

THE HISTORY AND CURRENT REALITY OF THE U.S HEALTH CARE SYSTEM

HEARING

BEFORE THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
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FIRST SESSION

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WEDNESDAY, SEPTEMBER 6, 2017

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senators Johnson, Daines, McCaskill, Carper, Tester, Heitkamp, Peters, Hassan, and Harris.

OPENING STATEMENT OF CHAIRMAN JOHNSON

Chairman JOHNSON. Good morning. This hearing will come to order.

I want to welcome the witnesses. Thank you for your testimonies. I certainly enjoyed reading it, and I am looking forward to your oral testimonies and getting into a discussion on America's health care system.

Now, earlier this morning, I attended an open, I guess, meeting with Senator Alexander and Senator Murray, who with their Health, Education, Labor and Pension (HELP) Committee are going to be holding a hearing actually at this exact moment grappling with what Congress should do to basically stabilize insurance markets: cost sharing reduction (CSR) funding, offering States some flexibility, those types of things. It was noted that 25 percent of the Senate was in attendance at that prehearing meeting, which I think gives us a pretty good sign that I think there is a strong desire to recognize that we have some problems in our health care system and those problems need some fixing, and hopefully on a bipartisan basis.

Members of my Committee have kind of asked some questions: "You do not have jurisdiction over health care. Why would you hold health care hearings?" We do have oversight jurisdiction over certainly government health care programs, and that is certainly part of it. But, I come from the private sector. I have solved an awful lot of problems, and I know my fellow Committee Members have heard me say this repeatedly. There is a process you follow in terms of solving a problem. You define the reality. You describe the problem, define the problem. It starts with a lot of information. Then you set yourself achievable goals. Once you have gone through that robust process, then you start designing solutions.

Unfortunately, what I have witnessed here in Washington, D.C., is people hop right to the legislation and they start fighting over what their legislative solution is, and we are often void of an awful lot of information. I kind of witnessed that during our whole effort to repeal and replace Obamacare.

So, seeing as that effort failed, we are what we are. We have certainly some real issues, and what I would like to do is use the hearing of this Committee to lay out that problem-solving process, gather the information, do it in hopefully a very thoughtful, hopefully very bipartisan fashion. Facts are facts. Hopefully we can agree on the reality, the fact-based definition of the problem. Where we do not necessarily agree, we should probably get that on the record as well. But, I just basically want to build up that record, and that is really the purpose of this hearing and hearings in the future.

In preparation for this, we have been gathering an awful lot of information, quite honestly, over a number of months, and we have put together for this hearing just a group of charts that we have developed on the basis of that information gathering, and I would just kind of like to highlight a couple of them, starting with page number 1, because I think—and this really does not have anything to do with health care, but it has everything to do with health care. The financial condition of America. We are currently \$20 trillion in debt. Over the next 30 years,¹ according to the Congressional Budget Office (CBO), our accumulated deficits will exceed at least \$100 trillion. We have taken CBO's percentage of gross domestic product (GDP), and we have converted it to dollars. I have actually been PolitiFact'd on this. We are using a 2015 model. It is really whatever it is, only \$107 trillion it is massive over the next 30 years as the baby-boom generation retires and we do not have enough people paying into these programs.

So, we have huge deficits, and how does this relate to health care? By the way, who is doing our charts here?

OK. Put up chart 2² on page 2?

The reason health care falls into this is, in my written testimony—which, by the way, I would ask consent to be entered into the record.³

Medicare, Medicaid, and Obamacare represent \$87 billion out of a total outlay of about \$328 billion. About 26.5 percent of all the outlays over the next 30 years are in Medicare, Medicaid, and Obamacare.

If you take a look at what drives the deficit, over 30 years \$129 trillion is comprised of about \$18 trillion of Social Security benefits—in other words, we are going to be paying out \$18 trillion more in benefits to Social Security than we bring in through the payroll tax; Medicare, about \$39 trillion. The Urban Institute did a study a number of years ago that said that for every \$1 that is paid into Medicare through the payroll tax, beneficiaries get \$3 in benefits. It is a program that is just simply not sustainable. Interest on the debt is about \$65 trillion.

¹ The chart referenced by Senator Johnson appears in the Appendix on page 73.

² The chart referenced by Senator Johnson appears in the Appendix on page 74.

³ The prepared statement of Senator Johnson appears in the Appendix on page 41.

So, if we do not want to pay our creditors \$65 trillion in interest payments over the next 30 years, we do need to address the deficit in Social Security and Medicare and just the entire Federal Government.

If you want to hop to page 10, when the staff put together this chart, to me it was pretty stunning. All this shows is that health care spending from 1960 until 2015 has gone from \$27 billion to \$3.2 trillion.¹ Now, had that spending just grown by the rate of inflation, we would be spending a little more than half a trillion dollars a year.

So, one of the things I would like this Committee to explore—and I might ask witnesses whether you have seen any studies on this—that is a differential of \$2.66 trillion. What is that comprised of? How much of that \$2.66 trillion of increase over inflation in health care spending is just due to advances in medicine? Obviously, we can do a whole lot more today than we could in 1960. But, how much is that through a very inefficient financing mechanism? How much of that is because of all the middlemen now with a third-party payer system has that added to our health care expenditures? I think that is kind of a table stakes piece of information that we need to try and glean.

If you turn to page 11,² who pays? And, here you can see the progression over time. Back in the 1940s the vast majority of health care expenditures was paid for directly by patients. There was a lot of consumer payment, a lot of consumer involvement in terms of what they pay in health care. Of course, there was not as much stuff to buy, but they were really involved, and over time you can see that the third-party payer system has really taken over so that today—and this is chart 12,³ and I am going quicker than my staff can replace those charts. Today only 11 cents of every health care dollar is paid for directly by the patient; 89 percent is either paid by government or insurance, the third-party payer.

So, I always look at this as one of the root causes of our problems is we have separated the consumer of the product from the direct payment of the product. We have removed the benefits of consumer-driven price competition out of health care. Not only do we not care what things cost; we do not even know what they cost.

We were just in the meeting with Senator Alexander and Senator Murray, and a lot of people were talking about price transparency. Well, when people have got to pay something themselves, they are going to demand price transparency. Right now we do not have it. So, about the only people that know what something costs is the accounting department of the provider and the accounting departments of insurance companies. That has to change. Consumers really need to know what things cost.

The last two charts I just want to highlight are on pages 24 and 25, and this really talks about premiums.⁴ This is a chart I honestly developed as we went through within the Republican conference our whole effort of what we are going to do with Obamacare, and it was frustrating to me that CBO scores were

¹ The chart referenced by Senator Johnson appears in the Appendix on page 82.

² The chart referenced by Senator Johnson appears in the Appendix on page 83.

³ The chart referenced by Senator Johnson appears in the Appendix on page 84.

⁴ The chart referenced by Senator Johnson appears in the Appendix on page 96.

talking about premiums going up 20 percent to the baseline 10 percent, and then the third year, 30 percent below, and nobody knew what that actually meant in dollar terms. So, I just put this chart together to try and show my colleagues what that actually meant. But, I think this is an important chart because if you take a look at the bottom line, that was the baseline in terms of premiums prior to Obamacare. In 2013, on average—and I believe this relates to a 40-year-old male. On average, nationally, somebody would be paying \$232 per month. A couple of years into Obamacare now, that average has increased, according to a Department of Health and Human Services (HHS) study, 105 percent, up to \$476. And, if you just grow that baseline—CBO does not tell us what baseline they are actually comparing it to, so we had to make some assumptions, grow that based on consumer price index (CPI) medical. You can see really what the Republican Senate bill, what little it did to bring those gross premiums down. And, the reason I concentrate on gross premiums, by the way, is because we are talking about CSR payments; we are trying to stabilize the market. But so much of our discussion was about government funding to bring down net premiums, which means that for every \$1 premiums have increased on a gross level, the American taxpayers are picking that up, or individuals, the forgotten men and women in health care who are not getting subsidies, do not get any cost sharing, they cannot afford coverage because their premiums have doubled. In Wisconsin, oftentimes I have heard people say premiums have tripled or more. So, I think our focus as we move forward has to be on gross premiums. What can we do to stabilize the markets, bring those down?

And, the final chart¹ is a McKinsey study commissioned by HHS, and this was quite disappointing to me. This information, I just have to say honestly, was being suppressed. A whistleblower had come to my office that this study was done, this information was available in May, and we could not get it. We finally had to write some letters, threaten to make those things public before I got this information.

Now, it is a limited study, but it is the kind of information we need. This one chart only shows one State. The study had four. This State is Tennessee, and what it shows, again, for a male 40 years of age, prior to Obamacare, they were paying about \$104 per month in health care premiums. As of 2017, that insurance premium had increased 3.14 times, 314 percent, had gone up to \$431. And, they explain what caused that, what elements of Obamacare caused premiums to more than triple in Tennessee for that 40-year-old male, and 73 to 76 percent was because of increased risk, which was guaranteed issue and community rating.

Now, we ignore that basic reality at our own peril if we are actually going to try to solve the problem. Now, I realize how popular guaranteed issue and community rating is. I think the good news from my standpoint by examples in Maine—I just read an article in the New York Times, with Minnesota, things like invisible high-risk pools. We had a high-risk pool in Wisconsin. It was not perfect. But, if we start looking at those things, recognizing what has

¹ The chart referenced by Senator Johnson appears in the Appendix on page 97.

caused these premiums to double nationally, triple in many cases, maybe we can start finding some solutions.

So, again, I will end my comments here, but hopefully what I have demonstrated is here is some information. I am not saying it is perfect. I want to encourage the Members of this Committee to provide more information focused on finding areas of agreement on the definition of the problem so we can actually move forward, because my belief is if we can agree on what the problem is, if we can really define it properly, I think it is going to be a whole lot easier finding common ground on a bipartisan solution, which I think we just realized now we are going to have to find bipartisan solutions, probably in multiple iterations of this thing going into the future.

So, again, I want to thank the witnesses. I want to thank Committee Members for attending, and I will turn it over to our Ranking Member, Senator McCaskill.

OPENING STATEMENT OF SENATOR MCCASKILL¹

Senator MCCASKILL. Thank you, Mr. Chairman. I am glad we are having this hearing today. I am even more excited about the hearing going on in the HELP Committee this morning. Many of us have said from the beginning of the year that the way to get at this was an open hearing process where people can contribute and we can find the way—"regular order" is short-cut for "finding the middle." It is an elegant way of—"regular order" does not mean anything to most Americans, but "finding the middle" means something to them. And, the way the Senate has worked over the years is there has been a group on the far right that has been left behind and a group on the far left that has been left behind, and about 60 to 70 folks in the middle hammered out some kind of common-sense compromise that did not make everybody happy. That is what has been missing in this effort so far, and I am encouraged—I think we have wasted a lot of time and a lot of angst and uncertainty for Americans getting to this point.

So, first, even though I think this is unusual to have this kind of hearing in this Committee, I want to applaud your motivation because I do think you understand that we are not going to get there just with those on the opposite ends of the spectrum. We have to find the middle.

I also acknowledge that we have made some mistakes in the way that we passed the Affordable Care Act (ACA). It became political the minute the final vote was tallied and it was all one party. And, we are never going to have an accepted health care solution in this country if it is just one party or the other. It is too easy to make it into a political football. It is too easy to try to win or lose elections around it when it is just one party. And so, I think that we tried to come up with a plan that would allow people who could not get insurance—and make no mistake about it, the increase in premiums was going on before the ACA. It was double-digit every year. Every small business—you are aware of this because you were probably buying insurance for your company. It was going up every year before the ACA, and those premiums were getting hi-

¹ The prepared statement of Senator McCaskill appears in the Appendix on page 42.

jacked, and in most States that were trying to do some kind of high-risk pool for those who were being shut out of the insurance market, they simply were not working. They were excessively unaffordable. That certainly was the case in my State.

So, we now know that we have the uninsured rate at a historically low level. You have one chart that talks about the increase in insurance, but there are not really a lot of charts in here that say that we have a historic low uninsured level.

Chairman JOHNSON. There is one in there.

Senator MCCASKILL. There is one. It is kind of hard to read.

Chairman JOHNSON. And, we will add to it.

Senator MCCASKILL. Yes, I mean, I found it. It was bar graphs that are a little hard to read.

Chairman JOHNSON. It is really not intended to be hidden, but, again, we will build on this.

Senator MCCASKILL. OK. All right. And then, the other thing is, about your graph I wanted to ask this question: In the government pays part, are you including the payroll taxes that individuals are paying for Medicare in that figure?

Chairman JOHNSON. First of all, understand that taxpayers pay all of this. I mean, individuals pay for all of this.

Senator MCCASKILL. No, I understand.

Chairman JOHNSON. It is just, how is it done indirectly.

Senator MCCASKILL. Yes, I understand. I think it would be helpful for us to get a graph of how much we are paying out in Medicare is actually supported by the people that are receiving Medicare through payroll taxes, the taxes they have paid in, and how much of it are we actually going in the hole for. I think it would be really helpful for us to know how out of whack is the actuarial numbers in terms of what people are paying into the Medicare system and what the government is paying out.

Chairman JOHNSON. But, again, what I am saying, Americans pay for 100 percent of this. It is just like we do not pay—so this is who pays directly for it.

Senator MCCASKILL. Right.

Chairman JOHNSON. Who is the payer of, let us call it, “last resort”?

Senator MCCASKILL. Exactly. So if, in fact, we have somebody who decides to buy a Harley Davidson motorcycle instead of buying health insurance, and we have no mandate for that man to buy health insurance, and he has traumatic brain injuries on that motorcycle, we all pay because it all comes through higher premiums. So, doing away with the individual mandate, I think it would also be helpful to look at what impact that has on how much more everybody is going to have to pay, because when we do away with that personal responsibility piece that we require with car insurance, then all we are saying is you get to choose that other people pay for your health care, because you know you get bankrupt in 10 minutes with some kind of severe diagnosis.

So, I think these are really helpful. I think there are a lot of other charts we need to look at if we are really going to get our arms around this issue.

I do not think I can finish my opening without talking about the urgent concern we have immediately in front of us, which is stabi-

lizing the individual market. In less than 2 months, Americans are scheduled to begin enrolling in 2018 plans. That is why I wish we would have started this much earlier, because this is really impacting people's lives. They are going to have to sign up. And, I just finished 25 town halls in my State, and I can tell you people are very worried. And, they understand that one of the reasons these premiums are going up is because the cost-sharing payments are not being made. They understand that advertising is not going on for healthy people to sign up for the markets. They understand that they are paying a higher bill because of these things. And, it is inexcusable that we are tagging them with this kind of increase in premium when it is all avoidable in the short term if we could get busy in the next 30 days and do the basic step that needs to be done on both cost sharing and acknowledging that until we have some other way to get healthy people into the pool, just unilaterally doing away with enforcing the individual mandate just means higher costs for everybody. That is all it means. And, it allows somebody to decide not to buy it, and then they surf off of all of us, and that is just not fair to many Americans who are paying, especially those who do not qualify for subsidies that are on the individual markets.

I certainly understand and agree with you that transparency is really important we get to work on that. You and I are in total sync on that. I tell this story, but it is a true one. I had my knee replaced as a U.S. Senator, so I thought it would be a good exercise—Americans are great shoppers. I know when an outlet mall is BS, when an outlet mall is really not outlet mall prices, they are just, kind of pretending they are, because I am a pretty good shopper. I mean, Groupon has been wildly successful because Americans love coupons. But, you cannot figure out what you pay for anything in health care, and so, when I had my knee replaced, I thought I would try. So, I did not let my staff call. I called myself, after my surgery was over, and I called my surgeon, I called the hospital, and I called the insurance company. And, I just asked a simple question: "What did it cost to replace my knee?"

Well, you would have thought I asked them, "Where is the Holy Grail located? And, can I get there in a week?" This was a very stumping question for them. They were stumped. They did not know what to tell me. The insurance company did not know what to say. The doctor did not know what to say. The hospital did not know what to say. I kept pressing them for numbers. I finally ended up with some numbers, and none of them matched.

So, if I cannot figure out what a knee replacement actually costs as a sitting U.S. Senator, what shot does the American consumer have? Why do we have apps? I can go online right now and find out where the best cheeseburger is within a 1-mile radius of where I sit. But, I cannot figure out what a knee replacement would cost. And, by the way, am I getting the right artificial joint or am I getting that joint because the doctor has a deal with the artificial joint replacement company? Why am I paying \$60 for a pill in this location and paying \$600 for a pill in that location?

It is crazy the way we have made this system so secret in terms of what hospitals are paying, what insurance companies are paying, and what people who do not have insurance are paying. And,

I agree with you. If we could work together and at a minimum come up with some kind of mandatory transparency on medical pricing, then that is the first step in making the American shopper in control of health care. And, once we do that, you are right, costs will come down. And, I certainly agree with you on that.

Thank you to the witnesses for being here. I look forward to your testimonies and questions.

Chairman JOHNSON. So, I think right there you are seeing an awful lot of areas of agreement, which is what we will focus on. And, again, this is just the starting point. I welcome additional information, provide charts, graphs, and information. I want to build that into the record.

Just so you understand, on the whole issue of CSRs, I was very vocal.

Senator MCCASKILL. You were.

Chairman JOHNSON. When we began the process, we should have funded those CSRs because that is hurting everybody. And let me make this point publicly because it is important, because there is pretty harmful rhetoric on my side of the aisle saying, "We are not going to bail out insurance companies." The truth of the matter is we either spend money on CSRs to stabilize the market or we will spend money on the increased premiums the insurance companies will charge. And, the forgotten men and women I have spoken an awful lot about, the people that Bill Clinton talked about that are busting it, working 60 hours a week, they have seen the premiums doubled, tripled in some places. You have seen the coverage cut in half. They will not be able to afford insurance.

So, I have been supportive of funding that, but also hopefully everybody recognizes on my side, if we do not fund that, the government through the mandatory Obamacare will fund higher premiums. I do not know the exact dollar for dollars. It is probably pretty close to dollar for dollar, quite honestly.

So, anyway, this is all about finding those areas of agreement, and hopefully we can do it over the course of a number of hearings here.

With that, again, I want to welcome the witnesses. It is the tradition of this Committee to swear in witnesses, so if you will all stand up and raise your right hand. Do you swear that the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. THOMASSON. I do.

Ms. BAICKER. I do.

Ms. CORLETTE. I do.

Chairman JOHNSON. Please be seated.

Our first witness is Dr. Melissa Thomasson. Dr. Thomasson is the Julian Lange Professor of Economics at Miami University. Her work on the economic history of health insurance and health care has been published in top journals and featured in the New York Times, the Financial Times, and other news outlets.

And, just for the record, what I have asked the witnesses to do is lay out the history, lay out the reality, lay out facts. I have not asked for any solutions to this. We are a long ways from really getting solutions. And, by the way, reading their testimony, they did a great job of that.

So, again, Dr. Thomasson, if you will begin.

**TESTIMONY OF MELISSA THOMASSON, PH.D.,¹ PROFESSOR
AND DIRECTOR OF GRADUATE STUDIES, DEPARTMENT OF
ECONOMICS, MIAMI UNIVERSITY**

Ms. THOMASSON. Thank you. Good morning, Chairman Johnson, Ranking Member McCaskill, and Members of the Committee. My name is Melissa Thomasson. I am the Julian Lange Professor of Economics at Miami University, and I want to thank you for the opportunity to appear here today to discuss the evolution of the health insurance market and its effects on health care costs in the United States. This is obviously a brief summary of my remarks, and more detailed discussion can be found in my written testimony.

