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before the

Energy and Commerce Committee
Subcommittee on Health
United States House of Representatives

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Chairman Pallone, Congressman Deal, and Members of the Committee, I am honored to be here today to testify on the importance of assuring affordable health care for all Americans. As you well know, health reform is critical to restoring prosperity for our nation's families. Reform means reducing the crushing burden of rising health care costs on America's families, businesses, and governments at all levels. Achieving that goal requires streamlining Medicare and refocusing our health care delivery system on prevention, primary care, and treatments that work. But it also requires that everyone, all the time, have affordable health insurance—regardless of where they work, their income, their age, or their health status. Affordable health insurance is the key to a productive work force, small business innovation, and the economic as well as health security of our nation's families. My focus today is on those families: how lack of affordable health insurance undermines their health and economic security and how health reform can and must assure affordability in order to restore families'—and the nation's—well-being.

The evidence on affordability

As health care costs continue to grow faster than the economy as a whole—not to mention faster than family incomes—individuals and families have felt the pinch of escalating health spending. People feel that pinch not only in insurance premiums, but also in the payments they make toward services their insurance covers (through deductibles, copayment, and other cost-sharing arrangements) and in payments they make for services that are not covered by their health insurance policies. Affordability—or unaffordability—has to look at all three.

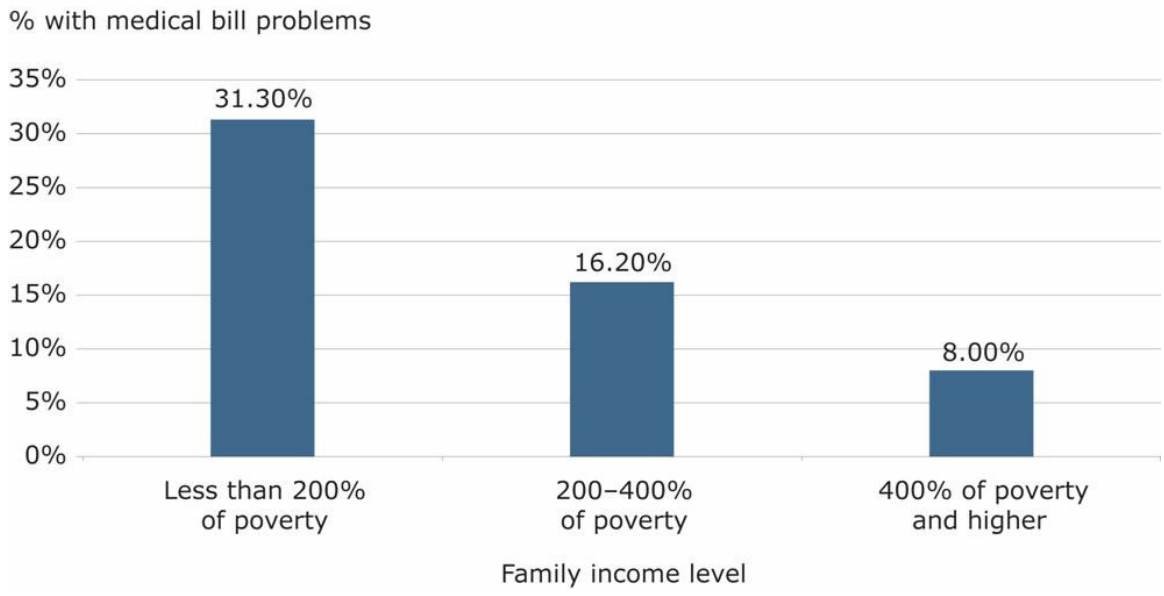
The problem of unaffordability is most apparent for the nearly 47 million Americans who lack health insurance. Roughly two-thirds of Americans without health insurance have incomes below 200 percent of the federal poverty level—or approximately $44,000 for a family of four. Most people without health insurance are workers or live in families with a worker, but do not have health coverage through an employer.[1] With the annual average cost of employer-sponsored health insurance nearing $13,000 in 2008, health insurance is clearly unaffordable for families who must purchase it on their own.[2]

Sadly, even people who actually have health insurance increasingly face affordability problems when it comes to paying for health care. Research documents that a growing number of Americans with health insurance face affordability problems for health insurance and for health care. Researchers define affordability in a number of ways. One set focuses on medical spending as a share of income, characterizing families that exceed specified thresholds as economically threatened or underinsured. For example, a recent analysis by the Commonwealth Fund identified families as underinsured if they had out-of-pocket medical spending that absorbed at least 10 percent of family income, or, for low-income adults (defined as 200 percent of the federal poverty level), at least 5 percent of family income; **or** if they faced deductibles of at least 5 percent of family income. Using these tests, the study identified 25 million adults who had health coverage as underinsured in 2007—a 60-percent increase from the 15.6 million Americans who were underinsured in 2003. [3]

