *Covering the Uninsured in 2008* (Washington: Henry J. Kaiser Family Foundation, August 2008).
[d] Includes uninsured elderly people.

Uncompensated Care Estimates From Provider And Government Sources

Using independent data from health care providers and government sources, we estimated that uncompensated care in 2008 is $57.4 billion: $35.0 billion provided by hospitals, $14.6 billion by community-based providers, and $7.8 billion by private office-based physicians. Given the similarity between these and the MEPS estimates, we conclude that the cost of uncompensated care is between $54.3 billion and $57.4 billion, or roughly $56 billion.

The hospital uncompensated care estimate comes from the AHA's 2007 Annual Survey of Hospitals inflated to 2008.[6] The estimate for community providers and direct care programs includes care provided to the uninsured by the Veterans Health Administration (VHA), the Indian Health Service, community health centers, the Maternal and Child Health Bureau, the HIV/AIDS Bureau, and the National Health Service Corps. In general, we estimated the amount of acute care services (excluding public health and long-term care and inflated to 2008) provided to the uninsured by each of these sources. We also included state and local governments' spending for tax appropriations allocated to hospitals and medical care delivered by public assistance programs.

Physicians' uncompensated care is based on data from the 2005 Community Tracking Study (CTS) Physician Survey, which suggested that little has changed since 2001 in total hours of charity care provided.[7] Therefore, we simply inflated our 2004 estimate of physicians' charity care to 2008. Although a recent study nets out excess payments that physicians sometimes receive from the uninsured, our estimate only accounts for the losses on uninsured patients.[8] We assumed that profits from all patients subsidize these costs.

Sources Of Funding For Uncompensated Care

Uncompensated care is subsidized by various public programs and private sources (Exhibit 3). Overall, public funds directed to the uninsured could account for as much as $42.9 billion—approximately 75 percent of total uncompensated care. If some public money is poorly targeted to providers who treat the uninsured—that is, overcompensating some and undercompensating others—then not all of the $42.9 billion spent in the name of the uninsured may actually finance uncompensated care. Consequently, private funding could be somewhat higher than $14.5 billion. Although impossible to develop exact estimates, it seems clear that public sources underwrite the dominant share of uncompensated care costs.

■ **Medicaid.** Medicaid has two major programs that help fund the cost of hospital uncompensated care: DSH payments and supplemental payment programs. These programs also offset low Medicaid reimbursement rates in hospitals that receive DSH payments.

Medicaid DSH payments support both hospitals and long-term care facilities

EXHIBIT 3
Sources Of Funding Available For Uncompensated Care To The Uninsured, Projected, Billions Of 2008 Dollars

	Funding source ($)				
Provider	**Federal**	**State/ local**	**Total gov.**	**Private**	**Total, all sources[a]**
Hospitals (total)	16.8	11.9	28.7	6.3	35.0
Medicare					
DSH payments	5.1	0.0	5.1	0.0	5.1
IME payments	2.1	0.0	2.1	0.0	2.1
Total Medicare	7.2	0.0	7.2	0.0	7.2
Medicaid					
DSH payments	8.6	2.0	10.6	0.0	10.6
Supplemental provider payments	12.2	0.9	13.1	0.0	13.1
Less Medicaid underpayments	−11.2	−1.6	−12.8	0.0	12.8
Total Medicaid	9.6	1.3	10.9	0.0	10.9
State and local governments					
Tax appropriations	0.0	8.6	8.6	0.0	8.6
Public assistance programs	0.0	2.0	2.0	0.0	2.0
Total state and local	0.0	10.6	10.6	0.0	10.6
Private philanthropy and financial surplus	0.0	0.0	0.0	6.3	6.3
Community providers and direct care programs (total)	8.8	5.3	14.2	0.4	14.6
Veterans Health Administration	5.4	0.0	5.4	0.0	5.4
Indian Health Service	1.6	0.0	1.6	0.0	1.6
Ryan White CARE Act Health	0.8	0.2	1.0	0.2	1.2
Maternal and Child Health	0.03	0.1	0.2	0.0	0.2
Community health centers	0.9	0.5	1.4	0.2	1.6
National Health Service Corps	0.1	0.0	0.1	0.0	0.1
Other state and local	0.0	4.5	4.5	0.0	4.5
Physicians	0.0	0.0	0.0	7.8	7.8
Total	25.6	17.2	42.9	14.5	57.4

SOURCE: Based on American Hospital Association (AHA) Annual Survey of Hospitals and various sources of federal budget and agency data. For details, see J. Hadley et al., *Covering the Uninsured in 2008* (Washington: Henry J. Kaiser Family Foundation, August 2008).

NOTES: DSH is disproportionate-share hospital. IME is indirect medical education. CARE is Comprehensive AIDS Research and Education.

[a] Row and column totals might not match because of rounding.

that treat large numbers of poor patients. To estimate the amount available for acute care hospitals' uncompensated care, it is necessary to subtract DSH payments that go to mental hospitals, nursing homes, and other providers and then adjust for the share of the state contribution that represents intergovernmental transfers and other financial transactions whose purpose is to increase federal matching dollars. These types of state funds are generally transferred back to state treasuries without actually being spent on care. Starting with data on total federal Medicaid DSH allotments and associated state matching funds and making the adjustments needed to identify new funding for hospitals, we estimated federal DSH spending to be $8.6 billion in 2008, with another $2.0 billion paid to acute care hospitals from state matching funds.[9]

States also use supplemental provider payment or other similar mechanisms to channel money to selected classes of hospitals by raising their rates above Medicaid payment rates, but no higher than Medicare levels. As with Medicaid DSH, it is necessary to estimate the amount of supplemental payments that go to hospitals (excluding nursing homes) and the amount of state dollars that truly come from general revenues (as opposed to intergovernmental transfers).[10] With these adjustments, we estimated that Medicaid payments to hospitals are $13.1 billion ($12.2 billion federal and $0.9 billion state) in 2008.

Finally, to estimate the amount potentially available to subsidize uncompensated care, we subtracted a portion of Medicaid DSH and supplemental provider payments that implicitly compensates some hospitals for low Medicaid payment rates. Inflating AHA data on medical underpayments to 2008 produced an estimate of $12.8 billion ($11.2 billion from federal payments and $1.6 billion from state payments).[11] Subtracting these amounts from the estimates reported above resulted in a final estimate of $10.9 billion ($9.6 billion federal and $1.3 billion state) in Medicaid hospital payments available for uncompensated care in 2008.

■ **Medicare.** Medicare subsidizes uncompensated care through its Medicare DSH payments and indirect medical education (IME) hospital payments. Medicare's DSH adjustment is applied to the payment rate for hospitals that treat a large number of poor patients. Although this is justified on the grounds that low- income patients are more costly than others to treat, Medicare Payment Advisory Commission (MedPAC) studies show that a hospital's low-income patient share is only loosely tied to higher Medicare cost per case and that DSH payments are distributed across a large number of hospitals, while hospital uncompensated care is concentrated in relatively few hospitals.[12] Given this apparent misallocation of Medicare DSH payments, we assumed that only half of Medicare DSH payments ($5.1 billion in 2008) actually support uncompensated care.

Medicare's IME adjustment recognizes higher costs in hospitals with graduate medical education (GME) programs, in part because these hospitals provide a large amount of care to the poor. MedPAC finds similar asymmetries in the distribution of these funds: the 10 percent of hospitals with the highest uncompensated care levels provided more than 40 percent of all uncompensated care but received just 15 percent of IME payments.[13] Because the IME adjustment, unlike Medicare DSH payments, is only indirectly intended to support uncompensated care, we assumed that one-third of IME payments ($2.1 billion in 2008) can be attributed to care for the uninsured.

■ **Other federal, state, and local government spending.** State and local governments also provide tax appropriations to support uncompensated care and operate indigent care or public assistance programs. Based on data from the Centers for Medicare and Medicaid Services (CMS), we estimated that state and local tax appropriations that support uncompensated care (as opposed to other hospital functions) are $8.6 billion in 2008.[14] CMS data also report that state and local public as-

sistance programs spent $5.5 billion on medical care in 2005, or $6.5 billion in 2008 dollars ($2 billion through public assistance programs and $4.5 billion to other state and local community providers).

Federal dollars constitute the largest share ($8.8 billion) of the $14.6 billion in uncompensated care spending by direct care programs (Exhibit 3). State and local spending ($5.3 billion) accounts for most of the remainder. When these sources are combined with the estimates of spending on uncompensated care by Medicaid and Medicare, and funding through state and local tax appropriations and public assistance programs, total government spending on uncompensated care is an estimated $42.9 billion, which covers roughly 75 percent of the total cost of uncompensated care. Federal programs pay $25.6 billion, mainly through Medicaid ($9.6 billion), Medicare ($7.2 billion), and the VHA ($5.4 billion). State and local governments spend $17.2 billion on care for the uninsured.

Private Sources Of Funding For Uncompensated Care

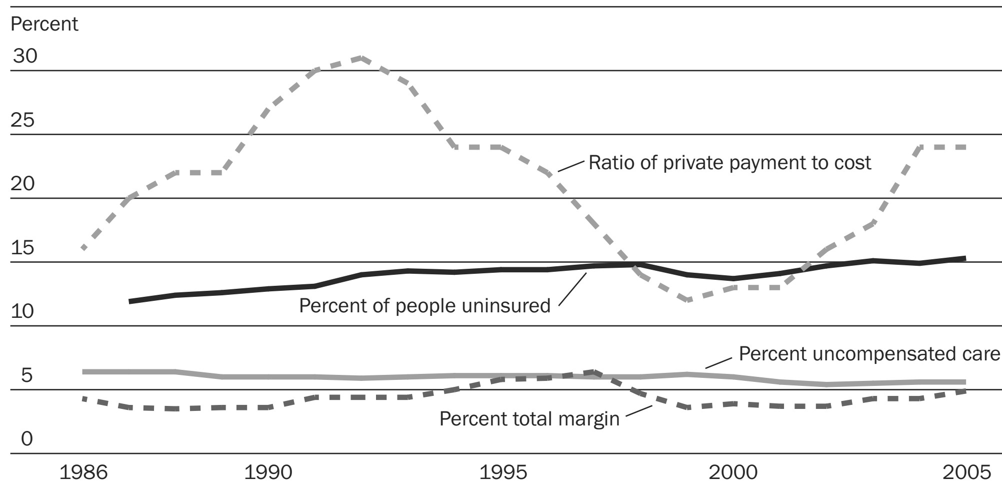
Various private sources help subsidize uncompensated care. Physicians' donated time and forgone profits amount to $7.8 billion. After government payments to hospitals are subtracted, private philanthropy and profit margins are responsible for at least an additional $6.3 billion.[15] The amount of private funding could be higher if government payments are more poorly targeted than we assumed—that is, if Medicare/Medicaid dollars overpay some hospitals for uncompensated care while underpaying others. Thus, the total amount of government ($42.9 billion) and private (at least $14.5 billion) funding potentially available to pay for care received by the uninsured apparently exceeds the $54.3 billion in uncompensated care estimated from the household survey data.

Cost Shifting And Premiums For Private Insurance

It is commonly argued that the privately insured pay for uncompensated care through cost shifting—that is, health care providers offset uncompensated care "losses" by charging higher prices to privately insured patients.[16] However, data presented in Exhibit 4 suggest that cost shifting as a result of uncompensated care probably has only a very small impact on private insurance premiums. We estimated that approximately $14.1 billion (Exhibit 3, excluding community providers) could be financed by cost shifting. (Our estimate is much lower than the Families USA estimate because we included several government sources omitted by its analysis, and we assumed that some providers absorb the cost of uncompensated care in the form of lower profits because they are unable to shift uncompensated costs to private payers.)[17] Given that total private health insurance expenditures in 2008 are estimated to be $829.9 billion (from NHEA projections), the amount potentially associated with cost shifting represents at most 1.7 percent of private health insurance costs.

Focusing on hospitals, where most cost shifting occurs, all generally agree that

EXHIBIT 4
Hospitals' Percentage Markup Of Private Payments Above Costs, Percentage Of Expenses For Uncompensated Care, Uninsurance Rate, And Hospitals' Total Margin, 1986–2005



SOURCES: American Hospital Association, "Uncompensated Hospital Care Fact Sheet" (Chicago: AHA, October 2007); Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program* (Washington: MedPAC, June 2007), 92 (1995–2005); MedPAC, *Report to the Congress* (Washington: MedPAC, March 1999), 66 (1986–1989); MedPAC, *Report to the Congress* (Washington: MedPAC, March 2002), 157 (1990–1994); and C. DeNavas-Walt, B.D. Proctor, and C.H. Lee, *Income, Poverty, and Health Insurance Coverage in the United States, 2006* (Washington: U.S. Census Bureau, 2006), 58.
NOTE: Uninsurance rates for 1987–1998 are adjusted by –1 percent to reflect the change in the Current Population Survey (CPS) instrument implemented in 1999.

hospitals receive higher payments from privately insured than from other patients and that they use profits from privately insured patients to support other missions. However, this does not mean that they raise charges in response to increased demand for care by the uninsured. If this were so, we would expect hospitals' uncompensated care costs to rise with the uninsured's share of the population.

Uncompensated care has been a relatively stable 6 percent of hospital costs for many years, despite a steady increase in the percentage of people uninsured (Exhibit 4). Increases in hospitals' ratio of private payment to cost, the primary mechanism for shifting costs, are unrelated to increases in uncompensated care and the percentage who are uninsured.[18] Rather, private-payer markups have fluctuated probably in response to the rise and fall of aggressive private managed care and perhaps to fluctuations in Medicare and Medicaid payment rates.[19]

Undoubtedly, some hospitals, especially major teaching hospitals, in some geographic areas have sufficient market power to negotiate higher payments from private insurers. (Some large physician groups may have similar negotiating leverage.) However, Exhibit 4 suggests that this is not the dominant pattern. Although the explanations for the fluctuations in markups to private payers remain controversial, it seems reasonably clear that uncompensated care is at most a minor player in the dynamics of hospital cost shifting.[20]

The Incremental Cost Of Care Used By The Uninsured If They Were Covered

How much more care would the uninsured receive if they were fully covered by insurance? To answer this question, we estimated two-part statistical models of medical spending and simulated how much more care the uninsured would receive if they had full-year insurance coverage. These models allow the effect of insurance coverage to vary with a person's health status while controlling for the effects on spending of demographic, health, and socioeconomic characteristics. Since many of the uninsured are younger and healthier than the insured, they would be expected to have lower medical spending independent of their lack of insurance. These statistical models adjust for the effects of these other factors when we predict how much more the uninsured would spend if insured.

The simulations suggest that people who are uninsured at any time during the year would increase their total spending per person by 70 percent, from $2,290 to $3,885 per person (Exhibit 5). The percentage increase in spending is much larger for the full-year insured (118 percent) than for the part-year insured (38 percent). The increase in spending is also much greater for adults (75 percent) than for children (37 percent), presumably reflecting differences in the incidence and costliness of adults' and children's health problems.

In the aggregate, total spending would increase by $122.6 billion to $298.7 billion, compared to the uninsured's current total spending of $176.1 billion (which includes insured spending by people with part-year coverage). Most of the increase in spending goes to the full-year uninsured and to adults, who make up

EXHIBIT 5
Simulated Increases In Total Spending By The Uninsured If They Were Fully Insured, By Age, Projected, 2008

	Per capita spending ($)			Total ($ billions)		
Total spending	Actual	Simulated if fully insured	Change in spending	Actual	Simulated if fully insured	Total change in spending[a]
All uninsured	2,290	3,885	1,595	176.1	298.7	122.6
Full-year uninsured	1,686	3,673	1,987	69.4	151.0	81.6
Part-year uninsured	2,983	4,129	1,146	106.7	147.7	41.0
Children	1,363	1,868	505	25.9	35.5	9.6
Full-year uninsured	1,076	1,857	781	8.2	14.2	6.0
Part-year uninsured	1,556	1,874	318	17.7	21.3	3.6
Adults[a]	2,595	4,543	1,948	150.5	263.4	13.0
Full-year uninsured	1,823	4,083	2,260	61.2	137.0	75.8
Part-year uninsured	3,655	5,175	1,520	89.3	126.4	37.2

SOURCE: Authors' tabulations using data from the Medical Expenditure Panel Surveys (MEPS), 2002–2004.
[a] Row and column totals might not match because of rounding.

most of the uninsured population and have a much larger increase in per person spending than is the case for children.

Comparisons With Other Estimates

Prior estimates (using MEPS data) of the incremental resource cost of covering the uninsured ranged from $34 billion to $69 billion in 2001 (2.8 to 5.6 percent of total national health spending), depending on whether the expanded coverage was primarily through Medicaid or through private insurance.[21] If we assume that 60 percent of the expansion was through the private insurance system, the weighted average of these 2001 estimates would be about $55 billion, or 3.7 percent of total national health spending, in 2001. Our current incremental cost estimate of $122.6 billion represents 5.1 percent of projected total national health spending for 2008, which is toward the higher end of the 2001 range of estimates.

The increase of about $68 billion in seven years in the cost of covering the uninsured is attributable to several factors: rapid increases in health care costs, continuing growth in the number of uninsured people, and changes in the characteristics of the uninsured population. Between 2001 and 2008, per capita health care spending, which incorporates changes in both price and use, grew by 52.8 percent—more than twice the 22.3 percent increase in the Consumer Price Index (CPI).[22] Inflating the $55 billion estimate for 2001 to 2008 by the increase in per capita health spending boosts the incremental cost estimate to $84 billion. Thus, inflation in health care costs and per capita use accounts for more than 42 percent of the difference between the 2001 and 2008 estimates.

The remaining difference between the $84 billion and our current estimate reflects a combination of an increase in the number of uninsured people and changes in their characteristics. Using the CPS data to illustrate the increase in the number of uninsured Americans, the size of the uninsured population grew by almost 3.4 percent per year between 2001 and 2006, from 39.7 million to 47 million.[23] Extrapolating to 2008 at the same rate results in a projected uninsured population of 50.2 million people—an increase of 26.4 percent over 2001. Applying this increase in the size of the uninsured population raises the incremental cost estimate from $84 billion to $106.2 billion, which accounts for another one-third of the difference between our current estimate and the 2001 estimate.

We believe that the remaining difference of about 25 percent ($16.3 billion) is attributable primarily to changes in the characteristics of the uninsured populations between the two time periods (Exhibit 6). The 2001 estimates were based on MEPS data from 1996–1998, while our current 2008 estimate is based on MEPS data from 2002–2004. First, the full-year uninsured make up a larger share of the total uninsured population—53.4 percent in the 2008 sample, compared to 51.4 percent in the 2001 sample. Since the incremental cost of covering someone who was uninsured all year is $841 higher than expanding coverage for someone uninsured for part of the year (Exhibit 5), total incremental cost also increases.

EXHIBIT 6
Selected Characteristics Of Uninsured Samples, 2008 And 2001

Characteristic	2008 sample (2002–2004 MEPS)	2001 sample (1996–1998 MEPS)
Uninsured all year	53.4%[a]	51.4%
Age distribution (years)		
0–18	24.7[a]	28.6
19–49	61.8	61.0
50–64	13.5	10.4
Health status distribution		
Excellent or very good	62.3[a]	64.5
Good, fair, or poor	37.7	35.5

SOURCE: Authors' tabulations of data from the Medical Expenditure Panel Survey, 1996–1998 and 2002–2004.
[a] Percentage or distribution is significantly different from 2001 sample ($p < 0.05$).

Second, the 2008 uninsured sample is both older and in poorer health (Exhibit 6). Given that much more is spent on older people than on children at every health status level and that people in fair or poor health spend much more than those in excellent to good health, these changes likely explain the higher level of spending per newly insured person in 2008 ($3,885) compared to 2001 ($3,751 in 2008 dollars).[24]

Other substantive factors that may also contribute to the higher incremental cost estimate for 2008 are the decline of tightly managed care, which might have restricted use by the insured in the earlier period, and poorer access to care by the uninsured in the later period. A coverage expansion in a tightly managed care environment would produce a smaller incremental effect of having coverage on spending by the uninsured. Conversely, poorer access to care in the later period would increase the size of the initial spending gap between the uninsured and the insured.

Methodological factors that may influence the 2008 estimate include improved measurement of spending while uninsured by people who are uninsured for only part of the year, the discrepancy between the MEPS data and the CPS data in their estimates of the number of uninsured people, and possible measurement error in reporting insurance status. More accurately assigning a larger share of the part-year uninsured's spending to the months when they are insured in effect increases the estimated effect of having insurance coverage on spending in the statistical models. From a more technical perspective, this result could be thought of as a type of endogeneity bias—that is, uninsured people who expect to incur medical spending have an increased incentive to seek insurance coverage. This behavior would tend to overstate the effect of insurance on spending.

As noted above, the CPS reports fewer uninsured people than MEPS reports. According to the CPS, 47.0 million Americans were uninsured in 2006, which we

"We estimate that cost shifting to private insurance finances a relatively small amount of uncompensated care."

generally regard as a point-in-time or full-year-equivalent estimate. Projecting the 2006 number to 2008 yields 50.2 million uninsured people. The comparable number for MEPS for 2008 is 54.9 billion, or 10 percent higher. Thus, using the CPS estimate of the number of uninsured Americans would reduce our estimate by about $12 billion.

Finally, Brent Kreider and Steven Hill investigated the effects of reporting errors in measuring insurance coverage.[25] They found that even though there is uncertainty about the number of people lacking insurance, under reasonable nonparametric assumptions, estimates from MEPS of the maximum cost of covering the uninsured are not much affected by this uncertainty.

Discussion And Implications For Policy

People uninsured for all or any part of 2008 receive approximately $86 billion in care during the time they lack insurance coverage. The uninsured pay for $30 billion of their care out of pocket and receive about $56 billion in uncompensated care. Uncompensated care represents 2.2 percent of health spending in 2008.

We estimate that government spends nearly $43 billion—roughly 75 percent of total uncompensated care costs—through Medicaid DSH and supplemental payment programs, Medicare DSH and IME payments, various direct care programs, and state and local tax appropriations. Given the magnitude of government payments, we estimate that cost shifting to private insurance finances a relatively small amount of uncompensated care. Private insurance premiums are at most 1.7 percent higher because of the shifting of the costs of the uninsured to private insurers in the form of higher charges.[26]

Providing full-year coverage to all Americans currently uninsured for any part of the year would increase their medical spending by $122.6 billion in 2008, over and above their current spending (while uninsured) of about $86 billion. The increase in total spending corresponds to 5.1 percent of total health care spending and 0.8 percent of gross domestic product (GDP). For comparison purposes, a recent analysis estimated that the tax subsidy received by privately insured workers with employer-sponsored insurance was more than $200 billion in 2006.[27] The 5 percent increase is also smaller than the average annual increase in total health spending of 7.6 percent per year since 2000.[28]

The estimate implicitly assumes that the uninsured's new coverage would reflect the distributions of public and private coverage and benefits held by lower-income and lower-middle-income insured people and that their medical care use would also be similar. The cost estimate would change if the new coverage were either much more generous (very low cost sharing, as in Medicaid) or less gener-

ous (high deductibles) than current coverage. Similarly, it assumes that provider payment rates and administrative costs under various public and private plans would stay largely the same. Various health system reforms, such as competing private health insurance plans within purchasing pools, greater use of public programs' fee schedules, or expanded use of health information technology, could reduce the estimated incremental resource cost of expanding coverage. A recent report from the Commonwealth Fund estimates that a menu of fifteen savings options could reduce health spending by $1.55 trillion over ten years.[29]

■ **Incremental resource cost versus transfer or crowd-out costs.** Most important for the policy debate, however, it is essential to differentiate the incremental resource cost of insurance expansion from transfer or crowd-out costs, and from the more thorny issue of the financing of insurance expansion. Incremental resource cost is a key number for assessing the cost-effectiveness of expanding insurance coverage—that is, comparing the value of improved health associated with expanded coverage to its resource cost.[30]

However, the additional cost of care used by the uninsured is not the same as the cost to the government of a coverage expansion, since out-of-pocket spending and income-related premium payments by the newly insured are likely to pay some of these extra costs. Further, the cost attributed to any broad health care financing reform could be much higher, depending on the extent to which people drop their prior coverage in favor of coverage under the new plan or retain their current coverage but receive new public subsidies to help pay their premiums.

These costs are not new national resources being devoted to health care but, rather, represent a transfer of spending from one type of coverage to another: although government spends more, many individuals, families, and businesses spend less. The savings to businesses and families in private insurance premiums and out-of-pocket spending can be large and are often overlooked in health reform cost calculations that focus on increased government spending. How the cost of the subsidies is distributed among different classes of people and geographic areas is at least as major a political issue as the amount of the subsidies.

■ **Federal cost implications.** Undoubtedly, covering all of the uninsured could have major cost implications for the federal government, regardless of how the reform is designed. Adding the cost of the additional care to current spending by or for the uninsured, total medical care costs for newly insured people will be about $208.6 billion (roughly $3,800 per full-year-equivalent newly insured person), consisting of $122.6 billion in new spending on top of the $86 billion already in the system. Although this is substantial, not all of this money necessarily represents new government spending. Of the $86 billion, the uninsured now pay $30 billion themselves. Much of this, and perhaps more, could be captured by premiums, since the MEPS data show that 71 percent of the uninsured have incomes above 125 percent of poverty and will therefore likely be responsible for some or all of the premium cost themselves. Whether this will be greater than the $30 billion that is already being

"A source of savings might accrue from the improved health of the uninsured, were they to gain coverage."

spent depends on the subsidy structure.

Some of the total costs of covering the uninsured could be offset by redirecting the nearly $43 billion that we estimate government programs now spend on the uninsured. Once the nation achieves universal coverage, there would be little need for much of this funding. Indirect payments to hospitals through Medicare and Medicaid would seem to be the most fungible. There is also an additional $5.1 billion of Medicare DSH spending (not included in the $43 billion) that appears to be misallocated to hospitals that provide little care to the uninsured. However, hospitals are likely to argue that these dollars should not be diverted until universal coverage is attained and that even then, some might still be needed if there are extra costs of caring for large numbers of poor people or undocumented immigrants, who might not be eligible for coverage. Direct service providers who treat special populations, such as veterans, Native Americans, non-English-speaking immigrants, and low-income children and pregnant women, may argue that their funding is needed to preserve the infrastructure that serves those populations.

■ **Savings through efficiency and improved health.** Recognizing the political difficulties of eliminating existing subsidies, most actual reform plans look to savings or increased efficiencies in other parts of the system (greater use of information technology, better care management, and increased use of medical effectiveness research) to fund increased coverage. Another source of savings might accrue from the improved health of the uninsured, were they to gain coverage. Numerous studies have shown that the uninsured delay seeking care for treatable conditions that often require more costly care when they progress to an advanced state.[31] More recent research suggests that Medicare would spend less on new beneficiaries who were previously uninsured if they had coverage in later middle age.[32] These sources of financing are less visible and more difficult to measure than the funding for existing programs, but they are no less real and should be taken into account in the policy debate over expanding coverage.

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24. The projected estimate of $3,751 was computed by taking a weighted average of per capita spending under private and public expansions in 2001 (from Hadley and Holahan, "How Much Medical Care Do the Uninsured Use?") and inflating to 2008 by the change in total national health spending per capita (from the National Health Expenditures Accounts).
25. B. Kreider and S. Hill, "Partially Identifying Treatment Effects with an Application to Covering the Uninsured," *Journal of Human Resources* (forthcoming).
26. Our estimate is lower than the Families USA estimate because we included several government sources omitted by their analysis and we assumed that some providers absorb the cost of uncompensated care in the form of lower profits—that is, that they are unable to pass on uncompensated costs to private payers. Families USA, "Paying a Premium." For details, see Hadley et al., *Covering the Uninsured in 2008,* chap. 5.
27. T.M. Selden and B.M. Gray, "Tax Subsidy for Employment-Related Health Insurance: Estimates for 2006," *Health Affairs* 25, no. 6 (2006): 1568–1579.
28. Calculated from average annual percentage changes reported in CMS, Office of the Actuary, "National Health Statistics Group, Table 2: National Health Expenditures Aggregate Amounts and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years 1960–2006," http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf (accessed 9 July 2008).
29. Commonwealth Fund Commission on a High Performing Health System, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: Commonwealth Fund, December 2007).
30. W. Miller, E.R. Vigdor, and W.G. Manning, "Covering the Uninsured: What Is It Worth?" *Health Affairs* 23 (2004): w157–w167 (published online 31 March 2004; 10.1377/hlthaff.w4.157).
31. J. Hadley, "Sicker and Poorer: The Consequences of Being Uninsured," *Medical Care Research and Review* 60, no. 2 Supp. (2003): 3S–75S.
32. J. Hadley and T. Waidmann, "Health Insurance and Health at Age Sixty-five: Implications for Medical Care Spending on New Medicare Beneficiaries," *Health Services Research* 41, no. 2 (2006): 429–451.

Exhibit 20

Nonprofit Hospitals and the Provision of Community Benefits

December 2006

The Congress of the United States ■ Congressional Budget Office

Nonprofit Hospitals and the Provision of Community Benefits

Introduction and Summary

The various tax exemptions provided to nonprofit hospitals have come under scrutiny by policymakers, with the central concern being whether those hospitals provide community benefits that justify forgone government tax revenues. In this paper, the Congressional Budget Office (CBO) measures the provision of certain community benefits and compares nonprofit hospitals with for-profit hospitals. For-profit hospitals do not receive tax exemptions and are not required to meet community-benefit standards; the level of community benefits provided by for-profit hospitals serves, therefore, as a useful benchmark against which to compare nonprofit hospitals. The analysis also examines the provision of community benefits by nonfederal government hospitals.[1]

Although nonprofit hospitals must provide community benefits in order to receive tax exemptions, there is little consensus on what constitutes a community benefit or how to measure such benefits. For the purposes of this analysis, community benefits include the provision of uncompensated care, the provision of services to Medicaid patients, and the provision of certain specialized services that have been identified as generally unprofitable. Those services were selected because they benefit the community but are not typically considered financially rewarding.

In general, the comparisons of nonprofit and for-profit hospitals yielded mixed results. CBO found that, on average, nonprofit hospitals provided higher levels of uncompensated care than did otherwise similar for-profit hospitals. Among individual hospitals, however, the provision of uncompensated care varied widely, and the distributions for nonprofit and for-profit hospitals largely overlapped. Nonprofit hospitals were more likely than otherwise similar for-profit hospitals to provide certain specialized services but were found to provide care to fewer Medicaid-covered patients as a share of their total patient population. On average, nonprofit hospitals were found to operate in areas with higher average incomes, lower poverty rates, and lower rates of uninsurance than for-profit hospitals.

Provision of Uncompensated Care

The level of uncompensated care provided by community hospitals is examined here for hospitals located in five states—California, Florida, Georgia, Indiana, and Texas—using data from 2003 (the latest year for which

1. Hospitals are identified as nonprofit, for-profit, or governmental on the basis of classifications reported by hospitals in the "control type" variable in the Medicare Hospital Cost Report. According to the control type variable, "nonprofit" refers to voluntary nonprofit (with or without church affiliation); "for-profit" refers to proprietary hospitals owned by individuals, corporations, partnerships, or other entities; and "government" refers to state, county, city-county, city, hospital-district, or other governmental entities (federal hospitals were excluded from the analysis).

such data are available).[2] "Uncompensated care" refers to the sum of charity care (services for which a hospital does not expect payment) and bad debt (services for which a hospital expects but does not collect payment). Although charity care is a better measure of the community benefits provided by a hospital, data limitations precluded CBO's analyzing charity care and bad debt separately.