We know that over half of Americans obtain their insurance through their workplace. While historiography suggests that this development occurred as a result of a series of rulings during World War II, the market actually centered on employment much earlier, beginning in the late 1920s. At the time, medical technology was advancing, and more people started being treated in hospitals. As a result, their health expenditures rose, and they started having trouble paying their bills.

Yet even though health expenditures were rising, traditional insurance companies refused to offer health coverage because they feared it would not be profitable if only sick people bought the insurance. That is, they worried about the same problem that we worry about today: adverse selection.

But, consumers at the time were not the only ones struggling. Hospitals were struggling, too because patients were having trouble paying for their care. An enterprising hospital administrator, seeking to increase revenues, came up with the forebear to Blue Cross plans, and he offered Dallas teachers the opportunity to pay \$6 per year and have up to 21 days in the hospital covered. The plan was simple. In any given year, the revenues collected from the premiums paid the bills of the few people likely to be hospitalized. The plan succeeded because most of the people who bought the coverage were healthy enough to work. By offering insurance to groups of healthy workers, the plan mitigated the problem of adverse selection. Soon commercial insurance companies began offering their own plans and competing with Blue Cross and Blue Shield (BCBS).

Now, government policy in the 1940s did cement the employer-based system that had earlier taken root. Fringe benefit packages were exempted from wage and price controls enacted during World War II, so employers turned to them to recruit workers. The government further encouraged firms to offer health insurance by providing employer-sponsored health coverage with favorable tax treatment. This so-called tax subsidy introduced a number of distortions into the market. For example, it makes it difficult for people without jobs to get coverage. Moreover, it induces health insurance plans to be more generous and to offer more complete coverage. And, as we have seen, over time coverage has become much more comprehensive. The share of health care expenses paid by

¹ The prepared statement of Dr. Thomasson appears in the Appendix on page 45.

consumers has decreased from 65 percent in 1950 to 12.4 percent today. And, as out-of-pocket costs have fallen, consumers have responded by increasing their use of medical care.

This situation, that economists call “moral hazard”, is problematic if the health care consumers purchase is not necessary or cost-effective. Moral hazard is significant. Research suggests that up to 50 percent of the increase in health expenditures between 1960 and 1990 can be explained by the spread of health insurance. But, cost sharing does reduce moral hazard. For example, the RAND Health Insurance experiment found that people enrolled in a high-deductible health plan (HDHP) spent 30 percent less on medical care than those who received their care for free.

The billing practices initially designed by Blue Cross and Blue Shield exacerbate moral hazard. These payment mechanisms, that still predominate today, reimburse physicians and hospitals for each service they provide. As a result, physicians and hospitals have incentives to perform as many services as possible. Insurance pays the bill, so neither consumers nor providers have incentives to weigh costs and benefits. The result is that consumers often receive care that is not cost-effective, may be unnecessary, and leads to escalating health care costs.

Expanding insurance also creates incentives for increased technological development, and while some technologies are good, some do not improve outcomes compared to existing treatments, yet cost more. Again, since consumers are not paying the bill and providers are paid, these technologies end up being adopted and further drive up health care costs.

History suggests that the problem of adverse selection presents a longstanding challenge to the effective provision of insurance in the non-group market. It also indicates that constraining cost growth will be difficult as long as health care providers profit from providing volume-based care. Research shows that consumers do respond to cost sharing by significantly reducing spending both in the short run and over time, but that high-deductible plans need to be carefully structured to motivate consumers to obtain necessary and high-value care, while at the same time minimizing the use of low-volume services.

Thank you.

Chairman JOHNSON. Thank you, Dr. Thomasson.

Our next witness is Dr. Katherine Baicker. Dr. Baicker is the Dean of the University of Chicago Harris School of Public Policy. Her research on health care policy has been published in top journals such as the *New England Journal of Medicine* and the *Quarterly Journal of Economics*. Dr. Baicker.

TESTIMONY OF KATHERINE BAICKER, PH.D.,¹ DEAN, HARRIS SCHOOL OF PUBLIC POLICY, THE UNIVERSITY OF CHICAGO

Ms. BAICKER. Thank you so much for the opportunity to meet with you today and discuss this really important issue. Dr. Thomasson did a wonderful job of laying out how we got to this situation where so much of our health care is insured and where there is a disconnect between the quality and value of the care that we are getting and what we are paying for it.

There is very little debate that we spend a lot of money on health care, much more than our trading partners and other developed countries, and that we are not getting as much value out of the system as we ought to. You can do international comparisons. You can even look within the United States. And, for example, the parts of the country where we spend the most per Medicare beneficiary are the parts of the country where those beneficiaries are the least likely to get high-quality, high-value care. It is that disconnect that suggests that we really could do better, we could get a lot more health for every dollar that we spend.

So, what is driving this inefficient use of health care resources that we can ill afford over the long run? Well, it is the way we finance health care. It is how we pay for it. I am an economist, so there are always two hands here. It can be supply and demand or the patient side and the provider side, maybe costs and benefits. It is very useful to have both hands.

On the patient side of things, there is this a disconnect between the cost that the patient sees for insured care and how much resource use there really is for that care.

Now, that seems like a problem, but it comes from a balancing act inherent in providing insurance value. Insurance is a really good thing to have. When health care is potentially catastrophically expensive, you need to protect yourself against financial ruin if you or a family member falls sick. And before we had Medicare, seniors who fell ill and had not been able to get insurance from their employers were likely not only to go without the care they needed but to be destitute and to bankrupt their families. So, the insurance protection that insurance provides is really valuable, but it comes at the cost of the moral hazard that was outlined. When you have insurance, you get less sensitive to the price of things. You think that a service is worth it if it is worth the \$10 co-pay, not if it is worth the real resource cost, which could be hundreds of dollars. We are very good shoppers as Americans. But, we do not think, "Hey, after the hearing, do you want to go get magnetic resonance imaging (MRIs)? I heard they are on sale." No, of course, we do not shop for health care that way. It sounds counterintuitive that prices would affect how we go about buying health care. But, we are sensitive to prices, and the fact that we are paying a small fraction of the cost of the health care services that we use really does drive us to use more care. There are decades' worth of evidence that that is the case, that when we pay less, we use more. So, there is a balancing act. You want to insure things because you do not want to risk financial ruin if something really expensive happens. You do not want to overinsure them because then you end

¹The prepared statement of Dr. Baicker appears in the Appendix on page 54.

up using more care that is of questionable health value. That extra care actually drives up the cost of health care for everyone, because insurance premiums rise to cover all this care that is of questionable health value.

So, the right answer is balancing those two things and designing nuanced cost sharing in a way that gives patients the protection they need, but does not encourage use particularly of low-value services. Moral hazard suggests that you want to have higher co-payments for things that patients are more sensitive to the price of.

There are psychological factors as well. When patients make decisions about health care, it is in the real world, and none of us is a perfectly rational economic agent. So, you may also want to have higher co-payments for services that are of lower value. You may want to subsidize preventive care or low-cost preventive care that is really cost-effective. You may want to have higher co-payments for that third MRI that is not really indicated medically, that is not improving your health, that is driving up expenses for everybody.

Having more innovation in insurance coverage, having competition between insurers to drive down premiums by offering a higher-value product could help produce a better use of health care resources.

Now, that is the patient side of things. On the provider side of things, it turns out that providers are human beings as well, and they are also sensitive to the incentives that they face. When providers are paid more for a service, they do more of it. When they are paid less for a service, they do less of it. So, the way we purchase health care from providers also drives utilization. For example, we could have incentives for innovative payment structures to providers so that the provider chose the joint for your knee replacement based on which one was the highest value, the highest quality, and the right joint for you, not the one that was most highly reimbursed or where they had the best deal with the manufacturer. That would be a better way to pay for health care than fee-for-service (FFS) that is based strictly on the quantity of care. We want competition to drive higher-value care by providing the right services that the patient really values.

Now, both those mechanisms on the patient side and the provider side rely on there being real choices for people. If there are not choices among insurers, we are not going to get innovation. If there are not choices among providers, we are not going to drive prices down and quality up. So, how we finance the system is going to be a major determinant of the value and health that we get and the financial sustainability of the system.

Chairman JOHNSON. Thank you, Dr. Baicker.

Our final witness is Sabrina Corlette. Ms. Corlette is a research professor at the Center on Health Insurance Reforms at Georgetown University's Health Policy Institute. She has published numerous papers relating to the regulation of private health insurance and health insurance marketplaces. Ms. Corlette.

**TESTIMONY OF SABRINA CORLETTE,¹ RESEARCH PROFESSOR,
CENTER ON HEALTH INSURANCE REFORMS, GEORGETOWN
UNIVERSITY HEALTH POLICY INSTITUTE**

Ms. CORLETTE. Thank you, Mr. Chairman, and thank you, Senator McCaskill and Members of the Committee. And I particularly want to thank you for holding this timely hearing and your willingness to engage in a thoughtful and bipartisan effort to understand some of the root causes of the challenges facing our health care system. And, as I sat listening to my fellow witnesses, I think we probably agree on more than we disagree about some of the true challenges facing our health care system.

Both critics and proponents of the Affordable Care Act can reasonably ask why it was structured the way it was, with an array of insurance reforms, an individual responsibility requirement, income-related subsidies for the purchase of private insurance, Medicaid expansion. Part of the reason it is such a complicated law is because it did not sweep away our existing system; rather, it was designed to fill gaps in the sort of patchwork quilt system of coverage that has evolved in our country over a century and more, and that Ms. Thomasson covered very well in her testimony, and she is absolutely right. I mean, in the early 20th Century, there was not much insurance as we understand it today. Most people paid their doctors in cash or in kind. But, remember, too, that health care at that time was much more primitive. You went to the hospital to die, not to get treated.

But over time, as new treatments and technologies came online, these saved lives, but they also increased the costs. And, as Ms. Thomasson noted, most commercial insurers were not willing to provide insurance because of the concerns about adverse selection.

I will not review, because she already did, some of the growth of the Blue Cross/Blue Shield plans and the Internal Revenue Service (IRS) rule that caused sort of this explosive growth of the employer-based system that we have today. But, I would note that just as our employer system was expanding, there were some really important changes taking place overall.

First of all, the Blue Cross/Blue Shield plans were initially community rated. No matter what type of employer group you had, you paid the same price. But, a number of commercial insurers, mostly for-profit, started to come into the market, and they recognized that they could make more money if they deterred enrollment among older or sicker individuals and groups. So, the types of things that they engaged in were outright denials of coverage, pre-existing condition benefit exclusions, and premium surcharges based on factors such as health status, age, and gender.

Over the years, Congress and other policymakers recognized that our employer-based system left a lot of groups out, such as the elderly, disabled, and poor. So, of course, we had in 1965 major reforms with Medicare and Medicaid. But, for many decades after that, we really only had piecemeal changes to fill in gaps in coverage, such as Consolidated Omnibus Budget Reconciliation Act (COBRA), Emergency Medical Treatment and Labor Act (EMTALA), some Medicaid eligibility expansions, Health Insurance

¹ The prepared statement of Ms. Corlette appears in the Appendix on page 64.

Portability and Accountability Act (HIPAA), Children's Health Insurance Program (CHIP), an alphabet soup leading up to Medicare Part D. But, in spite of these gap-filling efforts, on the eve of enactment of the ACA, we had 45 million Americans uninsured. An estimated 26,000 people per year died prematurely because they lacked insurance, and 60 percent of the uninsured reported having problems paying medical bills. The high and rising uninsured rate also led to high and rising uncompensated care costs for providers, estimated at \$1,000 worth of services per uninsured person.

Thanks to the ACA, an estimated 20 million people have gained coverage, and what does that coverage mean to those families? Well, the percentage of Americans reporting that they did not see a doctor or fill a prescription because they could not afford it has declined by more than one-third. More people are reporting that they have a primary care doctor or had a check-up in the last 12 months. The number of families who say they are having problems paying medical bills has fallen dramatically since 2013, particularly among low-income families. And, we have also witnessed a significant reduction in uncompensated care costs borne by providers.

Even so, the most ardent supporter of the ACA would likely agree that the law faces challenges, not least of which is the continued policy uncertainty created by threats to cutoff the CSR reimbursement, and concerns among insurers that the individual mandate will not be enforced.

I believe that a bipartisan consensus on a set of policies that could boost and maintain enrollment in the ACA marketplaces and stabilize participation is not out of reach. For Federal policymakers who want to improve the individual markets and build on the coverage gains launched by the ACA, these fixes would include: long-term commitment to paying the cost-sharing reductions; a reinsurance program or invisible high-risk pool; higher funding for outreach and enrollment; a fix to the family glitch; and affordability improvements, particularly for those forgotten folks who are unsubsidized and working hard and paying into the system.

Thank you very much, and I look forward to the discussion.

Chairman JOHNSON. Well, thank you, Ms. Corlette.

Listen, I appreciate Committee Members showing up, so I am happy to move on to—Senator McCaskill, are you ready to ask questions?

Senator MCCASKILL. I am happy to defer also to Senator Tester.

Chairman JOHNSON. Senator Tester then. It is your lucky day.

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. That is why we love the leadership on this Committee. Thank you very much.

First of all, thank you for your testimony. I have a number of questions, and you guys kind of all hit the same thing, so I am just going to pick on you, Katherine. And, the question is how to finance the system.

You have looked at the current method, and I think you have all spoken to the problems with the current method. My folks never had health insurance on the farm. They retired in 1978, never had health insurance ever. Their first insurance they had was Medi-

care. There is a reason for that. In the mid-1960s, when that happened, it was \$400. I do not know what it would be today, but it would be a lot more than that.

So, the question is—there has been a lot of debate, there have been amendments offered on single-payer for political purposes. There has been—but maybe not. I mean, maybe it is something we should, quite frankly, take a solid look at. And, there has been the subsidy issue, CSR and others. So, the question is: How do we finance the system? And, ultimately, can we make the finance system control the costs?

Ms. BAICKER. That is a great question, and, clearly, the central issue—

Senator TESTER. Yes.

Ms. BAICKER [continuing]. Of sustainability for the system is how do we pay for all this care and how do we make sure that we are only buying care that is actually improving health sufficiently to warrant the expense?

I would like to distinguish between private insurance and social insurance, concepts that are frequently intertwined in the debate. To me, private insurance is about financial risk. Insurance in other realms that we buy—homeowners' insurance, auto insurance, renters' insurance—protects against big expenses that are a surprise. It does not protect against routine expenses that are affordable or even big expenses that are known. You do not buy homebuyers' insurance to protect you against the risk of buying a house or college insurance to protect you against the risk of purchasing a college education. It is supposed to be for unexpected expensive things. Similarly, we do not buy insurance for mowing the lawn of the house because it is a predictable and affordable expense.

Health insurance that we buy today does not look like that at all, partly because of the Tax Code provisions that favor having more generous employer-sponsored insurance. That is something that I think could be improved by having insurance that is more value-based. But, that is private insurance. That is about protecting yourself against future risk, pooling risk with other people who also have unknown expenses.

Social insurance is about redistribution. Social insurance is about moving money from high-income people to low-income people, from healthy people to people who are known to be sick, who were born with disabilities, who have forecastable high health expenses. So, social insurance can do that kind of redistribution that private insurance can never do. When you try to design a private insurance market to move money from rich people to poor people, that does not work. That has to be a government action.

So, it would be helpful to have a separate debate about how much money we want to spend on social insurance programs, and reasonable people can differ on that. There are opportunity costs; there are lots of competing public demands on resources. How much do you want to spend on education? How much do you want to spend on infrastructure? This is a real debate we need to engage in.

How can we finance private insurance with higher value in a sustainable way? I think the improvements in design that we have been hinting at in terms of having better, more nuanced cost shar-

ing to drive higher-value use, more competition among providers, and more competition among insurers. That would ensure that we are at least getting high value for what we are spending.

Senator TESTER. So, you are talking about value-based versus fee-based?

Ms. BAICKER. On the patient side, I would like value-based insurance to be more prominent. On the provider side, I would like value-based payments rather than quantity-based payments to be more prominent.

Senator TESTER. And, who determines that? Who determines the value?

Ms. BAICKER. It should be the patient's valuation in terms of his or her own health outcomes.

Then there is the social insurance part where I think we have to decide how much we want to redistribute.

Senator TESTER. The problem is that the value may not be able to be determined until long after the bill is paid.

Ms. BAICKER. There is a lot of uncertainty in this, and it is never going to be perfect. You do not know "I am buying one extra year of life with this heart procedure."

Senator TESTER. Yes. The other thing I would say is this, that everybody, if not for the grace of God, could be in the emergency room tomorrow.

Ms. BAICKER. Which is why insurance is incredibly valuable for all people who want to protect against that risk.

Senator TESTER. Yes. And, even if you have a situation where, say, your kid has croup and you end up with a breathing treatment, I mean, it is so much money. And so, how do we drive those costs down? That is one thing the ACA was starting to do, but after it got butchered up some, it was not very effective at it, and that is, helping drive the cost down. And, what do we do to do that?

Ms. BAICKER. Well, enlisting provider—

Senator TESTER. And, I got what you are saying, but I really did not hear how we hold—because that is—and, look, I was going to ask you, who is driving the bus here? Is it hospitals? Is it doctors? Is it prescription drug companies? Who is really driving the cost of health care? Is it all three? And why?

Ms. BAICKER. The bulk of our health care dollars are going to hospitals and physicians and related services. There are other parts that are perhaps growing more quickly, but if you want to tackle the whole health care system, you have to address hospitals and physicians as the lion's share of what we are spending our money on. Having providers paid differently would serve a second function of giving them a much more active role in driving the bus. You want patients in consultation with their providers to drive the bus. You cannot expect patients to be doctors. They do not know whether they need that heart treatment, they need that procedure, which knee replacement joint is better for them. They need their providers to be on their side in thinking about what is right for them, and we need their providers to be thinking about how to do it most cost-effectively. Quality thresholds are vital to measure and incorporate to ensure getting good quality. You want the provider to steer patients to the hospital that is going to get them home healthier sooner.

Senator TESTER. You are correct, and I guess the cost issue is the big issue in my head, because we have seen the charts. We all know from personal experience how health care continues to go up. And, when we go in as patients, we want the best health care. We do not want a prescription drug that is a generic that might not be quite as good as the one that does not do much more but costs 10 times more. And so, part of it is on us, and I think the co-pay issue is an important issue. You have to have some skin in the game.

But, the problem also is that for those people that do not have any money to put skin in the game, it becomes a real problem. And, I think it is really easy to talk about undoing Medicaid expansion and those kinds of things, but the truth is it has real-world impacts and it is going to cost more money somewhere else if we do not deal with it up front. And, we have not even gotten into prevention. So, thank you all for being here. This is a very important issue, especially at this moment in time.

And thank you, Mr. Chairman and Ranking Member, for your courtesy.

Chairman JOHNSON. Happy to, but let me quickly chime in. I want to give a real-world anecdotal example of kind of how this could potentially work.

In my business, as Senator McCaskill was saying, our health insurance rates were skyrocketing, and Congress did pass what I thought was a pretty good law, the health savings account (HSA) law. And so, what we did is we shifted to a higher-deductible plan. Now, back then I think it was \$1,500 or maybe \$2,500. But, that was considered a high-deductible plan that you had to shift to in order for HSAs.