Similarly, Agency for Healthcare Research and Quality researchers Jessica Banthin and Didem Bernard found that while 15.8 percent of adults spent more than 10 percent of their family income on health care services in 1996, by 2003 the proportion of adults bearing what has historically been considered catastrophic financial burdens had increased to 19.2 percent of the population, or 48.8 million individuals.[4] An additional analysis by Jessica Banthin, Peter Cunningham, and Didem Bernard also determined that by 2004, financial burdens had increased to the point that, for low-income families, private coverage no longer provided adequate financial protection.[5]

Another approach has examined affordability problems directly—exploring families' actual problems paying medical bills. According to the Center for Studying Health System Change, one in seven Americans under age 65 reported problems paying medical bills in 2003—a figure that jumped to one in five Americans by 2007. This analysis indicates that even moderate levels of out-of-pocket spending relative to family income—that is, spending that is well below the 5 or 10 percent of family income considered to be underinsured by the studies just cited—created medical bill problems. For example, two-thirds of the individuals who reported trouble paying medical bills spent 5 percent or less of their family income on health care.[6] As author Peter Cunningham noted, many families have little wiggle room within their family budgets for large or unexpected out-of-pocket health care expenses. And even a relatively low level of health care spending compared to family income can create financial stress for low-income families.(See chart below).

Burden of medical bills for families spending 2.5% or less of family income



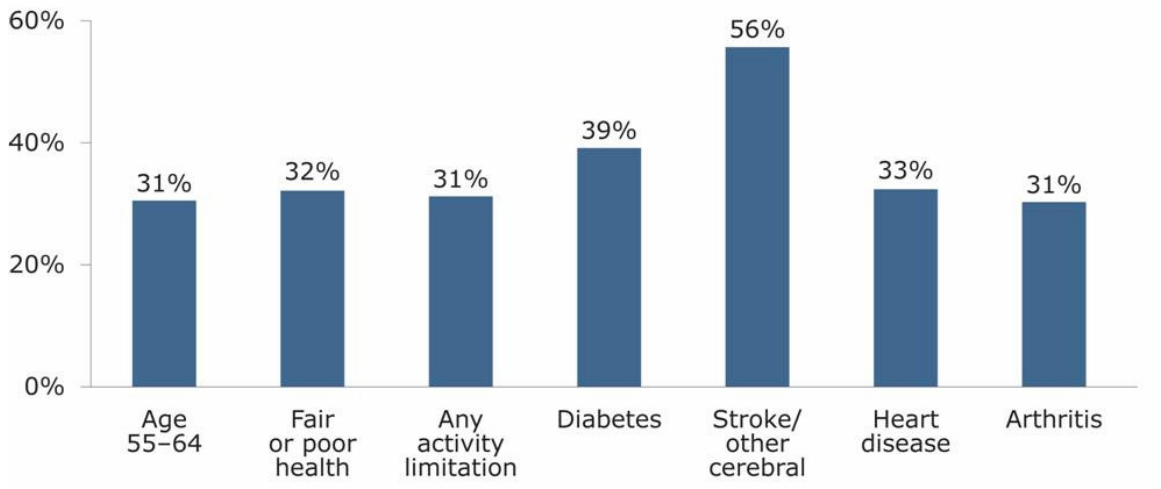
Medicaid and CHIP, established to provide special protection for low-income and modest income families, do not necessarily prevent these problems. First, no matter how low their incomes, working-aged adults who are not parents of dependent children (or are not disabled) are not eligible for Medicaid (except in states with waivers), and, in many

states, parents earning the minimum wage have too much income to qualify for Medicaid protection.

For populations they do cover, Medicaid and CHIP have been modified to give less recognition to low-income families' limited ability to absorb significant out-of-pocket health care spending. The traditional Medicaid program limits cost-sharing responsibilities to nominal deductibles and copayments for most services, and exempts children, pregnant women, and other vulnerable groups from service-related cost-sharing. The Deficit Reduction Act of 2005 made some important changes to Medicaid's traditional limitations on cost-sharing, thus exposing even some low-income children to cost-sharing that can equal 5 percent of family income. The CHIP program, which typically serves children with somewhat higher—although still modest—incomes also utilizes a 5 percent of income cap on aggregate cost-sharing.