The five selected states were chosen in part because sufficiently reliable data on uncompensated care were available in those areas. The data were provided to CBO by the Government Accountability Office (GAO) and were developed by GAO for use in its analyses of issues relating to the level of uncompensated care provided by different types of hospitals.[3] CBO's analysis expands on GAO's findings in several ways: first, regression techniques are used to calculate adjusted differences between nonprofit and for-profit hospitals in the provision of uncompensated care, taking into account hospital characteristics and the characteristics of local populations; and, second, the provision of Medicaid services and specialized services, such as emergency room care, are analyzed quantitatively.

2. "Community hospitals" include nonfederal short-term general hospitals. This definition includes most hospital facilities but excludes, for example, federal hospitals run by the Veterans Administration, psychiatric hospitals, and long-term-care hospitals. Several of the key data sources used are Medicare administrative files. Therefore, only Medicare-certified community hospitals were included in the analyses in this paper. Throughout the text "all community hospitals" refers to all Medicare-certified community hospitals. The findings are referred to as representing the year 2003, but the data are actually taken from either 2003 or 2002. For the analysis of uncompensated care, which includes hospitals in only five states, the data for 57 percent of hospitals are from federal fiscal year (FFY) 2003, and those for 43 percent of hospitals are from FFY 2002. For convenience, 2003 is used to describe the findings because the majority of hospitals report data for FFY 2003. For consistency, the analysis for all community hospitals used the same data years that were used to analyze uncompensated care costs in the five states. The FFY 2003 data were used for all hospitals not in the five states. For the other analyses, which include hospitals in all of the states, 90 percent of hospitals had FFY 2003 data and 10 percent of hospitals had FFY 2002 data.

3. See Statement of David M. Walker, Comptroller General of the United States, before the House Committee on Ways and Means, published as Government Accountability Office, *Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits*, GAO-05-743T (May 26, 2005), available at www.gao.gov/new.items/d05743t.pdf.

CBO's five-state analysis of uncompensated care yielded the following key findings:

- In the five states analyzed, nonprofit hospitals provided a total of about $3 billion in uncompensated care, government hospitals provided more than $3 billion, and for-profit hospitals provided about $1 billion in uncompensated care. The difference in the total amount of uncompensated care provided by nonprofit and for-profit hospitals is largely attributable to the fact that nonprofit hospitals accounted for a much larger share of the hospital market than did for-profits.
- The average "uncompensated-care share"—the cost of uncompensated care as a share of hospitals' operating expenses—was much higher at government hospitals (13.0 percent) than at either nonprofit hospitals (4.7 percent) or for-profit hospitals (4.2 percent).
- Individual hospitals varied widely in their uncompensated-care shares. Although nonprofit hospitals, on average, have slightly higher uncompensated-care shares than for-profits (by 0.5 percentage points), the distributions of uncompensated-care shares among those two types of hospitals overlap to a large extent.
- When regression techniques were used to adjust for the hospitals' size and location and for the characteristics of the local populations, nonprofit hospitals were estimated to have an average uncompensated-care share that was 0.6 percentage points higher than that for otherwise similar for-profit hospitals. That estimated difference corresponds to nonprofit hospitals in the five selected states providing between $100 million and $700 million more in uncompensated care than would have been provided if they had been for-profits.[4]

Provision of Medicaid-Covered Services

Medicaid's payment rates have, in general, been found to be somewhat below the costs that hospitals incur in providing Medicaid-covered services. Because providing hospital services to Medicaid patients is often unprofitable and serves a needy population, it can be thought of as a type of community benefit. Among all community hospitals nationwide, CBO found that the Medicaid share—Medicaid-covered days as a share of all patient

4. The range of $100 million to $700 million represents the 90 percent confidence interval from the underlying statistical analysis.

days—was, on average, 1.5 percentage points lower among nonprofit hospitals than it was among for-profit hospitals (15.6 percent versus 17.2 percent). The Medicaid share was substantially higher among government hospitals (27.0 percent). When regression techniques were used to control for hospital characteristics, nonprofit hospitals were found to have adjusted Medicaid shares that were 1.3 percentage points lower than those of otherwise similar for-profit hospitals.

Provision of Specialized Services

CBO also examined the share of hospitals of different ownership types that provide four specific types of specialized patient services: intensive care for burn victims, emergency room care, high-level trauma care, and labor and delivery services.[5] Each of those services addresses a community need and has been identified as being generally unprofitable. Among all community hospitals nationwide, emergency room care and labor and delivery services were both quite common, whereas few hospitals provided burn intensive care or high-level trauma care.

CBO found that nonprofit hospitals were more likely than for-profit hospitals to provide each of the four specialized services examined. After adjustment for hospital characteristics, nonprofit hospitals were found to be significantly more likely than for-profit hospitals to provide two of the four specialized patient services (emergency room care and labor and delivery services). Compared with otherwise similar for-profit hospitals, the share of nonprofit hospitals providing emergency room care was 3.8 percentage points higher, and the share providing labor and delivery services was 10.5 percentage points higher. CBO did not attempt to quantify the value to the community of the availability of those specialized services.

5. In CBO's analysis, a hospital provides "high-level trauma care" if it is a level 1 or level 2 adult trauma center (stand-alone pediatric trauma centers are not included). A hospital may be designated as a trauma center if it meets certain criteria developed by the American College of Surgeons. Trauma centers are assigned a level ranging from 1 through 5, with level 1 being the highest. To be designated a level 1 or level 2 trauma center, a hospital must "[provide] comprehensive trauma care" and must "have immediate availability of trauma surgeons, anesthesiologists, physician specialists, nurses, and resuscitation equipment." See Ellen J. MacKenzie and others, "National Inventory of Hospital Trauma Centers," *Journal of the American Medical Association*, vol. 289, no. 12 (March 26, 2003), pp. 1515-1522.

The Value of Tax Exemptions for Nonprofit Hospitals

The Joint Committee on Taxation (JCT) recently examined the value to nonprofit hospitals and their supporting organizations of the major tax exemptions they receive from federal, state, and local governments. Together, the value of the various tax exemptions in 2002 was estimated to be $12.6 billion, with exemptions from federal taxes accounting for about half of the total and exemptions from state and local taxes accounting for the remaining half.

JCT also estimated the value of some of the tax exemptions for nonprofit hospitals located in the five states for which uncompensated-care data were available. In those five states, the exemptions from federal and state corporate income taxes, state and local sales taxes, and local property taxes were valued at $2.5 billion. (Two important categories of tax exemptions—tax-exempt-bond financing and the deductibility of charitable contributions—were included in the national totals but were not available for the five states and are not included in the five-state total.)

Background

The hospital industry in the United States includes a mix of ownership forms. Nonprofit hospitals are the most common type, but for-profit and government hospitals also play substantial roles.[6] Of the 630,000 beds in Medicare-certified community hospitals in the United States in 2003, 68 percent were located in nonprofit hospitals, 16 percent were located in for-profit hospitals, and 15 percent were located in government (nonfederal) facilities.

This section of the analysis examines the differences between nonprofit hospitals and for-profit hospitals in their ownership structure, tax treatment, and the provision of collective goods. (Collective goods are defined as goods or services that, when used or consumed, generate well-

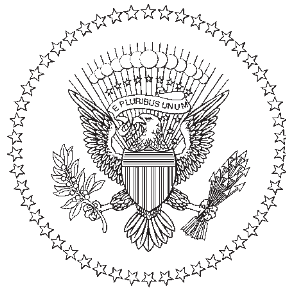
6. The terms "nonprofit" and "tax-exempt" (or "untaxed") are sometimes used interchangeably, but they are technically distinct. For the purposes of federal taxation, an organization may be deemed tax-exempt by meeting the requirements of section 501 of the Internal Revenue Code. Nonprofit status, on the other hand, is granted by state governments on the basis of criteria that vary from state to state. In CBO's analysis, hospitals that identify themselves as nonprofit in Medicare Hospital Cost Reports are assumed to be exempt from federal, state, and local taxes.

Exhibit 21

ECONOMIC REPORT

OF THE

PRESIDENT



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The Current State of the U.S. Health Care Sector

Although health outcomes in the United States have improved steadily in recent decades, the U.S. health care sector is beset by rising spending, declining rates of health insurance coverage, and inefficiencies in the delivery of care. In the United States, as in most other developed countries, advances in medical care have contributed to increases in life expectancy and reductions in infant mortality. Yet the unrelenting rise in health care costs in both the private and public sectors has placed a steadily increasing burden on American families, businesses, and governments at all levels.

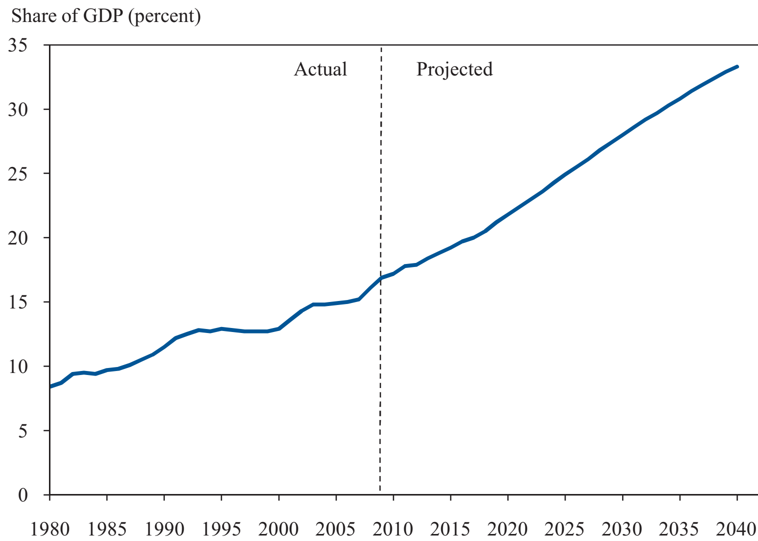
Rising Health Spending in the United States

For the past several decades, health care spending in the United States has consistently risen more rapidly than gross domestic product (GDP). Recent projections suggest that total spending in the U.S. health care sector exceeded $2.5 trillion in 2009, representing 17.6 percent of GDP (Sisko et al. 2009)—approximately twice its share in 1980 and a substantially greater portion of GDP than that of any other member of the Organisation for Economic Co-Operation and Development (OECD). As shown in Figure 7-1, estimates from the Congressional Budget Office (CBO) in June 2009 projected that this trend would continue in the absence of significant health insurance reform. More specifically, CBO estimated that health care spending would account for one-fourth of GDP by 2025 and one-third by 2040 (Congressional Budget Office 2009d).

The steady growth in health care spending has placed an increasingly heavy financial burden on individuals and families, with a steadily growing share of workers' total compensation going to health care costs. According to the most recent data from the U.S. Census Bureau, inflation-adjusted median household income in the United States declined 4.3 percent from 1999 to 2008 (from $52,587 to $50,303), and real weekly median earnings for full-time workers increased just 1.8 percent. During that same period, the real average total cost of employer-sponsored health insurance for a family policy rose by more than 69 percent (Kaiser Family Foundation and Health Research and Educational Trust 2009).

Because firms choose to compensate workers with either wages or benefits such as employer-sponsored health insurance, increasing health care costs tend to "crowd out" increases in wages. Therefore, these rapid

Figure 7-1
National Health Expenditures as a Share of GDP



Source: Congressional Budget Office (2009d).

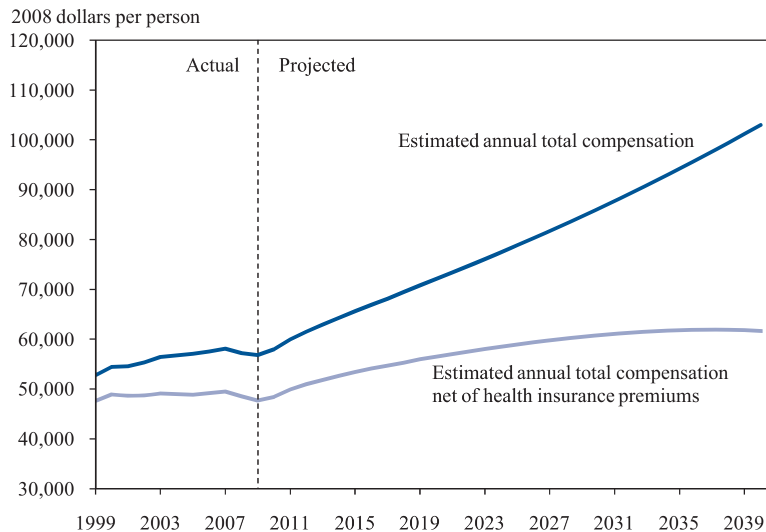
increases in employer-sponsored health insurance premiums have resulted in much lower wage growth for workers.

When considering these divergent trends, it is also important to remember that workers typically pay a significant share of their health insurance premiums out of earnings. According to data from the Kaiser Family Foundation, the average employee share for an employer-sponsored family policy was 27 percent in both 1999 and 2008. In real dollars, the average total family premium increased by $5,200 during this nine-year period. Thus, the amount paid by the typical worker with employer-sponsored health insurance increased by more than $1,400 from 1999 to 2008. Subtracting these average employee contributions from median household income in each year gives a rough measure of "post-premium" median household income. By that measure, the decline in household income swells from 4.3 percent to 7.3 percent (that is, post-premium income fell from $50,566 to $46,879).

This point is further reinforced when one considers the implications of rapidly rising health care costs for the wage growth of workers in the years ahead. As Figure 7-2 shows, compensation net of health insurance premiums is projected to grow much less rapidly than total compensation,

with the growth eventually turning negative by 2037.[1] Put simply, if health care costs continue to increase at the rate that they have in recent years, workers' take-home wages are likely to grow slowly and eventually decline.

Figure 7-2
Total Compensation Including and Excluding Health Insurance



Note: Health insurance premiums include the employee- and employer-paid portions.
Sources: Actual data from Department of Labor (Bureau of Labor Statistics); Kaiser Family Foundation and Health Research and Educational Trust (2009); Department of Health and Human Services (Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends), 2008 Medical Expenditure Panel Survey-Insurance Component. Projections based on CEA calculations.

Rising health care spending has placed similar burdens on the 45 million aged and disabled beneficiaries of the Medicare program, whose inflation-adjusted premiums for Medicare Part B coverage—which covers outpatient costs including physician fees—rose 64 percent (from $1,411 to $2,314 per couple per year) between 1999 and 2008. During that same period, average inflation-adjusted Social Security benefits for retired workers grew less than 10 percent. Rising health insurance premiums are thus consuming larger shares of workers' total compensation and Medicare recipients' Social Security benefits alike.

[1] The upper curve of Figure 7-2 displays historical annual compensation per worker in the nonfarm business sector in constant 2008 dollars from 1999 through 2009, deflated with the CPI-U-RS. Real compensation per worker is projected using the Administration's forecast from 2009 through 2020 and at a 1.8 percent annual rate in the subsequent years. The lower curve plots historical real annual compensation per person net of average total premiums for employer-sponsored health insurance during the same period. The assumed growth rate of employer-sponsored premiums is 5 percent, which is slightly lower than the average annual rate as reported by the Kaiser Family Foundation during the 1999 to 2009 period.

The corrosive effects of rising health insurance premiums have not been limited to businesses and individuals. Increases in outlays for programs such as Medicare and Medicaid and rising expenditures for uncompensated care caused by increasing numbers of uninsured Americans have also strained the budgets of Federal, state, and local governments. The fraction of Federal spending devoted to health care rose from 11.1 percent in 1980 to 25.2 percent in 2008. In the absence of reform, this trend is projected to continue, resulting in lower spending on other programs, higher taxes, or increases in the Federal deficit.

The upward trend in health care spending has also posed problems for state governments, with spending on the means-tested Medicaid program now the second largest category of outlays in their budgets, just behind elementary and secondary education. Because virtually all state governments must balance their budgets each year, the rapid increases in Medicaid spending have forced lawmakers to decide whether to cut spending in areas such as public safety and education or to increase taxes.

If health care costs continue rising, the consequences for government budgets at the local, state, and Federal level could be dire. And as discussed in Chapter 5, projected increases in the costs of the Medicare and Medicaid programs are a key source of the Federal Government's long-term fiscal challenges.

Market Failures in the Current U.S. Health Care System: Theoretical Background

As described by Nobel Laureate Kenneth Arrow in a seminal 1963 paper, an individual's choice to purchase health insurance is rooted in the economics of risk and uncertainty. Over their lifetimes, people face substantial risks from events that are largely beyond their control. When possible, those who are risk-averse prefer to hedge against these risks by purchasing insurance (Arrow 1963).

Health care is no exception. When people become sick, they face potentially debilitating medical bills and often must stop working and forgo earnings. Moreover, medical expenses are not equally distributed: annual medical costs for most people are relatively small, but some people face ruinously large costs. Although total health care costs for the median respondent in the 2007 Medical Expenditure Panel Survey were less than $1,100, costs for those at the 90th percentile of the distribution were almost 14 times higher (Department of Health and Human Services 2009). As a result, risk-averse people prefer to trade an uncertain stream of expenses for medical care for the certainty of a regular insurance payment, which buys a policy that pays for the high cost of treatment during illness or injury. Economic theory and

common sense suggest that purchasing health insurance to hedge the risk associated with the economic costs of poor health makes people better off.

Health insurance markets, however, do not function perfectly. The economics literature documents four primary impediments: adverse selection, moral hazard, the Samaritan's dilemma, and problems arising from incomplete insurance contracts. In a health insurance market characterized by these and other sources of inefficiency, well-designed government policy has the potential to reduce costs, improve efficiency, and benefit patients by stabilizing risk pools for insurance coverage and providing needed coverage to those who otherwise could not afford it.

Adverse Selection. In the case of adverse selection, buyers and sellers have asymmetric information about the characteristics of market participants. People with larger health risks want to buy more generous insurance, while those with smaller health risks want lower premiums for coverage. Insurers cannot perfectly determine whether a potential purchaser is a large or small health risk.

To understand how adverse selection can harm insurance markets, suppose that a group of individuals is given a choice to buy health insurance or pay for medical costs out-of-pocket. The insurance rates for the group will depend on the average cost of health care for those who elect to purchase insurance. The healthiest members of the group may decide that the insurance is too expensive, given their expected costs. If they choose not to get insurance, the average cost of care for those who purchase insurance will increase. As premiums increase, more and more healthy individuals may choose to leave the insurance market, further increasing average health care costs for those who purchase insurance. Over time, this winnowing process can lead to declining insurance rates and even an unraveling of health insurance markets. Without changes to the structure of insurance markets, the markets can break down, and fewer people can receive insurance than would be optimal. Subsidies to encourage individuals to purchase health insurance can help combat adverse selection, as can regulations requiring that individuals purchase insurance, because both ensure that healthier people enter the risk pool along with their less healthy counterparts.

Under current institutional arrangements, adverse selection is likely to be an especially large problem for small businesses and for people purchasing insurance in the individual market. In large firms, where employees are generally hired for reasons unrelated to their health, high- and low-risk employees are automatically pooled together, reducing the probability of low-risk employees opting out of coverage or high-risk workers facing extremely high premiums. In contrast, small employers cannot pool risk across a large group of workers, and thus the average risk

of a given small firm's employee pool can be significantly above or below the population average. As such, similar to the market for individual insurance described above, firms with low-risk worker pools will tend to opt out of insurance coverage, leaving firms with high-risk pools to pay much higher premiums.

Moral Hazard. A second problem with health insurance is moral hazard: the tendency for some people to use more health care because they are insulated from its price. When individuals purchase insurance, they no longer pay the full cost of their medical care. As a result, insurance may induce some people to consume health care on which they place much less value than the actual cost of this care or discourage patients and their doctors from choosing the most efficient treatment. This extra consumption could increase average medical costs and, ultimately, insurance premiums. The presence of moral hazard suggests that research into which treatments deliver the greatest health benefits could encourage doctors and patients to adopt best practices.

Samaritan's Dilemma. A third source of inefficiency in the insurance market is that society's desire to treat all patients, even those who do not have insurance and cannot pay for their care, gives rise to the Samaritan's dilemma. Because governments and their citizens naturally wish to provide care for those who need it, people who lack insurance and cannot pay for medical care can still receive some care when they fall ill. Some people may even choose not to purchase insurance because they understand that emergency care may still be available to them. In the context of adverse selection, a low insurance rate is a *symptom* of underlying inefficiencies. Viewed through the lens of the Samaritan's dilemma, in contrast, the millions of uninsured Americans are one *source* of health care inefficiencies.

The burden of paying for some of this uncompensated care is passed on to people who do purchase insurance. The result is a "hidden tax" on health insurance premiums, which in turn exacerbates adverse selection by raising premiums for individuals who do not opt out of coverage. One estimate suggests that the total amount of uncompensated care for the uninsured was approximately $56 billion in 2008 (Hadley et al. 2008).

Incomplete Insurance Contracts. Many economic transactions involve a single, straightforward interaction between a buyer and a seller. In many purchases of goods, for example, the prospective buyer can look the good over carefully, decide whether or not to purchase it, and never interact with the seller again. Health insurance, in contrast, involves a complex relationship between an insurance company and a patient that can last years or even decades. It is not possible to foresee and spell out in detail every contingency that may arise and what is and is not covered.

When individuals are healthy, their medical costs are typically lower than their premiums, and these patients are profitable for insurance companies. When patients become ill, however, they may no longer be profitable. Insurance companies therefore have a financial incentive to find ways to deny care or drop coverage when individuals become sick, undermining the central purpose of insurance. For example, in most states, insurance companies can rescind coverage if individuals fail to list any medical conditions—even those they know nothing about—on their initial health status questionnaire. Entire families can lose vital health insurance coverage in this manner. A House committee investigation found that three large insurers rescinded nearly 20,000 policies over a five-year period, saving these companies $300 million that would otherwise have been paid out as claims (Waxman and Barton 2009).

A closely related problem is that insurance companies are reluctant to accept patients who may have high costs in the future. As a result, individuals with preexisting conditions find obtaining health insurance extremely expensive, regardless of whether the conditions are costly today. This is a major problem in the individual market for health insurance. Forty-four states now permit insurance companies to deny coverage, charge inflated premiums, or refuse to cover whole categories of illnesses because of preexisting medical conditions. A recent survey found that 36 percent of non-elderly adults attempting to purchase insurance in the individual market in the previous three years faced higher premiums or denial of coverage because of preexisting conditions (Doty et al. 2009). In another survey, 1 in 10 people with cancer said they could not obtain health coverage, and 6 percent said they lost their coverage because of being diagnosed with the disease (USA Today, Kaiser Family Foundation, and Harvard School of Public Health 2006). And the problem affects not only people with serious medical conditions, but also young and healthy people with relatively minor conditions such as allergies or asthma.

System-Wide Evidence of Inefficient Spending

While an extensive literature in economic theory makes the case for market failure in the provision of health insurance, a substantial body of evidence documents the pervasiveness of inefficient allocation of spending and resources throughout the health care system. Evidence that health care spending may be inefficient comes from analyses of the relationship between health care spending and health outcomes, both across states in our own Nation and across countries around the world.

Within the United States, research suggests that the substantially higher rates of health care utilization in some geographic areas are not

associated with better health outcomes, even after accounting for differences in medical care prices, patient demographics, and regional rates of illness (Wennberg, Fisher, and Skinner 2002). Evidence from Medicare reveals that spending per enrollee varies widely across regions, without being clearly linked to differences in either medical needs or outcomes. One comparison of composite quality scores for medical centers and average spending per Medicare beneficiary found that facilities in states with low average costs are as likely or even more likely to provide recommended care for some common health problems than are similar facilities in states with high costs (Congressional Budget Office 2008). One study suggests that nearly 30 percent of Medicare's costs could be saved if Medicare per capita spending in all regions were equal to that in the lowest-cost areas (Wennberg, Fisher, and Skinner 2002).

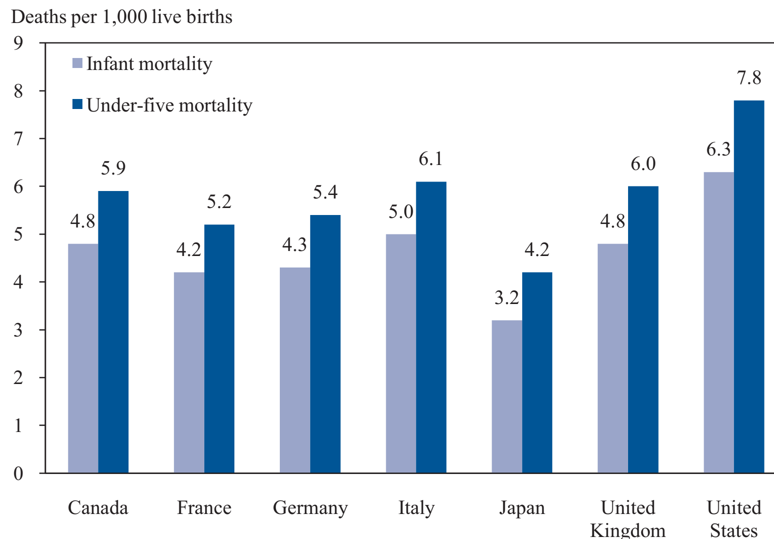
Variations in spending tend to be more dramatic in cases where medical experts are uncertain about the best kind of treatment to administer. For instance, in the absence of medical consensus over the best use of imaging and diagnostic testing for heart attacks, use rates vary widely geographically, leading to corresponding variation in health spending. Research that helps medical providers understand and use the most effective treatment can help reduce this uncertainty, lower costs, and improve health outcomes.

Overuse of "supply-sensitive services," such as specialist care, diagnostic tests, and admissions to intensive care facilities among patients with chronic illnesses, as well as differences in social norms among local physicians, seems to drive up per capita spending in high-cost areas (Congressional Budget Office 2008). Moral hazard may help to explain some of the overuse of services that do not improve people's health status.

Health care spending also differs as a share of GDP across countries, without corresponding systematic differences in outcomes. For example, according to the United Nations, the estimated U.S. infant mortality rate of 6.3 per 1,000 infants for the 2005 to 2010 period is projected to be substantially higher than that in any other Group of Seven (G-7) country, as is the mortality rate among children under the age of five, as shown in Figure 7-3 (United Nations 2007). This variation is especially striking when one considers that the United States has the highest GDP per capita of any G-7 country. Although drawing direct conclusions from cross-country comparisons is difficult because of underlying health differences, this comparison further suggests that the United States could lower health care spending without sacrificing quality. Similarly, life expectancy is much lower in the United States than in other advanced economies. The OECD estimated life expectancy at birth in 2006 to be 78.1 years in the United States

compared with an average of 80.7 in other G-7 countries (Organisation for Economic Co-operation and Development 2009).

Figure 7-3
Child and Infant Mortality Across G-7 Countries



Source: United Nations (2007).

Recent research suggests that differences in health care systems account for at least part of these cross-country differences in life expectancy. For example, one study (Nolte and McKee 2008) analyzed mortality from causes that could be prevented by effective health care, which the authors term "amenable mortality." They found that the amenable mortality rate among men in the United States in 1997–98 was 8 percent higher than the average rate in 18 other industrialized countries. The corresponding rate among U.S. women was 17 percent higher than the average among these other 18 countries. Moreover, of all 19 countries considered, the United States had the smallest decline during the subsequent five years, with a decline of just 4 percent compared with an average decline of 16 percent across the remaining 18. The authors further estimated that if the U.S. improvement had been equal to the average improvement for the other countries, the number of preventable deaths in the United States would have been 75,000 lower in 2002. This finding suggests that the U.S. health care system has been improving much less rapidly than the systems in other industrialized countries in recent years.

A further indication that our health care system is in need of reform is that satisfaction with care has, if anything, been declining despite the substantial increases in spending. Not surprisingly, this decline in satisfaction has been concentrated among people without health insurance, whose ranks have swelled considerably during the past decade. For example, from 2000 to 2009, the fraction of uninsured U.S. residents reporting that they were satisfied with their health care fell from 36 to 26 percent. And not only has dissatisfaction with our health care system increased over time, it is also noticeably greater than dissatisfaction with systems in many other developed nations (Commonwealth Fund 2008).

Declining Coverage and Strains on Particular Groups and Sectors

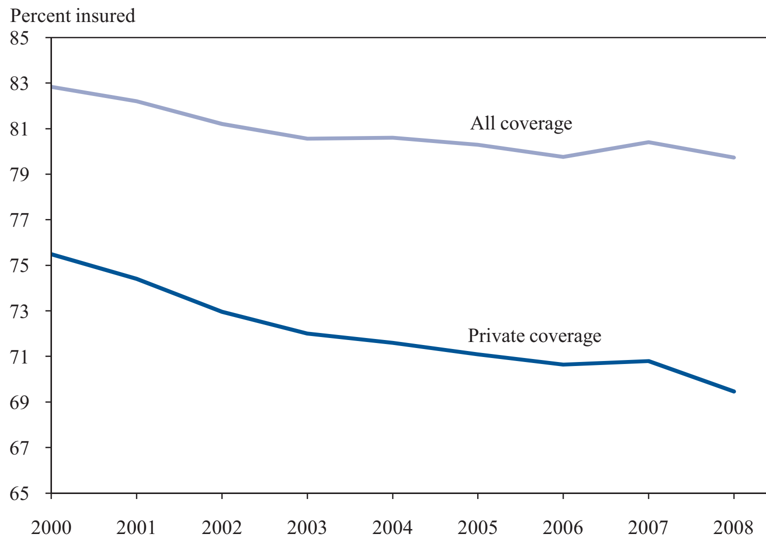
The preceding analysis shows that at an aggregate level, there are major inefficiencies in the current health care system. But, because of the nature of the market failures in health care, the current system works particularly poorly in certain parts of the economy and places disproportionate burdens on certain groups. Moreover, because of rising costs, many of the strains are increasing over time.

Declining Coverage among Non-Elderly Adults. The rapid increase in health insurance premiums in recent years has caused many firms to stop offering health insurance to their workers, forcing employees either to pay higher prices for coverage in the individual market (which is often much less generous than coverage in the group market) or to go without health insurance entirely. According to the Kaiser Family Foundation, between 2000 and 2009, the share of firms offering health insurance to their workers fell from 69 to 60 percent. Furthermore, 8 percent of firms offering coverage in 2009 reported that they were somewhat or very likely to drop coverage in 2010.

Largely because of these falling offer rates, private health insurance coverage declined substantially during this same period. As shown in Figure 7-4, the fraction of non-elderly adults in the United States with private health insurance coverage fell from 75.5 percent in 2000 to 69.5 percent in 2008.

These numbers, however, provide just a snapshot of health insurance coverage in the United States because they measure the fraction of people who are uninsured at a point in time and thus obscure the fact that a large fraction of the population has been uninsured at some point in the past. According to recent research, at least 48 percent of non-elderly Americans were uninsured at some point between 1996 and 2006 (Department of the Treasury 2009).

Figure 7-4
Insurance Rates of Non-Elderly Adults



Source: DeNavas-Walt, Proctor, and Smith (2009).