In my medium-size group, we were able to cut premiums so much—I did not pocket that money. I invested that money into HSAs, \$3,000 per year per employee, which we just continued. So, people that work for my business now—I do not know what my brother is doing, but, things have probably been kicking up further, but just one year's savings was \$3,000 per year per employee into an HSA. Now they are in control of money, and the question from my standpoint is how much of the total \$3.2 trillion can be paid for directly by the consumer versus what do you need in terms of insurance? And then, how do you control those costs? I mean, this is very complex. There is no doubt about it. I think you are asking great questions. But, I just wanted to throw out that anecdote in terms of starting to move us in the right direction.

Is Senator Carper here? Oh, there. You are up to the plate.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Welcome. I am a Senator from Delaware, a recovering Governor from Delaware, who thought a lot about these issues. I am delighted that the Chairman and Ranking Member have called this hearing. We appreciate very much your being with us here today.

I have a Bible study group that meets most Thursdays here. If you can imagine Democrats and Republicans reading the Scripture together, praying together, and sharing things together. We have a chaplain named Barry Black that my colleagues know pretty

well, and he is always reminding us of something called Matthew 25 which talks about “the least of these.” “When I was hungry, did you feed me? When I was naked, did you clothes me? When I was thirsty, did you give me to drink? When I was sick or in prison, did you come to visit me? When I was a stranger in your land, did you welcome me?”

It does not say one thing about when my only access to health care was the emergency room of a hospital or else I just did without. I think it is pretty clear the inference, though. If we are going to care about people having enough to eat, drink, clothing, that sort of thing, we probably ought to care about whether or not they have access to health care. I call that a moral obligation. A moral obligation. And, I think while we have that moral obligation to the least of these in our society, we also have a fiscal imperative to meet that moral obligation in a fiscally sustainable way.

I was out at another meeting, and I apologize. I missed your testimony. But each of you, just give us one good, clear example that you think might be transferable either among States or a good thing for us to do federally through legislation that attempts to fix those aspects of the ACA that need to be fixed, preserve those aspects that need to be preserved, and, frankly, drop those aspects that ought to be dropped. So, help us with just a good example how we can better meet that moral imperative in fiscally sustainable ways.

It is not every day we have a Sabrina Corlette come before us, and I am going to ask you to lead us off.

Ms. CORLETTE. Thank you, Senator. Well, I am glad you mentioned the States because we are seeing come up from the States some of the more pragmatic, thoughtful, innovative ideas right now in terms of how to stabilize the Affordable Care Act, how to make it work for their citizens. So, there are many State leaders, both States you would consider red, States you would consider blue, sort of coming up, stepping up to the plate, and saying, “We are going to devise a solution that works and keeps people covered.”

The primary example of that—and we are seeing it from States as diverse as Alaska, Oklahoma, Minnesota, New Hampshire—is a reinsurance or an invisible high-risk pool. For example, in Alaska, when they implemented it last year, the proposed premium increases went from 42 percent to 7 percent, and they are finding that that has been—it is sustainable. But, they need the Federal Government to partner with them on that, and I have been pleased to see that the Administration thus far has been willing to do it.

Senator CARPER. Thank you.

Katherine, how do you pronounce your last name?

Ms. BAICKER. “Baker.” There are just some extra letters in there for no good reason. [Laughter.]

Senator CARPER. Your parents did not even know how to pronounce their name.

Ms. BAICKER. Ellis Island fabrication.

Senator CARPER. Oh, OK. Thank you.

Ms. BAICKER. So, Ms. Corlette had mentioned in her testimony fixing the family glitch. There are a bunch of small provisions that I think just do not really work as the legislation is currently written. I would also argue for giving a little bit more bite to the tax

on employer-sponsored health insurance. A lot of the reason that we have so much of our insurance subsidized through employers that might look so much more like prepaid health care than like true insurance is that we favor the premiums paid by employer-sponsored plans over out-of-pocket payments or lots of other non-group purchases, with the exceptions of carve-outs for things like HSAs.

So, I would like to see a more level playing field between employer insurance, other insurance, and out-of-pocket costs to really take the thumb off the scale there.

Senator CARPER. All right. Thanks. Melissa Thomasson.

Ms. THOMASSON. No Ellis Island glitch.

Senator CARPER. OK, good.

Ms. THOMASSON. I have to agree with Dr. Baicker in that the tax treatment of employer-provided health insurance is a problem. But, what we see is that adverse selection is a problem, so we are all brought together in employment-based groups, and that makes it much cheaper for those of us who are healthy in employment-based groups to get insurance.

But, as Senator Johnson indicated, as Senator McCaskill indicated, there are uninsured people who have a motorcycle accident who really honestly get treated in this country, and that is our moral obligation. As a society, we have decided that is our moral obligation. I am in favor of expanding risk pools, either through reinsurance or by increasing the incentives for individuals to buy insurance in order to spread those costs among everybody and to make sure that people who need the insurance can afford it. People need to buy insurance so that they are paying their share of their costs when they are actually sick.

But, along with that, I do think we need provider-based reform. We cannot continue to pay providers a fee for every service that they do because, otherwise, we will have more and more services at increasing costs.

Senator CARPER. All right. Thank you.

Senator Johnson and I am not sure if our colleagues were there as well, but we had sort of a roundtable coffee with the insurance commissioners from five different States. They are testifying as we speak before the HELP Committee. And, one of the things that I asked them to think out loud about was reinsurance, and they seemed to be suggesting that one in terms of doing is stabilizing the exchanges, and they suggested do that now. If you are going to do anything, do that now. And, they suggested among the ways to do it, make it clear that the cost-sharing payments will be made available not just for the remainder of this year but also for a full year beyond in order to give the insurance companies some sense of permanency and predictability.

A number of them called for retaining the individual mandate. I think one of them said if you do not require the individual mandate, make sure it is going to be enforced, come up with something as good or maybe better and maybe give the States some flexibility on that.

The last thing they said is reinsurance. In fact, they all said do reinsurance. They talked about what they are doing in Alaska. Senator Kaine and myself have offered legislation that does this on

reinsurance: one, it provides for the Federal Government to pay for the next 3 years expensive claims, cover 80 percent of the amount between \$50,000 and \$500,000; and for the years after that, the Federal Government would cover everything between \$100,000 and \$500,000. Everything else was on the insurance companies. Would you just react to that, whether that is a reasonable starting place on reinsurance? Go ahead.

Ms. CORLETTE. Yes, I would agree with the insurance commissioners. I have not closely studied your bill, but, in general, I think it is reasonable to assume that the individual market will always be a somewhat sicker risk pool than the employer-based market simply because there are people who, because of their health, cannot work full-time. So, I think it is reasonable to subsidize the risk in that market. You showed that chart showing that the premium increases accountable for that increase in risk are pretty dramatic. So, it is reasonable to say that subsidization should not come on the backs of farmers and entrepreneurs and ranchers, but maybe by society as a whole.

And so, I think a reinsurance program is the right thing to do, and it can be done at the State level or at the Federal level, and there are lots of details about how it can be done. But, I would support a Federal program.

Ms. BAICKER. Yes, I agree that risk pooling is vital to insurance working at all. That is the whole point of insurance. And, the employer market is one natural place for risk pooling, although it is particularly regressive and inefficient given that it is based on the Tax Code. So, in the non-group market, you need lots of participation and you need really good risk adjustment. If you are not able to correctly risk-adjust, then insurers are always going to be in the business of trying to get healthier enrollees, and that is how they will make money instead of by providing higher-value services and lowering the premiums by being more effective.

Now, you need a lot of enrollees, but you also then may need to induce insurers to participate by having some guard rails, whether that is risk corridors or reinsurance, which serve slightly different functions. I would like to think that in the long run, once the market stabilizes and insurers know what the pool looks like and risk adjusters catch up, insurers ought to be able to protect themselves against having a handful of high-risk people if the system were well designed and risk adjusters were working well.

In the intermediate term, where they are not working so well, I think they probably do need those guard rails to feel comfortable participating.

Senator CARPER. Mr. Chairman, could Ms. Thomasson respond to this as well, please? Thank you.

Ms. THOMASSON. Yes, both of the witnesses are correct. Imagine, Senator Johnson, that you are starting a business, and you are entering a market where you know that it has been difficult for people to be profitable in the past. Then you are going to go out with a price that you are not sure will work and you can adjust it over time. In this case, there is a lot of money on the table. The mandate did not function as well as we wanted. We know that that risk pool ended up being sicker than we thought, and right now there is a lot of uncertainty introduced by political goings-on here that

makes it difficult for insurance companies to decide how to price insurance. Is there going to be continuation of the CSRs? Risk corridors were mitigated. The value of reinsurance has proven itself necessary, but it has fallen short.

So in this case, we need to stabilize the markets for the markets to continue. I definitely agree with reinsurance. As far as those numbers, suggested by Senator Carper they are higher than they are today, so that is a starting point. But, hopefully over time this is like any experience. As we get more people to participate in the market, and it is a competitive market, then we will see the market mechanisms kick in, and hopefully things will be better. And so, the role of government will be a more short-term thing.

Senator CARPER. Good. Thank you so much.

Thanks, Mr. Chairman.

Chairman JOHNSON. Well, thank you. And, by the way, just in the nick of time, I sent my staff out. This is from the Foundation for Government Accountability and really describing what happened in Maine. They instituted guaranteed issue. They did not repeal it. They just supplanted it with this invisible high-risk pool, a different concept than Wisconsin. Now I guess Minnesota has enacted something. I am not sure of the details. But, the results are pretty dramatic. Their premiums were cut by two-thirds to a half by putting in this reinsurance, this invisible high-risk pool. Again, I will not get into the details of it, but this is the kind of information that we need to bring to the table to hopefully on a bipartisan basis solve the problem.

Senator CARPER. Mr. Chairman, did you say the premiums were cut by two-thirds to a half?

Chairman JOHNSON. Yes—

Senator CARPER. Or the increases in premiums?

Chairman JOHNSON. Take a look at this. For somebody under 19, it went from \$617 to \$204. For somebody 60 and above, it went from \$1,233 per month to \$645 by instituting the invisible high-risk pool.

So, again, I think this is an accurate study. We will take a look at what happens in Minnesota. Those laboratories of democracy, the States, we need to take a look at best practice and what actually works, and I think this is hopefully some pretty solid information that will inform our future discussions.

Senator CARPER. All right. Again, thank you all very much.

Chairman JOHNSON. Senator Peters.

OPENING STATEMENT OF SENATOR PETERS

Senator PETERS. Thank you, Mr. Chairman, and thank you Ranking Member, for passing on your questions to allow us to have an opportunity to talk to this excellent panel. Thank you for being here today.

There is no question this is an incredibly important topic, and the fact that we can discuss this on a bipartisan basis, trying to get to the actual facts, I think is absolutely essential. I think I am as frustrated as everybody in this country with the partisan bickering and entrenchment that we see on both sides. We cannot solve this problem unless we are doing this together, and it is certainly a source of frustration for me when we cannot get to those practical

solutions, when I believe that in this great country of ours that everybody, no matter who you are and no matter where you live, should have access to quality, affordable health care. And, that should not be asking too much given the fact that all of our trading partners, as you mentioned, do that. Other countries that we deal with every single day do that. They do it with less cost and, even more significantly, they do it with better outcomes. They are actually delivering better-quality care to their citizens, and all of their citizens, at a lower cost. So, we have to get to this. We are a bunch of smart folks here in the United States of America. We can figure this out. But, we have to get past the partisanship. So, thank you for having the hearing. Thank you for your testimony here today.

A couple of issues. One that I hear a lot and one that I would like to get your sense on deals with our sensitivity to cost. And, there is no question that higher deductibles have an impact in lowering premiums. As the Chairman mentioned with his company, having co-pays is significant. But, when we are dealing with the health care market, it is different than going to an outlet store. We have a difference in opinion. When you are talking to a physician, it is different when you listen to his or her recommendation as to what you need. It is not simply a matter of cost that is involved.

Now, I have often heard the example of laser eye surgery (LASIK) as an example of a surgery that has dropped in cost dramatically over the years, and it is certainly very competitive, and people can shop for cost for their eye care. That has not happened with all other surgeries that continue to go up at a rate well in excess of the rate of inflation.

But, I would like the panelists to address how would it look to bring consumers involved in cost, given the asymmetrical relationship between a physician and other health care providers and the patient, even if they are paying out of their own pocket, it is difficult to make those decisions. So, we need an answer—my point is we need an answer more than just—as important as transparency is, and I believe we should know what everything costs. As important as transparency is and everybody having some skin in the game, how does it really work given the complexity of the health care market? We do not see that in other countries that have lower costs and higher outcomes. How would it work here? What is the practical aspect of it? We can just start with Ms. Thomasson and work down, if that is appropriate.

Ms. THOMASSON. That is an excellent question because depending on the kind of procedure, it is more difficult for consumers to shop. If I am going to an outlet store, I typically know what I want. I can visit several stores. The other day I was dutifully trying to get some exercise, and I ran into a tree while I was hiking, and I was covered in blood, and I have one emergency room in my town, and I was thinking, “Oh, no, this is going to cost me \$4,000 for two staples.” I guess that is \$2,000 per staple. In that case, I could not really price shop. Thank goodness I have a health savings account with money in it, and off I went. I am still trying to get the blood out of my seat belt.

But for things like LASIK, for MRIs, for drugs that are maintenance medications, consumers can and they do price shop if prices are transparent. For things like knee replacements and hip re-

placements, our university now offers bundles where we have had providers on a competitive basis bid so we know exactly what a knee replacement would cost. It costs \$28,000 at Miami University, and consumers pay \$750 of it.

Senator PETERS. How does that compare to other places? What is the range that you have seen?

Ms. THOMASSON. That was actually lower than what we have paid in the past, and I do not know nationally because that is just data from our university. But for the other things, if I go into the hospital and I need a stent put in or something else, you are right, we do not shop as well. We do not get second opinions when we are having a heart attack. In that case, we do need to rely on providers, and that is why payment reform is so key here, and evidence-based medicine. We were talking about an infant who goes to the hospital who needs treatment for croup. Well, there is a way that we treat croup that doctors know works. We do not need a Computerized Axial Tomography (CAT) scan. We do not need an X-ray. And so it is up for payment reform to incentivize providers to provide value-based care in those circumstances so that consumers do not have to shop while they are having a heart attack.

Senator PETERS. Ms. Baicker.

Ms. BAICKER. Yes, I very much agree that patient cost-sharing and transparency is necessary but far from sufficient. People also need to rely on their doctor's advice, which is why the doctor's incentives also have to be lined up with delivering high-value care. And, those pieces I think work much better together than in isolation. You can think of the example of accountable care organizations where doctors share in the savings if they meet quality and effectiveness thresholds of steering their patients to the hospital that is going to get them home healthy soonest, of getting to the right post-acute-care setting instead of staying in a more intensive or longer-duration place.

The providers have to take an active role in helping their patients manage through that. If the patient incentives are operating at odds to that, even if you get the provider incentives right, they are not going to be able to steer their patients toward the right sites of care. If both are working in concert, then maybe the provider says, "You know what? I do not think you need this as an inpatient procedure. I think you can get this as an outpatient procedure." And, the patient is going to be happier because of that—again, contingent on having good quality metrics to make sure that there is no incentive for stinting.

That said, it is surprising the circumstances in which patients do respond to information about prices and quality. You are having a heart attack. You are in an ambulance. Of course, you are in no position to price shop or think about where you should go. Yet hospitals develop reputations for being high quality or for being very expensive and not being any better. Ambulance drivers know it. Patients have heard about it. And so, when you see quality ratings improve for even emergency care for some hospital systems, you see patient volume shifting to those higher-quality and higher-value places. So, I do think that having that information plays a vital role, but it has to work with both levers at the same time.

Senator PETERS. Thank you. Ms. Corlette.

Ms. CORLETTE. I agree with my co-presenters here, but I would also just add one thing that we have not talked about is the issue of provider consolidation, which has been growing considerably. So, the whole issue of patients being active shoppers is dependent on them having choice. In a lot of communities, because of both vertical and horizontal integration by providers, hospitals buying up physician practices, hospitals merging, that choice just is not there. And, those providers are using their market clout to charge higher and higher prices. So, that is another issue that we need to be looking at far more aggressively than we are.

Senator PETERS. Thank you very much.

Chairman JOHNSON. Three quick points.

First of all, I would love to have a hearing on other systems around the world, Singapore, whatever, so I would like to have you contribute to that.

Walmart is actually flying their employees to Centers of Excellence for some of these major—and they have dramatically driven down the costs of some of these big procedures. So, again, the marketplace works there.

And then, I hope we can get into Medicare policies driving private insurance policies, the Diagnosis Related Groups (DRGs) and that type of thing, what that is all resulting in as well. Senator Harris.

OPENING STATEMENT OF SENATOR HARRIS

Senator HARRIS. Thank you, and thank you for this hearing.

I could not agree more, Senator Peters, and I know Senator Johnson feels the same way, which is that we need more transparency in the system.

I would like to focus my question on asking each of you what you believe we in Congress can do to create policy that creates incentives, or perhaps disincentives, where appropriate, but with the goal of creating more transparency around pricing. What would we craft? What would that policy look like? And, why do we not go in reverse order and start with you, Professor Corlette. What do you believe we can do in Congress to increase transparency so that the consumer has a much better idea of what they are paying for? And, I would suggest that we obviously cannot ask or expect the consumer to shop around if they do not have metrics to then determine what exactly it is that they are being given. So, what would you recommend we do here?

Ms. CORLETTE. Well, the biggest lever, I think, currently that Congress has is Medicare, which is the sort of 800-pound gorilla in any given health care market. So, using the Medicare payer as a lever with providers, get them to be more transparent, I think would be the place to start. And then, I also think that some States have done some very interesting work around all-payer claims databases. I do not know if folks are familiar with those, but essentially it is requiring payers to submit claims data into one big database so you can start to look at what providers are getting paid across multiple different care settings.

Senator HARRIS. Do you know which States are doing that?

Ms. CORLETTE. It is several at this point. There has been an issue with—some employer-based plans have challenged the re-

quirement to submit, and so there was actually a Supreme Court decision that has dampened the ability of these all-payer claims databases to really take off, and I think that would be another thing for Congress to look at, is to clearly get at not just the individual insurance and Medicare payers but also what employer-based plans are paying as well.

Senator HARRIS. And so, you are essentially talking about an open data system.

Ms. CORLETTE. An open data system that anybody can access to see what Dr. A is charging versus Dr. B versus Hospital A versus Hospital B. And, I think that there is a lot that could be done around those claims databases, yes.

Senator HARRIS. Please follow up with the Committee on the States. And any feedback you have about which among them presents best practices.

Ms. CORLETTE. Sure. Dr. Baicker, you are nodding. Maybe you know at this point how many—I cannot remember, but it is over a dozen States that have these databases.

Ms. BAICKER. There are differences across types of care. There are richer hospital databases than there are outpatient databases, so it is not an easy question to answer on the fly.

I draw a distinction between price transparency to the patient versus revealing prices negotiated between insurers and providers. I think we all agree patients absolutely need complete information on what it costs them to get care in different settings so that they can make good decisions. There is a little bit of a debate about whether the prices that Insurer A negotiates with Hospital 1 ought to be public or not. I still have my two hands. On the one hand, you might think “why those prices should not be revealed, too, and help drive prices down?” On the other hand, there is a saying that in a world where everyone gets a discount, no one gets a discount. There is a hypothesis that if you make insurers and providers reveal the prices they have negotiated amongst themselves, then there is diminished incentive to give a discount to one insurer by, say, a prominent hospital because they know they would have to give that discount to everyone. So, it is a little bit ambiguous.