The risk of being underinsured or experiencing financial problems due to health spending varies not only by family income but also by health status. Health care affordability is particularly elusive for individuals with chronic illness and other conditions that require ongoing, often costly, medical care. In particular, individuals who are older, have an activity limitation, have a chronic condition such as diabetes, heart disease, or arthritis, or have experienced stroke, are more likely to spend a high proportion of their income on health expenses. (See chart next page). If these individuals are not covered by an employer-sponsored health plan, or lose this coverage, their ability to purchase coverage in the nongroup market is limited at best. Far from serving as a safety net, the non-group market systematically denies coverage, limits benefits, or charges excessive premiums to individuals with pre-existing conditions or whom they perceive as likely to need care. Ironically, then, underinsurance or financial problems is most likely to arise for people who get sick—the very population that insurance is supposed to protect.

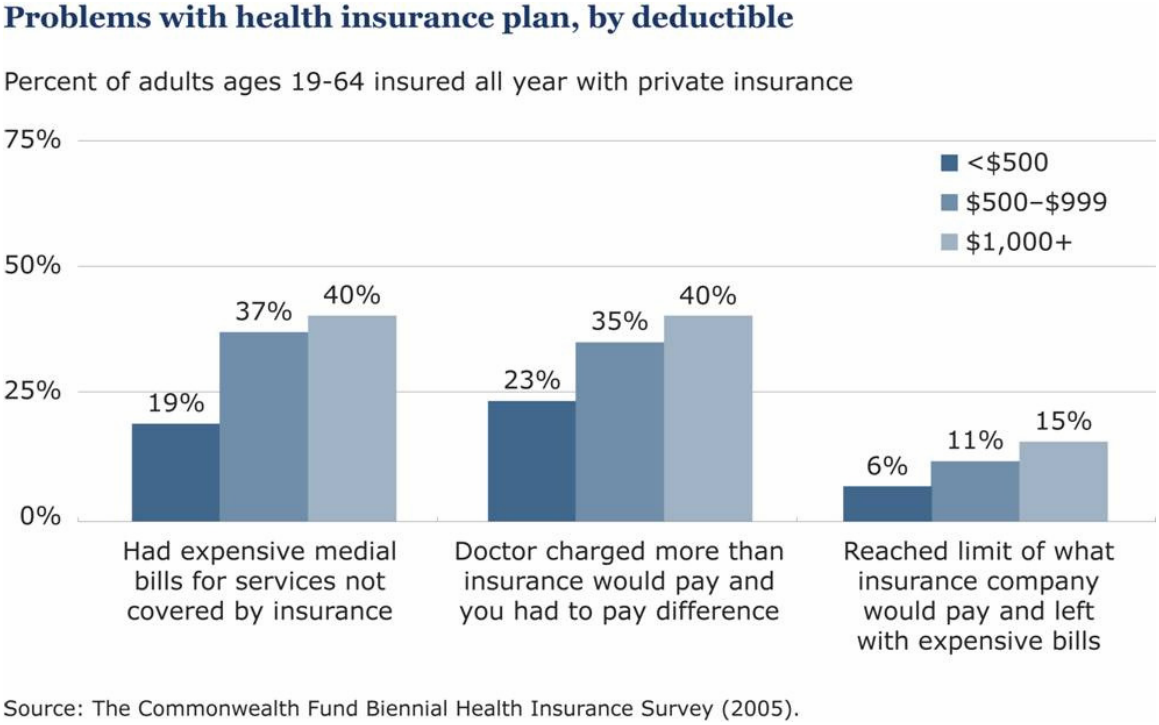
Groups at high risk of having high financial burden for health care, 2003



Note: High Financial Burden defined as families spending more than 10% of their after-tax income on health care, including premiums and out-of-pocket health costs.

Source: Kaiser Family Foundation, based on Banthin, JS and DM Bernard. "Changes in Financial Burdens for Health Care," JAMA 296(22), December 2006.

As stated at the outset, affordability problems do not reflect a single feature of insurance—its presence or absence, its premiums or its benefits. Rather they result from the interplay among various aspects of insurance design: premiums, deductibles, co-insurance and other cost-sharing, and spending on services that are not covered by health insurance. This means that insurance designs that aim to make premiums more affordable by imposing substantial deductibles or low annual lifetime benefit limits offer a false promise: They place individuals and families at substantial financial risk of facing unaffordable health care costs when they get sick. Similarly, benefit packages that constrain covered services—by excluding, for example, prescription drug or mental health benefits, placing arbitrary day or visit limits on specific benefits, or steeply tiering prescription drug cost-sharing—leave families at risk of being unable to afford necessary but uncovered services—again, undermining the very purpose for having insurance in the first place.



Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

The consequences of affordability problems

A strong and growing body of literature demonstrates that unaffordability of health insurance makes health care unaffordable and unavailable. As the Institute of Medicine recently noted, there is a chasm between the health care needs of people without health insurance and access to effective health care services. People without health insurance are more likely to delay care, to get less care, and to die when they get sick.[7]

Evidence suggests that people who are underinsured can experience very similar problems getting needed care. According to the Commonwealth Fund, underinsured individuals are two to three times as likely as insured individuals to forgo various needed medical services because of cost.[8] Of sicker underinsured adults, a full two-thirds went without needed care due to cost, including half of individuals with a chronic condition forgoing necessary medications.[9] In a recent Kaiser Family Foundation survey, concerns about affording needed medical care led insured individuals to cut back on care due to cost. Responses included postponing care (34 percent), skipping a recommended medical visit or treatment (30 percent), not filling prescriptions (27 percent), and skipping doses or cutting pills (21percent).[10]

People who are underinsured not only face the medical problems of inadequate treatment; but they also face financial problems from the treatment they actually get. High on the list is bankruptcy. Nearly half of all bankruptcies in the United States are related, at least in part, to health care expenses. And of those facing medical bankruptcies, roughly three-quarters had health insurance at the onset of their bankrupting illness.[11] Of sicker underinsured adults, three-fifths reported having been contacted by a collections agency. In a 2007 survey, respondents reported making difficult choices between using up a

lifetime of savings, running up credit card debt, skipping the purchase of other necessities, or trying to take out a mortgage.[12]

Home mortgage foreclosure, another personal financial catastrophe, is also related to health care expenses. Seven out of 10 respondents in a recent survey of borrowers in foreclosure self-reported unmanageable medical bills as an underlying cause of their foreclosure, or had experienced other medical disruptions to their income, such as lost work due to illness or using home equity to pay medical bills.[13]

Insurance that makes care unaffordable can be a problem for anyone facing serious illness, no matter what its cause. But an examination of the problems facing patients with cancer makes clear how people are dealing with overwhelming financial problems at the very point they are coping with overwhelming medical conditions. A recent report prepared by the Kaiser Family Foundation and the American Cancer Society illustrates how much people are actually "spending to survive."[14] Some patients who actually have insurance can pay more than $100,000 for their treatment because of high deductibles, high cost-sharing, and limited lifetime spending caps that shift the financial risk of care to the individual. And health insurance underwriting and rating practices leave many individuals whose cancer has been treated—like many others with significant health events or chronic illnesses—unable to obtain insurance against future illness.

Principles for assuring affordable health insurance

Assuring all Americans affordable health insurance is, in my view, the most fundamental goal of health reform. Families cannot be economically secure as long as they face financial catastrophe when illness strikes. And people cannot lead healthy and productive lives as long as they cannot afford the care they need when they get sick. Enacting health reform is a challenging task. But the concepts of affordability are straightforward. It's not enough to make health insurance affordable; affordable health insurance has to make health care affordable.

As you move forward with reform legislation, I therefore urge you to consider four basic principles.

First, keep your eye on total spending. Affordability depends not just on individual and family premium contributions, but also on deductibles, cost-sharing obligations, and other health care spending. Beware of a desire to keep premiums low by making cost-sharing high. If only some components of family health care spending "count" toward a consideration of what individuals and families can contribute toward their health care costs, some Americans—most likely those with ongoing, chronic illnesses—will continue to grapple with unmanageable and unaffordable health care expenses.

Second, benefits matter. Health insurance worthy of the name has to work for people when they are sick. Despite claims, which I'm sure you've heard, that "any insurance is better than none," insurance that leaves people without necessary protections is simply

not good enough. Adequate benefit packages with a defined set of services are another critical lynch-pin to health care affordability. If a health insurance policy doesn't cover the services people need when they get sick, it doesn't provide the financial protection Americans need and legitimately expect from health insurance coverage.

Third, affordability depends on income. Low-income families should be expected to contribute a lower proportion of family income toward their health care expenses, in recognition of their more limited ability to absorb unpredictable health care costs.

Finally, insurance must stop discriminating against sick people. Because premium prices will have a substantial effect on overall healthcare affordability, by extension so will insurance market rules that determine whether rates can vary based on people's "pre-existing conditions" or other health-related characteristics. As long as insurers can deny coverage, limit benefits or charge higher rates based on people's age or health status, insurance will remain unaffordable for people who know in advance they need its protections. Meaningful health reform cannot fail to assure that health insurance is affordable for people who have been (or whom insurers believe are likely to become) sick.

Enacting health reform is a challenging task. But achieving affordable health care for all Americans will be worth the effort. I applaud your commitment to achieving that goal and I look forward to working with you to achieve it.

Endnotes

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