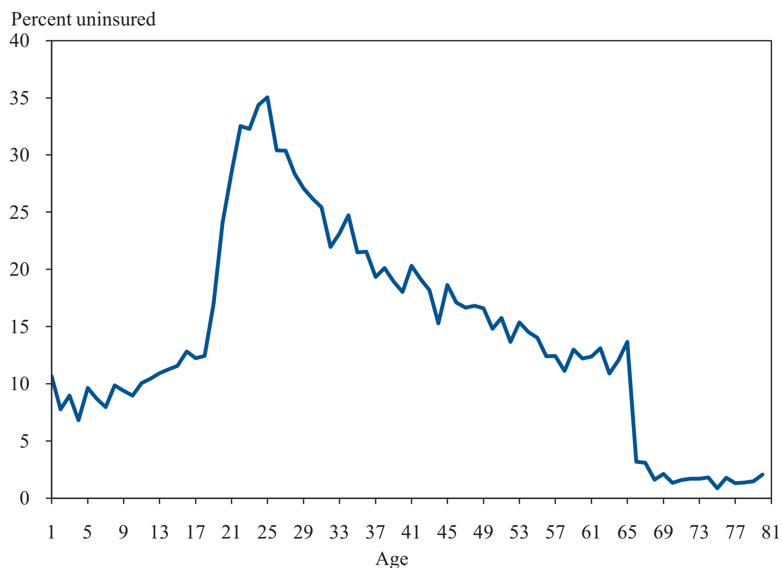
Although roughly half of the 2000–2008 decline in private coverage displayed in Figure 7-4 has been offset by an increase in public health insurance, the share of non-elderly adults without health insurance nevertheless rose from 17.2 to 20.3 percent. In other words, approximately 5.9 million more adults were uninsured in 2008 than would have been had the fraction uninsured remained constant since 2000. The decline in private health insurance coverage was similarly large among children, although it was more than offset by increases in public health insurance (most notably Medicaid and CHIP), so that less than 10 percent of children were uninsured by 2008 (DeNavas-Walt, Proctor, and Smith 2009).

The generosity of private health insurance coverage has also been declining in recent years. For example, from 2006 to 2009, the fraction of covered workers enrolled in an employer-sponsored plan with a deductible of $1,000 or greater for single coverage more than doubled, from 10 to 22 percent. The increase in deductibles was also striking among covered workers with family coverage. For example, during this same three-year period, the fraction of enrollees in preferred provider organizations with a deductible of $2,000 or more increased from 8 to 17 percent. Similar increases in cost-sharing were apparent for visits with primary care physicians. The fraction of covered workers with a copayment of $25 or more for an office visit with a primary care physician increased from 12 to 31 percent from 2004 to 2009. These rising costs in the private market

fall disproportionately on the near-elderly, who have higher medical costs but are not eligible for Medicare. A recent study found that the average family premium in the individual market in 2009 for those aged 60–64 was 93 percent higher than the average family premium for individuals aged 35–39 (America's Health Insurance Plans 2009).

Low Insurance Coverage among Young Adults and Low-Income Individuals. Figure 7-5 shows the relationship between age and the fraction of people without health insurance in 2008. One striking pattern is the sharp and substantial rise in this fraction as individuals enter adulthood. For example, the share of 20-year-olds without health insurance is more than twice that of 17-year-olds (28 percent compared with 12 percent).

Figure 7-5
Percent of Americans Uninsured by Age



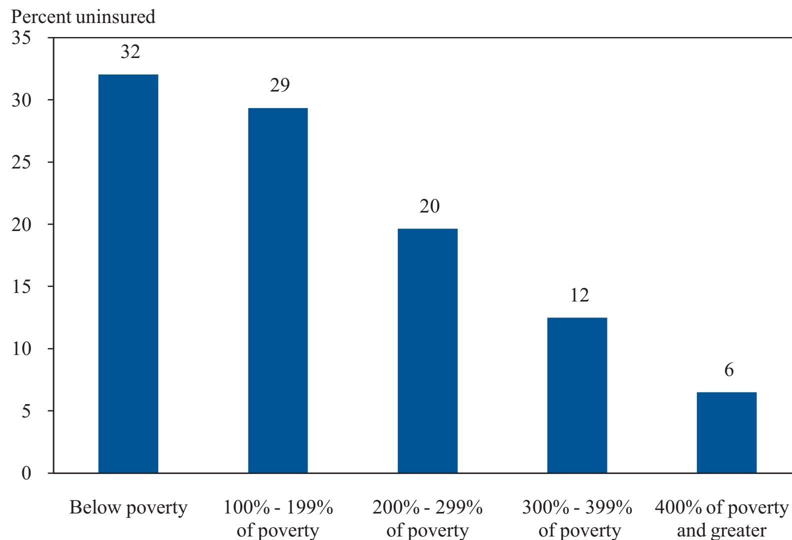
Source: Department of Commerce (Census Bureau), Current Population Survey, Annual Social and Economic Supplement.

Adverse selection is clearly a key source of this change. Many teenagers obtain insurance through their parents' employer-provided family policies, and so are in large pools. Many young adults, in contrast, do not have this coverage and are either jobless or work at jobs that do not offer health insurance; thus, they must either buy insurance on the individual market or go uninsured. As described above, health insurance coverage in the individual market can be very expensive because of adverse selection. Many young adults also have very low incomes, making the cost of coverage

prohibitively high for them. Furthermore, because they are, on average, in very good health, young adults may be more tolerant than other groups of the risks associated with being uninsured.

The burden of rising costs also falls differentially on low-income individuals, who find it more difficult each year to afford coverage through employer plans or the individual market. Indeed, as shown in Figure 7-6, low-income individuals are substantially more likely to be uninsured than their higher-income counterparts. As the figure shows, non-elderly individuals below the Federal poverty line ($10,830 a year in income for an individual and $22,050 for a family of four in 2009) were five times as likely to be uninsured as their counterparts above 400 percent of the poverty line in 2008. These low rates of insurance coverage increase insurance premiums for other Americans because of the "hidden tax" that arises from the financing of uncompensated care.

Figure 7-6
Share of Non-Elderly Individuals Uninsured by Poverty Status

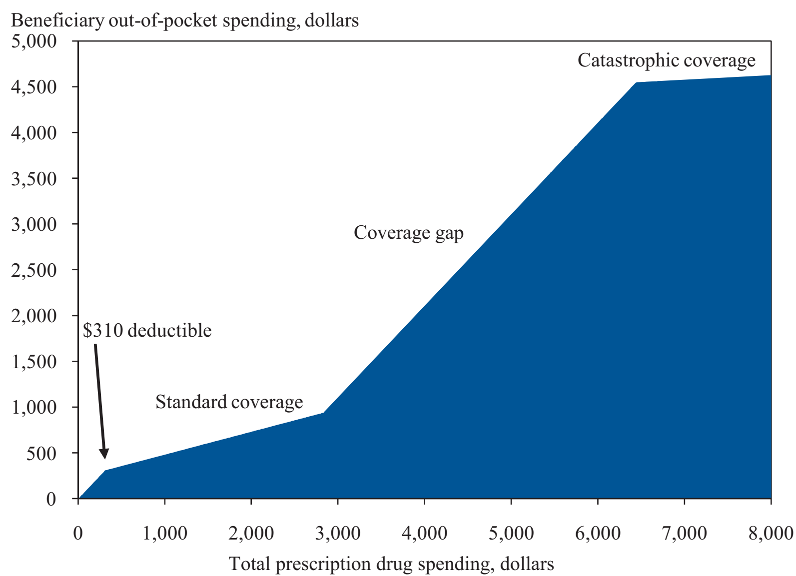


Source: Department of Commerce (Census Bureau), Current Population Survey, Annual Social and Economic Supplement.

The Elderly. Even those over the age of 65 are not protected from high costs, despite almost universal coverage through Medicare. Consider prescription drug expenses, for which the majority of Medicare recipients have coverage through Medicare Part D. As shown in Figure 7-7, after the initial deductible of $310, a standard Part D plan in 2010 covers 75 percent

of the cost of drugs only up to $2,830 in annual prescription drug spending. After that, enrollees are responsible for all expenditures on prescriptions up to $6,440 in total drug spending (where out-of-pocket costs would be $4,550), at which point they qualify for catastrophic coverage with a modest copayment. Millions of beneficiaries fall into this coverage gap—termed the "donut hole"—every year, and as a result many may not be able to afford to fill needed prescriptions.

Figure 7-7
Medicare Part D Out-of-Pocket Costs by Total Prescription Drug Spending



Note: Calculations based on a standard 2010 benefit design.
Source: Medicare Payment Advisory Commission, Part D Payment System, October 2009.

In 2007, one-quarter of Part D enrollees who filled one or more prescriptions but did not receive low-income subsidies had prescription drug expenses that were high enough to reach the coverage gap. For that reason, 3.8 million Medicare recipients reached the initial coverage limit and were required to pay the full cost of additional pharmaceutical treatments received while in the coverage gap, despite having insurance for prescription drug costs. One study found that in 2007, 15 percent of Part D enrollees in the coverage gap using pharmaceuticals in one or more of eight major drug classes stopped taking their medication (Hoadley et al. 2008).

Small Businesses. As described earlier, adverse selection is a serious problem for small businesses, which do not have large numbers of workers to pool risks. This problem manifests itself in two forms. The first is high costs. Because of high broker fees and administrative costs as well as adverse selection, small firms pay up to 18 percent more per worker for the same policy than do large firms (Gabel et al. 2006). The second is low coverage. Employees at small businesses are almost three times as likely as their counterparts at large firms to be uninsured (29 percent versus 11 percent, according to the March 2009 Current Population Survey). And among small businesses that do offer insurance, only 22 percent of covered workers are offered a choice of more than one type of plan (Kaiser Family Foundation and Health Research and Educational Trust 2009).

In recent years, small businesses and their employees have had an especially difficult time managing the rapidly rising cost of health care. Consistent with this, the share of firms with three to nine employees offering health insurance to their workers fell from 57 to 46 percent between 2000 and 2009.

As discussed in a Council of Economic Advisers report issued in July 2009, high insurance costs in the small-group market discourage entrepreneurs from launching their own companies, and the low availability of insurance discourages many people from working at small firms (Council of Economic Advisers 2009c). As a result, the current system discourages entrepreneurship and hurts the competitiveness of existing small businesses. Given the key role of small businesses in job creation and growth, this harms the entire economy.

Taken together, the trends summarized in this section demonstrate that in recent years the rapid rise in health insurance premiums has reduced the take-home pay of American workers and eaten into increases in Medicare recipients' Social Security benefits. Fewer firms are electing to offer health insurance to their workers, and those that do are reducing the generosity of that coverage through increased cost-sharing. Fewer individuals each year can afford to purchase health insurance coverage. The current system places small businesses at a competitive disadvantage. And finally, the steady increases in health care spending strain the budgets of families, businesses, and governments at every level, and demonstrate the need for health insurance reform that slows the growth rate of costs.

Health Policies Enacted in 2009

Since taking office, the President has signed into law a series of provisions aimed at expanding health insurance coverage, improving the quality of care, and reducing the growth rate of health care spending. The

American Recovery and Reinvestment Act of 2009 provided vital support to those hit hardest by the economic downturn while helping to ensure access to doctors, nurses, and hospitals for Americans who lost jobs and income. At the same time, legislation extended health insurance coverage to millions of children, and improvements in health system quality and efficiency benefited the entire health care system. These necessary first steps have set the stage for a more fundamental reform of the U.S. health care system, one that will ensure access to affordable, high-quality coverage and that genuinely slows the growth rate of health care spending.

Expansion of the CHIP Program

Just two weeks after taking office, the President signed into law the Children's Health Insurance Program Reauthorization Act, which provides funding that expands access to nearly 4 million additional children by 2013. This guarantee of coverage also kept millions of children from losing insurance in the midst of the recession, when many workers lost employer-sponsored coverage for themselves and their dependents. An examination of data from recent surveys by the Centers for Disease Control and Prevention found that private coverage among children fell by 2.5 percentage points from the first six months of 2008 to the first six months of 2009. Despite the fall in private coverage, however, fewer children were uninsured during that six-month period in 2009, in large part because public coverage increased by 3 percentage points (Martinez and Cohen 2008, 2009).

Approximately 7 million children (1 in every 10) were uninsured in 2008 (DeNavas-Walt, Proctor, and Smith 2009). Once fully phased in, the CHIP reauthorization legislation signed by the President will lower that number by as much as half from the 2008 baseline. In the future, this new legislation will enhance the quality of medical care for children and improve their health. Research has convincingly shown that expanding health insurance to children is very cost-effective, because it not only increases access to care but also substantially lowers mortality (Currie and Gruber 1996a, 1996b).

Subsidized COBRA Coverage

In part because of the difficulty of purchasing health insurance on the individual market (owing to adverse selection), most Americans get health insurance through their own or a family member's job. And what is true for dependent children is true for their parents: when economic conditions deteriorate, the number of people with employer-sponsored health insurance tends to fall. However, unlike the case with children, during the current recession public coverage has only offset part of the reduction

Exhibit 22

Calendar No. 184

111TH CONGRESS
1st Session

SENATE

REPORT
111–89

AMERICA'S HEALTHY FUTURE ACT OF 2009

R E P O R T

[TO ACCOMPANY S. 1796]

ON

PROVIDING AFFORDABLE, QUALITY HEALTH CARE FOR ALL AMERICANS AND REDUCING THE GROWTH IN HEALTH CARE SPENDING, AND FOR OTHER PURPOSES

together with

ADDITIONAL AND MINORITY VIEWS

COMMITTEE ON FINANCE
UNITED STATES SENATE

OCTOBER 19, 2009.—Ordered to be printed

Calendar No. 184

111TH CONGRESS *1st Session*	SENATE	REPORT 111–89

AMERICA'S HEALTHY FUTURE ACT OF 2009

OCTOBER 19, 2009.—Ordered to be printed

Mr. BAUCUS, from the Committee on Finance, submitted the following

R E P O R T

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany S. 1796]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, having considered an original bill, S. 1796, to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, reports favorably thereon and recommends that the bill do pass.

I. BACKGROUND AND NEED FOR LEGISLATION

The U.S. health system is in crisis. In 2008, over 46 million Americans were uninsured and millions more have lost their health coverage as a result of the recent economic downturn. Another 25 million people are underinsured, with coverage that is insufficient to protect against the cost of a major illness. The rising cost of health care outpaces wages by a factor of five to one, placing an ever greater strain on family, business, and government budgets.

Improving the health system is one of the most important challenges we face as a nation, and the inability to achieve comprehensive health reform will undermine any efforts to secure a full and lasting economic recovery. Health reform is an essential part of restoring America's overall economy and maintaining our global competitiveness.

Health care reform is also necessary to protect the finances of working families. Between 2000 and 2009, average family premiums for employer-sponsored health coverage increased by 93 percent—increasing from $6,772 to $13,073—while wages increased by only 19 percent in the same period. Rising health care costs and mounting medical debt account for half of all filed bankruptcies—affecting two million people a year.

Countless studies have shown that those without health coverage generally experience worse health outcomes and poorer health compared to those who are insured. The uninsured are less likely to receive preventive care or even care for traumatic injuries, heart attacks, and chronic diseases. As a result, 23 percent forgo necessary care every year due to cost, while 22,000 uninsured adults die prematurely each year as a result of lacking access to care.

A majority of the uninsured has low or moderate incomes—with two-thirds in families with an annual income less than twice the Federal poverty level (FPL). Eight in ten of the uninsured are in working families in which workers are either not offered coverage by their employer or they do not qualify for employer-offered coverage.

Hospitals and clinics provide an estimated $56 billion annually in uncompensated care to people without health insurance, and those with health coverage pay the bill through higher health care costs and increased premiums. This so-called "hidden health tax" cost the average family over $1,000 in high premiums last year. An estimated ten percent of health care premiums in California are attributable to cost shifting due to the uninsured.

Rising health costs have taken a toll on U.S. businesses as well. An estimated 159 million Americans receive health benefits through an employer, with the average cost of this coverage reaching $4,824 for single coverage and $13,375 for family coverage in 2009. Over the last decade, employer-sponsored coverage has increased by 131 percent, forcing employers—particularly small employers—to make difficult choices among painful options to offset increasing health costs. These choices include raising workers' premiums, limiting raises or reducing bonus pay, eliminating family health benefits, or providing less-than-comprehensive health coverage.

Federal and state governments have also struggled with health care costs. The Congressional Budget Office has noted that rising health care costs represent the "single most important factor influencing the Federal Government's long-term fiscal balance." The U.S. spends more than 16 percent of our gross domestic product (GDP) on health care—a much greater share than other industrialized nations with high-quality systems and coverage for everyone. By 2017, health care expenditures are expected to consume nearly 20 percent of the GDP, or $4.3 trillion annually. Spending for Medicare and Medicaid, due to many of the same factors found in the private sector, is projected to increase by 114 percent in ten years. Over the same period, the GDP will grow by just 64 percent.

Despite high levels of spending on health care, a recent study by the Institute of Medicine concludes that the current health system is not making progress toward improving quality or containing costs for patients or providers. Research documenting poor quality of care received by patients in the U.S. is shocking. A 2003 RAND

Corporation study found that adults received recommended care for many illnesses only 55 percent of the time. Needed care for diabetes was delivered only 45 percent of the time and for pneumonia 39 percent of the time. Patients with breast cancer fared better, but still did not receive recommended care one-quarter of the time.

Compared to other industrialized countries, our quality of care does not reflect the level of our investment. The U.S. ranks last out of 19 industrialized countries in unnecessary deaths and 29th out of 37 countries for infant mortality—tied with Slovakia and Poland, and below Cuba and Hungary. Our rate of infant mortality is double that of France and Germany.

In short, Americans are not getting their money's worth when patients receive services of little or no value—such as hospitalizations that could have been prevented with appropriate outpatient treatment, duplicate tests, or ineffective tests and treatments. Yet the current system does little to steer providers toward the right choices. Even though more care does not necessarily mean better care, Medicare and most other insurers continue to pay for more visits, tests, imaging services, and procedures, regardless of whether the treatment is effective or necessary, and pay even more when treatment results in subsequent injury or illness.

Providers are not consistently encouraged to coordinate patients' care or to supply preventive and primary care services, even though such actions can improve quality of care and reduce costs. Rewarding providers that furnish better quality care, coordinate care, and use resources more judiciously could reduce costs and, most importantly, better meet the health care needs of millions more American patients.

Each of the key challenges facing our health care system—lack of access to care, the cost of care, and the need for better-quality care—must be addressed together in a comprehensive approach. Covering millions of uninsured through a broken health system is fiscally unsustainable. Attempting to address the inefficiencies plaguing our system and the perverse incentives in the delivery system without covering the uninsured will not alleviate the burden of uncompensated care and cost shifting. The time for incremental improvements has passed; health care reform must be comprehensive in scope.

It is in this context that the Finance Committee developed the legislative proposal that would become the "America's Healthy Future Act." The legislation approved by the Finance Committee addresses the challenges facing our health care system by expanding health coverage to 29 million Americans, improving quality of care and transforming the health care delivery system, and reducing Federal health spending and the Federal deficit over the ten year budget window and in the long run.

As a general principle, the bill allows those who like their health insurance to keep what they have today. For the millions of Americans who don't have employer-sponsored coverage, cannot afford to purchase coverage on their own, or who are denied coverage by health insurance companies due to a pre-existing condition, the Chairman's Mark reforms the individual and small-group markets, making health coverage affordable and accessible. These market reforms would require insurance companies to issue coverage to all individuals regardless of health status, prohibit insurers from lim-

Exhibit 23

Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2009

by Robin A. Cohen, Ph.D., Michael E. Martinez, M.P.H., M.H.S.A., and Brian W. Ward, Ph.D.,
Division of Health Interview Statistics, National Center for Health Statistics

Highlights

- Once each year, this quarterly report presents insurance coverage rates for selected states. In 2009, the percentage of persons who were uninsured at the time of interview among the 20 largest states ranged from 3.7% in Massachusetts to 24.6% in Texas.
- In 2009, 46.3 million persons of all ages (15.4%) were uninsured at the time of interview, 58.5 million (19.4%) had been uninsured for at least part of the year prior to interview, and 32.8 million (10.9%) had been uninsured for more than a year at the time of interview.
- The percentage of adults aged 18-64 years who lacked coverage at the time of interview increased from 19.7% in 2008 to 21.1% in 2009. There was a corresponding decrease in private coverage among adults aged 18-64 from 68.1% in 2008 to 65.8% in 2009.
- In 2009, 22.4% of persons under age 65 years with private health insurance were enrolled in a high deductible health plan (HDHP), including 6.3% who were enrolled in a consumer-directed health plan (CDHP). Almost 50% of persons with a private plan obtained by means other than through employment were in a HDHP. An estimated 20.4% of persons with a private plan were in a family with a flexible spending account (FSA) for medical expenses.

Introduction

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) is releasing selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the 2009 National Health Interview Survey (NHIS), along with comparable estimates from the 1997-2008 NHIS. Data analyses for the 2009 NHIS were based on 88,129 persons in the Family Core.

Three measures of lack of health insurance coverage are provided: (i) uninsured at the time of interview, (ii) uninsured at least part of the year prior to interview (which also includes persons uninsured for more than a year), and (iii) uninsured for more than a year at the time of interview. Estimates of public and private coverage are also presented.

For individuals with private health insurance, estimates are presented for enrollment in high deductible health plans (HDHPs), enrollment in consumer-directed health plans (CDHPs), and being in a family with a flexible spending account (FSA) for medical expenses.

For more information about NHIS and the Early Release (ER) Program, please see the **Technical Notes** and **Additional Early Release Program Products** sections of this report.

This report is updated quarterly and is part of the NHIS ER Program, which releases updated selected estimates that are available from the NHIS website at **http://www.cdc.gov/nchs/nhis.htm**.

Results

Lack of health insurance coverage

In 2009, the percentage of persons uninsured at the time of interview was 15.4% (46.3 million) for persons of all ages, 17.5% (46.0 million) for persons under age 65 years, 21.1% (40.0 million) for persons aged 18-64, and

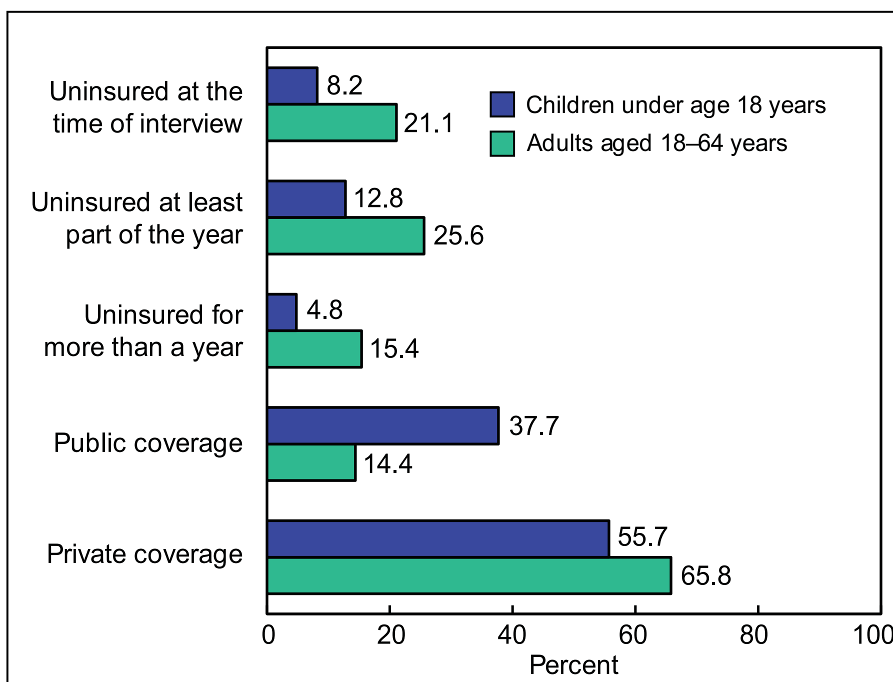


Figure 1. Percentage of persons without health insurance, by three measurements and age group, and percentage of persons with health insurance at the time of interview, by coverage type and age group: United States, 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

8.2% (6.1 million) for children under age 18 (**Tables 1** and **2**).

Based on data from the 2009 NHIS, a total of 58.5 million (19.4%) persons of all ages were uninsured for at least part of the year prior to interview (**Tables 1** and **2**). Adults aged 18-64 were twice as likely to experience this lack of coverage (25.6%) as children (12.8%).

Data from 2009 also revealed that 12.4% (32.6 million) of persons under age 65 (15.4% of adults and 4.8% of children) had been uninsured for more than a year (**Tables 1** and **2**). Adults aged 18-64 were three times as likely as children to have been uninsured for more than a year (**Figure 1**). The percentage of adults aged 18-64 who lacked coverage at the time of interview increased from 19.7% in 2008 to 21.1% in 2009.

Public and private coverage

In 2009, 21.0% of persons under age 65 years were covered by public plans at the time of interview (**Table 3**). More than one-third of children (37.7%) were covered by a public plan, compared with 14.4% of adults aged 18-64 (**Figure 1**). The percentage of children covered by a public health plan increased from 34.2% in 2008 to 37.7% in 2009.

In 2009, 62.9% of persons under age 65 were covered by private health insurance plans at the time of interview (**Table 3**). Almost two-thirds (65.8%) of adults aged 18-64 were covered by a private plan, compared with 55.7% of children under age 18 (**Figure 1**). The percentage of adults aged 18-64 covered by a private plan decreased from 68.1% in 2008 to 65.8% in 2009.

Insurance coverage by poverty status

In 2009, 11.8% of poor children and 12.1% of near poor children (see **Technical Notes** for definition of poverty) did not have health insurance coverage at the time of interview (**Table 4**). The percentage of near poor children who lacked coverage at the time of interview decreased from 15.6% in 2008 to 12.1% in 2009. The percentage of poor adults aged 18-64 years who

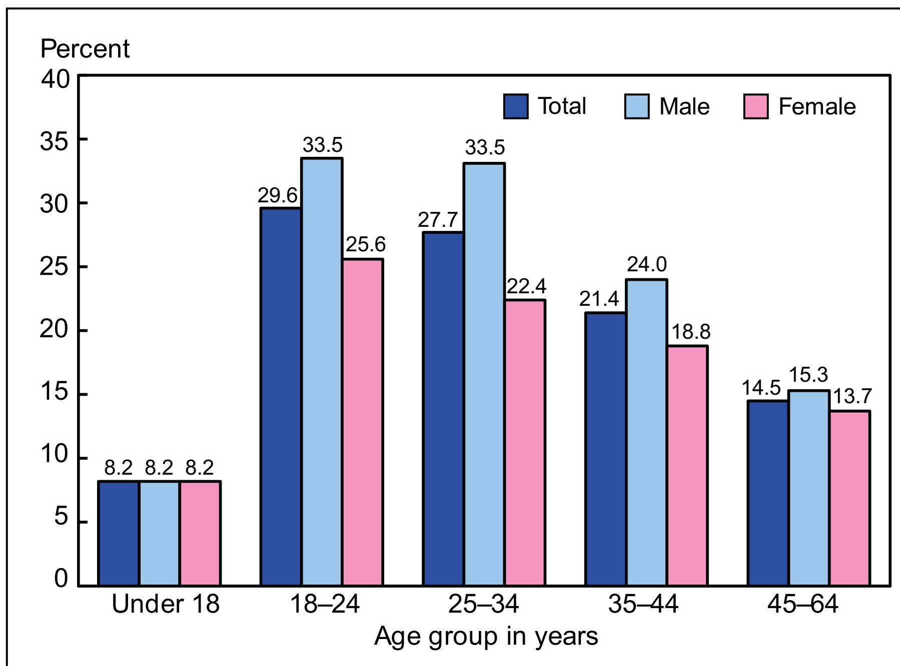


Figure 2. Percentage of persons under age 65 years without health insurance coverage at the time of interview, by age group and sex: United States, 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

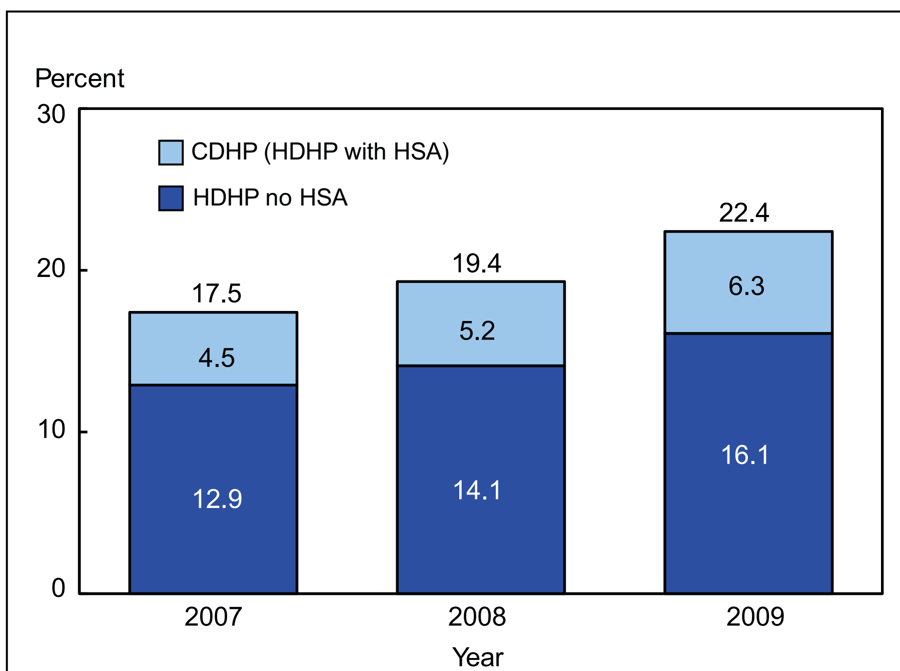


Figure 3. Percentage of persons under age 65 years who are enrolled in a high deductible health plan without a health savings account or in a consumer-directed health plan, among those with private health insurance: United States, 2007- 2009

NOTES: HDHP no HSA is high deductible health plan without a health savings account. CDHP is consumer-directed health plan, which is a HDHP with a HSA. The individual components of HDHPs may not add to up to the total, due to rounding.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2007-2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

lacked coverage at the time of interview increased from 37.7% in 2008 to 42.5% in 2009.

In 2009, 81.4% of poor children and 58.4% of near poor children were covered by a public health plan at the time of interview (**Table 5**). Public coverage for near poor children increased from 53.4% in 2008 to 58.4% in 2009. Based on 2009 data, 40.3% of poor adults aged 18-64 were covered by a public plan (**Table 5**).

In 2009, 8.2% of poor children and 32.8% of near poor children were covered by private health insurance at the time of interview (**Table 6**). There was no significant change in private coverage for poor, near poor, and not poor children between 2008 and 2009. Private coverage among poor adults aged 18-64 decreased from 22.7% in 2008 to 18.0% in 2009.

Lack of coverage, by selected demographic characteristics

Race/ethnicity

Based on data from the January to September 2009 NHIS, Hispanic persons were more likely than non-Hispanic white persons, non-Hispanic black persons, and non-Hispanic Asian persons to be uninsured at the time of interview, to have been uninsured for at least part of the past 12 months, and to have been uninsured for more than a year (**Table 7**). Approximately one-third of Hispanic persons were uninsured at the time of interview or had been uninsured for at least part of the past year, and almost one-fourth of Hispanic persons had been without health insurance coverage for more than a year.