Senator HARRIS. But, you would not agree that greater transparency actually encourages competition in the spirit of all that we want, which is that we ultimately bring the best product to the market for the consumer and in the interest of innovation in all of these areas?

Ms. BAICKER. I would absolutely agree on the patient side. I think that is going to work best on the provider/insurance side when there is real competition—

Senator HARRIS. Well, are we trying to create incentives for the patient or the insurer?

Ms. BAICKER. Both. I am trying to address those levers separately. I agree with you we want incentives on both sides, that we want full information for patients, and every incentive for competitive pricing between insurers and providers, and that requires a lot of insurers and a lot of providers. So, I think we are totally agreed on the goals, but the levers may be a little different for those two sides of the equation.

Senator HARRIS. What policies would you recommend we consider in terms of our legislative opportunities to create the incentives?

Ms. BAICKER. I very much agree with whatever we can do from a regulatory or statutory perspective to make full information available to patients. I think one thing that would help with that is having the freedom for patients to reap as much of the benefit of their wise choices as possible, because that will then add patients to the mix in agitating for better information.

I had a similar experience to Senator McCaskill when I first had an HSA in trying to get information about how much a shot cost. I had a sore elbow. I needed a shot for the elbow, apparently, and I said, "Oh, OK. How much does that cost?" And, they looked at me like I had just questioned their medical integrity, like, "That is not your business. Why are you asking me that?" Of course, it was my business.

Senator HARRIS. Right.

Ms. BAICKER. So having patients enlisted in that——

Senator HARRIS. Sure.

Ms. BAICKER [continuing]. To have the information available and have patients agitating to say, "You need to be able to tell me how much that costs."

Senator HARRIS. So, for example, Professor Corlette mentioned doing that through Medicare. Do you agree with that as a recommendation?

Ms. BAICKER. I definitely agree with having Medicare beneficiaries have all that information about all their care.

Senator HARRIS. And in an open data type system?

Ms. BAICKER. I am being slightly hesitant just because of patient confidentiality. In the aggregate, yes. We have to be very careful about revealing too much information about patients' individual care and individual situations. So, assuming that all of that was taken care of, then I think that information is really valuable and ought to be available much more quickly than it is now. Even researchers have a many-year lag in getting information from the Medicare system. So, that is the least we can do, and then let patients share in the benefit of opting for cheaper, high-quality service.

Senator HARRIS. So, would you agree, though, that the concern is that it is not about the information in terms of what type of illness, what type of patient demographically is being charged? The issue in terms of confidentiality is that we not identify the patient, but anything short of identifying the patient should be the subject of an open data system. Would you agree with that?

Ms. BAICKER. Yes.

Senator HARRIS. OK. Thank you.

Thank you, Mr. Chairman.

Chairman JOHNSON. Senator Daines.

OPENING STATEMENT OF SENATOR DAINES

Senator DAINES. Thank you, Mr. Chairman and Ranking Member McCaskill.

Dr. Thomasson and Dr. Baicker, you both stated that one of the major drivers in health care costs is the way we finance health care

by limiting the knowledge of the patient of what the true costs of health care are by financing through a number of structures that encourage the patient to get as much health care as possible, sometimes needed or even not needed, and for the driver to drive up the quantity of services they provide. In fact, I was taking my smartphone, used the example of LASIK eye surgery, googled “LASIK eye surgery.” What do you see, the first three hits, the top of it? All deal with the price, incentives, \$400 off per eye. Google “knee surgery,” and you will see technical issues related to knee surgery, but there is nothing about the cost if you look at the top hits on Google.

You also indicated that a major reason for this is the financial structure of government-funded programs that typically require nothing of the patient. I appreciate the line of questioning we have seen here around when you responded about you asked how much the shot was going to cost. Well, it is not that complicated why that information is not available and why it is not being asked, because the patient ultimately, it is not coming out of their pocket. And, that is why when it comes out of the patient’s pocket, when there is skin in the game for the patient, you start asking questions like, “What will it cost?” It is one of the few financial transactions where the first thing that you do not ask is, “How much will this cost?” But, everything else we do in life, that is the first question, except when it relates to health care most of the time.

As we know, health programs represent nearly half of all of our entitlement spending, 46 percent this year, 51 percent by 2026, and nearly 30 percent of our total Federal spending, and this is clearly unsustainable.

So, for Drs. Thomasson and Baicker, how do you recommend restructuring our government programs to disincentivize overutilization and incentivize the patient asking the question, “How much will this cost?”

Ms. THOMASSON. That is an excellent question. To be fair, we did not—I, at least, did not talk about out-of-pocket costs for government-sponsored insurance, and there are some deductibles. But, the truth is that high-deductible health plans, incentivizes us to ask questions. My insurance company does not cover LASIK.

Senator DAINES. Right, and that is, in terms of zeroing it to—distilling this, the reason the LASIK is the number one hit, why? Because insurance companies do not pay for it. It is coming out of either the pocket directly, HSAs, or some combination of the two.

Ms. THOMASSON. Right. And you are right, I would not show up to buy a car and just turn over the money.

Senator DAINES. Right.

Ms. THOMASSON. But, I would do that if somebody else were paying the bill. Economists are generally in agreement that cost sharing is a good thing, and the question is how you structure that. We have right now, for example, a Medicare deductible that is equal to a one day stay in the hospital. To some extent, for things that are not emergent, we need to structure high-deductible health plans, perhaps give Medicare beneficiaries the opportunity to contribute to HSAs that do put skin in the game. But, we also have to be aware of the fact that evidence shows that consumers cut down on the purchase of all kinds of spending when they have a

high-deductible health plan. And so, the high-deductible structure itself may be a little bit of a blunt object. We want to encourage the use of high-value care. We do not want to give, in this case, the elderly incentives to not take their diabetes drugs so that they end up in the hospital later at a cost that is much greater to us. But, certainly, incentivizing the use of high-value care, like taking medicines for diabetes and hypertension, and disincentivizing the use of care that is not necessary nor effective, for example, MRIs for back pain.

Senator DAINES. So, when you chat with, as I have had several discussions with, say, some of the neurosurgeons, they will tell you their fear of lawsuits oftentimes drives some of these additional tests, because the patient will say, “I want to have an MRI.” So how much do you think costs are influenced by practicing defensive medicine?

Ms. THOMASSON. Well, the most recent estimates that I have seen suggest that up to 10 percent of costs are driven by defensive medicine practice. So, there is some of that, certainly. But, we have seen that providers can help educate consumers. For example, we all used to give antibiotics to every little kid with a sniffle or an earache, and providers who did not want to have to explain to a patient that that was not necessary, they just wrote a prescription. But, the culture is changing. Now we have kind of a discussion, a dialogue, so my pediatrician will say, “I do not know. Let us give it a few days. Let us not write a prescription.” Providers can have those conversations.

Senator DAINES. Let me shift gears for a moment here. There is so much to talk about here and so little time. We have just heard that a significant contributor to the increasing cost of health care is the size of the government footprint in the health care space. From what we have heard, this is through incentivizing overutilization of health care. It does little in the way of recognizing that health care does not have an unlimited supply, as we are currently seeing, certainly over in Europe, particularly in England.

In my home State of Montana, we have seen that to be true with the Affordable Care Act. I have spoken to many Montanans that are now bearing the cost of increasing expansion of government into health care. One small business owner had to pay \$35,000 in premiums and deductibles for a bronze plan before anything is covered, and my Montana farmers and Montana ranchers are facing similar costs.

This poverty tax has been a huge problem for Montana. In fact, 40 percent who pay this penalty on the mandate earn less than \$25,000. We have a chart¹ here: 80 percent made less than \$50,000. The very people that can afford it the least are getting hit with billions of dollars in what we call a “poverty tax.”

Your recommendation is that we continue to infuse taxpayer cash into government programs. That seems to go against the very goal of decreasing health care costs and availability. How do you square or reconcile those two positions?

Ms. THOMASSON. Well, with all due respect, Senator, I have also indicated that more people need to buy insurance—there needs to

¹ The chart referenced by Senator Daines appears in the Appendix on page 171.

be more teeth in the mandate. What we are seeing here—and all the premiums that we have talked about so far are average premiums. For these people suddenly facing higher premiums, there is a whole group of people who can now actually buy insurance who could not even get it before. In essence, the price was infinite. These are average premiums. When healthy people buy insurance, too, then that is what it does. It will lower average premiums. It is going to stabilize risk. We look at this with flood insurance right now. If you are in a flood-prone area, it is very expensive. But if we pool nationwide and we average the non-flood areas with the flood areas, the average cost goes down.

It is my belief that premiums are rising because, one, insurance companies did not have any experience with the market, and that is why I recommended increased stabilization; and, two, that premiums are rising because they are still being selected against in those non-group markets.

Senator DAINES. But, if we get back to the point around it, if the patient is not asking the question, “What will it cost?” as the first question—or maybe at least the first couple. Obviously, if your situation as you described there when you had your staples, the first thing is you want to get treated, you want to get well, you want help. But, if it is not part of the calculus in terms of what will it cost, I am just concerned that we never, ever will bend the cost curve. It comes back to accountability and responsibility and ensuring you are asking, “What is the price?”

Ms. THOMASSON. And, you are absolutely right, and that is why we need more accountability, we need more skin in the game for consumers, and we need a health culture, frankly, where we start to ask questions about cost. And, I believe that will only happen when consumers have to pay more costs and they recognize that. It is not going to happen instantly, but markets can evolve over time with information and competition.

Senator DAINES. Yes. Thank you. I am out of times.

Chairman JOHNSON. Thank you, Senator Daines.

I have always said that if there is one metric in terms of fixing this whole health care mess, one metric we would look at telling us we are moving in the right direction, it really is that. We say 11 cents, you said 12.4 cents of every dollar paid directly by the patient. If we could move that up to a higher percentage where you actually have patients demanding the price transparency, “What am I going to pay for this service?” that really starts my—first, an anecdote in terms of what I had staff take a look at and then my question.

I literally had my brother outside of his normal area get sick and have to go to a clinic and he wanted to pay cash rather than insurance. He got a 75-percent discount, which prompted me to ask my staff to start calling up clinics. They called up 748 different clinics on two different conditions—an ear infection and strep throat. Only about 20 percent of the clinics, 21 and 20, knew what the price was. In other words, 79 and 80 percent of the clinics did not know what the price was. The discount for cash when they asked for it was about 20 percent, 20 to 21 percent, which kind of shows you the whole middleman cost of this completely dysfunctional financing system.

Let me go to my question. Of the \$2.66 trillion I was talking about, the difference between inflated spending from 1960 to the \$3.2 trillion we spend, do you know of any studies that have kind of quantified how much of that is because of what we can do nowadays, the advances in medical technology and science, versus just an inefficient financing marketplace? Anybody on that? Dr. Baicker.

Ms. BAICKER. It is a harder question to answer than it ought to be, in part because there have been studies that have shown the spread of insurance has very much led to higher spending on health care, but some of that is driving innovation in new medical technologies that did not exist before, building infrastructure that did not exist before. So then maybe even a simpler breakdown might be how much of it is price and how much of it is quantity. When you look at spending, it is number of units times price per unit. But, even that is harder than it ought to be because it is hard to define the quantity. A day in the hospital means something different now than it used to mean in terms of the intensity of services.

So, surely it is some of both, which is a really unsatisfying answer to give, I know, but we are treating people a lot more intensively. A lot of that is flat of the curve medicine, where we are delivering more services of diminishing value, and then some of it is the price per service. But, I think a lot of it is technological innovation, some of which is very high value on average but very low value on the margin. In the MRI example for low back pain, MRIs are good. I am glad there exists an MRI technology. But, the marginal person on whom it is deployed is probably not getting much benefit from it.

Chairman JOHNSON. So, I would ask you, after the hearing, if you know of studies or can search for studies or indicate to our staff where we could kind of look to start getting some quantification of that \$2.66 trillion, where that is all broken out.

You mentioned staying in a hospital room. A question I always have, just basic, a really nice Hampton Inn costs less than \$100 a night versus I do not know what they are charging for hospitals now but it is outrageous. Now, I realize there are costs spread—you got nurses at stations, that type of thing. But, let us face it, I do not know how much you spend for an aspirin, but generally those hospital charges are pretty well quantified, and they are covering their costs.

We need to explore what is the cost of the middlemen in this third-party payer system. I am a private sector guy. I am not going to beat people up and try to make a profit. But, because we have this third-party payer system, we have a lot of people involved in actually paying the bills. And, they all make a cut, and they all have salaries and it just continues to increase that.

I do want to ask to what extent has the Medicare policies, DRGs, contributed to this process. Dr. Baicker, as long as you are—whoever wants to go, but you seem ready.

Ms. BAICKER. I was poised, fast finger. The Medicare payment system I think drives a lot of the care that we get. One thing that you mentioned is the insurance payment versus the underlying cost, and it is misleading in Medicare to look at something like hos-

pital margins and say, “Oh, they are not so big.” Well, the payment is actually driving a lot of the investment that is driving the costs up, and the reason it is so expensive to treat certain conditions is because we are paying so much for them. There is a chicken-and-egg problem there. And, a lot of the policies in Medicare that might help dampen down overuse of low-return care are undermined by the ubiquity of Medigap policies. Senator Daines asked about whether there were other things, other government policies that could improve that allocation problem. Well, a lot of the innovation you might do in Medicare payments really has no bite on the patient side because more than 90 percent of Medicare beneficiaries have a wrap-around policy, whether it is a retiree plan or a Medigap plan. So, even when you try to change cost sharing, it gets undone by those policies. That would be one thing to potentially reform.

Also, you see a lot of innovation on Medicare Advantage, private plans offered to Medicare beneficiaries that have a little more room to maneuver in innovative benefit design in selective contracting with providers to help drive down prices. But, there is a limit to how much Medicare beneficiaries can save in that. They cannot actually get cash back in terms of premiums if they choose the highest-value, lowest-cost policy available to them. Reforming that might allow them to do a little more shopping among plans that are delivering innovative policies.

And, if you look at spending on health care, Medicare coverage decisions and Medicare payments drive a lot of what happens even in commercial markets. Medicare is a huge share of our health care system, and it has an even outsized impact because other providers follow the Medicare rules and coverage provisions.

Chairman JOHNSON. Does anybody want to comment on that?

Ms. CORLETTE. Well, the only thing I would say—and I say this a little bit as a former Senate staffer myself—is let us not underestimate how challenging it is for Congress to go after some of the historic payment methodologies that are in the Medicare program. I mean, history is littered with examples of efforts either by the Centers for Medicare and Medicaid (CMS) or by Congress, whether it is the sustainable growth rate (SGR) or the Part B demo—I mean, the list goes on and on and on—of efforts to try to rein some of these—

Senator McCASKILL. Death squads.

Ms. CORLETTE [continuing]. Disincentives and cost drivers out of the system. And, the problem is, one person’s cost is another person’s paycheck. And so, that is just a reality that you all need to grapple with, and it is not—

Chairman JOHNSON. OK. I want to keep going back to that. How much of health care really could be paid directly by the patient? I think we really underestimate that. I can just tick—whether LASIK—certainly what I saw in my business career because of HSAs we had Walgreens, Walmart, CVS, walk-in clinics, \$35. There is a doctor in Wisconsin that just really primarily focuses on farmers, charges \$55, cash, basically to the rural community for a half-hour appointment. Now, he has the infrastructure. He has hospitals with the equipment and stuff. But, there is an awful lot of innovation. Dermatology, there are so many things in our health

care system that I think really could be paid directly. You have the patients demanding the price. And, I really want to explore how much can be used—really use the consumer-driven free market competition to, as you said, agitate for better pricing, better quality, better service. I mean, it works in every other area of our economy, consumer-driven free market competition. I know there is a breakdown because you have the high cost, you have the catastrophic instances where you need insurance. But, I think it has just gotten completely out of whack. And so, again, anything you can do to help us, point this Committee in the direction of what those things could be. Go ahead.

Ms. THOMASSON. I am trying not to appear too eager here, but I think—

Chairman JOHNSON. No, I appreciate that. Otherwise, I will just keep yakking. [Laughter.]

Ms. THOMASSON. This is definitely a case—well, you were kind enough to say that there were no bodies littering the floor where politicians are concerned with trying to tackle some of these issues. But, I think history can be illustrative here.

When Medicare was enacted, its chief opponents were physicians. They wanted nothing to do with it. They were very vocal. I have recently been reading Senate testimony on the Medicare hearings for a book I am writing, and the American Medical Association (AMA) came out staunchly opposed.

Part of the way that the reimbursement structure for Medicare was set up was to placate physicians and get them to participate. And so, we set it up on this fee-for-service basis with extra costs for capital depreciation and replacement, which was a bonanza, and we saw health expenditures increased 37 percent in the first 5 years of Medicare alone, and it was just more services being done. I mean, I think you could argue that in 5 years technology did not change significantly to lead to that kind of rise in medical expenditures, although, true, some patients did actually see the doctor for the first time, as Senator Tester was suggesting, and have it be paid for with insurance.

So, I think that cost transparency is vital. I think provider payment reform is vital, and the providers are still actually opposing it. In Ohio, there was a State law that has been proposed—it is currently subject to an injunction. A State representative had suggested a bill where providers had to provide consumers with a good-faith estimate when they entered the hospital, like you would get when you repaired your car. And like I said, providers complained. They do not want to tell their prices, they said it would be bad for care. And, they will argue that a lot of it has to do with the fact that you do not know what you are going to do for that patient, and so you cannot really commit to an estimate. But, there is still opposition to transparency among the people who are providing the services, clearly.

Chairman JOHNSON. One of you in your testimony I think said that costs increased 70 percent after Medicare. Did I just read that in something else or is that in the testimony?

Ms. THOMASSON. Well, I said in my testimony, Medicare provides a good laboratory experiment for trying to gauge how much the spread of insurance has increased overall health expenditures, and

the best estimate is that up to 50 percent of the increase in costs between 1960 and 1990 are due to the spread of overall health insurance.

Ms. BAICKER. Not just Medicare.

Chairman JOHNSON. Not just Medicare, right.

Chairman JOHNSON. OK. Senator McCaskill.

Senator MCCASKILL. I want to talk about why the market is not working better. What are the barriers to the market working better?

Now, the irony is, I have had a number of people say—and one of you mentioned it this morning—that, well, you need to ask your doctor and rely on your doctor's advice; and, therefore, being able to shop on an app for a knee replacement or being able to shop on an app for a cheap MRI does take the doctor out of the equation. Well, then how can we explain the billions of dollars of advertising that are flooding television stations right now, telling consumers what prescription drug they need? Why do we have this breakout? I mean, we now know that some of these pharmaceutical companies are spending more on trying to convince me I need Humira the number one prescribed drug in America right now—that is abusing the patent process, I might add. Why are they flooding magazines and the air waves that I need this drug when a doctor is not driving that? And why are we not seeing the same thing from doctors about, “You need to come to see me for your allergies,” or, “You need to come see me, I can give you all your allergy tests for free if you come and see me”? Why are we not seeing loss-leader type advertising from doctors? We are seeing it from hospitals, primarily in certain areas like for cancer or for heart or for delivering babies, but not at all from doctors. What is that?

Ms. THOMASSON. There are big billboards between Oxford and Cincinnati that advertise various hospitals, a few doctors, mostly for plastic surgery and these things that are very—

Senator MCCASKILL. Or LASIK.

Ms. THOMASSON. Right, or LASIK.

Senator MCCASKILL. Where people are paying.

Ms. THOMASSON. I mean, the thing is that this is not a competitive market, and there has been substantial provider consolidation, which gives them room to advertise. And, since consumers are not paying the bills and providers—it is much easier for a provider to say, “Oh, Humira, you want to try that?” “Sure, why not?” It is not going to cost you anything. You advertise to consumers, and then consumers go to physicians who are not likely to have any incentive to provide a barrier there, and, in fact, it takes some time to explain why that might not work. Patient satisfaction surveys: great idea except that now doctors have to be pleasers, too. So, there are not a lot of incentives for them to put the brakes on drugs right now.

Senator MCCASKILL. Not only put the brakes on drugs, but also begin—I mean, we have to figure out something on this advertising. This is ridiculous. And, we are paying for it. They get to deduct it all, right? What is the economic rationale for being able to deduct the cost of prescription drug advertising? Anybody?

Ms. THOMASSON. See, this is why I am not an accountant. [Laughter.]

I actually want to say that there are tradeoffs with advertising. Advertising can communicate differences in price or quality. In competitive markets, that is what its function is. But, it can also, like you said, kind of drive demand and drive extra use of services. The American Medical Association—I think actually historically—I do not know whether it is true now—actually prohibited members from advertising because they did not want prices to get lower. They did not want people to say, “Oh, that doctor is offering this service for less.”

Senator MCCASKILL. I think that is something we need to look at.

Ms. THOMASSON. But, I do not think it is advertising that is the problem. It can be beneficial.

Senator MCCASKILL. You can be, obviously, thin, wealthy, run through fields with a smile on your face, play with your grandchildren, and have sex whenever you want it based on these ads. And, it is like so nuts that we are underwriting that; the taxpayers are underwriting that kind of effort.

Let me address also end-of-life costs. You all have not discussed what percentage of our health care costs are attributable to the last 6 months or year of folks’ lives. Could you address that? Because I think it is an important thing for us to talk about.

Ms. BAICKER. This is a really important issue, and it is a great example of a place where we spend a lot of money on care that does not seem to make patients better off and in some cases may make them substantially worse off. And, when we have seen concerted efforts to implement joint decisionmaking between patients and physicians where good information is elicited about what patients and their families really want, you end up spending less on end-of-life care because patients would rather be at home. They would rather forgo some of the more intensive treatments.

There is a great example from a commercial insurer that experimented with changing requiring patients who enter hospice care to sign something saying that they would forgo curative care. It used to be that to get into hospice you had to say, “I hereby give up on trying to be cured,” and then you could get hospice care, presumably to prevent people from using a lot of extra hospice care—

Senator MCCASKILL. That is just bizarre.

Ms. BAICKER [continuing]. Which seems like a very low risk. But you can imagine saying to a patient and the patient’s family saying, “Hey, will you just sign right here saying you are definitely dying and you have given up on trying not to die?”

Senator MCCASKILL. Right.

Ms. BAICKER. What a terrible thing to ask someone to do. When you say instead, “You do not need to sign that, just let us know that you would like to enter hospice care,” patients were more likely to enter hospice care because they were not confronted with that horrible moment of giving up, and, in fact, they were more likely to forgo curative care because it was not improving their quality of life and hospice was making them much more comfortable. That innovation saved money for the system but, more importantly, created a better end-of-life experience for patients and their families and did not curtail their options at all. And, it is that kind of inno-

vation that I think could have us treating patients better, more kindly, more carefully in the last—

Senator MCCASKILL. Yes, and, this is when I knew things were going to go south fast, because the whole misinformation about death panels was just us reimbursing doctors for them taking the time to make end-of-life explanations about nutrition and hydration so that patients could make those decisions prior to the moment where their families are trying to make them for them. That is all it was. It is a really good idea. It had nothing to do with forcing anybody into any forced—you do not get care at the end. And, it got so misinformed, and that obviously is something—thank goodness my mother, let us all know that we were going to burn in hell if we put her on a feeding machine or artificial hydration, and so she was able to come home and died with us around her. And, I cannot imagine the costs that would have been incurred had she not pounded that into our heads every day. But, a lot of families do not have that.

I know I am out of time. I have one other thing that I want to talk about, the poverty tax. I wish that Senator Daines was still here. Every person on that chart that he talked about—I do not know how many people were in the family, but basically you have to make more than \$80,000 a year for a family of three to not get subsidies on the exchanges. So, when you choose not to take those subsidies on the exchanges, you are making a decision to have somebody else pay for your health care. You are making the decision that—now, I guarantee you those people that are paying those penalties are going to go to the emergency room if their child begins to turn blue or if somebody gets a broken arm or if there is a car accident, and then all those costs are passed on to everyone else. And so, the irony is that those are the people the subsidies are designed to help, and they are just refusing to take the help of the subsidies and say, “I want somebody else to pay the bill.”

So, I think to call it a “poverty tax” is terribly unfair. It is not a poverty tax. It is trying to instill in people the idea that you all discussed very eloquently, that if you do not have responsibility to get insurance, then those of us who have insurance are just going to pay more for what we have. There is no escaping that—right?—in terms of the economics of this issue. There is no way to get around that, correct? OK. Thank you, Mr. Chairman.

Chairman JOHNSON. Two quick comments. I was involved in a bipartisan group on end-of-life issues, and one of the articles I brought to the table—and I will try and get it for the Committee—was written by Dr. Murray. The title was, “How Doctors Die It’s Not Like the Rest of Us, But It Should Be.” A really thoughtful piece.¹

In terms of advertising, the reason we allow it to be deducted is we let every business deduct marketing expenses. Now, from my standpoint, when I watch those commercials, all the caveats, all the disclaimers, all the warnings, I do not know why anybody would ever want to, first of all, take one of those drugs that is being advertised, because it is pretty scary. But, anyway, Senator Carper, do you have further questions?

¹The article referenced by Senator Johnson appears in the Appendix on page 173.

Senator CARPER. I do. Thank you. Thank you again for holding this. I have been bouncing back and forth between this hearing and the HELP Committee, where several of the Nation's insurance commissioners are testifying. And, they have it almost wrapped up, ready to put a bow on it, and send it our way.

One of the great values of a hearing like this is for you to help us develop consensus. And, the thing that we need to develop consensus on right now, I am told, is the marketplaces, stabilizing the marketplaces. And, we have heard a variety of ideas suggested to do that. One made clear that CSRs are not going away, not just for the rest of this year, but for at least one more year, maybe for two—at least one more year, but maybe even two additional years.

Two, reinsurance. Senator Johnson talked a little bit about the invisible high-risk pool and the idea of maybe working something like that into this. Some say it is just another way to do reinsurance.

Three, individual mandate or something as effective as the individual mandate in getting young people off the bench and into the game so they are part of the high-risk pools.

Help us. Just very briefly, starting with you, Ms. Corlette, for consensus, what should we do right now on stabilizing the exchanges? Where do you think there is consensus among the three of you? Thanks.

Ms. CORLETTE. My top three would be just that, number one, insurers need certainty that they will be reimbursed for the costs associated with the cost-sharing reduction plans that they are required by law to offer to eligible enrollees.

Number two is they need to be confident that the individual mandate will be enforced.

And, number three, I would do a little bit of reinsurance. I think even though now we do not have any bare counties, knock on wood, the States and insurers have stepped up to make sure that everybody everywhere will have some option. But, I think we do need to look at places where there is still only one insurer, where costs are rising. So, those are the three things I would do right now.

Senator CARPER. Good. Dr. Baicker.

Ms. BAICKER. I think we all agree that those rules also need to be in place for more than just 6 months or a year, that insurers participating in a relatively new marketplace need to know what the playing field looks like for a good period of time, whether rules that are on the books are going to be enforced, that they are competing in a fair way with each other to participate.

Senator CARPER. All right. Dr. Thomasson, who comes from the real University of Miami, which has been a university for longer than Florida has been a State.

Ms. THOMASSON. That is correct.

Senator CARPER. I went to Ohio State. I have heard this often.

Ms. THOMASSON. I will send you the T-shirt.

Senator CARPER. There you go. [Laughter.]

All right. What is the consensus here on stabilizing the exchanges?

Ms. THOMASSON. I agree with everything that has been said so far, and I would actually add, too, that insurance companies entered this market because they were incentivized with the CSRs,

the cost-sharing reductions, the risk corridors, and reinsurance. To the extent that government does not fulfill its end of the bargain, it is going to be difficult not only in this endeavor but in future endeavors to come up with private market-based solutions to some very thorny issues. And so, I agree that we need to fulfill our terms of the agreement, and we probably need to do it for more than a year to allow them to have experience.

Senator CARPER. I was on the phone with some folks from Highmark, which runs Blue Cross/Blue Shield programs in Delaware, Pennsylvania, I think West Virginia, maybe another State or two, and talked with them and with other folks, folks at the America's Health Insurance Plans (AHIP), the health insurance coalition. Most of them said, "We could reduce our premiums if you basically will do these three things that you are talking about." If we could do this, they could reduce premiums by as much as 35 percent. And, the great thing about that is it is not just to save some money for people who are getting health insurance within the exchanges. It is Uncle Sam. In some ways, Uncle Sam is actually the biggest beneficiary of all. Is that correct?

Ms. CORLETTE. That is right because as premiums go up in the markets, the tax credit subsidy has to go up dollar for dollar with it.

Senator CARPER. Do you all agree with this? OK. Let the record show heads nodding from Oxford, Ohio, and other places.

Chairman JOHNSON. Can I just interject?

Senator CARPER. Please.

Chairman JOHNSON. That was the point I made in our pre-meeting, that whether we fund the CSRs—if we do not fund the CSRs, premiums will go up, and we will fund the premium tax credit. So, either way, the American taxpayer is going to pay for this. The problem with allowing premiums to increase, the forgotten men and women who do not qualify for the subsidies, whatever that level is, they are going to—insurance is going to be even more unaffordable.

So, this is, from my standpoint, some very unhelpful demagoguery on our side of the aisle, "We are not going to bail out the insurance companies." Well, the insurance companies are going to get the money one way or the other. The American taxpayers are going to pay for it, so let us be honest. Again, let us take a look at the reality of the situation, which is why I was supportive of funding the CSRs a number of months ago to stabilize those markets before it is too late.

But, anyway, sorry for interjecting.

Senator CARPER. That is OK. If I could, one last question on HSAs. I share the interest of some of our Republican colleagues in looking for ways to improve and possibly expand health savings accounts. At the same time, one of my constituent's main complaint is about high deductibles and cost sharing with their health plan.

Last year, Senator John Thune from South Dakota and I sent a letter to the Treasury Department. We asked that high-deductible plans with HSAs be permitted to cover health care services to treat chronic conditions before the deductible. And, I would just ask each of you just to briefly let us know what do you think this time of would reform to improve the value of high-deductible insurance

plans make sense? And, what other reforms to HSAs should we consider? Dr. Thomasson?

Ms. THOMASSON. But, do not ask me to do CPR.

Senator CARPER. OK.

Ms. THOMASSON. Well, I think that—

Senator CARPER. Looking for some consensus on HSAs to add more value.

Ms. THOMASSON. Yes. Well, I do think that research has shown that just a simple high-deductible health plan with a one-size-fits-all deductible is a blunt instrument. And so, there is evidence that high-deductible health plans could be structured in such a way to encourage, for example, adhering to diabetic medication or hypertensive drugs, treating some of these chronic conditions, while minimizing your use of low-value services. So, I think there is certainly room for improvement. But, I would actually say that Dr. Baicker has actually done research on this.

Senator CARPER. Dr. Baicker, is that true?

Ms. BAICKER. I will not deny it. There is, I think, a huge potential gain from more value-based insurance design, taking the principle behind HSAs that patients ought to be more price-sensitive and have an incentive to choose the care that is right for them, not just more care. But, an HSA is fairly blunt. And what you would really like to see is not just co-payments that vary for different treatments, but co-payments that vary for different patient circumstances. An example is a statin to lower cholesterol. For a diabetic patient, a statin is incredibly valuable. In fact, lots of providers, even though I am not a real doctor either, recommend using statins for diabetics even before their cholesterol is elevated because it is such good prevention for adverse cardiovascular events. So, maybe diabetics ought to have a negative \$5 co-pay. Maybe we ought to pay them \$5 to take their statins. Whereas for somebody with mildly elevated cholesterol and no other risk factors, the statins may not be really doing much good, maybe that person ought to have a \$50 co-pay. And so, you could have something that is actuarially equivalent that is actually increasing or rationalizing patient cost sharing. Things that are high value could have and has very low cost sharing, and I might add cost sharing that varies based on income, because \$5 means something different to lower-income people than to higher-income people. With that kind of insurance you can push people toward high-value care and not subsidizing low-value care.

Senator CARPER. Ms. Corlette, the last word.

Ms. CORLETTE. I would agree that we should creative incentives to push toward value-based insurance design. It is a terrific concept. I think the challenge becomes who decides what is high value, who decides what is low value. And, while there are services on both ends that I think there is broad consensus around, there is a lot in the middle around which there is no consensus, and it becomes very challenging very quickly.

With respect to HSAs and high-deductible plans, I think it is important to keep in mind that close to half of the American public reports that they could not afford to pay \$400 for an unanticipated emergency medical expense. Four hundred dollars. They could not afford it. So, we need to bear in mind—

Senator CARPER. Say that again. How many? What percent?

Ms. CORLETTE. Almost half of Americans surveyed say they could not afford even a \$400 bill for an unexpected medical expense. So, it is important to know that most people do not have the kind of disposable income you would need to adequately fund an HSA to pay for the kinds of deductibles that we see, for example, in a bronze level plan.

Senator CARPER. Colleagues, I think Dr. Baicker has done some research on this in terms of affordability, and your research has suggested some possible solutions to address what Ms. Corlette has just talked about. Is that correct?

Ms. BAICKER. Tangentially.

Senator CARPER. OK.

Ms. BAICKER. Less in my wheelhouse, but I would like to follow up on something that Senator Johnson said about pre-funding the HSAs. A limited view of cost sharing is it is just a way of making patients pay more for a fixed bundle of care, that it is shifting costs from insurers to patients. But, really what cost sharing ought to be doing is incentivizing use of high-value care and disincentivizing use of low-value care. It should change the bundle of care that you consume, not just change who pays for a given bundle. If you can actually save money in the overall spend by shifting people away from low-value care, that leftover money can be used, for example, to fund HSAs I very much agree that especially low-income Americans do not have enough money to cover the typical deductible in a high-deductible plan, but it does not have to be coming out of resources they already have. You can share back the savings from reducing overall health spending with them in a way that is incentive-compatible, and I think that kind of change could be sustainable and affordable across the income spectrum.

Senator CARPER. Great. Thank you so much.

Thanks, Mr. Chairman.

Chairman JOHNSON. Just quickly chiming in here, that, by the way, is kind of a depressing statistic right there, 50 percent cannot—I think part of that is attributed to the fact that we have conditioned Americans to the point that they do not have to pay for their health care because of zero-deductible plans, because of—again, so nobody plans on it. It is just that has become the culture, that we really do not have to pay for our own health care. We have to buy our own food. We have to pay for our own shelter. We have to buy our own cars. But, health care? Do not have to pay a buck for it, or a \$10 deductible. So, it is going to be a cultural shift that is going to be required here.

Again, I just want to kind of end, I guess, on that statement but to thank you for I think just really good testimony. The fact that you had Senator Carper, who was actually involved in the higher-profile health care here, the fact that he got back here I am assuming means we had a pretty good set of witnesses here. And, hopefully this hearing had some real value. It had a great deal of value to me. I want to thank my colleagues for attending.

I really do want to hold more of these. I want to work with all of my colleagues to provide the information. We will beef up this with your charts and graphs as well. Again, I do not want this one-sided. I want this completely bipartisan. Again, that problem-solv-

ing process, describe the reality, define the problem, get the information, set achievable goals. Then we will design the solutions hopefully in a bipartisan fashion to address—again, we all share the same goal. We want our fellow citizens to have access to high-quality health care at an affordable cost. So, again, thank you very much.

With that, the hearing record will remain open for 15 days until September 21st, at 5 p.m. for the submission of statements and questions for the record. This hearing is adjourned.

[Whereupon, at 12:01 p.m., the Committee was adjourned.]

A P P E N D I X

Opening Statement of Chairman Ron Johnson
“The History and Current Reality of the U.S. Health Care System”
September 6, 2017

As submitted for the record:

Good morning. I want to welcome and thank our witnesses for testifying today.

The purpose of this and subsequent hearings on health care is to begin a problem-solving process that can produce continuous improvement in America's health care system, thereby improving the lives of our fellow citizens. That process must begin with the description and acknowledgement of reality.

The first reality to be acknowledged—and that should overshadow every congressional action—is that gross federal government debt is \$20 trillion and the Congressional Budget Office projects we will accumulate additional deficits of \$129 trillion over the next thirty years. Federal spending on health care (Medicare, Medicaid, and Obamacare) will account for 26.5% of projected thirty-year outlays—\$87 trillion of \$328 trillion.

Overall, spending on the U.S. health care system is one of this nation's largest and fastest growing expenditures. In 2015, the U.S. spent \$3.2 trillion on health care, approximately one-sixth of the U.S. economy. Over the last half century, patients have been separated from the direct payment for health care products and services, with third parties (government and insurance) taking over the primary role of payer. Today, only 11 cents of every dollar spent on health care is paid directly by patients. Without patients directly paying for care, pricing information is minimal and the benefits of consumer-driven competition have been greatly reduced. As a result, since 1960 the cost of health care has risen at 5.9 times the rate of inflation.

My hope is that we can find agreement on basic facts that can help us lay the groundwork for developing solutions. In the private sector, successful businesses tenaciously follow a well-defined problem-solving process that concentrates on facts, defining reality, employing root-cause analysis, and developing consensus. Unfortunately, in politics, demagoguery and exploiting divisions are too often the coin of the realm.

For today's hearing, I have asked the witnesses to testify on the facts and figures relating to the history and current state of health care in this country. One goal of this process is to dispel myths about the American health care system by analyzing health care data and market trends dating back decades. By focusing on information, we can begin to identify root causes of the current problems, and later, consider solutions. I hope that the information derived from these hearings will inform the debate and lead to a more productive discussion on health care in the future. I thank the witnesses for appearing today and look forward to a fruitful discussion on this important topic.

**U.S. Senate Committee on Homeland Security and Governmental Affairs
Hearing on “The History and Current Reality of the U.S. Health Care
System”**

September 6, 2017

Ranking Member Claire McCaskill

Opening Statement

Thank you, Mr. Chairman.

During a Finance Committee hearing back in June, I called for bipartisan hearings on healthcare reform. Unfortunately, there was never an opportunity to participate in hearings in the Senate on the Better Care Reconciliation Act or on any other Republican health care repeal or replacement plan before they were brought to the floor, in July. I appreciate that several committees are now holding open, bipartisan hearings addressing health care. This is a huge step forward. I hope that today marks the beginning of a return to regular order in the Senate and kicks off a new era in which we work to seek bipartisan solutions to the health care system and the many other challenges facing our nation.

In June, I also acknowledged that Democrats made mistakes when we passed the Affordable Care Act, and I value the opportunity to address some of those shortcomings. The ACA was a complicated piece of legislation that was designed to fill gaps and provide coverage to individuals that did not have access to affordable

health care coverage. Although the ACA is far from perfect, it succeeded in providing health care coverage to more than 20 million Americans. In August, the Centers for Disease Control and Prevention reported that the uninsured rate remains at historically low levels – only 8.8 percent of Americans are uninsured. But there is still much work to do – we need to build on these gains and ensure that more people have access to affordable health care coverage.