Age and sex

For all persons under age 65 years, the percentage who were uninsured at the time of interview was highest among those aged 18-24 (29.6%) and lowest among those under age 18 (8.2%) (**Figure 2**). Starting at age 18, younger adults were more likely than older adults to lack health insurance coverage. Among adults under age 65, men were more likely than women to

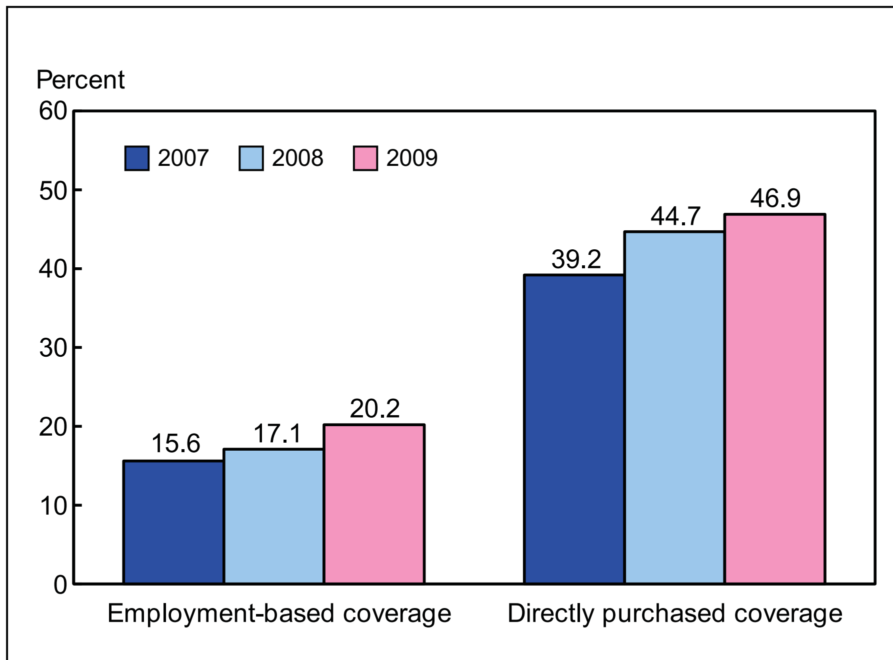


Figure 4. Percentage of persons under age 65 years with private health insurance who are enrolled in a high deductible health plan, by source of coverage: United States, 2007- 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2007-2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

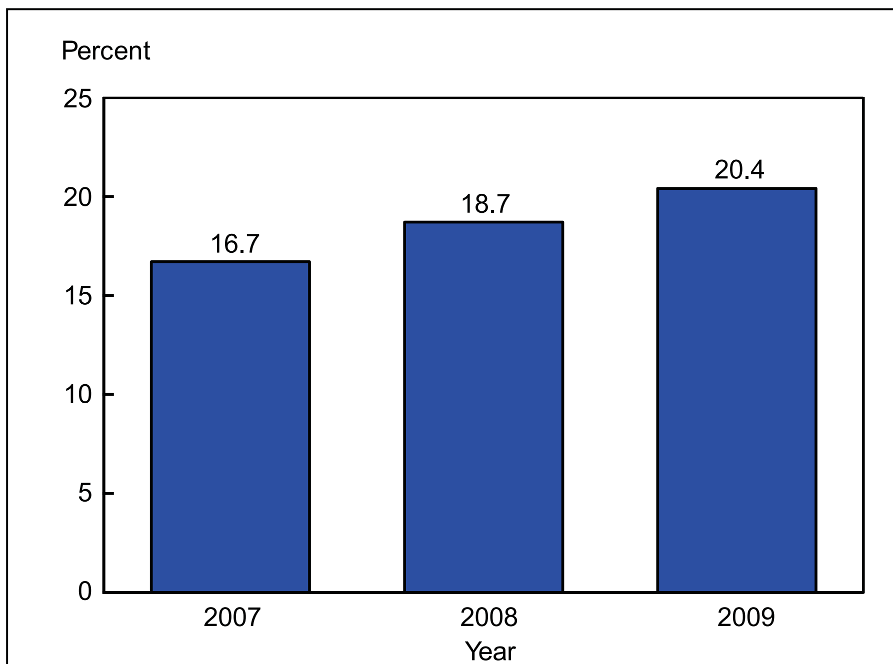


Figure 5. Percentage of persons under age 65 years with private health insurance who are in a family with a flexible spending account for medical expenses: United States, 2007- 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2007-2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

lack health insurance coverage at the time of interview.

Other demographic characteristics

Lack of health insurance coverage was greatest in the South and West regions of the United States (**Table 7**). Among adults who lacked a high school diploma, 32.9% were uninsured at the time of interview, 36.4% had been uninsured for at least part of the past year, and 27.4% had been uninsured for more than a year at the time of interview. These rates are two to more than three times as high as those for persons with more than a high school education. Among currently unemployed adults aged 18-64 years, 59.7% had been uninsured for at least part of the past year, and 32.3% had been uninsured for more than a year. Among employed adults aged 18-64, 22.1% had been uninsured for at least part of the past year, and 13.8% had been uninsured for more than a year. Married or widowed adults were more likely to have coverage than those who were divorced, separated, living with a partner, or never married.

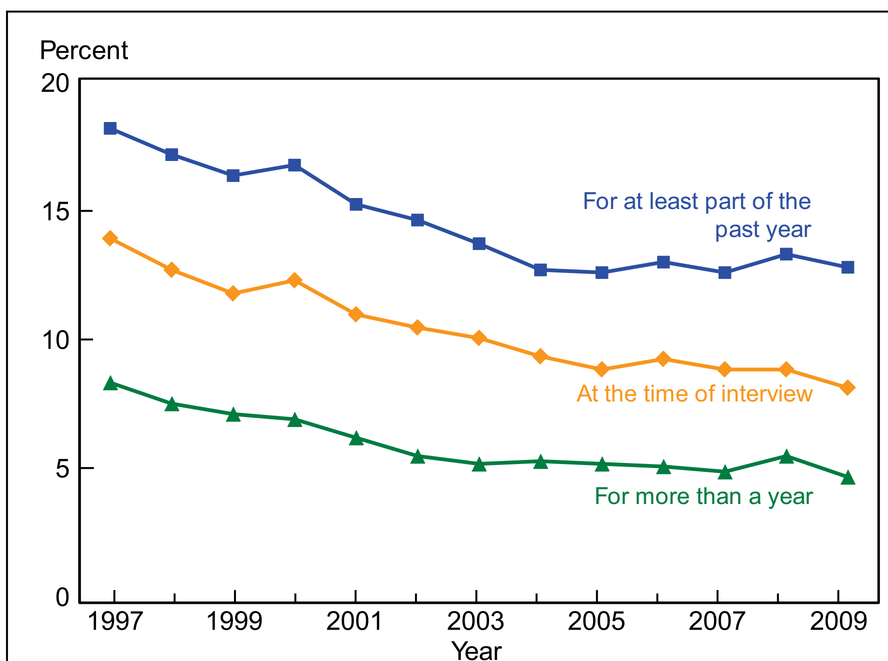


Figure 6. Percentage of children under age 18 years who lacked health insurance coverage at the time of interview, for at least part of the past year, or for more than a year: United States, 1997- 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997-2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

Estimates of enrollment in HDHPs, CDHPs, and FSAs

Based on data from the 2009 NHIS, 22.4% of persons under age 65 years with private health insurance were enrolled in a HDHP, including 6.3% who were enrolled in a CDHP and 16.1% who were enrolled in a HDHP without a health savings account (HSA) (**Figure 3**). (See **Technical Notes** for definitions of HDHP, CDHP, and HSA.) Enrollment in HDHPs increased from 17.5% in 2007 to 22.4% in 2009. There was a significant increase in enrollment in HDHPs without HSAs and in CDHPs between 2007 (when NHIS started collecting this information) and 2009.

Based on data for 2009, among persons under age 65 with private health insurance, 20.2% with employment-based coverage were enrolled in a HDHP, compared with 46.9% of those with a private plan that was directly

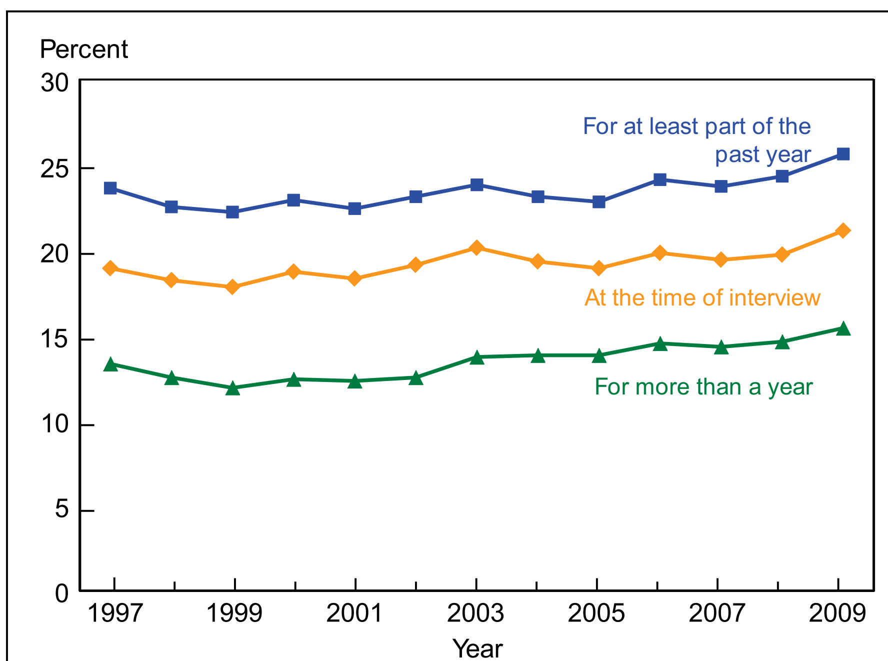


Figure 7. Percentage of adults aged 18-64 years who lacked health insurance coverage at the time of interview, for at least part of the past year, or for more than a year: United States, 1997- 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997-2009, Family Core component. The Data are based on household interviews of a sample of the civilian noninstitutionalized population.

purchased or obtained through means other than employment (**Figure 4**). The percentage of persons covered by employment-based private plans that are HDHPs increased from 15.6% in 2007 to 20.2% in 2009. The percentage of persons covered by directly purchased private health plans that are HDHPs increased from 39.2% in 2007 to 46.9% in 2009. For persons under age 65, approximately 8% of private health plans are directly purchased (estimates not shown). HDHPs constitute a growing share of both employment-based and directly purchased health plans.

In 2009, among persons under age 65 with private health insurance, 20.4% were in a family that had a FSA for medical expenses (**Figure 5**). (See **Technical Notes** for definition of FSA.) This is an increase from 2007, when 16.7% of persons under age 65 with private insurance were in a family with a FSA.

Insurance coverage in selected states

Nationally, 17.5% of persons under age 65 years lacked health insurance coverage at the time of interview in 2009 (**Table 8**). However, approximately one in four persons under age 65 in Florida and Texas, and one in five persons under age 65 in California and Georgia, lacked coverage at the time of interview. By contrast, rates of noncoverage at the time of interview in Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, Washington, and Wisconsin were lower than the national average.

Nationally, 8.2% children in 2009 lacked coverage at the time of interview, but rates were higher in Florida (13.1%), Indiana (14.0%), and Texas (16.9%).

Nationally 37.7% of children had public health care coverage. Among the states examined for this report, public coverage for children ranged from 24.6% in New Jersey to 43.0% in Washington.

Nationally, 62.9% of persons under age 65 had private coverage. Among the states examined, private coverage rates

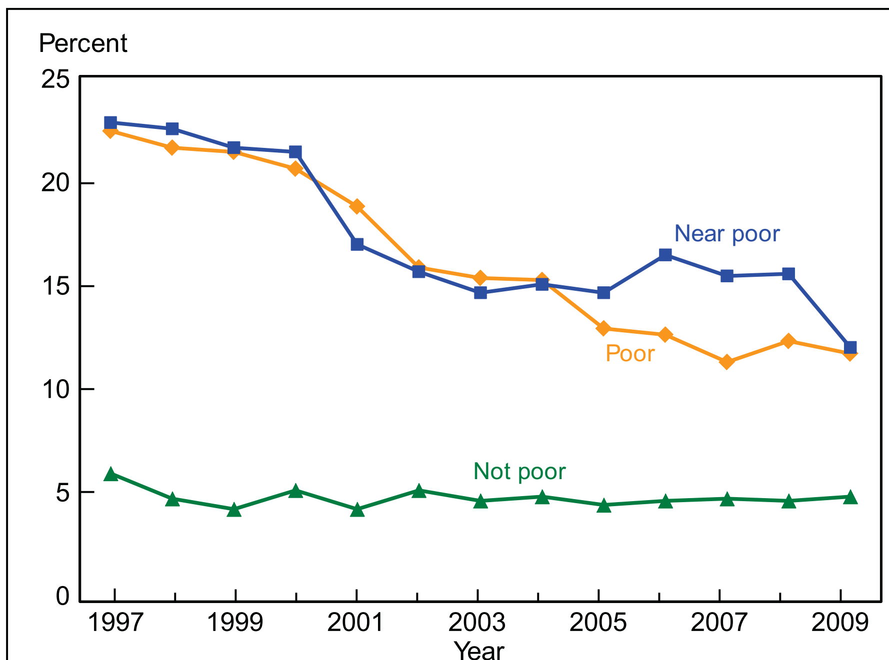


Figure 8. Percentage uninsured at the time of interview, by poverty status, for children under age 18 years: United States, 1997- 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997-2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

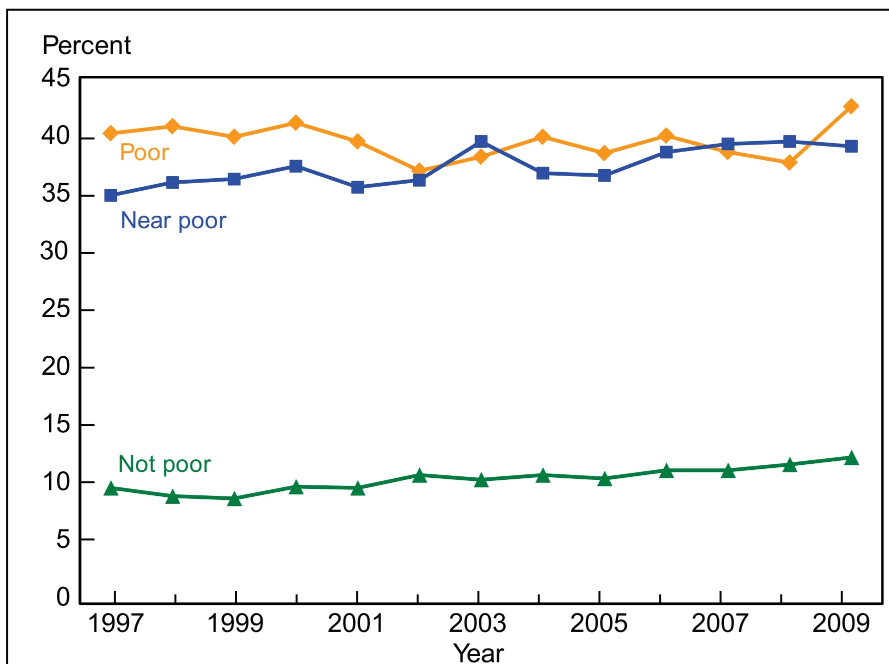


Figure 9. Percentage uninsured at the time of interview, by poverty status, for adults aged 18-64 years: United States, 1997- 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997-2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

for persons under age 65 ranged from 75.2% in Massachusetts to 52.2% in Texas. Maryland, Massachusetts, New Jersey, Ohio, Pennsylvania, and Wisconsin had rates above the national average.

Long-term trends in coverage

Lack of health insurance coverage

The percentage of children uninsured at the time of interview decreased from 13.9% in 1997 to 8.2% in 2009 (**Figure 6**). Since 1997, the percentage of adults aged 18-64 years who were uninsured at the time of interview has ranged between 17.8% in 1999 and 21.1% in 2009 (**Table 1**). There has been a generally increasing trend in the percentage of adults aged 18-64 who lacked coverage at the time of interview.

The percentage of children who were uninsured during at least part of the year prior to interview decreased from 18.1% in 1997 to 12.8% in 2009 (**Figure 6**). However, since 2004, the percentage of children uninsured during at least part of the year prior to interview has remained relatively stable and has ranged from 12.6% to 13.3%. Between 1997 and 2009, the percentage of adults aged 18-64 who lacked coverage for at least part of the year prior to interview ranged between 22.2% in 1999 and 25.6% in 2009 (**Figure 7** and **Table 1**). However, there has been an generally increasing trend in the percentage of adults aged 18-64 who lacked coverage for at least part of the year from 1997 to 2009.

Among adults aged 18-64, between 1997 and 2009 the percentage uninsured for more than a year ranged between 11.9% in 1999 and 15.4% in 2009 (**Figure 7**). By contrast, the percentage of children uninsured for more than a year decreased from 8.4% in 1997 to 5.3% in 2003 (**Figure 6**). Since 2003, the percentage of children uninsured for more than a year has remained relatively steady, ranging between 4.8% and 5.6%.

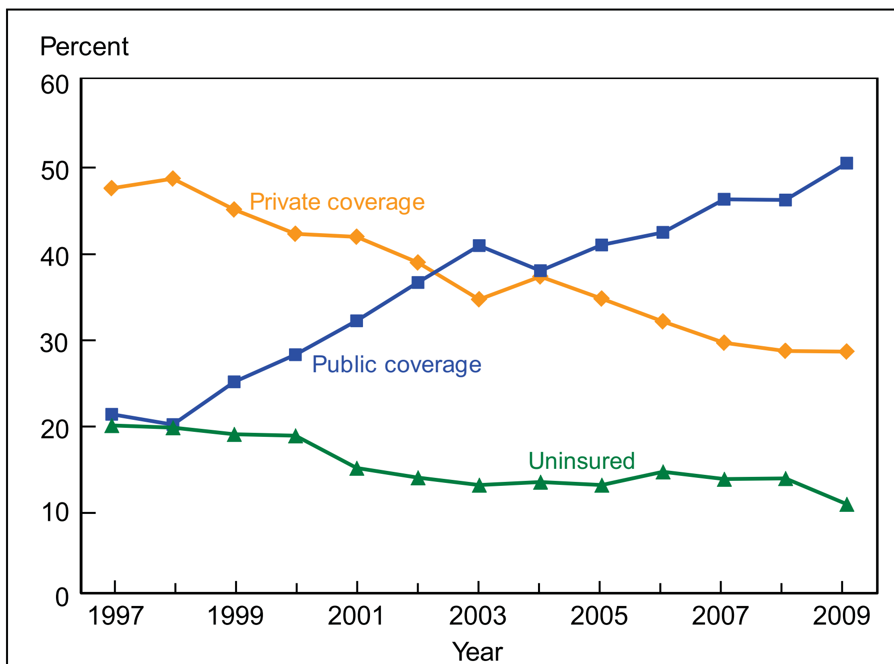


Figure 10. Percentage with health insurance, by coverage type, and percentage uninsured at the time of interview, for near poor children under age 18 years: United States, 1997- 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997-2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

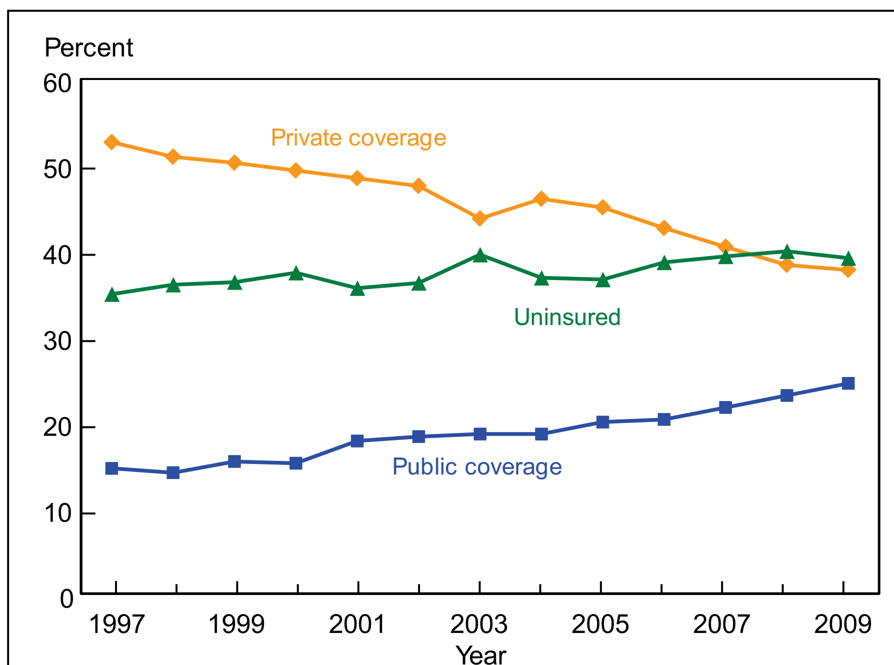


Figure 11. Percentage with health insurance, by coverage type, and percentage uninsured at the time of interview, for near poor adults aged 18-64 years: United States, 1997- 2009

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997-2009, Family Core component. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

Public and private coverage

Public coverage rates among both children and adults aged 18-64 years are higher now than in 1997. However, the increase among adults is smaller than the increase among children (**Table 3**). Conversely, private health care coverage rates among both children and adults aged 18-64 are lower now than in 1997.

Insurance coverage by poverty status

The percentage of poor children who were uninsured at the time of interview decreased from 1997 through 2009 (**Figure 8**). During the same period, the percentage of poor adults who were uninsured remained relatively stable (**Figure 9**).

Among children, all poverty status groups experienced an increase in public coverage between 1997 and 2009 (**Table 5**). However, the largest increase was seen among near poor children, for whom coverage by a public plan more than doubled during the same period.

The rate of private coverage among near poor children was 22.2 percentage points lower in 2009 than in 1997 (**Table 6**). As shown in **Figure 10**, among near poor children the percentage without health insurance and the percentage with private health insurance coverage have declined since 1997, while public coverage increased. Private coverage decreased among near poor adults aged 18-64 years, from 52.6% in 1997 to 37.7% in 2009, so that the uninsured and private coverage rates for this population are almost the same (**Figure 11**). Private coverage among not poor adults aged 18-64 decreased from 87.1% in 1997 to 81.4% in 2009.

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Exhibit 24

Current Population Survey (CPS)

A joint effort between the Bureau of Labor Statistics and the Census Bureau

Annual Social and Economic (ASEC) Supplement

There is also additional background information for this table group.

Contents for Table

Symbols Used in Tables
(B) Base less than 75,000.
(NA) Not available.
(X) Not applicable.

Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2008

All Races

For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apsd/techdoc/cps/cpsmar09.pdf [PDF].

Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.

(Numbers in thousands)

	Total	Not covered at any time during the year	Covered by some type of health insurance during the year	Covered by private insurance	Covered by Employment based	Covered by Own Employment based	Covered by Direct-purchase insurance	Covered by government health plan
All Races								
Number/Percent								
Total	301,483	46,340	255,143	200,992	176,332	92,901	26,777	87,411
Age								
Under 18 years	74,510	7,348	67,161	47,282	43,874	228	3,812	24,767
Under 6 years	25,273	2,209	23,064	14,828	13,989	0	1,155	9,969
6 to 11 years	24,001	2,211	21,791	15,456	14,503	0	1,276	7,898
12 to 17 years	25,236	2,929	22,307	16,998	15,382	228	1,381	6,900
18 to 24 years	28,688	8,200	20,488	16,947	13,450	5,052	1,700	4,741
25 to 34 years	40,520	10,754	29,766	25,879	24,130	18,632	2,189	5,086
35 to 44 years	41,322	8,035	33,287	29,780	27,899	19,702	2,444	4,685
45 to 54 years	44,366	7,054	37,312	33,234	30,861	22,393	3,182	5,797
55 to 64 years	34,289	4,301	29,989	25,584	22,906	16,877	3,346	6,901
Under 65 years	263,695	45,693	218,002	178,705	163,119	82,885	16,673	51,977
65 years and over	37,788	646	37,142	22,287	13,212	10,016	10,103	35,434
Sex								
Male	148,094	25,208	122,886	98,346	87,414	51,367	12,278	39,868
Female	153,388	21,131	132,257	102,647	88,917	41,534	14,499	47,542
Nativity								
Native	264,733	34,036	230,697	182,479	159,993	82,229	24,317	79,301
Foreign-born	36,750	12,304	24,446	18,514	16,338	10,673	2,460	8,110
Naturalized citizen	15,475	2,792	12,683	9,739	8,561	5,858	1,371	4,484
Not a citizen	21,274	9,511	11,763	8,774	7,777	4,815	1,089	3,626

Exhibit 25

Frist: An Individual Mandate for Health Insurance Would Benefit All

Nobody should fear bankruptcy due to illness or injury

By WILLIAM H. FRIST
Posted: September 28, 2009

William H. Frist, a Tennessee Republican, is a heart surgeon and the former U.S. Senate majority leader.

I believe in limited government and individual responsibility, cherish the freedom to choose, and generally oppose individual mandates—except where markets fail, individuals suffer, and society pays a hefty price. Let's face it, in a country as productive and advanced as ours, every American deserves affordable access to healthcare delivered at the right time. And they don't have it today.

It is time for an individual health insurance mandate for a minimum level of health coverage. Catastrophic coverage would be an appropriate place to start.

In our reimbursement-driven, public-private health sector (which delivers the most robust health services on the globe), the only way affordable access can be achieved is for every citizen to have some type of insurance. Today as many as 46 million don't have it (some estimates are lower, with President Obama pegging it at 30 million), and about 15 million are "hard-core uninsured," without access to either government or private plans. No industrialized country in the world leaves such a large proportion of its citizens without coverage. And insurance matters. Those without health insurance on average receive poorer care and die sooner.

The argument for an individual mandate centers on three principles.

First, it would achieve fairness. No family in America should fear bankruptcy because of an accident, a child's cancer, or a heart attack. That is the purpose of insurance. An individual mandate is the only way to achieve affordable insurance coverage for every American in a pluralistic, public-private sector.

Second, it would eliminate wasteful cost-shifting. Though many uninsured people do eventually get care in emergency rooms, the $30 billion to $50 billion in bills for "uncompensated care" or "bad debt" they generate are inefficiently shifted to the privately insured, wasting scarce health dollars. These economic distortions are behind the dollar aspirin tablet and the $10 Band-Aid you discover on your hospital bill. No one knows the real price of anything. Such lack of transparency destroys any hope for true market forces, like prudent purchasing by the consumer, which would normally hold the "health spending curve" in check.

And few today who remain "voluntarily uninsured" fully appreciate the risks they would face in the case of a catastrophic event.

Third, it would reduce adverse selection. When healthier people opt not to carry insurance, only those with poorer health, and thus higher costs, remain in. This leads insurance prices to spiral up. And it further impedes markets' ability to mitigate risks and prevent personal economic catastrophe. The "free-riders" who do not purchase insurance and the "voluntarily uninsured" who depend on emergency room care paid by others would then pay their fair share for services received.

Critics argue that pooled risk-sharing indeed requires cross-subsidization of the sick and thus becomes an added cost to the healthy. It requires net additional spending, and it is difficult to administer because of necessary subsidies for the near poor. And it is challenging to enforce. While these critiques are fair, they are not insurmountable, especially if the new mandate was at least initially limited to catastrophic care.

The policymaker's challenge is to determine the societal risk of establishing an individual mandate. Since we have no national experience with such coverage, we must tread gently. Indeed, the only experiment under way in the country began just three years ago in Massachusetts.

Advocates and critics alike use the Massachusetts plan's early results to support their respective positions. Almost half a million are newly insured, and, remarkably, more than 40 percent of these have purchased private insurance. Employer-sponsored private coverage has increased by 160,000 in the state because people who had previously refused coverage now see it as advantageous. Uncompensated care has fallen by almost half. But—and this is the unfinished story that haunts the policymakers—costs have been very high and continue to escalate. Estimates are approximately $2,000 per person, well beyond policymakers' initial predictions. And universality has not been achieved.

The experiences in my home state of Tennessee illustrate the danger of trying to transplant Massachusetts's ongoing experiment to a national level. We came close to achieving the goal of universal care under the much heralded TennCare program, begun in 1994. But cost inflation caused the system to implode, and it was junked 10 years later. It would have been disastrous to the American people if the program had been adopted federally based on its initial success.

But that does not mean some lessons cannot be learned. The Massachusetts experience thus far, I would argue, suggests that mandated coverage would enhance health and improve equity. But because it is costly, it should be considered nationally only when we are confident that the economy can sustainably withstand the added burden and when appropriate restraints on the rate of healthcare inflation are simultaneously adopted.

A mandate's details are critical. Too large a benefit package and it will be unaffordable; too small and it will be meaningless. Since we have no national experience and the results in Massachusetts are incomplete, we should begin smaller rather than larger, with catastrophic

Politics & Policy

As other states experiment with Massachusetts-type plans and as our economy strengthens, other innovations could be incorporated at the federal level in a way that minimizes risk.

It is a conservative approach that would affordably achieve necessary goals.

Read why a mandate would not do what it promises, by Dick Armey, Texas Republican, former U.S. House majority leader and chairman of FreedomWorks.

What do you think? Should Health Insurance Be Required of Everyone?

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Exhibit 26

MarketWatch

Community Rating And Sustainable Individual Health Insurance Markets In New Jersey

Trends in New Jersey's Individual Health Coverage Program reveal troubled times for the program.

by Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox

ABSTRACT: The New Jersey Individual Health Coverage Program (IHCP) was implemented in 1993; key provisions included pure community rating and guaranteed issue/renewal of coverage. Despite positive early evaluations, the IHCP appears to be heading for collapse. Using unique administrative and survey data, we examined trends in IHCP enrollment and premiums. We found the stability of the IHCP to be fragile in light of improving opportunities for job-related health insurance. We also found that it is retaining high-risk enrollees. Institutional realities and the difficulty of identifying a control group preclude attributing causality to the plan's pure community rating and open enrollment provisions.

In an effort to stabilize a financially precarious individual health insurance market, assure access to affordable coverage regardless of health risk, and stimulate premium competition among insurers, New Jersey implemented the Individual Health Coverage Program (IHCP) in August 1993.[1] The IHCP adopted a number of sweeping regulatory provisions, most prominently guaranteed issue and renewal of health plans, pure community rating within specific plans, restrictions on waiting periods for preexisting health conditions, and the requirement that carriers maintain a minimum loss ratio of 75 percent. In addition, all carriers selling health insurance in New Jersey were required to participate in the IHCP, either by selling policies to meet an enrollment target or by not selling and paying a share of the losses incurred by other carriers.[2] Finally, IHCP enrollees were given a broad choice of health plans with standardized benefits, including traditional indemnity plans with varying deductible and coinsurance provisions and health maintenance organization (HMO) coverage with differing copayments.

■ **Previous research and the current context.** In 1999/2000 evaluations, Katherine Swartz and Deborah Garnick concluded that initially the IHCP achieved its stated goals, and they found no evidence of adverse selection by enrollees.[3] While they noted that a decline in IHCP enrollment began in 1996 and was accompanied by rising premiums, they attributed the latter to perverse incentives inherent in the IHCP loss assessment system rather than adverse selection.

In contrast, the IHCP's current situation

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points to a market that is heading for collapse. Enrollment has declined from a peak of 186,130 lives at the end of 1995 to 84,968 at the end of 2001. In addition, premiums have increased two- to threefold above their early levels. These changes have raised concerns as to whether a comprehensive regulatory effort such as the IHCP can yield a sustainable health insurance market.

In this paper we examine trends in IHCP enrollment and premiums and consider whether the IHCP regulatory provisions may be associated with some unintended consequences for insurance market stability and access to coverage. We also consider whether the institutional and economic realities that confronted the IHCP contributed to these trends. We find evidence suggesting that the stability of the IHCP market may be sensitive to changing economic circumstances and opportunities to obtain employment-related health insurance. The trends that we observe also suggest that the IHCP may be retaining adverse health risks.