I would be remiss if I did not mention the giant elephant in the room – the immediate concerns affecting the individual market. In less than two months, Americans are scheduled to begin enrolling in 2018 plans on the individual market. And in order for that to successfully happen, we need to act today. First and foremost, we must take steps to stabilize the individual market. I held over 25 town halls in Missouri in August, and I heard from my fellow Missourians that they are extremely concerned about what will happen to their healthcare next year and want to know what can be done about rising health care costs.

Fortunately, for those in the individual market, there is an easy answer on how to help address concerns over uncertainty in the market and rising premiums, and that is for the Administration to commit to making cost sharing reduction (CSR) payments. Experts on both sides of the aisle agree that the uncertainty surrounding the future of CSR payments is causing instability in the individual market. The individual market depends on the voluntary participation of health insurance

providers. If the insurance companies that do participate in the exchanges do not receive CSR payments, they will find a way to offset the increased costs. For many of these companies, that will mean increasing premiums by an additional 20% in the individual market, or simply declining to participate in the exchanges at all.

We should not miss the opportunity to address the immediate problem before us—we must stabilize the individual marketplace and incentivize providers' participation in the exchanges by making the CSR payments permanent.

Even so, stabilization of the individual market is only one piece of the puzzle. The fact remains that health care costs are rising, and more and more Americans are concerned about access to affordable, quality health care. We all know that high drug prices and the lack of price transparency for health care services are significant cost drivers. Americans struggle to get answers to a relatively simple question: How much does this cost? We should make it easier for folks to get answers to that question. We also have to address high drug prices, which are driving up health insurance premiums and forcing too many people to choose between buying their medication and paying their bills.

I look forward to hearing the testimony from our witnesses who spend every day working to understand the complex nature of our health care system.

Thank you, Mr. Chairman.



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September 6, 2017

Good morning Chairman Johnson, Ranking Member McCaskill, and Members of the Committee. I am Melissa Thomasson, the Julian Lange Professor of Economics at Miami University. Thank you for the opportunity to appear before you today to discuss the economic development of the health insurance system in the United States and its effect on health care costs. In an environment where the overall share of health care spending as a percent of GDP has more than tripled, from five percent in 1960 to roughly 18 percent today, understanding the evolution of health insurance is crucial to developing effective policies that improve health care access and quality, and that constrain cost growth.¹

Why the United States has an employment based system of health insurance

The fundamental function of any kind of insurance is to reduce financial uncertainty by pooling risks. Consider homeowners insurance. On average, if a large number of people pay a premium in advance, a relatively small number will have their houses burn down. Because not everyone has their homes burn, there is sufficient money in the pool to replace the homes of those who suffer the loss. This system works because both higher-risk and lower-risk people pay money into the pool, not just the people who face a high risk of loss.

At the turn of the 20th century, medical care was largely ineffective and medical costs were low. People rarely entered the hospital, did not face unexpectedly high health care costs, and did not need health insurance.² For example, only five percent of infants were born in hospitals in 1900. As medical technology advanced in the early 20th century and more people sought treatment in hospitals, health care costs began to rise. The costs of hospitalization also introduced wide variation in health care expenses for American families, so that middle class families that could previously pay bills might not be able to pay a large hospital bill.³

Even though the need for health insurance had grown, the market did not develop because insurance companies were concerned that “health” was uninsurable for two reasons. First, they feared a problem known as “moral hazard,” which occurs when an insurance changes the behavior of the insured person. In health insurance, moral hazard occurs because health

insurance increases the amount of medical care people consume by lowering the cost of care. Moral hazard affects all types of insurance, but is less of a problem in some areas; for example, few people begin driving recklessly simply because they have insurance to repair their car in the event of an accident. A second reason insurance companies were reluctant to enter the health business was because they recognized that people who knew they might be more likely need medical care would be more likely to seek out insurance. This problem – known as adverse selection – was as big as a problem for insurance markets in the 1920s and 1930s as it is today in the non-group market. For insurance to be effective and affordable, both healthy people and people more likely to become ill must buy insurance.

The problem of adverse selection was solved in 1929 when Justin Ford Kimball, an administrator at Baylor University Hospital, devised a means to alleviate the financial pressure the hospital faced from unpaid hospital bills. A former superintendent of schools, Kimball worked with Dallas teachers to develop a plan to help them pay their bills – and improve the financial position of the hospital. They came up with a simple plan based on the principles of insurance to help teachers pay: Baylor would provide each teacher with 21 days of hospital care for an annual fee of \$6.00. These hospital-based plans – which later became known as Blue Cross – had unwittingly solved the problem of adverse selection. By selling health insurance to a group of employed teachers who were healthy enough to work, the plan ensured that the risk pool would not be overwhelmed by people who were likely to be sick. The problem of moral hazard was also mitigated because the Blue Cross plans reimbursed hospitals directly and patients generally could not admit themselves to hospitals.

The Blue Cross plans became enormously popular, both among members and hospitals. They enabled hospitals to receive a constant stream of revenue and offered financial protection for Blue Cross members. By 1940, roughly nine percent of Americans had insurance against hospital expenses.⁴ Several factors combined to lead to rapid growth in the number of people with health insurance coverage. Medical technology advanced, and discoveries such as sulfa in 1937 and penicillin during WWII increased the demand for medical care.⁵ Commercial insurance companies, which had initially been reluctant to offer health insurance, witnessed the success of the Blues in conquering adverse selection, and soon began to compete with the Blue Cross plans by offering insurance to employee groups.⁶

In the 1940s, a series of events ensured the expansion of the health insurance market and its employment-based nature. The tremendous mobilization of troops and resources during World War II led to a huge decline in unemployment, which fell to a low of 1.2 percent in 1945.⁷ Beginning in 1942, the National War Labor Board limited the ability of firms to raise wages to attract increasingly scarce labor. Health insurance (and other fringe benefits) were exempted from this ruling. As a result, firms began to offer health benefit packages to secure workers.

Unions worked to negotiate for health insurance on behalf of workers, a right that was assured in 1949 when the National Labor Relations Board ruled in a dispute between the Inland Steel Co. and the United Steelworkers Union that the term “wages” included pension and insurance benefits. Therefore, when negotiating for wages, unions were also allowed to negotiate for benefit packages on behalf of workers. This ruling, later affirmed by the U.S. Supreme Court, further reinforced the employment-based system.⁸

Perhaps the most influential aspect of government intervention that shaped the employer-based system of health insurance is the tax treatment of employer-provided contributions to employee health insurance plans. Employers are permitted to deduct health insurance contributions (like wages) from their taxes as a cost of doing business. But unlike wages, employer contributions to employee health insurance premiums are exempt from employee taxable income. This “tax subsidy” of employer contributions to employee health insurance premiums first occurred in 1943 with an administrative tax court ruling and was later codified under the 1954 Internal Revenue Code.⁹ The tax treatment of employer provided health insurance provided an additional incentive for its expansion; research shows that the 1954 statute increased the generosity of existing plans and the number of firms that offered coverage.¹⁰ The tax treatment cemented the institution of employment-based health insurance in the United States and introduced a number of distortions into the system. First, workers whose employers pay for their health insurance receive lower wages (since employers look at total compensation when making hiring decisions). Workers may also be reluctant to leave their job if they fear their health insurance may be less comprehensive elsewhere.¹¹ The tax subsidy of premiums provides greater value to higher income individuals with higher marginal tax rates, and today results in an estimated revenue loss to government of \$266 billion – which is 4.5 times greater in magnitude than the \$59 billion revenue loss resulting from the home mortgage interest deduction.¹² Finally, the tax treatment of employer-provided health insurance prevents non-employment based groups from providing coverage, and leaves anyone who is unable to work at risk of not having health insurance.

How our health insurance system leads to rising health care costs

Policies that encourage the development of very generous health insurance plans, such as the favorable tax treatment of employer sponsored health insurance coverage, contribute to rising health care costs because they increase moral hazard. To the extent that the additional health care purchased by consumers is necessary and cost-effective, this increase in utilization is not problematic. But if the care consumers are purchasing is of low value, the extra utilization does not improve health and adds to rising expenditures. In the early days of health insurance, the risk of consumers receiving low-value care was small, since health insurance plans were much less generous. Blue Cross initially covered only hospital bills, since physicians were slower in

developing the Blue Shield plans that offered financial protection for their bills. In 1940, when most Americans only had hospital coverage, Blue Cross directly paid hospitals a set rate for a finite number of covered days. Moral hazard was small because patients did not admit themselves to hospitals, and patients did not receive indemnity (cash) benefits.¹³ In this regard, benefits were not open-ended. Even as Blue Shield developed, it initially only covered physician visits while a patient was in the hospital.

This changed rapidly. Health insurance became more generous in the 1940s and 1950s. Consumers could purchase not only hospital insurance, but also coverage for medical expenses both inside and outside of the hospital, so benefits became less limited and defined. At the same time, the charge and cost-based reimbursement systems developed by Blue Cross ensured that hospital costs would be covered. By paying for whatever costs hospitals incurred, the structure of Blue Cross did not emphasize efficiency and economy, and there was little incentive to weigh costs and benefits. During the post-WWII period when the economy was strong and medical developments such as penicillin were seemingly miraculous, hospitals placed an emphasis on expansion and investment. The federal government endorsed and funded this expansion, with the passage of The Hospital Survey and Construction Act (the Hill-Burton Act) in 1946. Between 1947 and 1971, the federal government disbursed \$29.3 billion (inflation-adjusted 2016 dollars) to construct, replace, and renovate health care facilities. Analysis suggests that the Hill-Burton program accounted for 17 percent of the growth in hospital beds between 1948 and 1975, and resulted in a net increase of 70,000 beds nationwide, while smoothing disparities in hospital access between high- and low-income counties and rural and urban areas.¹⁴ These new hospitals had new and improved laboratories, operating suites, and equipment – and they were expensive. In 1963, a task force set up by the American Hospital Association (AHA) and the Blue Cross Association affirmed the cost-plus reimbursement system, where hospitals were reimbursed for the cost of treating patients, with further allowances for capital depreciation and replacement.¹⁵

As time has passed, insurance coverage has become more generous and the share of health care expenses paid by consumers has decreased. In 1950, when approximately 50 percent of the population had hospital coverage, consumers paid 64.9 percent of health care expenditures out of pocket. Only 10 years later, this number had fallen to 55 percent, and to 40.8 percent in 1968, just a few years after the implementation of Medicare.¹⁶ Today, consumers pay only about 12.4 percent of their health care bills.¹⁷ Given that the function of insurance is to provide financial protection against large, unexpected losses, reducing consumer out of pocket payments so they can afford care is not necessarily a bad thing, but it is important that the care consumers receive is necessary and cost-effective so that health care expenditures do not rise unnecessarily.

The problem is that as insurance has become more generous, our system has tended to reward providers on a fee-for-service basis. Under the fee-for-service system, providers are

reimbursed for every service they provide. This system incentivizes volume-based care. Providers do not have a financial interest in limiting services; in fact many have a financial incentive to perform more services.¹⁸ Patients rely on physicians to determine the services they need, since medical decisions are complex.¹⁹ When patients pay little for their care, they consume more; the RAND Health Insurance experiment showed that people with who paid for 25 percent of their care spent 20 percent less than participants with “free” care. Patients enrolled in a plan where they paid 95 percent of their care (similar to what we would consider a high deductible plan today) spent 30 percent less than participants with no cost sharing.²⁰

The implementation of Medicare in 1966 provides an excellent example of how cost-based reimbursement coupled with insurance coverage can lead to high utilization and rising expenses. From 1966 until 1983, hospitals were reimbursed on a cost-plus basis. Research shows that within four years of its implementation, Medicare resulted in a 37 percent increase in real health expenditures, with about half of that increase coming from the entry of new hospitals into the market and the other half coming from expansion of services.²¹ Even after 1983, when Medicare switched to a system of fixed prospective payment based on Diagnosis Related Groups (DRGs), a hospital’s revenue is still a function of patient admissions, thus incentives for volume based care still exist. The response of health care expenditures to the introduction of Medicare suggests that up to 50 percent of the rise in real health care costs between 1960 and 1990 may be due to the overall spread of health insurance.²² Moreover, evidence suggests that as insurance expands the market for health care, it generates incentives for increased development of technology. While some of this new technology represents a significant improvement over current treatments, other innovations do not improve outcomes compared to existing procedures, yet cost more.²³

It is worth emphasizing that at least some of the increase in expenditures was probably “worth it” in the sense that the benefit to patients outweighed the costs. Moreover, there is evidence that Medicare significantly reduces financial risk for elderly people with the highest health care expenditures, which is one of its goals as a social insurance program.²⁴ The development of cost-effective technologies that help patients is also worthwhile. What is not worthwhile is inefficient, low-value care that emerges when providers are incentivized to deliver high-volume care regardless of cost that patients with generous health insurance coverage are willing to pay for.

How can the past inform present health care policy?

History can guide policymakers seeking to improve health care delivery and constrain health care cost growth, but it does not offer a simple solution. Rather, it suggests that the problem of adverse selection presents a long-standing challenge to the effective provision of insurance in the non-group market. History also suggests that constraining cost growth will be

difficult as long as health care providers profit from providing volume-based care. Movements to shift payment to reward value-based care that emphasizes quality and cost-effectiveness will be key to any policy seeking to limit the growth of health care expenditures. Finally, research shows that consumers respond to cost sharing such as high-deductible health plans (HDHPs) by significantly reducing spending both in the short run and over time.²⁵ Studies show that consumers with high-deductible health plans engage in cost-conscious medical decision making, such as increasing use of generic drugs, but it also suggests that they reduce spending on both low-value care as well as necessary care.²⁶ In addition, at least one study finds no evidence of consumers learning to price shop, even after two years in a high deductible plan, although this may be related to the fact that employer contributions to employee health savings accounts may engender moral hazard.²⁷ Combined, these studies suggest high-deductible health plans are effective at reducing costs, but need to be carefully structured to motivate consumers to obtain necessary and high-value care while minimizing the use of low-value services.²⁸

Notes

1. Centers for Medicare and Medicaid Services, "National Health Expenditures 2015 Highlights." Available from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>.
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3. In 1927, the government formed the Committee on the Costs of Medical Care (CCMC) to investigate the medical expenses of American families. Comprised of physicians, economists, and public health specialists, the CCMC published 27 research reports, offering reliable estimates of national health care expenditures. According to one CCMC study, the average American family had medical expenses totaling \$108 in 1929, with hospital expenditures comprising 14 percent of the total bill. In 1929, medical charges for urban families with incomes between \$2,000 and \$3,000 per year averaged \$67 if there were no hospitalizations, but averaged \$261 if there were any illnesses that required hospitalization (see Falk, I.S., C. Rufus Rorem and Martha D. Ring. *The Cost of Medical Care*. Chicago: University of Chicago Press, 1933).
4. Four percent had surgical coverage, and 2 percent had coverage for in hospital medical benefits. Health Insurance Institute, *Source Book of Health Insurance Data*, 1961.
5. Thomasson, Melissa A. (2002). "From Sickness to Health: The Twentieth Century Development of U.S. Health Insurance." *Explorations in Economic History*, 39(3), pp. 233-53.
6. See Thomasson, Melissa A. (2004). "Early evidence of an adverse selection death spiral? The case of Blue Cross and Blue Shield." *Explorations in Economic History*, 41, pp. 313-328. Commercial insurance plans were less interested in the non-group market, where they still viewed adverse selection to be a severe problem. They aggressively screened applicants in this market, while Blue Cross plans, operating as non-profits, did not. Analysis shows that the Blue Cross plans suffered from adverse selection, which may have ultimately led them to dump their nonprofit status and limit their offerings in non-group markets.
7. Bureau of Labor Statistics, "Employment status of the civilian noninstitutional population, 1940 to date." Available at <https://www.bls.gov/cps/aa2009/cpsnat1.pdf>.
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9. The first such exclusion occurred under an administrative ruling handed down in 1943 which stated that payments made by the employer directly to commercial insurance companies for group medical and hospitalization premiums of employees were not taxable as employee income (*Yale Law Journal*, 1954, pp. 222-247). This ruling was highly restrictive and limited in its applicability since it only affected direct employer contributions to group plans issued by commercial insurance companies. Private programs of employee associations or of employers were not covered under the ruling, nor were employer contributions to the individual health plans of employees. In addition, there was confusion as to what actually constituted "insurance." Even plans that could meet the criteria of insurance such as contractual enforceability, indemnification, and limits of liability were often not covered under the 1943 ruling (*Yale Law Journal*, 1954, pp. 222-47).
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13. A nationwide study of employer plans in the late 1940s found that of 215 employer plans, the most generous plans paid \$8 per day for hospital care, while 69 percent of plans paid \$5.00 per day or less. Strong, Jay V. *Employee Benefit Plans in Operation*. Washington, D.C.: The Bureau of National Affairs, 1950, p. 326.

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17. Calculated from Centers for Medicare and Medicaid Services, National Health Expenditures Accounts, Table 4, 2015. Available from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>. Out of pocket expenditures as a share of total personal health care expenditures.
18. Several studies suggest that physicians respond to financial incentives by changing treatment when the incentives change. For example, a 2011 study found that after Medicare implemented an average sales price payment system for physician-administered drugs (such as chemotherapy drugs) that reduced the reimbursement for a common lung cancer drugs, oncologists responded by increasing the rate of chemotherapy for patients with lung cancer; rates of treatment for lung cancer increased by more than 10 percent within the first 30 days after diagnosis. See Jacobson, M., Earle, C.C. and Newhouse, J.P. (2011). "Geographic variation in physicians' responses to a reimbursement change." *New England Journal of Medicine*, 365(18), pp. 1653-55.
19. Consumers can shop for some types of care (such as outpatient MRIs, non-emergent surgeries and certain drugs), but are often at the mercy of providers who recommend imaging, drugs, or surgery in the first place. These providers may have financial incentives that influence their behavior. For example, a 2012 study by the U.S. Government Accountability Office examined the number of imaging services referred by physicians between 2004 and 2010 found that the number of self-referred imaging studies (in which a patient goes to an imaging facility in which the physician has a financial interest) increased by 80 percent over the period, compared to an increase of 12 percent for non-self-referred services. ("Higher Use of Advanced Imaging Services by Providers who Self-Refer Costing Medicare Millions." U.S. Government Accounting Office Report # GAO-12-966, September 2012.
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23. For example, a 2013 study found that proton beam therapy offers no long-term benefit over traditional radiation for prostate cancer, yet Medicare pays \$32,000 per patient for proton beam therapy compared to under \$19,000 for radiation. See Yu, James B., Pamela R. Soulos, Jeph Herrin, Laura D. Cramer, Arnold L. Potosky, Kenneth B. Roberts and Cary P. Gross. (2013). "Proton Versus Intensity-Modulated Radiotherapy for Prostate Cancer: Patterns of Care and Early Toxicity." *Journal of the National Cancer Institute*, 105(1), 25-32, doi: 10.1093/jnci/djs463.
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My name is Katherine Baicker, and I am Dean of the Harris School of Public Policy at the University of Chicago and a health economics researcher. I would like to thank Senator Johnson, Senator McCaskill, and the Distinguished Members of the Committee for giving me the opportunity to speak today about the current landscape of the U.S. health care system.

We devote \$3.2 trillion to health care annually.¹ We spend substantially more per capita than other countries – and substantially more in some parts of our country than others – without commensurate improvements in health outcomes. For example, areas of the country where we spend the most on Medicare beneficiaries’ care are areas where they are less likely to get some types of high-quality, high-value care.²

Fundamentally, the key challenge in our health care system is not how much we spend per se, but that we are not getting the valuable health improvements that we should for each dollar that we do spend. The quantity and value of the care that we get is driven by the way that we pay for it – both the cost-sharing that patients face and the payment system that reimburses providers.

Where Does the Money Come From?

The way that we purchase health care, as patients and insurance enrollees, has changed dramatically in the last 50 years – and in some surprising ways. Through the advent and expansion of Medicare and Medicaid, the rise of employer-sponsored insurance, and the introduction of subsidized non-group insurance plans, the number of uninsured Americans has dropped substantially. The share of Americans who are uninsured declined from about 15% in 1994 to about 9% in 2015 (see Figure 1). Insurance provides vital benefits for enrollees, but also affects the quantity and value of the care we use.

Beyond access to care, insurance coverage provides crucial financial protection against the unfortunate circumstance of falling ill – the key characteristic of insurance (regardless of how it is financed). Subsidized “social insurance” can also redistribute resources from rich to poor, or from those who are healthy to those who are known to be sick. Private insurance can spread the risk of uncertain future needs, but fundamentally does not redistribute resources in the way that social insurance can.³

People are markedly better off being insured than being uninsured: they have better health outcomes and more financial security.⁴⁻⁶ But insurance changes the quantity and nature of care that patients consume, and how that insurance is designed can determine whether health and financial benefits are gained efficiently or at a cost that is too high. This is because patients’ cost-sharing has a marked effect on the care they use.

There has been a notable, consistent decline in the share of health care that is purchased “out of pocket,” versus through a public or private insurance plan (see Figure 2). Health insurance does not look like most other kinds of insurance we buy – like renter’s, homeowner’s, or car insurance, which typically have substantial deductibles and do not cover routine expenses – but rather includes a substantial “prepaid health care” component, covering routine care that does not carry the kind of financial risk that insurance is normally designed to address. This is in large part because of the tax preference for employer-sponsored insurance (versus out-of-pocket purchases), alongside the structure of our public insurance programs. Insurance has also evolved as the main channel for patients to get discounted prices from providers.

The broad decline seen in aggregate cost-sharing runs counter to public discourse about the rise in high-deductible plans and increases in cost-sharing. This disconnect may arise from the fact that a greater share of the population is now covered by plans with very limited cost-sharing (e.g. Medicaid, ubiquitous supplemental Medicare coverage), while there has been a rise in cost-sharing in many commercial plans. For example, the share of employees in plans with deductibles of \$1,000 or more has increased from about 10% in 2006 to 51% in 2016, at the same time that the share covered by Medicaid has risen from about 13% to 20%.^{7,8}

What is the “right” level of cost-sharing? At first blush, it might seem that cost-sharing is just a way of dividing up whether insurers or enrollees pay the bills, but decades of evidence shows that lower cost-sharing leads patients to consume more care of limited health benefit – such as unnecessary tests – and that this inefficient use leads to higher premiums.⁹⁻¹¹ Insurance that covers too much care with too little cost-sharing can lead beneficiaries to consume care of diminishing value, which raises costs overall. The idea that someone could have “too much insurance” may not be intuitive, but there is a fundamental trade-off between the financial protection afforded by insurance and the cost of the higher utilization that insurance induces: too little cost-sharing means patients have no incentive to spend health care dollars wisely; too much cost-sharing means that a policy fails to perform its insurance function.¹²

Many criticisms of higher cost-sharing in employer plans are based on the presumption that it is possible to have high wages, lower premiums, and lower cost-sharing, but the three are intertwined. The employee share of premiums has been fairly stable between 25 and 30 percent for the last two decades.⁷ This is difficult to observe for most employees. More important – but even less transparent – is the fact that employees ultimately pay both the employee and the employer shares, because when the cost of health insurance rises, less money is available for wages.^{3,13,14} This wage-fringe trade-off does not occur instantaneously for each individual, but in the long-run employees pay for the full cost of health insurance premiums through lower wages or lower employment. The tax preference for employer health insurance also pushes people into more expensive plans with lower copays – which is both regressive (the biggest benefits go to those with the highest income) and inefficient (artificially low cost-sharing leads to greater use of care with questionable benefit, driving premiums up and wages down). There is also very little cost-sharing in many public policies.

There has been some experimentation with innovative insurance coverage, basing cost-sharing on the value of care in improving health.¹⁵⁻¹⁷ Some experiments involve sharing the savings with patients who choose lower cost, high-quality options.¹⁸⁻²⁰ For such measures to be effective, patients need transparent information about the price of the care they are using – although transparency alone may not be sufficient if information does not reach patients at the right time and from by a trusted source.²¹ Of course, patients need choices among competing insurers (as

well as providers) to spur innovation and lower costs. In areas where there are fewer insurers, premiums tend to be higher.^{22,23}

Where Does the Money Go?

Alongside how patients pay for care, health care spending is driven by the way that providers are reimbursed for the care they deliver. The categories of care on which we spend by far the most are hospitals and physician services (see Figure 3). Although some other categories of spending are rising more rapidly, these still comprise the lion's share of health care spending – both overall and within different insurance market segments. This highlights the centrality of these particular services to health care spending overall.

Like patients, providers also respond to the payment system.^{24,25} We get more of the services that are generously reimbursed, and fewer of the services that are paid less well. The traditional fee-for-service reimbursement system still covers the majority of Medicare enrollees, basing payments on the quantity of care delivered rather than the quality or value of that care. Furthermore, Medicare's payment structure and utilization patterns can drive spending throughout the health care system.^{26,27}

There has been experimentation by private insurers with “value-based” payments and accountable care organizations, along with alternative payment models introduced in Medicare's payment schedule for physicians and other services.^{15,28-30} These alternative payment systems aim to generate an incentive for physicians to play an active role in managing the cost of their patients' care – vital given the central role that physicians and other health care providers play in helping their patients make informed decisions. Having adequate risk adjustment and quality monitoring are crucial to such systems working effectively to improve both value and quality. Financial incentives for providers to increase value delivered to patients – rather than just quantity – are also more likely to be effective when there is robust competition among providers. Analogous to insurer competition, in areas where there are fewer providers for patients to choose among, provider prices tend to be higher.^{31,32}

The Central Role of Health Care Financing

The way that we finance health care is a key determinant of the current landscape of health care spending. With about 18% of GDP devoted to health care spending, it is crucial that we get as much health as we can in the most efficient way possible from our health care system.³³ Health insurance provides vital financial protection and access to care, but can also lead to inefficient use of health care resources. A close examination of the way that health care financing drives both spending and how the burden of that spending is shared can lay the foundation for a high-value, sustainable health care system.

FIGURES

Figure 1

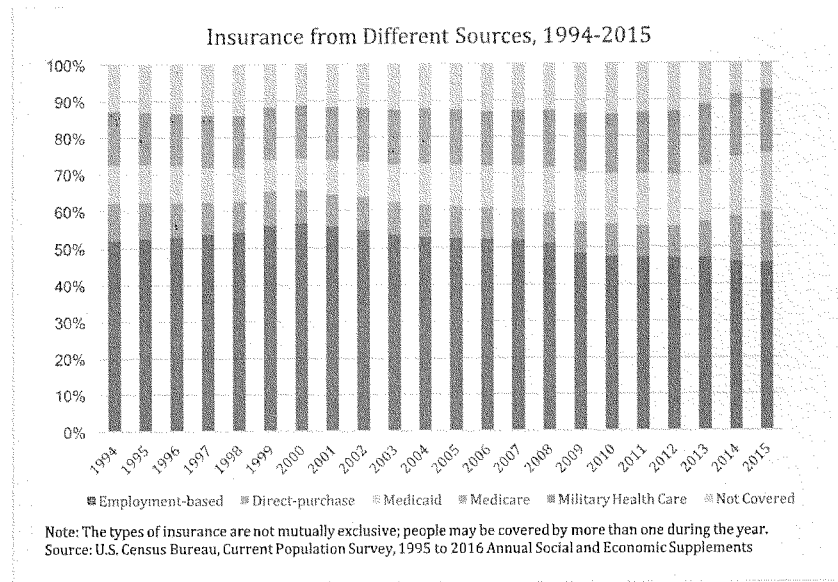


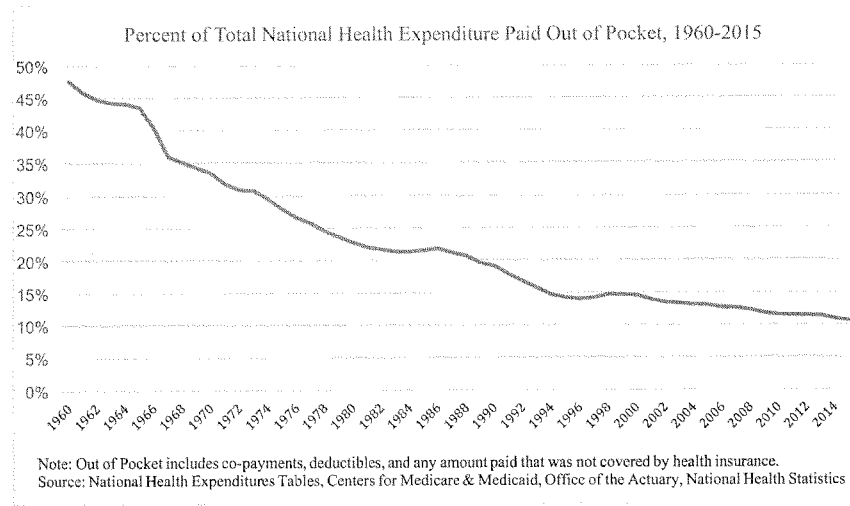
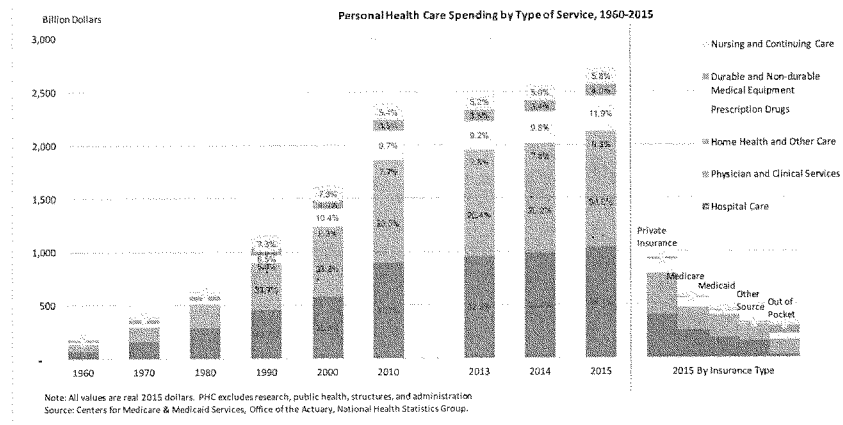
Figure 2

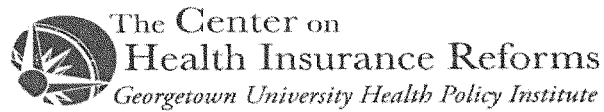
Figure 3



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**STATEMENT OF
SABRINA CORLETTE, SENIOR RESEARCH FELLOW
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**BEFORE THE
U.S. SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS COMMITTEE**

**HEARING
"THE HISTORY AND CURRENT REALITY OF THE U.S. HEALTH CARE SYSTEM"**

SEPTEMBER 6, 2017

Good morning Mr. Chairman, Ranking Member McCaskill, Members of the Committee. I am Sabrina Corlette, a Senior Research Fellow and Project Director at Georgetown University's Center on Health Insurance Reforms (CHIR). CHIR has a team of faculty and staff devoted to studying private health insurance and insurance markets. We are based at Georgetown University's McCourt School of Public Policy. Please note that I am here in my individual capacity and that my views do not necessarily represent the views of Georgetown University.

I want to thank this Committee for holding this timely and important hearing. We have had over the last several months – over the last several years in fact – an extended and rancorous debate about the future of health care reform. I appreciate this Committee's willingness to engage in a thoughtful, bipartisan effort to understand the root causes of some of the challenges facing our health care system. It is only with that understanding that policymakers can effectively tackle the necessary solutions.

Know Your History: Understanding Health System Challenges Requires Understanding How We Got Here

Both critics and proponents of the Affordable Care Act (ACA) can reasonably ask why it was structured the way it was, with an array of insurance reforms, an individual responsibility requirement (known as the individual mandate), and income-related subsidies for the purchase of private insurance alongside Medicaid expansion for low-income families. Part of the reason it is a complicated law is because it did not sweep away our existing system; rather, the ACA was designed to fill gaps in a patchwork quilt system of coverage that has evolved over a century and more.

How did we arrive at the patchwork quilt health care system we have today? By the middle of the last century, the United States was the only country in the developed world without some sort of system to provide health care for all its citizens. Instead, we have developed an array of disparate programs to provide coverage to specific, politically favored groups of people.

In the early decades of the 20th century, there wasn't much "insurance" as we'd understand it today. Most people paid their doctors in cash or in kind. But health care was also much more primitive – it was not the technology-driven, extraordinarily expensive enterprise it is today.

Over time, however, new treatments, drugs, and technologies advanced the practice of medicine, saving lives but also increasing the costs of medical care. As people were less able to afford the rising cost of care, it created a financing problem for hospitals and other providers. Some of the more entrepreneurial hospital providers decided to create the first plans for groups of employees to buy insurance for hospital expenses. These plans evolved into the "Blue Cross" system, founded in 1929. "Blue Shield" plans to help finance physician care followed a decade later, in 1939.

The Rise of an Employer-based System of Coverage

Before the advent of the Blue Cross/Blue Shield plans, traditional commercial insurers had not been in health insurance business because of their concerns about adverse selection. In general, the only people willing to pay for such insurance were those with high health care costs. Also, the administrative costs of selling insurance directly to individuals was very high.

But the Blue Cross plans demonstrated that if you could target the coverage to employer groups, you could make health insurance a viable business enterprise. Targeting large employer groups meant creating a naturally balanced risk pool – an individual's coverage was tied to their employment, not their need for health care services. It also came with lower marketing costs. Even so, our current system of employer-sponsored coverage didn't really take off until around World War II.

During the war, the government imposed wage and price controls, which led employers to offer generous health benefits in lieu of wages. Additionally, the post-war era was a golden age for labor unions, and millions of workers gained insurance through collective bargaining agreements.

Then, a key federal policy caused employer-based insurance to expand exponentially. In 1953, the Internal Revenue Service (IRS) ruled that a contribution to a group health insurance policy was not taxable (even though a contribution to an individual health insurance policy was deemed taxable). The Eisenhower administration then adopted a blanket exclusion for all employer contributions to an employee health plan. At the time, there was no Congressional Budget Office, meaning that policymakers had no estimates of how much the IRS rule would cost. We now know that it is one of the most expensive federal policies ever adopted. Today, with approximately 150 million Americans covered through their employer, that subsidy costs the federal government about \$250 billion per year in lost income and payroll taxes.

The Rise of Risk Segmentation in Commercial Insurance

As employer-sponsored coverage expanded, other important insurance market changes were also taking place. The early Blue Cross Blue Shield plans were non-profit organizations and in general offered coverage at a "community rate," meaning that all employer groups paid the same price, regardless of the age or health status of their employees.

But soon, for-profit commercial insurers entered the market and realized they could make more money if they cherry picked: They would offer certain employers a lower rate if they had younger, healthier workers. This is called "experience rating." Blue Cross Blue Shield was left with sicker employee groups and ultimately adopted their competitors' rating practices in order to survive.

Similarly, before the ACA, insurers found they could make money in the individual market if they engaged in health status "underwriting," or the practice of deterring the enrollment of individuals considered to pose a health risk. These tactics included outright denials of coverage,

pre-existing condition benefit exclusions, and premium surcharges based on factors such as health status, age, and gender.

Medicare and Medicaid

Just as employer coverage became widespread, many policymakers in the middle of the last century recognized that an employer-based market alone wouldn't deliver health coverage to certain vulnerable groups, such as the poor, elderly and disabled. Although many in the progressive community at the time pushed for government-sponsored, universal coverage, ultimately Congress enacted in 1965 a "three layer cake" of reforms: Medicare Part A for hospital bills, Part B for physicians, and Medicaid for welfare recipients (Medicaid was later de-linked from welfare under the 1996 "Personal Responsibility and Work Opportunity Reconciliation Act").

Incremental Reforms: More Gap-filling

For many decades after passage of Medicare and Medicaid, efforts to enact comprehensive reform had little traction. Perhaps surprisingly, it was President Nixon who was the first president to send a legislative plan for near-universal coverage to Congress. The plan included a mandate that employers provide coverage and required a comprehensive benefit package.

While President Nixon's health reform effort ultimately failed, Congress did enact a major law affecting health insurance that few people at the time recognized as a health law: ERISA (the Employee Retirement Income Security Act of 1974). While focused on pension reform, ERISA preempts state insurance laws that would regulate employee benefit plans, including health plans.

Later incremental reforms that attempted to fill gaps in our coverage system include COBRA (1986), which allowed workers to buy into their employer's plan up to 36 months after being laid off, EMTALA (1986), which required hospital emergency departments to stabilize emergency patients even if they had no insurance, and limited expansions of Medicaid eligibility to include the disabled, people with end-stage renal disease (ESRD), and qualifying Medicare beneficiaries.

In the 1990s a more sweeping effort to provide universal coverage sponsored by President Clinton failed. In the aftermath, Congress enacted HIPAA in 1996, which, in addition to providing for the privacy and security of personal health information also modestly improved the "portability" of health coverage by requiring insurers to "guarantee issue" an individual policy to a person leaving employer group coverage. In 1997, Congress enacted the Children's Health Insurance Program (CHIP), a joint federal-state program to extend health insurance coverage to eligible children. Another reform, enacted in 2003, created a prescription drug benefit for Medicare beneficiaries, known as "Medicare Part D."

The Affordable Care Act – Improving Access to Affordable, Comprehensive Coverage

In spite of efforts to fill gaps in our coverage system over the years, on the eve of enactment of the ACA, 45 million Americans were uninsured; over 80 million reported having to go without coverage for at least one month during the prior 12-month period. Those without insurance coverage have lower life expectancy than those with coverage. Before the ACA was enacted, an estimated 26,000 people per year died prematurely because they lacked insurance. This is likely because the uninsured are more than six times as likely as the privately insured to delay or forego needed care due to cost. Uninsured cancer patients are more than five times more likely than their insured counterparts to forego cancer treatment due to cost.

Being uninsured also results in financial insecurity. In 2010, when the ACA was enacted, sixty percent of the uninsured reported having problems with medical bills or medical debt.

Prior to the ACA, the high and rising uninsured rate also led to high and rising uncompensated care costs for providers, in 2009 estimated at \$1000 worth of services per uninsured person. Providers ultimately pass those costs onto insured consumers and taxpayers, amounting to almost \$700 per family per year.

In attempting to expand coverage to the uninsured, the ACA focused largely on the failures of a dysfunctional individual market, which was inaccessible to those with pre-existing conditions and unaffordable to millions of working families who lacked job-based coverage. The ACA included relatively modest reforms to the employer group market, largely because the approximately 150 million people in that market are generally satisfied with their coverage. In fact, employer-sponsored health coverage was, and remains, one of the top most-valued benefits among employees.