■ **Community rating, adverse selection, and market stability.** IHCP provisions such as pure community rating and guaranteed issue were intended to expand access to coverage by limiting insurers' risk selection and medical underwriting practices. However, such requirements can also have a destabilizing effect on specific health plans within an insurance market and, ultimately, upon the entire market.

Since pure community rating imposes the same premium on low- and high-risk people, the premiums of low risks exceed their actuarially fair level, while those of high risks are lower than their fair level. A sustainable market equilibrium may be tenuous under such a requirement.[4] In a market with choice among community-rated health plans, low risks will seek entry to cheaper, more restrictive health plans that are unattractive to high risks, leaving the latter in the more generous and expensive plans. As low-risk people leave the more generous health plans, higher risks will dominate such plans, and their premiums will rise.

Such a "separating market equilibrium" can be sustained only if low risks find the more restrictive plans to be of value and remain in the market. Should low-risk people defect from the market, total plan enrollment will decline. The market risk profile will become increasingly dominated by high risks, and a marketwide adverse-selection death spiral may ensue as cycles of rising premiums spur further defections of lower-risk enrollees. As we discuss below, the decline in IHCP enrollment and rise in premiums has been accompanied by retention of potentially adverse health risks. However, establishing a causal link to the presence of pure community rating remains difficult.

Data And Methods

Data on IHCP aggregate enrollment, plan-specific enrollment, and premiums were obtained from administrative records of the IHCP board.[5] For our analysis, we use premiums for single coverage, the predominant form of IHCP contracts.

Our tabulations are based on enrollment data from the first quarter of 1994 to the fourth quarter of 2001 for representative IHCP plans: Plans B, C, and D (all indemnity) and all HMO plans. Trends in IHCP plan premiums are based upon data from March 1996 to December 2001. For each of the following plan types—Plans B and C (40 percent and 30 percent coinsurance, respectively, and both with $1,000 deductibles); Plan D (20 percent coinsurance and $500 deductible, the most generous plan offered based on these provisions); and an HMO plan ($15 copayment)—we constructed a plan-specific composite premium. This measure is based upon premiums for each plan from the top four carriers (based on enrollment) weighted by their enrollment shares.[6] We also compare trends in the composite premiums to those for selected small carriers.

We supplement these tabulations with household data from the Current Population Survey (CPS) on the health insurance status of New Jersey residents, published data on residents' employment, data on premiums for employment-based coverage in New Jersey from

the Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), and data on premiums in the New Jersey small-employer group market. Finally, we include data from the 2001 New Jersey Family Household Survey (NJFHS), a statewide probability sample of 2,265 families conducted by the Center for State Health Policy, Rutgers University, and its 2002 supplement of 601 families with IHCP subscribers.

Findings

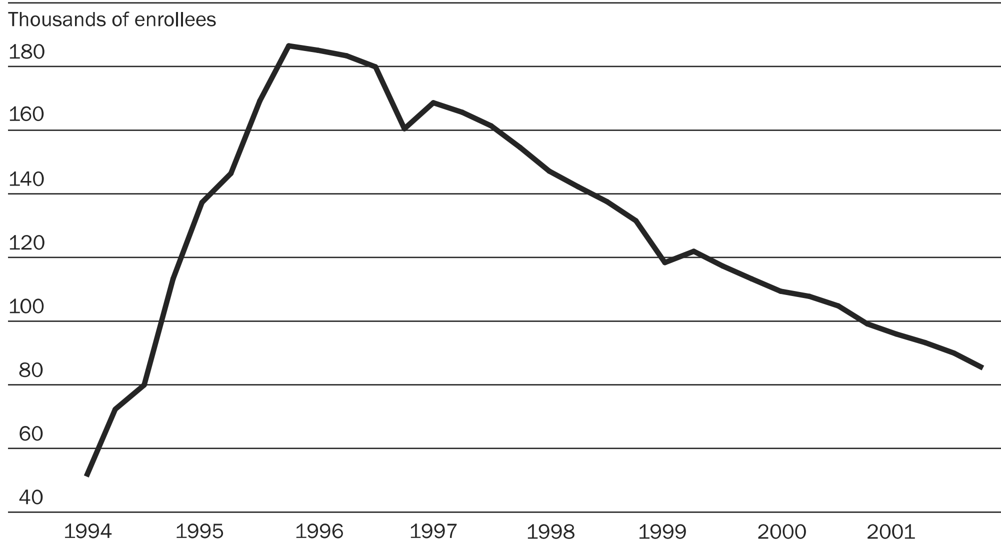
■ **Trends in IHCP enrollment and premiums.** The IHCP initially experienced a sharp increase in enrollment, from 51,648 lives in the first quarter of 1994 to 186,130 lives in the fourth quarter of 1995. However, since then IHCP enrollment has declined dramatically (Exhibit 1).

Enrollment declined among all three indemnity plans that we track, with the sharpest decline in Plan D, the most generous indemnity plan (Exhibit 2). In contrast, after an initial increase and subsequent decline, enrollment in more restrictive HMO coverage remained relatively stable for much of 2000 and 2001.[7] HMO enrollment also increased from roughly a third to more than ten times Plan D enrollment over our study period.

The shift in enrollment was also accompanied by rising premiums for all IHCP plans sampled (Exhibit 3). Plan D displayed the most pronounced increase in composite monthly premiums, rising by more than 3.5 times its initial level. Although at any point in our series, composite premiums for the other indemnity plans were considerably lower than those for Plan D, the other plans displayed similar growth. In contrast, the growth in monthly premiums for the representative HMO plan ($15 copay) was comparatively smaller. In fact, HMO premiums fell from 70 percent to 38 percent of Plan D premiums.

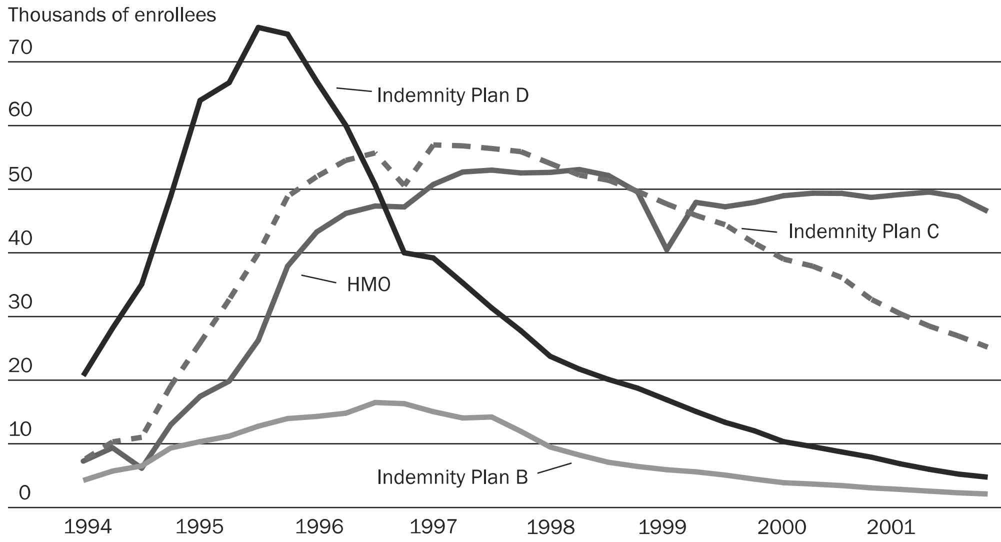
These trends appear consistent with a marketwide adverse-selection death spiral spurred by open enrollment and pure community rating. However, such causality is difficult to identify, because of the presence of a number of additional factors, including pricing incentives inherent in the IHCP regulatory structure, institutional changes in New Jersey's regulated health insurance products, and

EXHIBIT 1
Enrollment In The New Jersey Individual Health Coverage Program (IHCP), First Quarter 1994 Through Fourth Quarter 2001



SOURCE: Individual Health Coverage Program (IHCP) Board, New Jersey Department of Banking and Insurance.
NOTE: Data are plotted by quarter, but labels show years only (year label corresponds with first quarter of that year).

EXHIBIT 2
Enrollment In The New Jersey Individual Health Coverage Program (IHCP), By Plan Type, First Quarter 1994 Through Fourth Quarter 2001

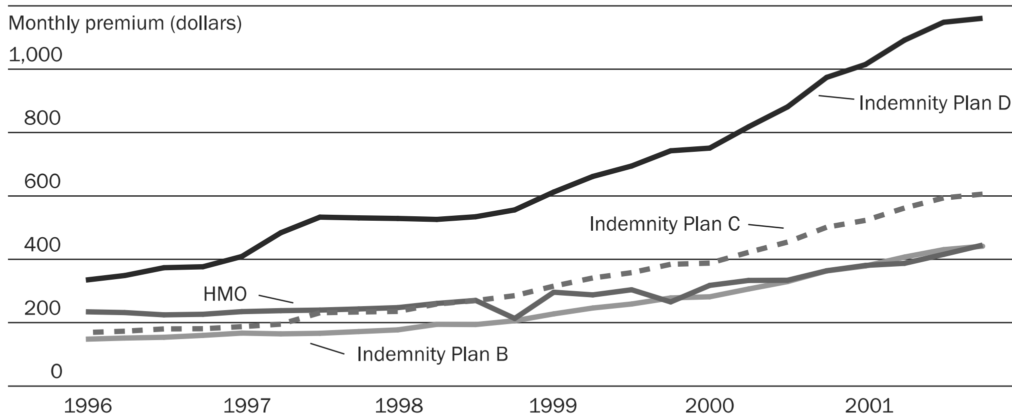


SOURCE: Individual Health Coverage Program (IHCP) Board, New Jersey Department of Banking and Insurance.
NOTE: Data are plotted by quarter, but labels show years only (year label corresponds with first quarter of that year).

improved economic circumstances.

■ **Potential factors contributing to IHCP market instability.** *Carrier loss assessment mechanism.* As Swartz and Garnick noted, the loss assessment mechanism (which allowed reimbursement for payouts in excess of 75 percent of net premium income) encouraged small carriers to sell coverage in the IHCP and to charge very low premiums during their initial years, to expand their market share.[8] However, this strategy was not successful. By charging low premiums, these small carriers incurred larger-

EXHIBIT 3
Trends In Premiums For Selected New Jersey Individual Health Coverage Program (IHCP) Plans, By Plan Type, First Quarter 1996 Through Fourth Quarter 2001



SOURCE: Individual Health Coverage Program (IHCP) Board, New Jersey Department of Banking and Insurance.
NOTE: Data are plotted by quarter, but labels show years only (year label corresponds with first quarter of that year).

than-expected losses, which led them to raise premiums and, later, led several small carriers to defect from the market. This contributed a certain degree of "market chaos," as many enrollees shifted carriers or dropped coverage. Swartz and Garnick have argued that the rise in IHCP premiums between 1995 and early 1998 reflected the behavior of these small carriers rather than adverse selection against certain carriers or the IHCP.[9]

We find evidence that is consistent with this assertion. Compared with the trend in the composite premium over this period, the premiums of such small carriers increased markedly. For example, between the first quarters of 1996 and 1998, Plan B premiums for Manhattan National Life Insurance increased by 415 percent; for Metropolitan Life Insurance, 86 percent; and for Time Insurance Company, 110 percent. In contrast, the composite premium for Plan B increased by only 20 percent. As small carriers raised premiums, their market shares declined precipitously from 27 percent of insured lives in 1996 to less than 1 percent by 1998. Eight small carriers accounted for roughly half of enrollment losses over this period. By 2000 only one of the carriers (Metropolitan) remained in the market.

Subsequently, the state legislature changed the loss assessment mechanism to a two-year retrospective period effective 1 January 1998 and required reimbursable losses to exceed 115 percent of carriers' income. State officials believe that the latter provision greatly reduced incentives for carriers to "game" the system.[10] Small carriers continued to raise premiums and lose enrollment; after 1998 several additional small carriers withdrew from the market.

Access to employer-sponsored health insurance. Over our study period, a lower-cost substitute for IHCP coverage—employer-sponsored insurance—became more widely available. This was the result of two factors. First, New Jersey experienced sizable increases in economic activity and employment opportunities, which provided increased access to employer coverage. For example, between January 1994 and January 2000 seasonally adjusted resident employment increased from 3.702 million to 4.035 million.[11] Correspondingly, CPS data for New Jersey reveal that enrollment in employer coverage increased from 4.7 million in 1996 to 5.3 million in 2000.[12]

Next, coincident with the implementation of the IHCP, New Jersey created the Small Employer Health Benefits Program (SEHBP) in January 1994, which provided small employers (those with 2–50 full-time employees) with open enrollment into standardized health plans at modified community rates (adjusted for employees' age, sex, and family status and for business location). The SEHBP experienced a rapid increase in enrollment, from 694,312 in the fourth quarter of 1994 to a peak of 937,784 in the third quarter of 1999 (declining to 884,104 in the third quarter of 2001). Finally, IHCP data also indicate a decline in contracts issued to employed relative to nonemployed subscribers, from just over 2:1 in June 1994 to just over 1:1 in January 2001, consistent with the shift to employer-sponsored coverage.

Exhibit 4 suggests that differential premiums provided ample incentives for IHCP enrollees to obtain employer-sponsored coverage. The data indicate that by 2000, IHCP premiums for our sampled individual coverage plans exceeded and (with the exception of HMO coverage) rose faster than employer coverage premiums. Moreover, if people perceive the cost of employer coverage as their own contribution rather than the full premium, then the differential in out-of-pocket premium costs between employer and IHCP plans is substantial. As well, modified community rating in the SEHBP may have exacerbated the impact of growing availability of employer coverage on IHCP enrollment and premiums, as the cost advantage of employer coverage would be greatest for lower-risk (that is, younger) workers.[13]

Finally, to the extent that insurers were unable to vigorously enforce the requirement that self-employed "groups of one" obtain coverage from the IHCP rather than the SEHBP, the premium differentials between these sources of coverage provided such people with clear incentives to defect from the IHCP.

EXHIBIT 4
Annual Premiums For Single Coverage, Employer-Sponsored Insurance And New Jersey IHCP Plans, 1996 And 2000

Plan	1996 ($)	2000 ($)	Percent change
Employer-sponsored insurance			
Total premium	2,354	2,911	23.7
Employee contribution	263	486	84.8
IHCP plans			
Indemnity Plan B	1,792	3,797	111.9
Indemnity Plan C	2,063	5,254	154.7
Indemnity Plan D	4,245	10,231	141.0
HMO plan	2,702	4,001	48.1

SOURCES: Premiums for employer-sponsored insurance were obtained from the Medical Expenditure Panel Survey—Insurance Component (MEPS-IC); premiums for Individual Health Coverage Program (IHCP) plans were obtained from administrative records of the New Jersey IHCP Board. See text for descriptions of payment provisions of the specific IHCP plans used in the comparisions.
NOTE: HMO is health maintenance organization.

Elimination of the Health Access subsidy program. After the beginning of 1996, New Jersey eliminated Health Access, the state's subsidy program for IHCP enrollees with incomes below 250 percent of the federal poverty level. The program began in May 1995; by March 1996 it subsidized as many as 20,000 enrollees. Fiscal constraints ended new enrollments in the program after 31 December 1995. This precluded replacement of low-income enrollees whose circumstances no longer warranted use of the access program.[14]

Implementation of the New Jersey SCHIP program. As part of the State Children's Health Insurance Program (SCHIP), the state enacted NJ KidCare in December 1997 for children under age nineteen in families earning less than 350 percent of poverty. The program was expanded to adults with incomes less than 200 percent of poverty through NJ FamilyCare in July 2000. It is unlikely that these programs resulted in sizable crowding out of IHCP enrollees. Enrollment in KidCare lagged initially, and much of the subsequent enrollment growth was in plans for children with family incomes below 150 percent of poverty (who were very unlikely to have enrolled in IHCP coverage). In addition, FamilyCare was implemented toward the very end of our study period and was not a factor for most of the period of declining IHCP enrollment.[15]

■ **Further considerations.** Carrier loss assessment, growth in employer coverage, and elimination of the Health Access program may explain a substantial part of the decline in IHCP enrollment and rise in premiums before 1998. Although the robustness of the employer coverage market through 2000 may have continued to fuel IHCP trends, its effect was diminishing as economic activity slowed down. Indeed, since 1998 IHCP enrollment has continued to decline at a rate of about 3 percent per quarter, and premiums have continued to rise. Thus, it is reasonable to ask whether these continuing trends are unique to the IHCP, reflecting an adverse-selection death spiral, or simply consistent with national trends in enrollment and premiums.

Changing age composition of the IHCP. Comparisons between data from the NJFHS and published 1996 tabulations provide evidence that the IHCP has shifted markedly toward older and thus potentially higher-cost enrollees.[16] In 1996, 44.6 percent of new adult enrollees to the IHCP (those ages 18–64 enrolled less than a year) were ages 45–64, with a mean age of 41.9 years; by contrast, in 2002, 66.3 percent of new adult enrollees were between those ages, and their average age rose to 48.4 years (both figures significantly different from 1996, $p <$

.01). As noted below, the change in these data for IHCP enrollees during this period also exceeded that for people with employer coverage. Finally, we also find some evidence that the percentage of new adult enrollees reporting fair or poor health rose between 1996 and 2002 (4.3 percent compared with 8.1 percent, $p < .10$), although this increase was not statistically different from that for people with employer coverage.

Following Swartz and Garnick, we also compared the age composition of new adult IHCP enrollees with all New Jersey adults having employer coverage. We found that the former were older (48.4 years compared with 40.7 years, $p < .01$) and more likely to be ages 45–64 years (66.3 percent compared with 39.5 percent, $p < .01$). These differences have widened considerably compared with those reported for 1996 (data not shown). When we compare all adult IHCP enrollees with adults having employer coverage, we observe that the former are older, more likely to be female, and more likely to be in fair/poor health (data not shown). Thus, the IHCP may be attracting and retaining more potentially costly enrollees.

"Trends for New Jersey may reflect the unique circumstances of the IHCP rather than national trends."

Comparison with national trends. The decline in IHCP enrollment appears to be far more severe than national declines in individual coverage. While IHCP enrollment declined by 41 percent between 1996 and 2000, national CPS estimates of individual coverage indicate only a 4 percent decline.[17] MEPS data between 1996 and 1999 reveal an 18 percent decline in nongroup coverage—well below the 34 percent decline in IHCP enrollment during this period. Comparisons with national survey data on employer-sponsored coverage also suggest that the IHCP sustained a more pronounced shift in enrollment from indemnity to HMO coverage.[18] Correspondingly, IHCP premiums rose more than employer coverage premiums did. These comparisons suggest that the trends for New Jersey may reflect the unique circumstances of the IHCP rather than national trends.

A caveat regarding interpretation. While the trends in IHCP enrollment and age composition may reflect necessary conditions for an adverse-selection death spiral in a community-rated insurance market, we cannot establish that they are sufficient. This reflects at least two important limitations. First, the unique nature of our administrative and household data on IHCP enrollment limits comparisons with potential control states that lack the IHCP regulatory provisions. Thus, we cannot infer whether community rating in the IHCP played a causal role in the trends we observe. Next, while household data suggest that the age composition of new IHCP enrollees may have changed over time, further analysis is required to discern whether such health-related characteristics have also changed across IHCP plan types. Thus, while the IHCP trends that we observe may be consistent with adverse selection and the retention of poor health risks, we cannot definitively assign causality to pure community rating.

Conclusions

Our analysis strongly suggests that the IHCP is in the midst of an enrollment crisis that threatens its market stability and ability to fulfill its stated goals. In assessing the New Jersey experience, it is important to note that enrollment in individual health insurance is fragile to begin with, representing a small minority of all nonelderly, privately insured people. A certain amount of churning and disenrollment is also expected in this market, since enrollment spells are typically short and frequently serve to bridge spells without employer coverage.[19] One must further recognize that the IHCP is a voluntary and unsubsidized insurance market.

Critics will be quick to attribute problems in the IHCP to community rating and open enrollment. However, other factors we have identified may have played a key role in the decline

in covered lives and rise in premiums. These trends exceed those observed nationally and have been accompanied by a deterioration in the IHCP's risk composition. While the IHCP's market rules may have contributed to an adverse-selection death spiral, we cannot definitively identify this market dynamic. More importantly, it is not clear whether the decline of this market would have continued absent the buoyant employer coverage market. In this regard, the New Jersey experience raises the critical policy issue of whether the individual market can serve as "private insurer of last resort" when it is inherently unstable and encounters alternative private coverage with considerably lower out-of-pocket premium costs. Market stability may be further threatened should pure community rating exacerbate disparities in coverage costs between these markets for low-risk enrollees.

In this context, existing research points to the difficulty of sustaining the individual market, especially when small-group market reform is present and robust economic circumstances provide better access to lower-cost employer coverage.[20] The interrelationship between the individual and employment-based markets, therefore, is an unavoidable reality confronting policymakers in the design of individual market reform.

Finally, the behavior of the individual insurance market in New Jersey raises some hard choices for policymakers. Given the state's current fiscal difficulties and empirical evidence suggesting that large subsidies would be required in the face of low demand responsiveness, efforts to stabilize the IHCP through subsidized premiums would seem prohibitive.[21] Alternatives such as moving to modified community rating might make individual coverage more attractive to low-risk enrollees. However, such a strategy might further segment the market to the disadvantage of higher risks, the very group whose access to coverage the IHCP is seeking to ensure. While pooling of IHCP together with the SEHBP was earlier evaluated and dismissed because of the potential for a sizable increase in SEHBP premiums, such pooling may have less of an impact now, as IHCP enrollees now represent less than a tenth of total enrollment in the SEHBP market (compared with nearly a quarter when blending was first evaluated).[22]

In sum, should IHCP enrollment continue to decline and premiums continue to increase, New Jersey policymakers may face the dilemma of seeing the goals of the IHCP vitiated, plan choice diminished, and the market segmented between plans enrolling high- and low-risk people. Should this be the case, history may repeat itself as insurers experience unsustainable losses and the availability of even high-cost individual coverage diminishes.

Financial support from the Commonwealth Fund and the Changes in Health Care Financing and Organization (HCFO) initiative of the Robert Wood Johnson Foundation is gratefully acknowledged. The authors are indebted to Ellen F. DeRosa, New Jersey Department of Banking and Insurance (NJDOBI), for the data used in this analysis. They are grateful to DeRosa, Wardell Sanders, and Vicki Mangiaracina of the NJDOBI for helpful discussions regarding the interpretation of trends in IHCP enrollment and premiums. They also thank Kathy Swartz and two anonymous referees for useful and insightful comments, and Piu Banerjee for excellent research assistance.

NOTES

1. For a discussion of circumstances leading to the IHCP's formation, see K. Swartz and D. Garnick, "Lessons from New Jersey," *Journal of Health Politics, Policy and Law* 25, no. 1 (2000): 45–70.
2. The loss assessment system served to reduce the costs to carriers seeking to enter the market and to provide subsidies to sustain a market with potential adverse selection. See ibid.; and K. Swartz and D. Garnick, "Regulating Markets: Lessons from New Jersey's Individual Health Insurance Coverage Program" (Unpublished manuscript, Harvard University, October 1998).
3. Swartz and Garnick, "Lessons from New Jersey"; and K. Swartz and D. Garnick, "Can Adverse Selection Be Avoided in a Market for Individual Insurance?" *Medical Care Research and Review* 56, no. 3 (1999): 373–388.
4. M. Rothschild and J. Stiglitz, "Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information," *Quarterly Journal of Economics* 90, no. 4 (1976): 630–649; and T. Buchmueller and J. DiNardo, "Did Community

Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut," *American Economic Review* 92, no. 1 (2002): 280–293.

5. For the most recent IHCP plan characteristics and monthly premiums, see "New Jersey Individual Health Coverage Program Rates," 4 March 2004, www.nj.gov/dobi/ihcrates.htm (13 April 2004).
6. Carriers' market share changed over time, so the composite premium will include different carriers.
7. We expect that network and referral restrictions would lead most enrollees to consider HMOs to be less generous than indemnity plans. See Buchmueller and DiNardo, "Did Community Rating Induce an Adverse Selection Death Spiral?"; and R. Feldman and B. Dowd, "Risk Segmentation: Goal or Problem?" *Journal of Health Economics* 19, no. 4 (2000): 499–512.
8. The discussion follows Swartz and Garnick, "Lessons from New Jersey"; Swartz and Garnick, "Regulating Markets"; and K. Swartz and D. Garnick, "Unintended but Predictable Outcomes of Regulations: The Case of New Jersey's Individual Health Care Program" (Unpublished manuscript, Harvard University, 12 January 1998).
9. Swartz and Garnick, "Lessons from New Jersey"; and Swartz and Garnick, "Regulating Markets." The small carriers were Manhattan National Life Insurance, Metropolitan Life Insurance, National Casualty, Protective Life Insurance, Time Insurance, TMG Life Insurance, Travelers Insurance, and Washington National Insurance.
10. Based on discussions with representatives from the New Jersey Department of Banking and Insurance, Fall 2003.
11. New Jersey Department of Labor, "New Jersey Economic Indicators: Historical Data Series, 1976–2001, Resident Employment, Series 2," www.wnjpin.net/OneStopCareerCenter/LaborMarketInformation/lmi07/series2.htm (13 April 2004).
12. Data are from P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: An Analysis of the March 2001 Current Population Survey,* EBRI Issue Brief no. 240 (Washington: Employee Benefit Research Institute, December 2001). Following Fronstin, we have adjusted the estimates to reflect the inclusion of an insurance status verification question in the CPS in 1998.
13. See New Jersey Small Employer Health Benefits Program Board, "The Effects on the Individual and Small Employer Health Coverage Markets of Permitting Individuals to Purchase Small Employer Health Benefits Plan: A Report to the New Jersey Legislature" (Unpublished report, 25 September 1996), for a comparison of monthly premiums for a small employer group insured through specific IHCP and SEHBP plans.
14. Swartz and Garnick, "Regulating Markets."
15. S. Silow-Carroll et al., *Assessing State Strategies for Health Coverage Expansions: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (New York: Commonwealth Fund, November 2002).
16. Swartz and Garnick, "Lessons from New Jersey."
17. Fronstin, *Sources of Health Insurance.*
18. Data are from Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey* (Washington: Kaiser Family Foundation, September 2002).
19. T. McBride et al., "The Dynamics of Individual Insurance Coverage in the U.S." (Paper presented at the Twentieth Annual Research Meeting of AcademyHealth, Nashville, Tennessee, 27–29 June 2003). Median spell length for people with individual coverage is five months. On average, older people, especially those nearing retirement, remain in the market longer than younger people.
20. See M. Hall, "An Evaluation of New York's Reform Law," *Journal of Health Politics, Policy and Law* 24 no. 1 (2000): 71–100; K. Thorpe, "Who Purchases Individual Insurance? A Comparision of New York State, Regional, and National Patterns, 1994–1997" (Unpublished manuscript, Tulane University Medical Center, March 1999); and D. Chollet, "Changes in the Individual Insurance Market" (Paper presented at the Annual Research Meeting of AcademyHealth, Washington D.C., 23 June 2002).
21. M.S. Marquis and S.H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics* 14, no. 1 (1994): 47–63.
22. See New Jersey SEHBP Board, "The Effects on the Individual and Small Employer Health Coverage Markets." Figures in the text are the authors' computations; details are available on request by e-mailing Alan Monheit, monheiac@umdnj.edu.

Exhibit 27

Medical Progress Report | No. 10 September 2009

HEALTHIER CHOICE: An Examination of Market-Based Reforms for New York's Uninsured

CENTER FOR MEDICAL PROGRESS
AT THE MANHATTAN INSTITUTE

Published by Manhattan Institute

Millions of Americans are living without health insurance. Congress is currently considering a variety of insurance market reforms intended to reduce their number. In New York, there are well over 2 million uninsured adults, representing 14 percent of the non-elderly population, a figure just below the national average. The goal of this paper is to estimate the reduction in the number of uninsured New Yorkers that would result from expanding access to unsubsidized, private health insurance.

Bills before both houses of Congress contain provisions similar to New York State laws that mandate guaranteed issue (which prohibits denial of coverage on the basis of health status) and community rating (which requires insurance companies to charge policyholders the same premium, regardless of their age, gender, or health status). Four other states have similar regulations. Yet New York's individual-insurance market is unique in requiring insurers to offer coverage to all individuals at all times at exactly the same price.

Although New York's guaranteed-issue and community-rating laws were adopted with the best of intentions, they have not been effective in substantially reducing the size of the state's uninsured population. In fact, as a result of a significant increase in the cost of private-insurance coverage for individuals, the market for individual health insurance in New York has nearly disappeared, declining by 96 percent since 1994.

Uninsured New Yorkers of all income levels would benefit from access to a reasonably priced private-insurance market. The existence of such a market would ensure that scarce public dollars are reserved for government programs like Medicaid that protect New York's poorest and sickest citizens.

With data collected from a survey and three focus groups composed of uninsured New Yorkers and conducted by Zogby International, the authors of this study constructed a micro-simulation model to assess the potential impact of four individual-insurance market reforms on the level of premiums that individuals would pay for private-insurance coverage and the potential willingness of the uninsured to purchase coverage voluntarily. This model was first used by the U.S. Department of Health and Human Services to simulate the effect of the Medicare Modernization Act of 2003 on take-up rates of lower-premium, catastrophic-protection health plans in the individual health-insurance market that were compatible with Health Savings Accounts. Such accounts are not available in New York State.

The market reforms that this paper proposes are:

1. Repeal of community-rating and guaranteed-issue laws
2. Approval of Health Savings Accounts for New York's individual-insurance market
3. Permission to individuals to shop for approved and affordable health-insurance policies across state lines
4. Approval of "mandate-lite" plans, which permit insurers to offer plans with narrower coverage for sale in New York

While each of these reforms would have some effect on reducing the number of uninsured, repeal of New York's community-rating and guaranteed-issue laws would have the greatest impact, potentially reducing the price of individual insurance coverage by 42 percent and encouraging up to 37 percent of the uninsured to buy coverage.

However, as the report also notes, a small portion of the uninsured—those with certain preexisting conditions—could be deemed uninsurable or find individual insurance coverage too expensive. Therefore, the authors recommend a modest assessment on policyholders in the individual and small-group insurance markets, with the proceeds used to fund a guaranteed-access, high-risk pool for this population. The pool would offer portable private health insurance at a subsidized price. Such a program would ensure that all New Yorkers had access to health insurance.

Exhibit 28

The Senate Bill Lowers Non-Group Premiums: Updated for New CBO Estimates

Jonathan Gruber, MIT

November 27, 2009

The Senate Bill issued this week provides premium assistance and market reforms which will make health insurance much more affordable for individuals facing purchase in the non-group market. The premiums that individuals will face in the new exchanges established by this legislation are, according to the non-partisan Congressional Budget Office, considerably lower than what they would face in the non-group insurance market, due to the market reforms put in place by the Senate Bill, the mandate on individuals to participate regardless of health, and the market economies of new exchanges. This memo illustrates this point by relying solely on analysis available from CBO, as well as the details of the premium assistance available through premium credits in the Senate plan.

Background

In a letter to Senator Reid on November 20, the Congressional Budget Office (the official government scoring agency) reported that they estimated the cost of an individual low-cost plan in the exchange to be $5200 in 2016. This is a plan with an "actuarial value" (roughly, the share of expenses for a given population covered by insurance) of 70%. In their most recent communication with Congress, CBO also projected that, absent reform, the cost of an individual policy in the non-group market would be $5500 for a plan with an actuarial value of 60%. This implies that the same plan that cost $5500 without reform would cost $4460 with reform, or almost *20% less*.

The CBO has not reported many of the details of their analysis, such as the age distribution of individuals in the non-group market or in the exchange. So these data do not provide a strictly apples to apples comparison of premiums for the same individual in the exchange and in the no-reform non-group market. And their conclusion may change as legislation moves forward. But the key point is that, as of now, the most authoritative objective voice in this debate suggests that reform will significantly reduce, not increase, non-group premiums.

This conclusion is consistent with evidence from the state of Massachusetts. In their December 2007 report, AHIP reported that the average single premium at the end of 2006 for a non-group product in the U.S. was $2613. In their October 2009 report, AHIP found that the average single premium in mid-2009 was $2985, or a 14% increase. That same report presents results for the non-group markets in a set of states. One of those states is Massachusetts, which passed a health care reform similar to the one contemplated at the federal level in mid-2006. The major aspects of this reform took place in 2007, notably the introduction of large subsidies for low income populations, a merged non-group and small group insurance market, and a mandate on individuals to purchase health insurance. And the results have been an enormous *reduction* in the cost of non-group insurance in the state: the average individual premium in the state fell from $8537 at the end of 2006 to $5143 in mid-2009, a *40% reduction while the rest of the nation was seeing a 14% increase*.

Example

As an example of the savings individuals may see under the Senate Bill, I consider the case of the typical single person buying non-group insurance compared to the typical single person in the exchange, as well as comparing the typical four person family in both the non-group market and the exchange. For the non-group market, I assume that the typical premium for a family of four is 2.7 times the single premium, as with group insurance. The impact is for 2016, when reforms are fully phased in, although income is expressed in $2009 for ease of interpretation. To deflate costs from 2016 to 2009, I use the CPI (the rate of growth of the poverty line) for those who are paying a percentage of income, and I use the rate of premium growth for those who are paying the full premium.[1] The analysis compares what they would pay if they are currently insured in the non-group market versus what they will pay in the exchange.

Figures 1 and 2 show the results of this analysis. I find that the savings are large for both singles and families, and that they are particularly large for the lowest income families that qualify for premium credits under the Senate Bill but would be left to face the full high non-group premium without legislation. In particular, I find that the single individual would save over $2500 at low incomes (175% of poverty), and would save $200 even at higher incomes (425% of poverty or higher). For families, the savings are much larger, ranging from nearly $7500 for low income families (at 175% of poverty) to $500 for higher incomes (425% of poverty or higher).

It is worth noting that these savings are all *in addition* to the more generous benefits that these groups will receive through the exchange compared to the non-group market. The CBO reports that their estimated premium in the non-group market corresponds to an actuarial value of 60%. The actuarial values used in these estimates are as high as 80% (for those at 175% of poverty) and are at their lowest 70% (for those above 350% of poverty). So not only does the Senate proposal lower premiums, it does so while also improving coverage.

Conclusion

Analysis of the non-partisan information from the CBO suggests that for those facing purchase in the non-group market, the House bill will deliver savings ranging from $200 for singles to $500 for families in today's dollars – even without subsidies. The savings are much larger for lower income populations that receive premium credits. This is in addition to the higher quality benefits that those in the exchange will receive, with actuarial values for low income populations well above what is typical in the non-group market today. It is also in addition to all the other benefits that this legislation will deliver to those consumers – in particular the guarantee, unavailable in most states, that prices would not be raised or the policy revoked if they became ill.

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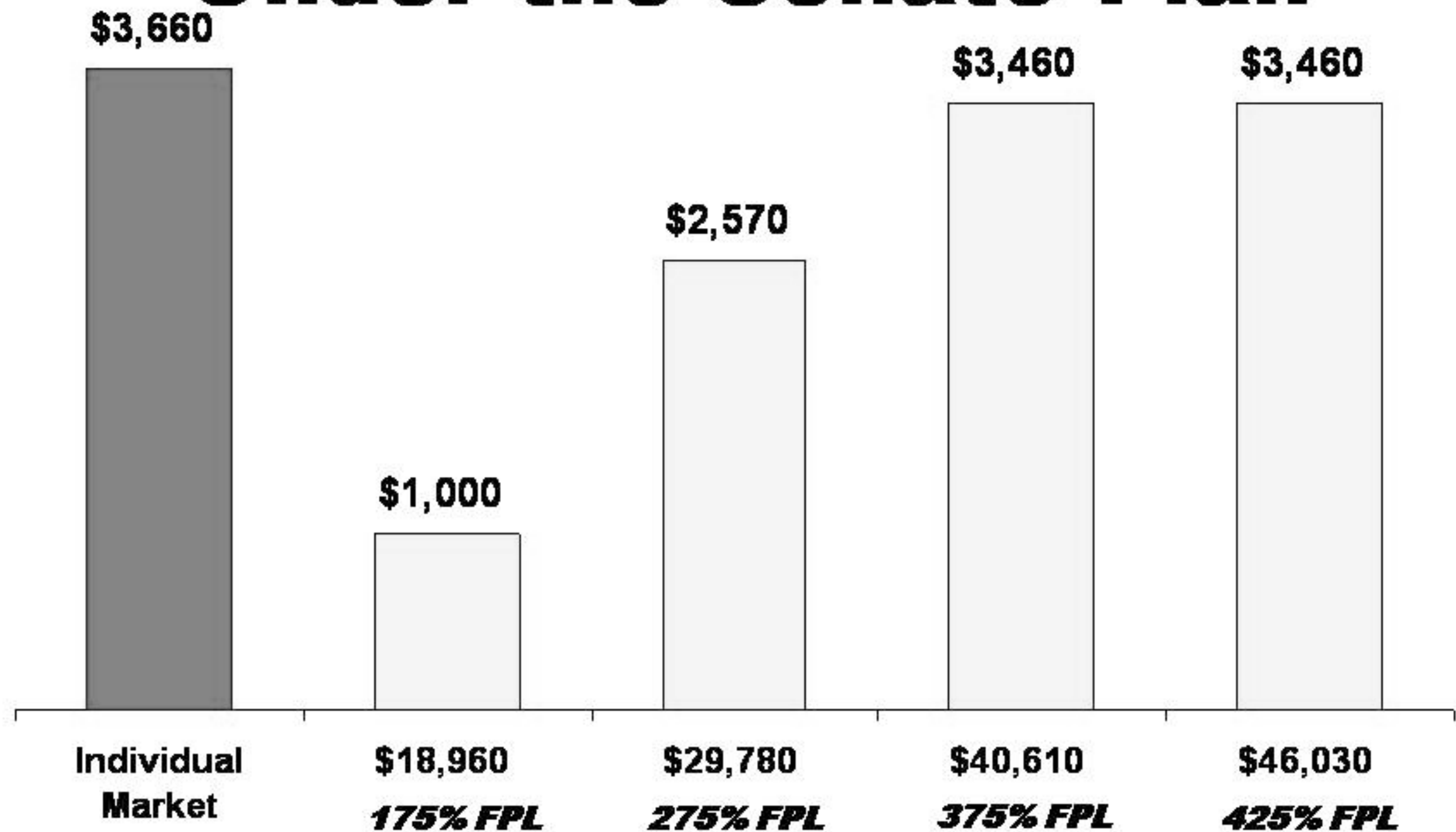
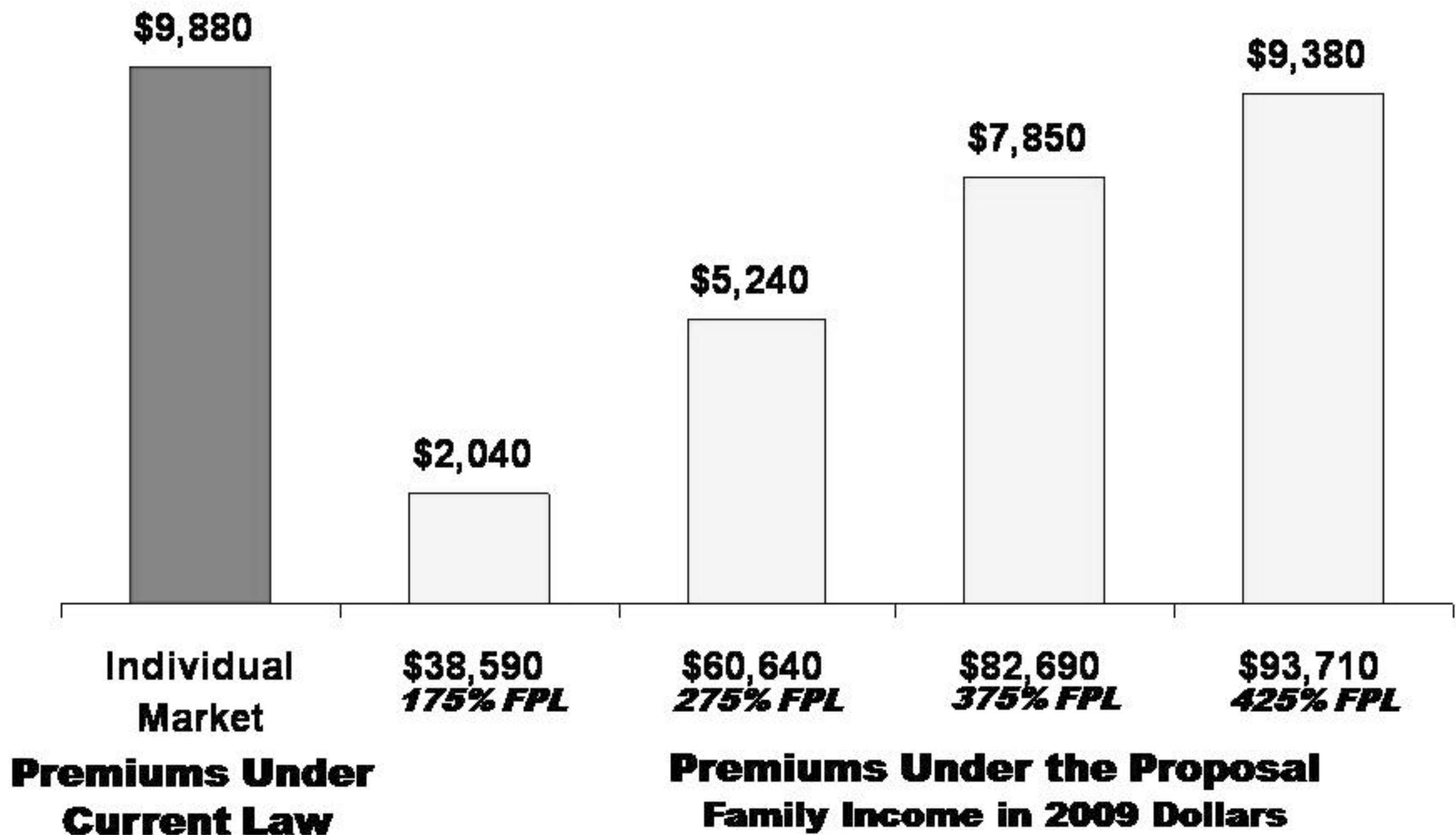
[1] Note that my methodology here differs slightly from a comparable analysis for the Senate Finance bill, where I used one common deflator for all figures and undertook the comparison for the first year of the legislation, rather than the third year. But the savings estimates are similar to what I would get under that alternative method.

Premiums for a Single Person Under the Senate Plan



Source: Gruber microsimulation model. Analysis for 2016 (full implementation) displayed in 2009 dollars. Updated 11-27.

Premiums for a Family of Four Under the Senate Plan



Source: Gruber microsimulation model. Analysis for 2016 (full implementation) displayed in 2009 dollars. Couple, 2 kids. Updated 11-27

Exhibit 29

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE DEPARTMENT
STATE HOUSE • BOSTON 02133
(617) 725-4000

HD 5160

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

April 12, 2006

To the Honorable Senate and House of Representatives:

Pursuant to the provisions of Section 5 of Article 63 of the Amendments to the Constitution, I am today signing House Bill No. 4479, "An Act Providing Access to Affordable, Quality, Accountable Health Care."

With the signing this law today, every resident will have health insurance by 2009. An achievement like this comes around once in a generation, and it proves that government can work when people of both parties reach across the aisle for the common good. Today, Massachusetts is leading the way with health insurance for everyone, without a government takeover and without raising taxes.

By allowing insurers greater flexibility to design and offer more consumer responsive health insurance products and by remedying market breakdowns by merging the small group and non-group markets, this law will substantially reduce the average monthly premium for individuals and small businesses. In order to simplify the offer and purchase of insurance, especially by small businesses, the law creates a new independent authority call the insurance Commonwealth Care Health Insurance Connector Authority. The Connector will offer a choice of comprehensive, good value health insurance products to individuals and to small businesses for purchase on a pre-tax basis.

For those residents of the Commonwealth who do not qualify for Medicaid, but do not earn enough annual income to purchase health insurance on their own, this law will provide Commonwealth Care, a sliding scale premium assistance program for the purchase of private health insurance. With the creation of Commonwealth Care, every resident of the Commonwealth will be able to buy health insurance according to their means.

Because this law will result in a greater availability of affordable health insurance products and subsidies will be provided to the working poor, it is fair to expect that all Massachusetts residents have health insurance by July 1, 2007. No longer can individuals free ride by seeking healthcare and expecting society to bear the cost.

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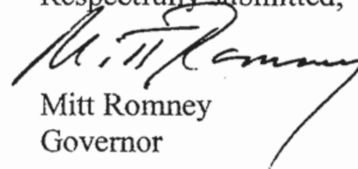
Lastly, but perhaps most critically, this bill takes bold steps to contain healthcare costs. By putting an end to cost-shifting from the uninsured and from the Medicaid program, businesses and individual will no longer bear the cost of others' healthcare. This bill places critical healthcare cost and quality information in the hands of businesses and consumers. By creating cost and quality transparency, individuals will make more informed decisions about where and how to seek care.

In addition, I am vetoing in their entirety those sections of House 4479 itemized in Attachment A of this message, for the reasons set forth in that attachment.

The remainder of the bill I hereby approve.

Respectfully submitted,



Mitt Romney
Governor

Attachment A
Health Care Reform
Veto Items: Outside Sections

Public Health Council Section 5 I am vetoing this section because the Legislature has given authority to private organizations to make appointments to the Public Health Council. Appointment of these members as prescribed by the legislature in this section is a violation of the separation of powers required by the Massachusetts Constitution.
MassHealth Eligibility for AWSS Section 27 I am vetoing this section because it codifies into General Law, MassHealth Essential Benefits for special status aliens, and specifically mandates that the benefits shall not be subject to sponsor income deeming or related restrictions. Federal reimbursement for medical coverage for special status aliens was eliminated by President Bill Clinton in 1996, when he signed into law a measure requiring sponsors to sign an affidavit swearing they will take personal financial responsibility for these aliens in their care. It is important to take into consideration the financial status of the sponsor in determining if the medical coverage for these special status aliens should be made available.
MassHealth Optional Services Section 29 I am vetoing this section because it will cost $75 million annually and is therefore financially unsustainable. Furthermore, this provision would extend to adult Medicaid recipients a dental benefit not provided by 60 percent of employers in Massachusetts.
Establishes Fair Share Assessment Section 47 I am vetoing this section because it is not necessary to implement or finance health care reform.

Waivers and Federal Financial Participation

Section 112

I am vetoing this section because it inappropriately imposes Legislative controls on Executive Branch management decisions.

Behavioral Health Procurement Report

Section 113

I am vetoing this section because it inappropriately imposes Legislative controls on Executive Branch management decisions.

Report on Fair Share Assessment Impact

Section 134

I am vetoing this section consistent with my veto of section 47 of this act.

Terms of Public Health Council

Section 137

I am vetoing this section consistent with my veto of section 5 of this act.

Exhibit 30

The NEW ENGLAND JOURNAL of MEDICINE

Perspective
DECEMBER 24, 2009

Getting the Facts Straight on Health Care Reform

Jonathan Gruber, Ph.D.

The United States stands on the verge of the most significant change to our health care system since the 1965 introduction of Medicare. The bill that was passed by the House and a parallel bill before the Senate would cover most uninsured Americans, saving thousands of lives each year and putting an end to our status as the only developed country that places so many of its citizens at risk for medical bankruptcy. Moreover, the bills would accomplish this aim while reducing the federal deficit over the next decade and beyond. They would reform insurance markets, lower administrative costs, increase people's insurance choices, and provide "insurance for the insured" by disallowing medical underwriting and the exclusion of preexisting conditions. And the Senate bill in particular would move us closer to taming the uncontrolled increase in health care spending that threatens to bankrupt our society.

Despite the many reasons to be excited about this legislative breakthrough, skeptics abound. Their criticism is only going to get louder as the bill is debated on the Senate floor over the next few weeks. But the primary criticisms of the bills are largely unwarranted.

One common refrain of opponents of reform is that it represents a government takeover of health care. But reformers made the key decision at the start of this process to eschew a government-driven redesign of our health care system in favor of building on the private insurance system that works for most Americans. The primary role of the government in this reform is as a financier of the tax credits that individuals will use to purchase health insurance from private companies through state-organized exchanges. In Massachusetts, which passed a similar reform in 2006, private health insurance has expanded dramatically. The public insurance alternative that is included in the Senate bill simply adds another competitor — on a level playing field — to the insurance market, and the Congressional Budget Office (CBO) projects that it will enroll only a tiny minority of Americans.[1]

A second criticism is that the bills are budget busters. This is simply incorrect. Both bills are completely paid for — indeed, both would reduce the deficit by more than $100 billion over the coming decade. And the CBO estimates that both would reduce the deficit even more in the long

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run, particularly the Senate bill with its strong cost-containment measures.[1] Some argue that the bills won't reduce the deficit because Congress won't follow through on its cost-reduction plans, as it has failed to do with the sustainable-growth-rate program for Medicare's physician payments. But this one example has been ridiculously overused, given the sizable Medicare reductions that Congress has made in the past; the proposed reduction in Medicare spending is less than half of the percentage reduction enacted in 1997, for example.[2] To oppose a bill because of a misplaced fear that the government cannot keep its promises is essentially to shut down the legislative process.

In addition, some claim that the bills are an attack on Medicare and argue that it is unfair to pay for expanded coverage by reducing overpayments to hospitals and to the private insurers that offer Medicare Advantage plans. It's ironic that the people taking this position are often the same ones who make the first criticism (Medicare, after all, is a government-run insurance system) or the second (if the government will never follow through on its promises, we needn't worry about reduced payments). In any case, there is substantial evidence that reducing these overpayments will not harm the health of Medicare patients — just the pocketbooks of those who profit from them. This reform would simply use market bidding to set the reimbursement rate for Medicare Advantage plans, rather than setting administrative prices, which have traditionally been much too high; and it would reduce payments to hospitals by a small percentage, while tying them to outcome measures. Moreover, the dollars that are raised will save thousands of lives each year by increasing insurance coverage among the nonelderly.

The bills are also said to impose unaffordable mandates on individuals. Without the individual mandate, fundamental insurance-market reform is impossible and we cannot cover the majority of the uninsured. But an individual mandate without financial assistance for low-income families is unethical. Both bills contain billions of dollars in subsidies to help families pay for health insurance — and an exclusion from the mandate for families that still find coverage unaffordable. Rather than imposing an unaffordable mandate, these bills would finally guarantee that almost all Americans could find affordable insurance.

Some argue that the bills would harm the privately insured. But although a primary focus of reform has been on helping the uninsured, the bills also deliver enormous benefits to the privately insured. Americans who previously purchased insurance in an overpriced, unpredictable nongroup insurance market will have the ease and certainty of buying through an organized marketplace where insurance loads are lower, prices do not vary according to health status, and preexisting conditions cannot be excluded from coverage. CBO data show that the average enrollee in the new exchanges will either pay substantially less or obtain more generous coverage than the average person in today's nongroup insurance market.[3] Employees of small businesses that enroll in the exchange will also benefit from the lower prices and wide variety of health plan choices available to larger groups, and their employers will benefit from a small-business tax credit. Employees in large businesses will benefit from a shifting of their employers' money from excessively expensive insurance to increased wages. Most important for the insured, this reform will start us down the road to fundamental cost control, which will reduce costs for everyone in the long run.

Some critics also argue, however, that the bills don't do enough to control costs. This argument ignores fundamental reforms in the Senate bill in particular, which includes a four-pronged attack on health care costs. First, it imposes a tax on high-cost insurance plans that will put pressure on insurers and employers to keep the cost of insurance down, while delivering $234 billion in wage income to workers over the next decade.[4] Second, it includes funds and a structure for comparative-effectiveness research that will provide the information necessary to guide our health care system toward care that works and away from care that doesn't. Third, it establishes a Medicare advisory board with the power to set rates (subject to an up-or-down vote by Congress) if costs grow too rapidly. Finally, it sets up an innovation center within the Centers for Medicare and Medicaid Services and launches pilot projects to explore alternative reimbursement and organizational structures that could transform the delivery of care.

This argument also misses the important point that universal coverage is vital for cost control. Most of the reforms that are aimed at controlling costs work through changes in the ways in which insurers reimburse and or-

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ganize care. These changes can't work if an ever-growing proportion of our population lacks insurance. Moreover, as we have seen in Massachusetts, dealing with the problem of the uninsured allows policymakers to focus more single-mindedly on cost control: after our universal-coverage law passed, the state moved aggressively to set up a cost-control commission that recommended important changes in provider reimbursement.[5]

The current bills are not perfect. The Senate bill has a mandate that's too weak and doesn't provide generous enough insurance to low-income individuals, and the House bill doesn't do enough to control costs. Nevertheless, passage of a hybrid of these bills would be a major accomplishment and a turning point for our dysfunctional health care system. We should constructively support Congress's efforts to create a combined bill, rather than leveling unsubstantiated criticisms from the sidelines.

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From the Massachusetts Institute of Technology, Cambridge.

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On Mammography — More Agreement Than Disagreement

Ann H. Partridge, M.D., M.P.H., and Eric P. Winer, M.D.

Breast cancer is the most common cancer in women in the United States, with more than 190,000 women receiving a diagnosis of invasive disease annually[1] and more than 40,000 dying of breast cancer each year. Worldwide, more than 1 million women are diagnosed with breast cancer and more than 500,000 die from it each year.[2] During the past two decades, there have been modest but real decreases in breast-cancer mortality that have been attributed to improvements in early detection and treatment. It is in this context that the recent controversy surrounding the optimal approach to breast-cancer screening should be considered.

On November 16, 2009, the U.S. Preventive Services Task Force (USPSTF) released updated recommendations for breast-cancer screening,[3] informed by additional follow-up from previous studies and a new study focused on statistical modeling.[4,5] The two most substantive and controversial recommendations were that mammography be eliminated as a "standard test" for women 40 to 49 years of age and that mammography be performed biennially rather than annually in women from 50 to 74 years of age.

The rationale for the changes was clearly delineated by the task force. Although mammography decreases breast-cancer mortality among women in their 40s, the absolute benefit is smaller than among older women, because the disease is less common in the younger age group. Younger women are also more likely to have false positive results, which lead to additional testing, anxiety, and psychological distress. For women in their 40s who are not at increased risk for breast cancer, the USPSTF recommends that the benefits of mammography be carefully weighed against the potential adverse consequences.

The recommendation for biennial rather than annual screening was based on the modeling study and cross-study comparisons suggesting that more frequent screening is not associated with better outcomes. Moreover, the panel concluded that the rate of false positive results appears to be much lower with biennial mammography.

The updated recommendations sparked substantial controversy and have had a polarizing effect in the breast-cancer community. There has been confusion, fear, and anger on the part of patients with breast cancer, their families, and women's health advocates. The intensity of the controversy

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Exhibit 31

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

March 20, 2010

Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Madam Speaker:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed an estimate of the direct spending and revenue effects of an amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010. The amendment discussed in this letter (hereafter called "the reconciliation proposal") is the one that was made public on March 18, 2010, as modified by subsequent changes incorporated in a proposed manager's amendment that was made public on March 20.

This estimate differs from the preliminary estimate that CBO issued on March 18 in that it reflects CBO and JCT's review of the legislative language of the earlier amendment and the manager's amendment, as well as modest technical refinements of the budgetary projections.[1] This estimate is presented in two ways:

- An estimate of the budgetary effects of the reconciliation proposal, in combination with the effects of H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), as passed by the Senate; and

- An estimate of the *incremental* effects of the reconciliation proposal, over and above the effects of enacting H.R. 3590 by itself.[2]

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[1] For the preliminary estimate by CBO and JCT of the direct spending and revenue effects of the reconciliation proposal, see Congressional Budget Office, letter to the Honorable Nancy Pelosi providing a preliminary analysis of the reconciliation proposal (March 18, 2010).

[2] For the estimate by CBO and JCT of the direct spending and revenue effects of H.R. 3590 as passed by the Senate, see Congressional Budget Office, cost estimate of H.R. 3590, Patient Protection and Affordable Care Act (March 11, 2010). JCT's detailed table of revenue effects is available at www.jct.gov.

CBO and JCT have not yet updated their preliminary and partial estimate of the budgetary impact of the reconciliation proposal under the assumption that H.R. 3590 is not enacted—that is, the reconciliation proposal's impact under current law.

H.R. 3590 would, among other things, establish a mandate for most residents of the United States to obtain health insurance; set up insurance exchanges through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs. The reconciliation proposal includes provisions related to health care and revenues, many of which would amend H.R. 3590. (The changes with the largest budgetary effects are described below.) The reconciliation proposal also includes amendments to the Higher Education Act of 1965, which authorizes most federal programs involving postsecondary education. (Those provisions and their budgetary effects are described below as well.)

Estimated Budgetary Impact of the Legislation
CBO and JCT estimate that enacting both pieces of legislation—H.R. 3590 and the reconciliation proposal—would produce a net reduction in federal deficits of $143 billion over the 2010–2019 period as result of changes in direct spending and revenues (see Table 1). That figure comprises $124 billion in net reductions deriving from the health care and revenue provisions and $19 billion in net reductions deriving from the education provisions. Approximately $114 billion of the total reduction would be on-budget; other effects related to Social Security revenues and spending as well as spending by the U.S. Postal Service are classified as off-budget. CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

CBO and JCT previously estimated that enacting H.R. 3590 by itself would yield a net reduction in federal deficits of $118 billion over the 2010–2019 period, of which about $65 billion would be on-budget. The incremental effect of enacting the reconciliation proposal—assuming that H.R. 3590 had already been enacted—would be the difference between the estimate of their combined effect and the previous estimate for H.R. 3590. That

incremental effect is an estimated net reduction in federal deficits of $25 billion during the 2010–2019 period over and above the savings from enacting H.R. 3590 by itself; almost all of that reduction would be on-budget.[3]

Additional details on the budgetary effects of the reconciliation proposal and H.R. 3590 are provided in Tables 2 through 7 attached to this letter:

- Table 2 shows budgetary cash flows for direct spending and revenues associated with the two pieces of legislation combined.

- Table 3 summarizes the incremental changes in direct spending and revenues resulting from the reconciliation proposal, assuming that H.R. 3590 had already been enacted.

- For the two pieces of legislation combined, Table 4 provides estimates of the changes in the number of nonelderly people in the United States who would have health insurance and presents the primary budgetary effects of the provisions related to health insurance coverage.

- For the two pieces of legislation combined, Table 5 displays detailed estimates of the costs or savings from the health care provisions that are not related to health insurance coverage (primarily involving the Medicare program). The table does not include the effects of revenue provisions; those effects are reported separately by JCT in JCX-17-10 at www.jct.gov.

- Table 6 presents details on the incremental effects of the health care and revenue provisions of the reconciliation proposal—that is, the difference between the effects of those provisions in the two pieces of legislation combined and the effects of H.R. 3590 by itself (as shown in CBO's cost estimate of March 11, 2010).

- Table 7 summarizes the incremental effects of the health care, revenue, and education provisions of the reconciliation proposal, also assuming that H.R. 3590 had been enacted.

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[3] As originally introduced, the reconciliation proposal would require transfers from on-budget general funds to the off-budget Social Security trust funds to offset any reduction in the balances of those trust funds resulting from other provisions of the proposal. The effects of that provision were reflected in CBO's preliminary estimate. However, the manager's amendment to the reconciliation proposal strikes that provision, so its effects are not included in this estimate.

- Increasing the federal share of spending for certain Medicaid beneficiaries;

- Changing eligibility for Medicaid in a way that effectively increases the income threshold from 133 percent of the federal poverty level to 138 percent for certain individuals;

- Reducing overall payments to insurance plans under the Medicare Advantage program;

- Expanding Medicare's drug benefit by phasing out the "doughnut hole" in that benefit;

- Modifying the design and delaying the implementation of the excise tax on insurance plans with relatively high premiums; and

- Increasing the rate and expanding the scope of a tax that would be charged to higher-income households.

Effects of the Legislation on Insurance Coverage

CBO and JCT estimate that by 2019, the combined effect of enacting H.R. 3590 and the reconciliation proposal would be to reduce the number of nonelderly people who are uninsured by about 32 million, leaving about 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the legislation, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent.

Approximately 24 million people would purchase their own coverage through the new insurance exchanges, and there would be roughly 16 million more enrollees in Medicaid and the Children's Health Insurance Program than the number projected under current law. Relative to currently projected levels, the number of people purchasing individual coverage outside the exchanges would decline by about 5 million.

Under the legislation, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in Table 4 as enrollees in employment-based coverage rather than as exchange enrollees). Approximately 5 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 29 million in that year.

On balance, the number of people obtaining coverage through their employer would be about 3 million lower in 2019 under the legislation, CBO and JCT estimate. The net change in employment-based coverage under the proposal would be the result of several flows, which can be illustrated using the estimates for 2019:

- Between 6 million and 7 million people would be covered by an employment-based plan under the proposal who would not be covered by one under current law (largely because the mandate for individuals to be insured would increase workers' demand for coverage through their employers).

- Between 8 million and 9 million other people who would be covered by an employment-based plan under current law would not have an offer of such coverage under the proposal. Firms that would choose not to offer coverage as a result of the proposal would tend to be smaller employers and employers that predominantly employ lower-wage workers—people who would be eligible for subsidies through the exchanges—although some workers who would not have employment-based coverage because of the proposal would not be eligible for such subsidies. Whether those changes in coverage would represent the dropping of existing coverage or a lack of new offers of coverage is difficult to determine.

- Between 1 million and 2 million people who would be covered by their employer's plan (or a plan offered to a family member) under current law would instead obtain coverage in the exchanges. Under the legislation, workers with an offer of employment-based coverage would generally be ineligible for exchange subsidies, but that "firewall" would be enforced imperfectly and an explicit exception to it would be made for workers whose offer was deemed unaffordable.

Effects of the Legislation on Discretionary Costs

CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action. Discretionary costs would arise from the effects of the legislation on several federal agencies and on a number of new and existing programs subject to future appropriation. Those discretionary costs fall into three general categories.

"federal budgetary commitment to health care," a term that CBO uses to describe the sum of net federal outlays for health programs and tax preferences for health care.[10] CBO estimated that H.R. 3590, as passed by the Senate, would increase the federal budgetary commitment to health care over the 2010–2019 period; the net increase in that commitment would be about $210 billion over that 10-year period. The combined effect of enacting H.R. 3590 and the reconciliation proposal would be to increase that commitment by about $390 billion over 10 years. Thus, the incremental effect of the reconciliation proposal (if H.R. 3590 had been enacted) would be to increase the federal budgetary commitment to health care by about $180 billion over the 2010–2019 period.

In subsequent years, the effects of the provisions of the two bills combined that would tend to decrease the federal budgetary commitment to health care would grow faster than the effects of the provisions that would increase it. As a result, CBO expects that enacting both proposals would generate a reduction in the federal budgetary commitment to health care during the decade following the 10-year budget window—which is the same conclusion that CBO reached about H.R. 3590, as passed by the Senate.

Members have also requested information about the effect of the legislation on health insurance premiums. On November 30, 2009, CBO released an analysis prepared by CBO and JCT of the expected impact on average premiums for health insurance in different markets of PPACA as originally proposed.[11] Although CBO and JCT have not updated the estimates provided in that letter, the effects on premiums of the legislation as passed by the Senate and modified by the reconciliation proposal would probably be quite similar.

CBO and JCT previously determined that H.R. 3590, as passed by the Senate, would impose several intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO and JCT estimated that the total costs of those mandates to state, local, and tribal governments and the private sector would greatly exceed the annual thresholds established in UMRA ($70 million and $141 million,

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[10] For additional discussion of that term, see Congressional Budget Office, letter to the Honorable Max Baucus regarding different measures for analyzing current proposals to reform health care (October 30, 2009).

[11] See Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

TABLE 2. Estimate of Changes in Direct Spending and Revenue Effects of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

By Fiscal Year, in Billions of Dollars

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING (OUTLAYS)												
Education	*	*	4	-6	-3	-5	-4	-2	-2	-2	-5	-19
Health Insurance Exchanges												
Premium and Cost Sharing Subsidies	0	0	0	0	14	32	59	75	82	88	14	350
Start-up Costs	*	*	*	1	*	*	0	0	0	0	2	2
Other Related Spending	0	1	2	2	1	*	*	*	*	0	5	5
Subtotal	0	2	2	2	15	33	59	75	82	88	21	358
Reinsurance and Risk Adjustment Payments[a]	0	0	0	0	11	18	18	18	19	21	11	106
Effects of Coverage Provisions on Medicaid and CHIP	*	-1	-2	-4	29	56	81	87	91	97	22	434
Medicare and Other Medicaid and CHIP Provisions												
Reductions in Annual Updates to Medicare FFS Payment Rates	*	-1	-5	-9	-13	-19	-25	-33	-41	-51	-28	-196
Medicare Advantage Rates based on Fee-for-Service Rates	0	-2	-6	-9	-13	-17	-19	-21	-23	-25	-30	-136
Medicare and Medicaid DSH Payments	0	0	*	*	-1	-4	-5	-7	-9	-11	*	-36
Other	2	1	*	*	-16	-11	-10	-14	-18	-22	-12	-87
Subtotal	2	-2	-11	-17	-42	-50	-59	-75	-92	-108	-71	-455
Other Changes in Direct Spending												
Community Living Assistance Services and Supports	0	0	-5	-9	-10	-11	-11	-9	-8	-7	-24	-70
Other	2	6	8	5	5	4	2	-1	-1	*	26	30
Subtotal	2	6	2	-4	-5	-7	-10	-10	-8	-7	2	-40
Total Outlays	4	5	-5	-28	6	44	86	92	90	90	-20	382
On-Budget	4	5	-5	-28	5	44	85	92	89	89	-20	379
Off-Budget	0	*	*	*	*	*	1	1	1	1	*	4

Continued

TABLE 2. Estimate of Changes in Direct Spending and Revenue Effects of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN REVENUES												
Coverage-Related Provisions												
Exchange Premium Credits	0	0	0	0	-5	-11	-18	-22	-24	-26	-5	-107
Reinsurance and Risk Adjustment Collections	0	0	0	0	12	16	18	18	19	22	12	106
Small Employer Tax Credit	-2	-4	-5	-6	-5	-3	-3	-3	-4	-4	-21	-37
Penalty Payments by Employers and Uninsured Individuals	0	0	0	0	3	9	12	13	13	14	3	65
Excise Tax on High-Premium Plans	0	0	0	0	0	0	0	0	12	20	0	32
Associated Effects of Coverage Provisions on Revenues	*	-1	-2	-5	1	6	14	18	10	7	-8	46
Other Provisions												
Fees on Certain Manufacturers and Insurers[b]	0	2	3	5	12	15	15	18	19	18	22	107
Additional Hospital insurance Tax	0	0	1	21	17	29	33	35	37	39	38	210
Other Revenue Provisions[c]	*	7	8	13	22	4	11	12	13	14	49	103
Total Revenues	-3	3	5	27	57	65	83	89	95	104	89	525
On-Budget	-3	4	5	27	55	62	78	82	87	95	88	492
Off-Budget	*	*	-1	1	2	3	5	7	8	9	1	33
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES[d]												
Net Change in the Deficit	6	1	-10	-56	-51	-20	3	4	-5	-15	-109	-143
On-Budget	6	1	-10	-55	-50	-18	8	10	2	-6	-108	-114
Off-Budget	*	*	1	-1	-1	-2	-5	-6	-7	-9	-1	-29

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Note: Does not include effects on spending subject to future appropriation. Components may not sum to totals because of rounding.
* = between $0.5 billion and -$0.5 billion.
CHIP = Children's Health Insurance Program; FFS = Fee-for-service; DSH = Disproportionate Share Hospital.

a. Risk-adjustment payments lag revenues shown later in the table by one quarter. Reinsurance payments total $20 billion over the 10-year period.
b. Amounts include fees on manufacturers and importers of branded drugs and certain medical devices as well as fees on health insurance providers.
c. Amounts include $89 billion in increased revenues, as estimated by JCT, for tax provisions other than those broken out separately in the table.
In addition, this line includes an increase in revenues of about $14 billion for other provisions shown in Table 5.
d. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Table 4. Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid & CHIP	*	-1	-2	-3	10	15	17	16	16	16
	Employer	*	3	3	3	4	1	-3	-3	-3	-3
	Nongroup & Other /c	*	*	*	*	-2	-3	-5	-5	-5	-5
	Exchanges	0	0	0	0	8	13	21	23	24	24
	Uninsured /d	*	*	-1	-1	-19	-25	-30	-31	-31	-32
Post-Policy Uninsured Population											
Number of Nonelderly People /d		50	50	50	50	31	26	21	21	22	23
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	82%	82%	82%	89%	91%	92%	92%	92%	92%
Excluding Unauthorized Immigrants		83%	83%	83%	83%	91%	93%	95%	95%	95%	94%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e						*	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees						1	2	4	5	5	5
Average Exchange Subsidy per Subsidized Enrollee							$5,200	$5,300	$5,500	$5,700	$6,000

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = between 0.5 million and -0.5 million people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Other, which includes Medicare, accounts for about half of current-law coverage in this category; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies via an exchange.

Table 4. Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

EFFECTS ON THE FEDERAL DEFICIT / a,b (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid & CHIP Outlays /c	0	-1	-2	-4	29	56	81	87	91	97	434
Exchange Subsidies & Related Spending /d	0	2	2	2	20	45	77	97	106	113	464
Small Employer Tax Credits /e	2	4	5	6	5	4	3	3	4	4	40
Gross Cost of Coverage Provisions	2	5	5	5	54	104	161	187	201	214	938
Penalty Payments by Uninsured Individuals	0	0	0	0	0	-2	-3	-4	-4	-4	-17
Penalty Payments by Employers /e	0	0	0	0	-3	-8	-10	-10	-10	-11	-52
Excise Tax on High-Premium Insurance Plans /e	0	0	0	0	0	0	0	0	-12	-20	-32
Other Effects on Tax Revenues and Outlays /f	1	3	4	5	-1	-7	-15	-20	-11	-7	-48
NET COST OF COVERAGE PROVISIONS	**3**	**7**	**9**	**10**	**49**	**87**	**132**	**154**	**164**	**172**	**788**

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program.

a. Does not include federal administrative costs that would be subject to appropriation.
b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would increase by about $20 billion as a result of the coverage provisions.
d. Includes $5 billion in spending for high-risk pools and the net budgetary effects of proposed collections and payments for reinsurance and risk adjustment.
e. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.
f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $2 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Exhibit 32

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 30, 2009

Honorable Evan Bayh
United States Senate
Washington, DC 20510

Dear Senator:

The attachment to this letter responds to your request—and the interest expressed by many other Members—for an analysis of how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Specifically, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation have analyzed how health insurance premiums might be affected by enactment of the Patient Protection and Affordable Care Act, as proposed by Senator Reid on November 18, 2009.

I hope this information is helpful to you. If you have any further questions, please contact me or the CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf

Attachment

cc: Honorable Harry Reid
Majority Leader

Honorable Mitch McConnell
Republican Leader

Congressional Budget Office

An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act

November 30, 2009

There is great interest in how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Consequently, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have analyzed how those premiums might be affected by the Patient Protection and Affordable Care Act, an amendment in the nature of a substitute to H.R. 3590, as proposed by Senator Reid on November 18, 2009. The analysis looks separately at the effects on premiums for coverage purchased individually, coverage purchased by small employers, and coverage provided by large employers.

Key Elements of the Proposed Legislation

The proposal includes many provisions that would affect insurance premiums:

- New policies purchased from insurers individually (in the "nongroup" market) or purchased by small employers would have to meet several new requirements starting in 2014. Policies would have to cover a specified set of services and to have an "actuarial value" of at least 60 percent (meaning that the plan would, on average, pay that share of the costs of providing covered services to a representative set of enrollees). In addition, insurers would have to accept all applicants during an annual open-enrollment period, and insurers could not limit coverage for preexisting medical conditions. Moreover, premiums could not vary to reflect differences in enrollees' health or use of services and could vary on the basis of an enrollee's age only to a limited degree.

- A less extensive set of changes would be implemented more quickly and would continue in effect after 2013. Among other changes, health insurance plans: could not impose lifetime limits on the total amount of services covered; could rescind coverage only for certain reasons; would have to cover certain preventive services with no cost sharing; and would have to allow unmarried dependents to be covered under their parents' policies up to age 26. Those changes would also apply to new coverage provided by large employers, including firms that "self-insure"—meaning that the firm, rather than an insurer, bears the financial risk of providing coverage.

subsidies), CBO and JCT estimate that relatively few nongroup policies would remain grandfathered by 2016.

Effects on Premiums for Employment-Based Plans Would be Much Smaller
The legislation would impose the same minimum actuarial value for new policies in the small group market as in the nongroup market. That requirement would have a much smaller effect on premiums in the small group market, however, because the great majority of policies sold in that market under current law have an actuarial value of more than 60 percent. Essentially all large group plans have an actuarial value above 60 percent, so the effect on premiums in that market would be negligible. In sum, the greater actuarial value and broader scope of benefits in the legislation would increase the average premium per person in the small group market by about zero to 3 percent (with other factors held constant). Those requirements would have no significant effect on premiums in the large group market.

Differences in the Price of a Given Amount of Coverage for a Given Population

A second broad category of differences in premiums encompasses factors that reflect an "apples-to-apples" comparison of the average price of providing equivalent insurance coverage for an equivalent population under the legislation and under current law.[14] The main provisions of the legislation that fall into this category are the new rules for the insurance market, including the establishment of exchanges and availability of a public plan through those exchanges, which would reduce insurers' administrative costs and increase slightly the degree of competition among insurers, and several new fees that would be imposed on the health sector, which would tend to raise insurance premiums.[15]

Some observers have argued that private insurance premiums would also be affected by changes in the extent of "cost shifting"—a process in which lower rates paid to providers for some patients (such as uninsured people or enrollees in government insurance programs) lead to higher payments for others (such as privately insured individuals). However, the effect of the proposal on premiums through changes in cost shifting seems likely to be quite small because the proposal has opposing effects on different potential sources of cost shifting, and

[14] In this description, "equivalent coverage" means policies that have the same scope of benefits and cost-sharing requirements. The benefits received by enrollees in plans with equivalent coverage also depend on factors such as the benefit management being used and the size and composition of the provider network.

[15] The effect of the excise tax on health insurance plans with relatively high premiums is discussed separately, below. Also, to focus on permanent elements of the legislation, this analysis does not include the effect of the reinsurance that would be provided for new nongroup plans between 2014 and 2016 only. Those payments would be financed by a fee levied on all private insurers, so the effects would differ by market but the overall impact on premiums would be modest.

the total amount of cost shifting in the current health care system appears to be modest relative to the overall cost of health insurance.

CBO and JCT estimate that the elements of the legislation that would change the price of providing a given amount of coverage for a given population would, on net, reduce the average premium per person for nongroup coverage in 2016 by about 7 percent to 10 percent relative to the amount under current law. Those elements of the legislation would reduce the average premium per person in the small group market by about 1 percent to 4 percent and would not have a measurable impact on premiums in the large group market.

New Market Rules Would Reduce Administrative Costs

Compared with plans that would be available in the nongroup market under current law, nongroup policies under the proposal would have lower administrative costs, largely because of the new market rules:[16]

- The influx of new enrollees in response to the individual mandate and new subsidies—combined with the creation of new insurance exchanges—would create larger purchasing pools that would achieve some economies of scale.

- Administrative costs would be reduced by provisions that require some standardization of benefits—for example, by limiting variation in the types of policies that could be offered and prohibiting "riders" to insurance policies (which are amendments to a policy's terms, such as coverage exclusions for preexisting conditions); insurers incur administrative costs to implement those exclusions.

- Administrative costs would be reduced slightly by the general prohibition on medical underwriting, which is the practice of varying premiums or coverage terms to reflect the applicant's health status; nongroup insurers incur some administrative costs to implement underwriting.

- Partly offsetting those reductions in administrative costs would be a surcharge that exchange plans would have to pay under the proposal to cover the operating costs of the exchanges.

In the small group market, some employers would purchase coverage for their workers through the exchanges.[17] Such policies would have lower administrative costs, on average, than the policies those firms would buy under current law,

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[16] Those market rules would also affect premiums by changing the scope of coverage provided and the types of people who obtain coverage, as discussed in other sections.

[17] In 2016, states would have to give all employers with 100 or fewer employees the option to purchase coverage through the exchanges. States could give larger employers that option starting in 2017. However, CBO and JCT expect that few large firms would take that option if offered because their administrative costs would generally be lower than those of nongroup policies that would be available in the exchanges.

particularly for very small firms.[18] The primary sources of administrative cost savings for small employers would be the economies of scale and relative standardization of benefits in the exchanges noted above; currently, the use of exclusions for preexisting conditions is rare in the small group market, so the rules affecting coverage of those conditions would have only a small effect on administrative costs in that market.

In addition, the administrative simplification provisions of the legislation would require the Secretary of HHS to adopt and regularly update standards for electronic administrative transactions such as electronic funds transfers, claims management processes, and eligibility verification. In CBO and JCT's estimation, those provisions would reduce administrative costs for insurers and providers, which would result in a modest reduction in premiums in all three broad insurance markets.

Increased Competition Would Slightly Reduce Premiums in the Nongroup Market

The exchanges would enhance competition among insurers in the nongroup market by providing a centralized marketplace in which consumers could compare the premiums of relatively standardized insurance products. The additional competition would slightly reduce average premiums in the exchanges by encouraging consumers to enroll in lower-cost plans and by encouraging plans to keep their premiums low in order to attract enrollees. In particular, insurers probably would adopt slightly stronger benefit management procedures to restrain spending or would slightly reduce the rates they pay providers. Those small employers that purchased coverage through the exchanges would see similar reductions in premiums because of the increased competition among plans.

One other feature of the proposal would also put a modicum of downward pressure on average premiums in the exchanges—namely, the provisions allowing exchange administrators to act as "prudent purchasers" when reviewing and approving the proposed premiums of potential insurers.[19] Although the administrators' authority would be limited, evidence from the implementation of an exchange system in Massachusetts suggests that the existence of such authority would tend to reduce premiums slightly.

CBO and JCT's analysis of exchange premiums has also taken into account the availability of a public plan through those exchanges in some states. Premiums for the public plan as structured under the proposal would typically be somewhat

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[18] Among small employers, administrative costs decline as a share of premiums as the size of the firm increases. Thus, the smallest employers would be most likely to see lower administrative costs for policies in the exchanges than what they would be charged under current law.

[19] Specifically, the legislation would require insurers seeking to participate in the exchanges to submit a justification for any premium increase prior to implementing it; the legislation also would give exchanges the authority to take that information into consideration when determining whether to make a plan available through the exchanges.

higher than the average premiums of private plans offered in the exchanges.[20] By itself, that development would tend to increase average premiums in the exchanges—but a public plan would probably tend to reduce slightly the premiums of the private plans against which it is competing, for two reasons:

- A public plan as structured in the proposal would probably attract a substantial number of enrollees, in part because it would include a broad network of providers and would be likely to engage in only limited management of its health care benefits. (CBO and JCT estimate that total enrollment in the public plan would be about 3 million to 4 million in 2016.) As a result, it would add some competitive pressure in the exchanges in areas that are currently served by a limited number of private insurers, thereby lowering private premiums to a small degree.

- A public plan is also apt to attract enrollees who are less healthy than average (again, because it would include a broad network of providers and would probably engage in limited management of benefits). Although the payments that all plans in the exchanges receive would be adjusted to account for differences in the health of their enrollees, the methods used to make such adjustments are imperfect. As a result, the higher costs of those less healthy enrollees in the public plan would probably be offset partially but not entirely; the rest of the added costs would have to be reflected in the public plan's premiums. Correspondingly, the costs and premiums of competing private plans would, on average, be slightly lower than if no public plan was available.

Those factors would reduce the premiums of private plans in the exchanges to a small degree, but the effect on the average premium in the exchanges would be offset by the higher premium of the public plan itself. On balance, therefore, the provisions regarding a public plan would not have a substantial effect on the average premiums paid in the exchanges.[21]

New Fees Would Increase Premiums Slightly

The legislation would impose several new fees on firms in the health sector. New fees would be imposed on providers of health insurance and on manufacturers and importers of medical devices. Both of those fees would be largely passed through

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[20] Under the proposal, the public plan would negotiate payment rates with providers. CBO and JCT anticipate that those rates would be similar to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs than private plans, on average, but would probably engage in less benefit management and attract a less healthy pool of enrollees (the effects of which would be offset only partially by the risk adjustment procedures that would apply to all plans operating in the exchanges). On net, those factors would result in the public plan's premiums being somewhat higher than the average premiums of private plans in the exchanges.

[21] The presence of the public plan would have a more noticeable effect on federal subsidies because it would exert some downward pressure on the premiums of the lower-cost plans to which those subsidies are tied.

In contrast, CBO and JCT estimate that changes in the characteristics of people with insurance in the large group market would reduce average premiums per person in that market by about zero to 3 percent. One factor that would contribute to that difference is the shift of some less healthy workers to the nongroup market, as noted above. Another factor is the individual mandate, which would encourage younger and relatively healthy workers who might otherwise not enroll in their employers' plans to do so. Other factors that would slightly increase coverage of relatively healthy individuals under large group plans are the provisions of the legislation that would require large employers to automatically enroll new employees in an insurance plan and to offer coverage for unmarried dependents up to age 26. The proposal's restrictions on variation in premiums would have minimal effect on premiums in the large group market; many large firms self-insure and thus would not be affected by those changes, and firms that might be adversely affected could be grandfathered and thus avoid the restrictions.

Effects of the Proposed Exchange Subsidies and Small Business Tax Credit

Under the proposal, the government would subsidize the purchase of nongroup insurance through the exchanges for individuals and families with income between 133 percent and 400 percent of the FPL, and it would provide tax credits to certain small businesses that obtained health insurance for their employees. Although the preceding analysis accounted for the effects of those subsidies on the number and types of people who would obtain coverage and on the amount of coverage that enrollees would obtain, the direct effect of the subsidies on enrollees' payments for coverage were not included in the figures presented above because the objective there was to assess the impact of the legislation on the average premiums *paid to insurers*. This section builds on the earlier calculations by quantifying how the exchange subsidies and tax credits would directly affect the average premiums *paid by individuals and families* who would receive that government assistance.

Premium subsidies in the exchanges would be tied to the premium of the second cheapest silver plan (which would have an actuarial value of 70 percent). The national average premium for that reference plan in 2016 is estimated to be about $5,200 for single coverage and about $14,100 for family coverage (see Table 2). The national average premium for all nongroup plans would be higher—about $5,800 for single coverage and about $15,200 for family coverage—because many people would buy more expensive plans.

Under the proposal, the maximum share of income that enrollees would have to pay for the reference plan would vary depending on their income relative to the FPL, as follows:

- For enrollees with income below 133 percent of the FPL, the maximum share of income paid for that plan would be 2.0 percent in 2014; for enrollees with income between 133 percent and 300 percent of the FPL,

that maximum share of income would vary linearly from about 4 percent of income to 9.8 percent of income in 2014; and for enrollees with income between 300 percent and 400 percent of the FPL, that maximum share of income would equal 9.8 percent.

- After 2014, those income-based caps would all be indexed so that the share of the premiums that enrollees (in each income band) paid would be maintained over time. As a result, the income-based caps would gradually become higher over time; for 2016, they are estimated to range from about 2.1 percent to about 10.2 percent.

- Enrollees with income below 200 percent of the FPL would also be given cost-sharing subsidies to raise the actuarial value of their coverage to specified levels: 90 percent for those with income below 150 percent of the FPL, and 80 percent for those with income between 150 percent and 200 percent of the FPL.

- Enrollees with income above 400 percent of the FPL would not be eligible for exchange subsidies, and enrollees with income below that level whose premiums for the reference plan turned out to be less than their income-based cap also would not receive subsidies.

CBO and JCT estimated that roughly 23 million people would purchase their own coverage through the exchanges in 2016 and that roughly 5 million of those people would not receive exchange subsidies.[31] Therefore, of the 32 million people who would have nongroup coverage in 2016 under the proposal (including those purchased inside and outside the exchanges), about 18 million, or 57 percent, would receive exchange subsidies. For the people who received subsidies, those subsidies would, on average, cover nearly two-thirds of the premiums for their policies in 2016. Putting together the subsidies and the higher level of premiums paid to insurers yields a net reduction in average premiums paid by individuals and families in the nongroup market—for those receiving subsidies—of 56 percent to 59 percent relative to the amounts paid under current law. People in lower income ranges would generally experience greater reductions in premiums paid, and people in higher income ranges who receive subsidies would experience smaller reductions or net increases in premiums paid.

The government would also provide some subsidies for the purchase of health insurance in the form of tax credits to small firms. Under certain circumstances, firms with relatively few employees and relatively low average wages would be eligible for tax credits to cover up to half of their contributions toward insurance premiums. Of the people who would receive small group coverage in 2016 under the proposal, roughly 12 percent would benefit from those credits, CBO and JCT estimate. For the people who would benefit from those credits, the credits would

[31] See Congressional Budget Office, cost estimate for the amendment in the nature of a substitute to H.R. 3590, the Patient Protection and Affordable Care Act (November 18, 2009), Table 3.

tend to reduce the net cost of insurance to workers relative to the premiums paid to insurers by a little less than 10 percent, on average, in 2016. In the small group market, the other factors that were the focus of earlier sections of this analysis would cause premiums paid to insurers to change by an amount that could range from an increase of 1 percent to a reduction of 2 percent (compared to current law). Putting together the tax credits and the change in premiums paid to insurers yields a net reduction in the cost of insurance to workers in the small group market—for those benefiting from tax credits—of 8 percent to 11 percent relative to that under current law.

Effects of the Excise Tax on High-Premium Insurance Plans

The legislation would impose an excise tax on employment-based policies whose total premium (including the amounts paid by both the employer and the employee) exceeded a specified threshold. The tax on such policies would be 40 percent of the amount by which the premium exceeded the threshold. In general, that threshold would be set at $8,500 for single policies and $23,000 for family policies in 2013 (the first year in which the tax would be levied), although a number of temporary and permanent exceptions would apply. After 2013, those dollar amounts would be indexed to overall inflation plus 1 percentage point.

CBO and JCT estimate that, under current law, about 19 percent of employment-based policies would have premiums that exceeded the threshold in 2016. (Because health insurance premiums under current law are projected to increase more rapidly than the threshold, the percentage of policies with premiums under current law that would exceed the threshold would increase over time.) For policies whose premiums remained above the threshold, the tax would probably be passed through as a roughly corresponding increase in premiums. However, most employers would probably respond to the tax by offering policies with premiums at or below the threshold; CBO and JCT expect that the majority of the affected workers would enroll in one of those plans with lower premiums. Plans could achieve lower premiums through some combination of greater cost sharing (which would lower premiums directly and also lower them indirectly by leading to less use of medical services), more stringent benefit management, or coverage of fewer services.

Thus, people who remained in high-premium plans would pay higher premiums under the excise tax than under current law, and people who shifted to lower-premium plans would pay lower premiums under the excise tax than under current law—with other factors held constant. On net, CBO and JCT estimate that the excise tax and the resulting behavioral changes, incorporating the changes in premiums for employer-sponsored insurance that were discussed earlier in this analysis, would reduce average premiums among the 19 percent of policies affected by the tax by about 9 percent to 12 percent in 2016.

Exhibit 33

STATE COVERAGE INITIATIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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implementation of their coverage initiative and its progress to date, and perhaps discuss the challenges ahead.

Dr. Jack Lewin is familiar to many of us. He made a terrible, terrible mistake in his career path years ago when he left the great state of Hawaii, because we could have had the hearing there if he was still there. He moved from Hawaii—I must say moved up to the great state of California—and now is chief executive officer of the American College of Cardiology. I don't know just what Jack is going to tell us about, but I am sure he will discuss Hawaii's—I think first state to mandate coverage for all residents. And back in 1986, whenever that started, and what's happened to that since, and I think we will find that interesting.

Mr. Haislmaier, with the Heritage Foundation, and he has worked with several states in designing their health reform initiatives. I think he will talk to us about the themes that states have raised during his work, and the challenges they face. He is a strong proponent of consumer-driven health care, and is going to give us some alternatives to the plans that are on the books.

Ms. Trish Riley is the director of Maine Governor's Office of Health Policy and Finance. She will talk about Governor Baldacci's successful passage of a comprehensive health reform act, the Dirigo Heath Reform Act of 2003, and advise us to how that is doing, and whether or not our former colleague can run for reelection on the success of that plan, or whether he should look to his cousin success in writing mystery novels, and perhaps move that way.

So, we will just start down with the panel. Mr. Weil, if you would like to lead off, if you each want to take about 5 minutes to summarize, I am sure that the Members will want to inquire in more depth as you complete your testimony. Please proceed.

STATEMENT OF ALAN R. WEIL, EXECUTIVE DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY

Mr. WEIL. Thank you, Chairman Stark, Ranking Member Camp, distinguished Members of the Committee. My name is Alan Weil, I am the executive director of the National Academy for State Health Policy. NASHP is a non-profit, non-partisan organization that works with leaders in state health policy to identify emerging issues and address challenges in state health policy and practice.

This is an exciting time for states in our Nation, as the call for significant health care reforms grows louder. States are considering and implementing innovative and promising strategies to reverse the trend of an increasing number of Americans without health insurance.

Yet, given the barriers states face, my overarching message to you today is that states cannot do this alone. Federal leadership is required. In the absence of Federal action, a broad array of states in all regions of the country representing quite varied ideological perspectives is pursuing health reforms. You will hear about some of these efforts from other witnesses.

But despite successes, the states' ability to address our health care challenges is limited. States are constrained for many reasons. They lack authority to affect many of the health care activities within their borders. About half of a typical state's residents are completely outside the reach of state authority, because they are

enrolled in Medicare, have coverage through an employer that self-insures, or obtains services through various Federal programs.States face budgetary constraints, due to balanced budget requirements, and due to Federal policy that requires that Medicaid waivers be budget-neutral with respect to Federal costs. Expecting states to address the many vexing health policy issues on their own is unrealistic, and constrains the number of states that can even make such an effort.

Given these challenges, it is not surprising that only three states in the last decade—Maine, Vermont, and Massachusetts—have adopted comprehensive reforms, and efforts in larger states, such as California, Illinois, and Pennsylvania, remain stalled.

Now, while state efforts make a real contribution, Federal leadership is needed to make substantial sustained progress in health reform. Federal leadership could take several forms, including one that provides a substantial role for states to operate within a national framework. Indeed, approaches that combine the resources, stability, and uniformity of Federal involvement, with the dynamism of local involvement and creativity of states, can foster excellent results.

The Federal Government can bring its clout, as the largest purchaser, and stable funding to weather economic ups and downs, and standards that ensure that all Americans have meaningful access to needed services. States can design the details of a plan to conform to local market and medical practice conditions, develop models that enable us to learn what does and does not work, and ensure that program operations reflect local values. Federal waivers, though helpful in some instances, are no substitute for a clear, Federal commitment.

Federal leadership is required, if we are to bring down unwarranted variation across the country in health care practice and costs. A recent Commonwealth Fund report describes interstate variation in the use of antibiotics to reduce the risk of infection during surgery. Variation across states in the share of the adult population without health insurance has existed for decades. And in recent studies, they have ranged from a high of 35 percent in Texas to a low of 11 percent in Minnesota. National requirements, resources, and benchmarks can all serve to close some of these gaps.

The importance of Federal leadership is clearly demonstrated in the contrast between our recent experience covering adults and children. For adults, we have no national coverage strategy. Medicaid, which is the nation's primary commitment to health care to the poor, explicitly excludes non-elderly adults, unless they have a disability or dependent children.

For children, we have a national strategy. Despite some limitations, Medicaid and SCHIP extend coverage to nearly all children in families with incomes up to twice the poverty level. And the contrast, then, is stark. Between 1996—1999 and 2006, the percentage of uninsured adults increased in 43 states, while the percentage of uninsured children decreased in 32 states. The combination of a national priority with the resources to support it and state flexibility and the methods for achieving it can yield tremendous results.

In my job, I have the opportunity to speak to many state officials. Their message is surprisingly consistent, regardless of job title, political affiliation, or state. They are doing what they can to address issues and problems that are bigger than the resources available to them. They are eager for Federal leadership, they feel its absence, but they are also nervous about a heavy-handed or one-size-fits-all approach.

A true Federal solution to our health care problems requires something like a joint venture: cooperation between the Federal Government and the states that states have not seen lately. Delays in SCHIP reauthorization, CMS's August 17th letter, the new Medicaid citizenship and identity documentation burdens have all impeded state efforts to cover more folks.

Ultimately, in the absence of federal action, states will lead and states will accomplish as much as they can, given the constraints they face. But piecemeal state action will never add up to what the nation needs. A national response that honors the history of American Federalism would include a series of national commitments to universal coverage, improved access and quality, and tempering cost growth that frame and support what states can do.

I thank you for the opportunity to appear before the Committee today.

[The prepared statement of Mr. Weil follows:]

Statement of Alan Weil, Executive Director, National Academy for State Health Policy

Chairman Stark, Ranking Member Camp and other distinguished Members of the Ways and Means Health Subcommittee, my name is Alan Weil and I am the Executive Director of the National Academy for State Health Policy (NASHP). NASHP is a non-profit, nonpartisan organization that has worked with state leaders for more than two decades helping them to identify emerging issues and address challenges in state health policy and practice. NASHP seeks to amplify the voice of state health officials and support interstate learning—roles that we believe will be particularly important as health care rises on the national agenda.

This is an exciting time for states and our nation as the call for significant health care reforms grows louder. States are considering and implementing innovative and promising strategies to reverse our nation's trend of an increasing number of Americans without health insurance. Yet, states face substantial limitations in what they can accomplish in the absence of further support at the national level. States have demonstrated critical leadership and hold great promise for the success of any major coverage reforms, but states cannot do this alone. States need a national framework in order to achieve the promise of health reform—a framework of federal support, assistance, and guidance. I will discuss each of these points in my testimony [1]

1. **States are leading the way addressing major health system challenges.**

In the absence of federal action, states are leading the way in addressing many of the major challenges facing the American health care system. States are responding to the concerns raised by families, businesses, and health care providers and have made progress in improving access to health coverage, containing health costs, and improving quality.

A broad array of states in all regions of the country representing quite varied ideological perspectives is pursuing health reforms. Some state efforts are comprehensive in scope; others focus on particular problems facing the health care system. Although Massachusetts has received the most attention recently for its groundbreaking reforms that have already cut the number of people without health insurance in their state by half, many other states are also making real progress toward this goal. Iowa recently passed legislation to improve enrollment and retention for children in public programs and strengthen consumer protections in the pri-

[1] Much of this testimony draws from my article "How Far Can States Take Health Reform?" which appeared in the May/June 2008 issue of *Health Affairs* at pages 736–747.

perimentation. We cannot reform our health system piecemeal, or even by further state-to-state innovation. In the spirit of Federalism, the national government must commit to a national policy and a clear road map that achieves affordable, quality health care for all, and finally answers the question: Who pays?

Thank you very much.

[The prepared statement of Ms. Riley follows:]

Statement of Trish Riley, Director, Maine Governor's Office of Health Policy and Finance, Augusta, Maine

Thank you for this opportunity to talk with you about lessons learned at the state level about health care reform. Perhaps the most important lesson about state health reform is that it comes in waves, each building on the lessons of the past and learning from the challenges states find in building sustainable health reform over time. But each wave ultimately collides with the critical question—who pays?

I have been fortunate to have been directly involved in many of these efforts as a former Medicaid director and to have worked closely with the reforming states in my service over the past several decades with the National Academy for State Health Policy. Enactment of Medicaid in the 1960s was arguably the beginning of state health reform, although the initial wave of state *initiated* reform began in the 1970s when Hawaii enacted the first mandate requiring most employers to offer health coverage, advanced soon after President Nixon's health reform—that included a similar provision—had failed. In the decade of the 1970s the first high risk pools were created. In the 1980s Washington State established the subsidized Basic Health Plan, Massachusetts enacted the Health Security Act and Oregon created the Oregon Health Plan. Children's health plans began in Minnesota and Vermont.

By the early 1990's 46 states had adopted insurance reforms, children's health programs grew in other states and Medicaid waivers yielded Arizona Access, TennCare and RiteCare, Medicaid managed care based programs to expand coverage. Each of these initiatives had their advocates and detractors, some failed, some changed, most held on in some form but following the failure of the Clinton health plan in the early 1990's state action again stalled and states were in the ebb of a third wave of reform.

In 2003, Maine led the fourth wave with the establishment of our Dirigo Health Reform. Our approach was comprehensive health system reform, focusing on affordability and driven by Maine's per capita health spending, which ranks the second highest in the U.S.,by then the highest rates of uninsured in New England, decline in employer sponsored plans and by limits in state budget capacity. In 2002 state and local revenues in the United States had the slowest growth since records were kept. Absent any sustainable, new sources of revenue, Governor Baldacci sought to achieve health reform by improving the efficiency and effectiveness of the health care system. By improving the system's efficiency, savings would be created and reinvested in health care access.

Clear goals are important: "Covering the Uninsured" is not the same goal as "making sure every man, woman, and child has access to affordable, quality care".

Covering the uninsured generally implies that we will find adequate financing to bring those now without coverage into the insured tent—covered through one or more of the myriad of coverage options available today or by creating special plans for the uninsured. Such an approach generally accepts the status quo in how care is delivered and coverage provided. But with growing pressure on the affordability of our employer based system, more costs are shifted to employees andcoverage can become less comprehensive. As a growing number ofpeople use more of their incomes for sometimes less coverage, more people are *under* insured—forestalling needed care for fear of incurring out of pocket costs they cannot afford. And the literature is filled with data documenting concerns with quality of care. Our goal of assuring every man woman and child has access to affordable; quality care seeks to provide health security for all—those without coverage; those with inadequate coverage and those who fear rising costs will jeopardize their coverage.

Numerous studies have documented that the U.S. spends far more than other developed nations yet we leave 47 million uninsured and do not achieve better health outcomes or quality for that additional investment. In fact, we pay for redundancy, inefficiency, variation and oversupply. Recently, McKinsey Global Institute published "Accounting for the Cost of Health Care in the United States" that concludes

that even after adjusting for its higher per capita income levels, the United States spends some $477 billion more on health care than peer countries.

McKinsey notes that higher health spending in the U.S. is not explained by higher disease burden but by these factors:

1. Higher input costs—salaries, drugs, devices and profits, (e.g.: we use 20% fewer drugs yet pay 50–70% more for them and we are the largest consumers of medical devices in the world).
2. Inefficiencies and complexity in the system's operational processes (eg: we have 3–6 more scanners than Germany, UK, France and Canada).
3. Costs of administration, regulation and intermediation of the system.

McKinsey's study reinforces Maine's approach to comprehensive, system reform, stating "most components of the U.S. health care system are economically distorted and no single factor is either the cause or the silver bullet for reform".[1] While it is unlikely that Americans, who value choice, will adopt all the provisions that make other countries' health care more affordable, unless Americans are ready to embrace higher costs and a greater investment of our GDP in health, then the cost issues must be addressed head on.

In crafting the Dirigo Health Reform, Maine's strategy was to affect cost, quality and access together, reflecting our conclusion that we had an inefficient health care system which led to unaffordability of health insurance and a growing number of people who were under- and uninsured.

We built the program by expanding Medicaid for the poorest of our citizens, establishing a subsidy program for those just beyond Medicaid eligibility; launching comprehensive activities to improve health and reduce the costly burden of chronic disease; creating the Maine Quality Forum to remediate costly variation in the system; initiating a variety of cost containment mechanisms; requiring medical loss ratios in the small and non-group markets; increasing transparency through price posting and standardized reporting by insurers and hospitals; supporting electronic medical record diffusion; strengthening certificate of need; establishing a capital investment fund as an annual budget for new capital investment and facilitating collaboration among providers.

Our cost containment goal is to assure coverage remains affordable for those who buy it privately but subsidizing health coverage remains a tool to meet the affordability gap for those with lower incomes. The foundation of Maine's coverage expansion was Medicaid. From that base we built a sliding scale subsidized insurance plan, DirigoChoice, targeted to those 3 times the poverty level who were employed in small businesses with fewer than 50 emplyees,were sole proprietors or individuals—categories that include the majority of uninsured—and built the reform on the employer based system. Specifically, the plan pooled small businesses to achieve economies of scale and purchasing power and adopted medical loss ratios in the small group and individual market to help make those markets more affordable. DirigoChoice is a voluntary program, recognizing that unless and until insurance became more affordable, mandates would not be tolerated. The program is financed through an assessment on insurers and those who administer self—insured plans that can only be levied if Dirigo's comprehensive reforms result in documented savings

When the Dirigo Health Reform began in 2003, Maine had the highest rate of uninsured in New England. In the years following, as Medicaid expansions took hold and DirigoChoice became the fastest growing product in the marketplace, every New England state saw its rate of uninsured increase; only Maine saw its rate fall to the lowest in the region by 2006.

But our progress has stalled, lacking adequate financing. While $110 million in savings has been independently documented since the program began, those savings have been contentious, subject to court challenge and highlight the complexity of cost containment in health care. Payers of the surcharge assert that reducing the rate of growth of health care costs is not the same as cost savings. The Legislature enacted alternative financing this session, including taxes on beer, wine and sugared beverages, but this alternative is also being challenged.

Politics Trumps Policy—The process of enacting and implementing reform is as important as the reform.

To launch Maine's reform, stakeholders were convened in a Health Action Team that met often and in public to guide the Governor's office in developing the original

[1] McKinsey & Company, *Accounting for the Cost of Health Care in the United States, January 2007*; p. 19.

proposal. The Legislature created a Special Joint Committee on Health Reform with bipartisan members from the health, insurance and appropriation committees.

The reform debate played out largely between two camps—those who wanted deregulation and market based solutions like high risk pools, arguing that lower costs would assure more coverage and others who wanted more investment to sustain comprehensive coverage to cover all the uninsured. Long negotiations resulted in significant amendments to the original bill and found a middle ground that won a unanimous committee report and strong bi-partisan support in both chambers.

Both the Health Action Team and the Joint Committee were dissolved once the bill was enacted. Numerous commissions, workgroups and an independent Board of Trustees for the Dirigo Health Agency assured citizen input throughout the implementation of the reform, but each group was responsible for a part of the reform only. In hindsight, with oversight of the reform split among different legislative committees and no one single stakeholder group to provide guidance for the overall reform, a vacuum was created that allowed the parties to "return to their corners" when the inevitable implementation challenges occurred. Amendments to the original bill, that eliminated a planned global budget and a fixed assessment that could not be passed on to premium payers, reduced the ability to generate stable, predictable funding and attain the amount of cost savings initially envisioned. As the program was launched, additional revisions were required that further challenged the ability to meet enrollment target timetables developed with the original legislation and never revised. Rather than recognize that these unexpected factors would slow but not deter program enrollment, proponents of alternative strategies quickly declared Dirigo a failure and revived advocacy for their favored market based reforms, which created a challenging environment for program modification and mid-course improvements.

As Maine's experience clearly shows, enacting health reform is tough enough—few states have done so—but implementing reform is even tougher. The devil is indeed in the details and health reform is a work in progress. But to achieve that progress, all parties, with strong leadership, need to commit to it and to work together to make mid course corrections rather than to see each bump in the road as an opportunity to defeat reform.

Medicaid is a critical component for state-based reform but needs reliable, counter cyclical financing and clarity in its coverage for eligible, employed beneficiaries.

Should national health reform maintain the current employer based system, Medicaid's role will remain critical. Medicaid is the essential building block in state health reform and is of paramount concern to the states and to Congress. As states face recessions and budget challenges, Medicaid's funding formula needs to keep pace with rising costs and demand.

Since de-linking welfare and Medicaid eligibility and imposing work requirements, an increasing number of low wage and particularly part-time workers, work each day in firms large and small, and qualify for Medicaid—often ineligible for or unable to afford workplace coverage. The premium assistance provisions within the Medicaid program are difficult to administer, pay only for employee share of premium and require state match. Additional policy debate needs to address where the role of the Medicaid program ends and the role of the private employer begins. As costs escalate, private employers are increasingly reluctant to offer coverage to part-time workers and to make Medicaid eligible employees part of their workplace health plan. On the one hand, employers face difficult trade offs as the costs of health care grows. Increasingly employer—based coverage has passed more and more cost on to employees. As lower wage employees pay a larger part of their incomes for health care, we are witnessing a new and growing problem of underinsurance. But employers must balance the costs of health care against the ability to create jobs or increase wages and states need to be cautious in what demands they place on the very employers who assist in "welfare to work" programs or who, subject to state regulations they find intolerable, self insure, and abandon the consumer protections of the fully insured marketplace.

A design feature of the original Dirigo Health Reform sought to pool all revenues to the Dirigo Health Agency(employer contributions, employee contributions and others), and use those pooled state resources to match Medicaid for eligible employees and their dependents. CMS has rejected our approach, which will soon be reviewed by the courts.

The states that followed us in this fourth wave of state health reform relied heavily on Medicaid, unlike Maine which coupled system savings with program financing. Vermont accepted federal flexibility in exchange for a block grant—like approach to Medicaid. Massachusetts built its program with $400M in Medicaid funds

that had been supporting their uncompensated care. We appreciate the strength of Vermont's initiative but find the block grant approach, which abandons a long established health care entitlement program, to be counter—intuitive to efforts to expand access and, like most states, we did not have access to the Medicaid funds now supporting Massachusetts' landmark reform.

Its time for a national policy to achieve affordable, quality health coverage for all.

States serving as laboratories of innovation have gained public attention and achieved much, filling a void in the absence of national reform. The laboratories of democracy were at work testing reforms reflected in later Congressional action. Many states had adopted insurance regulations before HIPAA was enacted; had well running children's health programs before SCHIP was born and developed Patients' Bills of Rights before Congress took them up.

The many and varied state experiments have been operational since at least the early 1970's. While states have done extraordinary work to lay the foundation for reform, each state is operating relatively independently based on very different health systems, coverage and costs and reflecting different state priorities. While experimentation has generated significant reforms, it has also created state—to-state variation that may also account for fragmentation and complexity across the country which drives costs. Over three decades of state health reform, and the reams of studies and evaluations analyzing them, suggest to me that it is time to get out of the laboratory and learn from decades of state experimentation. This is certainly not to say that there will not be a role for the states in any emerging national health reform but that a national solution-and national financing—is essential. We cannot reform our health system piecemeal or even by further state by state imitative. In the spirit of federalism, the national government must commit to a national policy that achieves affordable, quality health care for all of us.

We need a national policy that makes the roadmap clear that will achieve the reforms needed to address cost and quality and to cover all of so that the U.S. can take our place as health leaders—not as the country that spends twice as much, doesn't get any better health or quality and leaves 47 million without any coverage.

There are several obvious first steps that the Federal Government can take.

Complexity and redundancy are costs in the system. Streamlining and creating a single system—that does not necessarily require a single payer—would help. The Federal Government should examine its considerable purchasing power across Medicare, Medicaid, FEHBP, Champus and others toward standardizing reporting, payment policy, benefits, eligibility and quality metrics. If states are to play a role in health care reform, they need the capacity to work in a level playing field. ERISA prohibits much creative work and even the collection of key data from self insured businesses.

In the end, then, the ultimate question remains—who pays? For those of us who believe we are already paying more than we need to through cost shifting of the uninsured and the inefficiency in our health care system, cost containment needs to be a part of any reform. But ultimately, the nation's uninsured, a growing number of under-insured and all of us who have coverage now and fear for its future, need a reliable and sustainable source of financing to affordable, quality care-that does not sacrifice the access expansions in place now—that only a strong and consistent national policy can assure.

Chairman STARK. Mr. Haislmaier.

STATEMENT OF EDMUND F. HAISLMAIER, SENIOR RESEARCH FELLOW, THE HERITAGE FOUNDATION

Mr. HAISLMAIER. Thank you, Mr. Chairman, Ranking Member Camp, and Members of the Committee, for inviting me to testify today. My name is Edmund Haislmaier, I am a senior research fellow at the Center for Health Policy Studies at the Heritage Foundation, and I have to give you the caveat that my testimony is my own, and the Foundation does not take any institutional positions on these or other matters.

I come here, having spent the last 3 years—or more, actually—working with over 18 different states throughout the country, with

Exhibit 34

The Journal of Risk and Insurance, December 1991

Market Insurance Versus Self Insurance: The Tax-Differential Treatment and Its Social Cost

M. Moshe Porat
Uri Spiegel
Uzi Yaari
Uri Ben Zion

ABSTRACT

Much resources have been expended over the years debating the tax treatment of insurance versus self insurance. This article reviews and analyzes the principal concepts and inconsistencies that have evolved in dealing with the issue of premium tax deductibility. The Internal Revenue Service considers market insurance as the only visible means of risk shifting and therefore the only one worthy of tax deductibility. It is argued that other forms of risk reduction can be equally effective in reducing risk. The social cost associated with the present tax policy that favors market insurance over other forms of pre-loss risk financing are evaluated and depicted. The implicit objective of the article is to shift the debate by refocusing on the question of an appropriate tax policy concerning risk financing, one that maximizes social welfare.

On July 27, 1989, the U.S Court of Appeals of the Sixth Circuit Court rendered its decision in the case of Humana Inc. versus Commissioner (No. 88-1403), upholding the lower court's decision that premiums paid by a parent company to its captive insurance subsidiary shall not be deductible for income tax purposes. The same court reversed the decision with regard to premiums paid by an affiliated subsidiary to a captive, allowing their deductibility. The underlying principle is based on appearance rather than economic substance. Later dubbed "the balance sheet theory," the guiding principle is the effect of the premium on the insured's consolidated balance sheet figure. If the premium is paid to a captive, there is no direct effect on the consolidated balance sheet of the parent and the wholly owned captive, there is no risk shifting, and therefore the expense is not recognized. In contrast, if the premium is paid by a subsidiary, who may insure itself with the same captive,

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assumption that exposure values are uniformly distributed over the interval $A_1 - A_0$.

The average social loss per displaced asset with insured exposure value between A_0 and A_1 is derived by spelling out equation (1):

$$L = \left(\frac{1}{2}\right)(A_1^2 - A_0^2)P_1 - 2P_0^{1/2} \int_{A_0}^{A_1} A^{1/2} dA$$

$$= \left(\frac{1}{2}\right)(A_1^2 - A_0^2)P_1 - \left(\frac{4}{3}\right)(A_1^{3/2} - A_0^{3/2})\, P_0^{1/2}.$$

Finally the last expression can be freed of parameters A_0 and A_1 by substituting their values based on equations (2) and (3): $L = 8P_0^2P_1^{-3} \{[(1-\delta)^{-4} - 1] - \left(\frac{4}{3}\right)[(1-\delta)^{-3} - 1]\}$ where the loss is stated as a function of only three parameters, the unit costs P_0 and P_1, and the effective subsidy rate of δ. This expression is strictly positive for $0 < \delta < 1$ and positive P_0 and P_1. If this is the loss per insured asset, the aggregate social loss is measured by this value times the number of insured assets in the interval $A_1 - A_0$, or, based on equations (2) and (3), in the interval $A_1 - A_0 = 4P_0P_1^{-2}[(1-\delta)^{-2} - 1]$.

Implications for Public Policy

Much resources have been expended in years of debate over the questions of what forms of self insurance schemes should benefit from tax deductibility. It is apparent from the position of the U.S. Internal Revenue Service that this tax authority considers market insurance as the only visible means of pre-loss risk reduction, and therefore the only one worthy of tax deductibility. Consistent with modern financial theory, we argue that risk reduction via self insurance can be equally effective in reducing risk and often more economic in doing so. Based on this observation, we argue that the focus of the debate should be on the question of which tax policy maximizes social welfare. Consistently, the objective of this paper is to describe the social cost associated with the present tax policy that favors market insurance over competing pre-loss risk-financing methods. The nature of that cost and its potential magnitude indicates a need to reevaluate the present tax policy with a view toward equal tax treatment for all sound methods of pre-loss risk financing. The pursuit of such a policy is likely to raise difficult questions in defining, measuring, and monitoring legitimate means of pre-loss risk financing. Nevertheless, an imperfect tax system recognizing the legitimate role of self insurance is likely to be superior to the present one which arbitrarily ignores it.

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Exhibit 35

TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATON ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT"

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

March 21, 2010
JCX-18-10

JOINT COMMITTEE ON TAXATION
May 4, 2010
JCX-27-10

ERRATA FOR JCX-18-10

Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act"

A. Refundable Tax Credit Providing Premium Assistance for Coverage Under a Qualified Health Plan (secs. 1401, 1411, and 1412 of the Senate amendment and new sec. 36B of the Code)

On page 15, Minimum essential coverage and employer offer of health insurance coverage, in the second sentence of the second paragraph, "the type of coverage applicable (e.g., individual or family coverage)" should be replaced with "self-only coverage."

B. Small Business Tax Credit (sec. 1421 of the Senate amendment and new sec. 45R of the Code)

On page 26, Small business employers eligible for the credit, in the penultimate sentence of the first paragraph, the word "less" should be replaced with "not more."

On page 28, Calculation of credit amount, in the last paragraph, the first sentence and the penultimate sentence should be deleted, and the first sentence should be replaced with two new sentences to read as follows:

> The credit is reduced for an employer with between 10 and 25 FTEs. The amount of this reduction is equal to the amount of the credit (determined before any reduction) multiplied by a fraction, the numerator of which is the number of FTEs of the employer in excess of 10 and the denominator of which is 15.

On page 29, the first two full sentences should be revised to read as follows:

> However, for tax-exempt organizations, instead of being a general business credit, the small business tax credit is a refundable tax credit limited to the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins. For this purpose, payroll taxes of an employer mean: (1) the amount of income tax required to be withheld from its employees' wages; (2) the amount of

hospital insurance tax under section 3101(b) required to be withheld from its employees' wages; and (3) the amount of the hospital insurance tax under section 3111(b) imposed on the employer.

C. Excise Tax on Individuals Without Essential Health Benefits Coverage (sec. 1501 of the Senate amendment and new sec. 5000A of the Code)

On page 33, the first full paragraph should be deleted and replaced with the following description of the limitations on administration and procedure of section 5000A as enacted:[1]

> The penalty applies to any period the individual does not maintain minimum essential coverage and is determined monthly. The penalty is an excise tax that is assessed in the same manner as an assessable penalty under the enforcement provisions of subtitle F of the Code.[2] As a result, it is assessable without regard to the restrictions of section 6213(b). Although assessable and collectible under the Code, the IRS authority to use certain collection methods is limited. Specifically, the filing of notices of liens and levies otherwise authorized for collection of taxes does not apply to the collection of this penalty. In addition, the statute waives criminal penalties for non-compliance with the requirement to maintain minimum essential coverage. However, the authority to offset refunds or credits is not limited by this provision.

On page 33, the third and fourth sentences of the final paragraph, and the accompanying footnote, should be deleted and replaced with the following three sentences:

> For employees, and individuals who are eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination of whether coverage is affordable to the employee and any such individual is made by reference to the required contribution of the employee for self-only coverage. Individuals are liable for penalties imposed with respect to their dependents (as defined in section 152). An individual filing a joint return with a spouse is jointly liable for any penalty imposed with respect to the spouse.

D. Excise Tax on High Cost Employer-Sponsored Health Coverage (sec. 9001 of the Senate amendment and new sec. 4980I of the Code)

On page 62, in the second line, "2013" should be replaced with "2018."

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[1] At page 33 of JCX-18-10, the explanation of the new excise tax that may be assessed against an individual who fails to purchase essential health benefits coverage erroneously included a paragraph based on an earlier version of the legislation. That paragraph was based on the language of the Report of the Senate Committee on Finance to accompany S. 1796, "America's Healthy Future Act of 2009." The reported bill imposed greater restrictions on collection of the penalty than the bill enacted. As a result, the limitations on administration and procedures regarding section 5000A were overstated in the JCX-18-10. See S. Rep. No. 111-89, p. 52 (2009).

[2] IRS authority to assess and collect taxes is generally provided in subtitle F, "Procedure and Administration" in the Code. That subtitle establishes the rules governing both how taxpayers are required to report information to the IRS and pay their taxes as well as their rights. It also establishes the duties and authority of the IRS to enforce the Code, including civil and criminal penalties.

E. Additional Requirements for Charitable Hospitals (sec. 9007 of the Senate amendment and secs. 501(c) and 6033 and new sec. 4959 of the Code)

On page 81, Community health needs assessment, in the fifth sentence, the words "of up" should be replaced with "equal."

F. Modification of Section 833 Treatment of Certain Health Organizations (sec. 9016 of the Senate amendment and sec. 833 of the Code)

On page 106, "sec. 9010" should be replaced with "sec. 9016." On page ii, item O, the same change should be made.

G. Study of Geographic Variation in Application of FPL (sec. 10105 of the Senate amendment)

On page 123, the last sentence in the Explanation of Provision section should be revised to read as follows:

> The territories are the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, American Samoa, and any other territory or possession of the United States.

H. Free Choice Vouchers (sec. 10108 of the Senate amendment and sec. 139D of the Code)

On page 124, Provision of vouchers, in the second sentence of the first paragraph, "9.5" should be replaced with "9.8."

On page 124, Provision of vouchers, in the third paragraph, "9.5" should be replaced with "9.8."

H. Excise Tax on Individuals Without Essential Health Benefits Coverage (sec. 1501[56] of the Senate amendment and new sec. 5000A of the Code)

Present Law

Federal law does not require individuals to have health insurance. Only the Commonwealth of Massachusetts, through its statewide program, requires that individuals have health insurance (although this policy has been considered in other states, such as California, Maryland, Maine, and Washington). All adult residents of Massachusetts are required to have health insurance that meets "minimum creditable coverage" standards if it is deemed "affordable" at their income level under a schedule set by the board of the Commonwealth Health Insurance Connector Authority ("Connector"). Individuals report their insurance status on State income tax forms. Individuals can file hardship exemptions from the mandate; persons for whom there are no affordable insurance options available are not subject to the requirement for insurance coverage.

For taxable year 2007, an individual without insurance and who was not exempt from the requirement did not qualify under Massachusetts law for a State income tax personal exemption. For taxable years beginning on or after January 1, 2008, a penalty is levied for each month an individual is without insurance. The penalty consists of an amount up to 50 percent of the lowest premium available to the individual through the Connector. The penalty is reported and paid by the individual with the individual's Massachusetts State income tax return at the same time and in the same manner as State income taxes. Failure to pay the penalty results in the same interest and penalties as apply to unpaid income tax.

Explanation of Provision

Personal responsibility requirement

Beginning January, 2014, non-exempt U.S. citizens and legal residents are required to maintain minimum essential coverage. Minimum essential coverage includes government sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and other coverage as recognized by the Secretary of HHS in coordination with the Secretary of the Treasury. Government sponsored programs include Medicare, Medicaid, Children's Health Insurance Program, coverage for members of the U.S. military,[57] veterans health care,[58] and health care for Peace Corps volunteers.[59] Eligible employer-sponsored plans include: governmental plans,[60] church plans,[61] grandfathered plans

[56] Section 1501 of the Senate amendment, as amended by section 10106, is further amended by section 1002 of the Reconciliation bill.

[57] 10 U.S.C. 55 and 38 U.S.C. 1781.

[58] 38 U.S.C. 17.

[59] 22 U.S.C. 2504(e).

[60] ERISA Sec. 3(32), U.S.C. 5: Chapter 89, except a plan described in paragraph (1)(A).

and other group health plans offered in the small or large group market within a State. Minimum essential coverage does not include coverage that consists of certain HIPAA excepted benefits.[62] Other HIPAA excepted benefits that do not constitute minimum essential coverage if offered under a separate policy, certificate or contract of insurance include long term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance or Medicare supplemental health insurance.[63]

Individuals are exempt from the requirement for months they are incarcerated, not legally present in the United States or maintain religious exemptions. Those who are exempt from the requirement due to religious reasons must be members of a recognized religious sect exempting them from self employment taxes[64] and adhere to tenets of the sect. Individuals residing[65] outside of the United States are deemed to maintain minimum essential coverage. If an individual is a dependent[66] of another taxpayer, the other taxpayer is liable for any penalty payment with respect to the individual.

Penalty

Individuals who fail to maintain minimum essential coverage in 2016 are subject to a penalty equal to the greater of: (1) 2.5 percent of household income in excess of the taxpayer's household income for the taxable year over the threshold amount of income required for income tax return filing for that taxpayer under section 6012(a)(1);[67] or (2) $695 per uninsured adult in the household. The fee for an uninsured individual under age 18 is one-half of the adult fee for an adult. The total household penalty may not exceed 300 percent of the per adult penalty ($2,085). The total annual household payment may not exceed the national average annual premium for bronze level health plan offered through the Exchange that year for the household size.

This per adult annual penalty is phased in as follows: $95 for 2014; $325 for 2015; and $695 in 2016. For years after 2016, the $695 amount is indexed to CPI-U, rounded to the next

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[61] ERISA sec. 3(33).

[62] U.S.C. 42 sec. 300gg-91(c)(1). HIPAA excepted benefits include: (1) coverage only for accident, or disability income insurance; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers' compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

[63] 42 U.S.C. 300gg-91(c)(2-4).

[64] Sec. 1402(g)(1).

[65] Sec. 911(d)(1).

[66] Sec. 152.

[67] Generally, in 2010, the filing threshold is $9,350 for a single person or a married person filing separately and is $18,700 for married filing jointly. IR-2009-93, Oct. 15, 2009.

lowest $50. The percentage of income is phased in as follows: one percent for 2014; two percent in 2015; and 2.5 percent beginning after 2015. If a taxpayer files a joint return, the individual and spouse are jointly liable for any penalty payment.

The penalty applies to any period the individual does not maintain minimum essential coverage and is determined monthly. The penalty is assessed through the Code and accounted for as an additional amount of Federal tax owed. However, it is not subject to the enforcement provisions of subtitle F of the Code.[68] The use of liens and seizures otherwise authorized for collection of taxes does not apply to the collection of this penalty. Non-compliance with the personal responsibility requirement to have health coverage is not subject to criminal or civil penalties under the Code and interest does not accrue for failure to pay such assessments in a timely manner.

Individuals who cannot afford coverage because their required contribution for employer-sponsored coverage or the lowest cost bronze plan in the local Exchange exceeds eight percent of household income for the year are exempt from the penalty.[69] In years after 2014, the eight percent exemption is increased by the amount by which premium growth exceeds income growth. If self-only coverage is affordable to an employee, but family coverage is unaffordable, the employee is subject to the mandate penalty if the employee does not maintain minimum essential coverage. However, any individual eligible for employer coverage due to a relationship with an employee (e.g. spouse or child of employee) is exempt from the penalty if that individual does not maintain minimum essential coverage because family coverage is not affordable[70] (i.e., exceeds eight percent of household income). Taxpayers with income below the income tax filing

[68] IRS authority to assess and collect taxes is generally provided in subtitle F, "Procedure and Administration" in the Code. That subtitle establishes the rules governing both how taxpayers are required to report information to the IRS and pay their taxes as well as their rights. It also establishes the duties and authority of the IRS to enforce the Code, including civil and criminal penalties.

[69] In the case of an individual participating in a salary reduction arrangement, the taxpayer's household income is increased by any exclusion from gross income for any portion of the required contribution to the premium. The required contribution to the premium is the individual contribution to coverage through an employer or in the purchase of a bronze plan through the Exchange.

[70] For example, if an employee with a family is offered self-only coverage costing five percent of income and family coverage costing 10 percent of income, the employee is not eligible for the tax credit in the Exchange because self-only coverage costs less than 9.5 percent of household income. The employee is not exempt from the individual responsibility penalty on the grounds of an affordability exemption because the self-only plan costs less than eight percent of income. Although family coverage costs more than 9.5 percent of income, the family does not qualify for a tax credit regardless of whether the employee purchases self-only coverage or does not purchase self-only coverage through the employer. However, if the family of the employee does not maintain minimum essential benefits coverage, the employee's family is exempt from the individual mandate penalty because while self-only coverage is affordable to the employee, family coverage is not considered affordable.

threshold[71] shall also be exempt from the penalty for failure to maintain minimum essential coverage. All members of Indian tribes[72] are exempt from the penalty.

No penalty is assessed for individuals who do not maintain health insurance for a period of three months or less during the taxable year. If an individual exceeds the three month maximum during the taxable year, the penalty for the full duration of the gap during the year is applied. If there are multiple gaps in coverage during a calendar year, the exemption from penalty applies only to the first such gap in coverage. The Secretary of the Treasury shall provide rules when a coverage gap includes months in multiple calendar years. Individuals may also apply to the Secretary of HHS for a hardship exemption due to hardship in obtaining coverage.[73] Residents of the possessions[74] of the United States are treated as being covered by acceptable coverage.

Family size is the number of individuals for whom the taxpayer is allowed a personal exemption. Household income is the sum of the modified adjusted gross incomes of the taxpayer and all individuals accounted for in the family size required to file a tax return for that year. Modified adjusted gross income means adjusted gross income increased by all tax-exempt interest and foreign earned income.[75]

Effective Date

The provision is effective for taxable years beginning after December 31, 2013.

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[71] Generally, in 2010, the filing threshold is $9,350 for a single person or a married person filing separately and is $18,700 for married filing jointly. IR-2009-93, Oct. 15, 2009.

[72] Tribal membership is defined in section 45A(c)(6).

[73] Sec. 1311(d)(4)(H).

[74] Sec. 937(a).

[75] Sec. 911.

CERTIFICATE OF SERVICE

I hereby certify that on the 3rd day of September, 2010, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send a notification of such filing (NEF) to the following:

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