The ACA tried to address the individual market's three main problems:

- *Access.* Prior to the ACA, on average 19 percent of individual market insurance applicants were denied due to their health risk.
- *Affordability.* On the eve of the ACA's passage, the average cost of family coverage was \$12,700 – a price out of reach for most families trying to buy coverage on their own. Yet people buying in the individual market lacked any employer or other subsidy to pay their premium (although most of the uninsured work), their premium contributions were fully taxed, and applicants often faced premium surcharges due to their health status, gender, and age.
- *Adequacy.* Prior to the ACA, roughly half of individual market enrollees were in plans that covered no more than 60 percent of their medical costs. Insurers commonly imposed pre-existing condition coverage exclusions, meaning that any care required to treat a previously existing health condition would not be covered. Further, as many as 20 percent of individual policies didn't cover pharmacy or mental health benefits and only 12 percent of policies covered maternity services. These policies also often didn't limit the policyholder's annual out-of-pocket costs, and came with annual and/or lifetime limits on benefits.

The ACA tried to address these problems with 3-prong strategy, or “three-legged stool”:

- *Insurance reforms* to help people locked out of the system due to pre-existing conditions;
- *An individual mandate* to encourage healthy people to enroll in the insurance pool and keep premiums stable; and
- *Subsidies* to help people afford the insurance coverage (with Medicaid expansion available for people under 138 percent of the federal poverty line (FPL)). The subsidies included “advance payments of premium tax credits” (APTCs) to reduce premium costs for people between 100-400 percent of FPL and “cost-sharing reduction” (CSR) subsidies to reduce deductibles and other cost-sharing for people between 100-250 percent of FPL.

The ACA also created state-based insurance marketplaces where people can apply for the APTCs and CSR subsidies and shop for plans.

The ACA Today: Dramatic Improvements in Coverage but Modest, Bipartisan Fixes Needed

The ACA has improved the lives of millions by expanding access to insurance coverage, improving health outcomes, and increasing financial security. Specifically, thanks to the ACA, the percentage of people uninsured declined from 14.5 percent in 2013 to 8.9 percent in 2016 – an estimated 20 million people gained coverage because of the ACA.

What does coverage mean for these individuals and families? The reforms were fully implemented in 2014, so it is still early to assess the impact of the ACA. But we are starting to get data showing that the law has succeeded in improving Americans’ access to care, health outcomes, and financial security, as well as reduced the burden of uncompensated care for hospitals and other providers.

Since the ACA, the percent of Americans reporting that they didn’t see a doctor or fill a prescription because they couldn’t afford it has declined by more than one-third. Further, more people are reporting that they have a primary care doctor or had a check-up in the last 12 months.

The research to date also strongly suggests that expanding access to coverage leads to better health outcomes. For example, studies of the reforms in Massachusetts, upon which the ACA was modeled, have found that coverage expansion in that state led to reported improvements in physical and mental health, as well as reductions in mortality. The early data on changes in health outcomes due to the ACA’s coverage expansions are consistent with these findings.

Health insurance is not just about improving access to care. It also provides financial security, particularly in the event of a large, unanticipated health care expense. And make no mistake: health care in this country is expensive. For example, the average cost of a MRI today is \$1,119.

An uncomplicated hospital-based labor and delivery costs an average of \$10,808, while a C-section will average over \$16,000. One course of treatment for colon cancer will cost you roughly between \$21,000 and \$52,000. Yet almost half of American families report that they would not be able to afford to pay just \$400 in cash for an unanticipated medical event.

Recent research suggests that the ACA is helping to improve the financial security of the newly insured. Survey data show that the number of families who say they're having problems paying medical bills has fallen dramatically since 2013, particularly among low- and moderate-income families. Other studies have demonstrated that the ACA's Medicaid expansion has led to reductions in the amount of debt sent to collection agencies and improvements in credit scores.

The benefits of coverage expansions do not just affect the newly insured. Thanks to the ACA, we've witnessed a significant reduction in uncompensated care costs borne by providers. For example, hospital-based uncompensated care fell by over 25 percent between 2013 and 2015, and in Medicaid expansion states it has fallen by closer to 50 percent.

Even so, the most ardent supporter of the ACA would likely agree that the law faces challenges, not least of which is the continued policy uncertainty created by congressional efforts to repeal the law, threats by the Trump administration to cut off the CSR reimbursements to insurers, and concerns among insurers that the individual mandate will not be enforced.

Fix it, Don't End It: Common Sense Solutions for Individual Market Stability

While CBO has concluded that the ACA's insurance markets are likely to be stable in most places, if left unchanged, continued policy uncertainty over the law's future could cause more insurers to exit the market or to increase premiums.

A bipartisan consensus on a set of policies that would boost and maintain enrollment in the ACA marketplaces and stabilize insurer participation and premiums is not out of reach. For federal policymakers who want to improve the individual markets and build on the coverage gains launched by the ACA, such common sense policy fixes would include:

- *A clear and long-term commitment to paying the CSR reimbursements.* The Trump administration has threatened to cut off CSR reimbursements, which for 2018 are projected to be roughly \$8 billion. If these reimbursements do terminate at the end of this year, CBO has estimated it will result in an average 20 percent increase in 2018 premiums and many insurers have signaled they will need to exit the market if the funds are cut. For insurers to commit to continued participation, they need certainty from Washington that they will be reimbursed for those costs.
- *A reinsurance program or similar premium stabilization fund.* The individual health insurance market is likely always to have a somewhat sicker risk pool than the employer group market, if for no other reason than there are many people unable to work full time because of their health status. One of the primary drivers of premium increases in 2017 was the expiration of the ACA's reinsurance program. When Alaska enacted a

state-based reinsurance program in 2016, proposed premium increases were reduced from 42 percent to just 7 percent.

- *Higher funding for outreach and enrollment assistance.* Robust support for outreach and education campaigns and one-on-one assistance with eligibility determinations and plan selection are critical not just to keep enrollment stable and growing, but to maintain a healthy risk pool.
- *A fix to the “family glitch”.* Under Obama administration rules, families are denied access to financial assistance on the marketplaces if one family member has access to affordable employer-based self-only coverage, even if the coverage isn’t affordable for the family. Reversing this interpretation of the ACA would make coverage more affordable for significant numbers of families and boost enrollment in the marketplaces.
- *Affordability improvements.* The top reason people don’t enroll in individual market insurance is that they don’t perceive it to be affordable. One way to solve this problem is to improve the generosity of the subsidies to defray consumers’ premium and cost-sharing expenses.
- *A level playing field.* The continuation of health plans that do not have to comply with ACA rules, referred to as transitional or “grandmothered” plans, has perpetuated a segmented market and adverse selection against the ACA’s marketplaces. This, in turn, has led to higher premiums for people enrolled in ACA-compliant plans. Similarly, federal policy should prevent insurers or other entities, such as health sharing ministries, from marketing “look alike” products that mimic health insurance but do not comply with the ACA’s consumer protections. Entities selling these products siphon off healthy enrollees, leaving the ACA’s marketplaces with a sicker, more expensive risk pool.
- *A simpler eligibility and enrollment process.* When it takes as much as 90 minutes for a consumer with a relatively uncomplicated financial and health situation to apply for and enroll in coverage, something is wrong. An onerous and complicated process discourages healthy people from signing up and depresses overall enrollment. The federal and state marketplaces need to invest more in the design and user testing of their IT systems to make the sign up process as simple and quick as possible.
- *Smarter, not skimpier, benefit design.* What to do about high deductibles? Every year, as many as 20 percent of marketplace enrollees drop out, in part because of dissatisfaction with high deductibles. What we need are not skimpier benefit designs but smarter designs. For example, policymakers could require high deductible plans to provide some benefits pre-deductible, such as two or three annual primary and urgent care visits and a prescription or two, in addition to preventive services like birth control and pediatric wellness visits. This could, in turn, improve the attrition rate in marketplace plans, as consumers receive more high-value services without having to pay the full cost.
- *A fallback plan.* Under the ACA, private insurers are the sole route through which consumers can obtain premium tax credits and cost-sharing subsidies. But the law doesn’t require those insurers to participate. When Congress created the Medicare Part D program, the authors were worried there might be some parts of the country that would lack a willing insurer, so they created a fallback option, to be triggered only if

there weren't at least two plans available. With many parts of the country down to just one insurer participating in the individual market, Congress could take a page from Medicare Part D and create a similar fallback option for the marketplaces.

- *Flexibility to provide regulatory relief.* Congress could also consider giving HHS and states greater flexibility to provide regulatory relief to insurers willing to compete in underserved markets, such as by relaxing network adequacy standards, supporting the use of telemedicine for some services, or offering the ability to recoup losses in future years if an insurer had an unexpectedly bad year.

Are all of the above politically feasible in today's polarized climate? Probably not. Several would require more federal spending. But in the late 1990s, Medicare Advantage faced similar challenges, with many private insurers pulling out of that market. In response to that crisis, Congress did not repeal the program or reduce its funding. Rather, congressional leaders negotiated and passed bipartisan reforms that injected new financing to enhance plan payments. Plenty of people criticized the costs of that policy at the time, but it did result in dramatic enrollment growth and stable insurer participation.

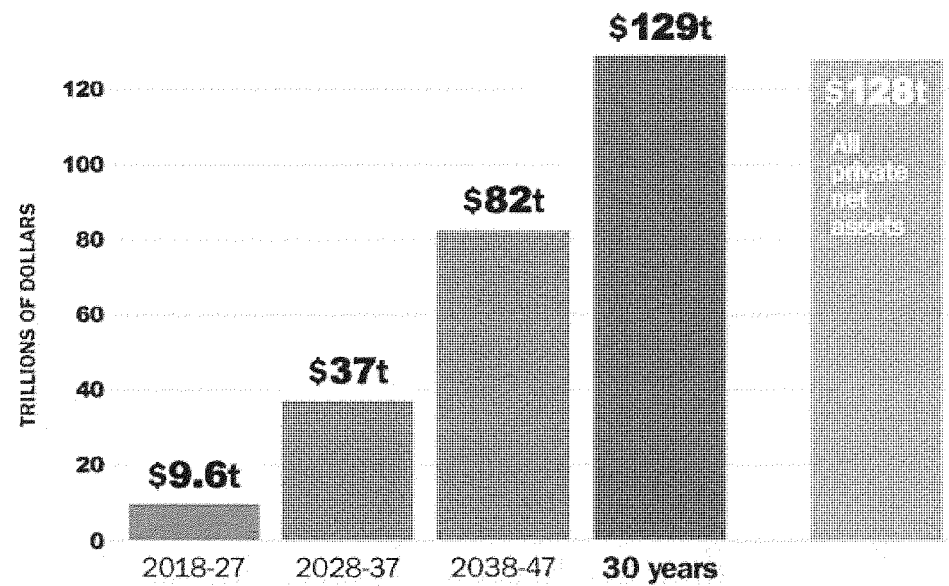
As this Congress considers potential improvements to the ACA, I encourage you to continue the bipartisan, civil discussions that you are engaged in today. The law is by no means perfect, but it has improved the health and financial well-being of millions of American families. Future efforts to amend the ACA must be judged by whether they build upon the ACA's coverage expansions and keep insurance accessible, affordable, and adequate to meet enrollees' health care needs.

Thank you and I look forward to your questions.

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30-YEAR PROJECTED DEFICITS

CBO ALTERNATE ASSUMPTIONS



Congressional Budget Office, Office of Management and Budget, Federal Reserve

JOHN JOHNSON
CONGRESS

30-YEAR DEFICIT: \$129 TRILLION

TWO WAYS OF DESCRIBING THE PROBLEM

<u>30-year deficit</u>		<u>30-year rev & outlays</u>	
Soc Sec:	- \$18t	Revenue:	\$199t
Medicare:	- \$39t	Outlays:	
Interest:	- \$65t	Soc Sec:	\$69t
		Medicare:	\$55t
		Mcaid/Ocare:	\$32t
Total:	- \$122t		
		Subtotal:	\$156t
Accounts for:	95%	Interest:	\$65t
...of:	- \$129t		\$221t

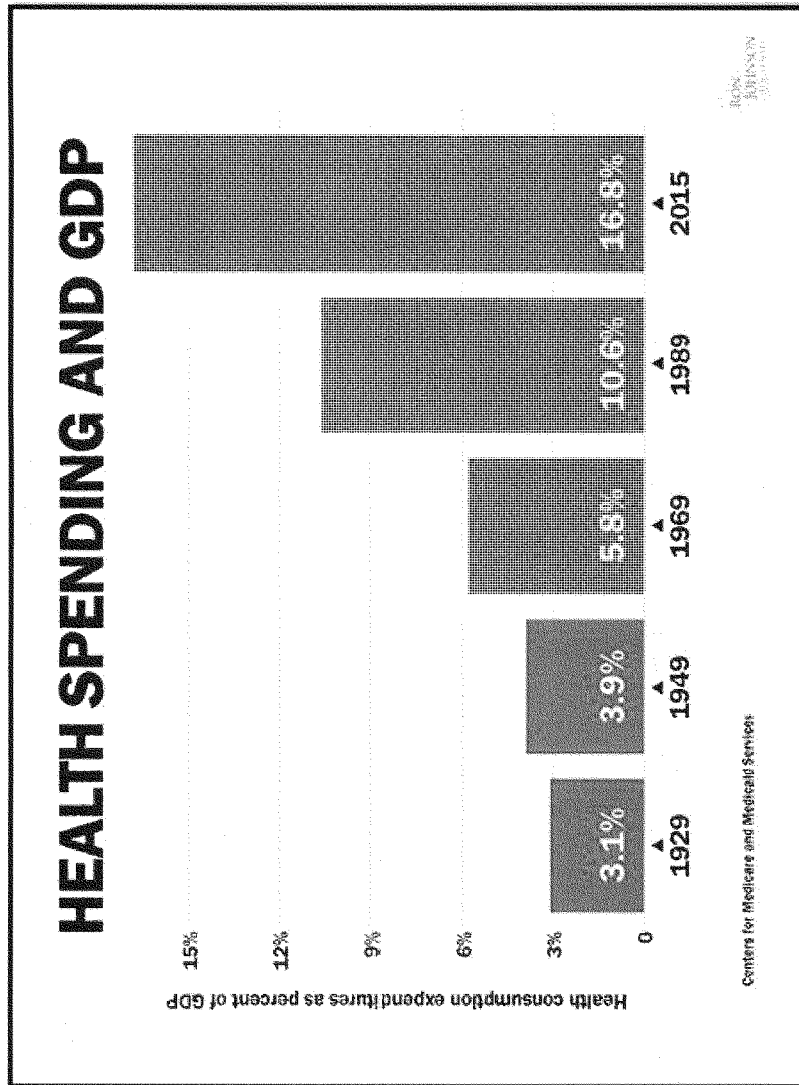
CBO, staff analysis



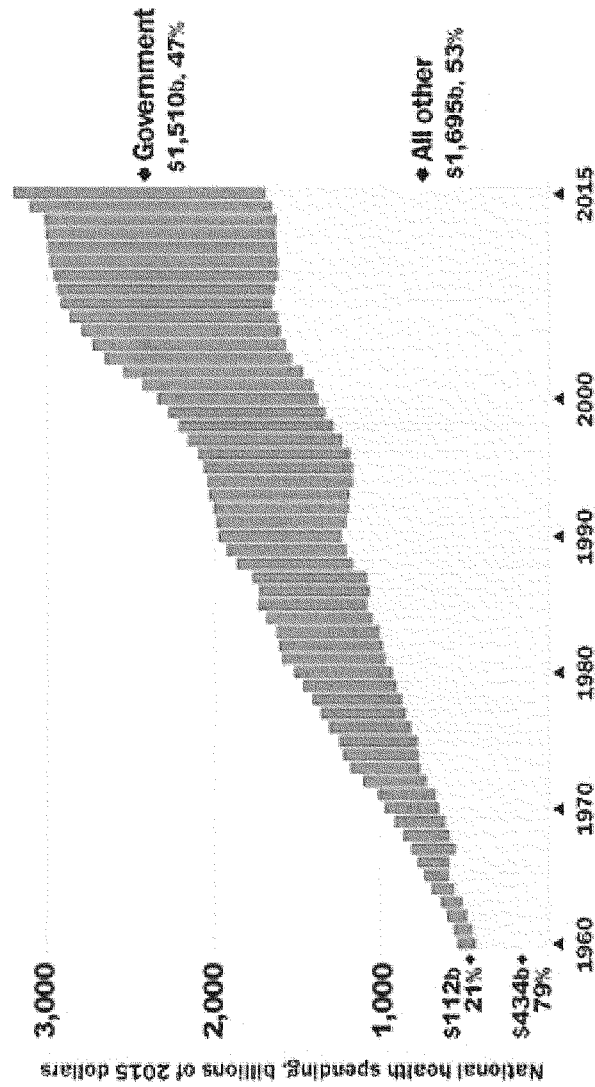
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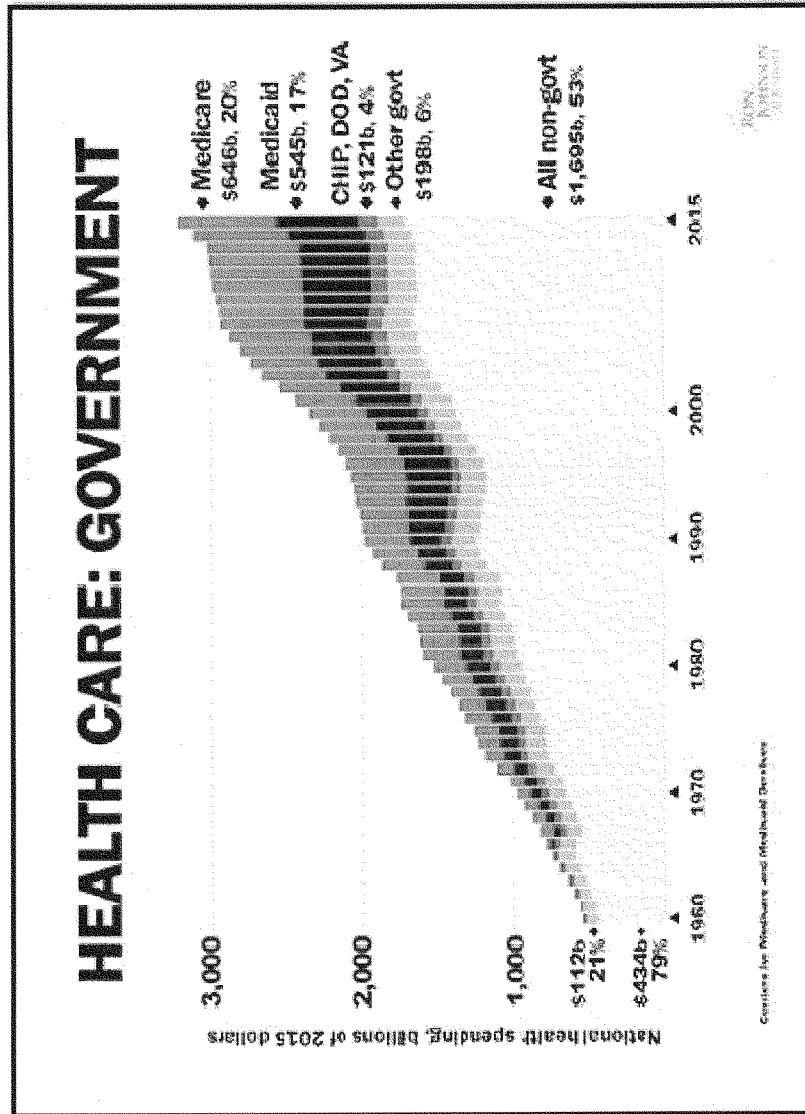


HEALTH CARE: GOVERNMENT



Centers for Medicare and Medicaid Services

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES



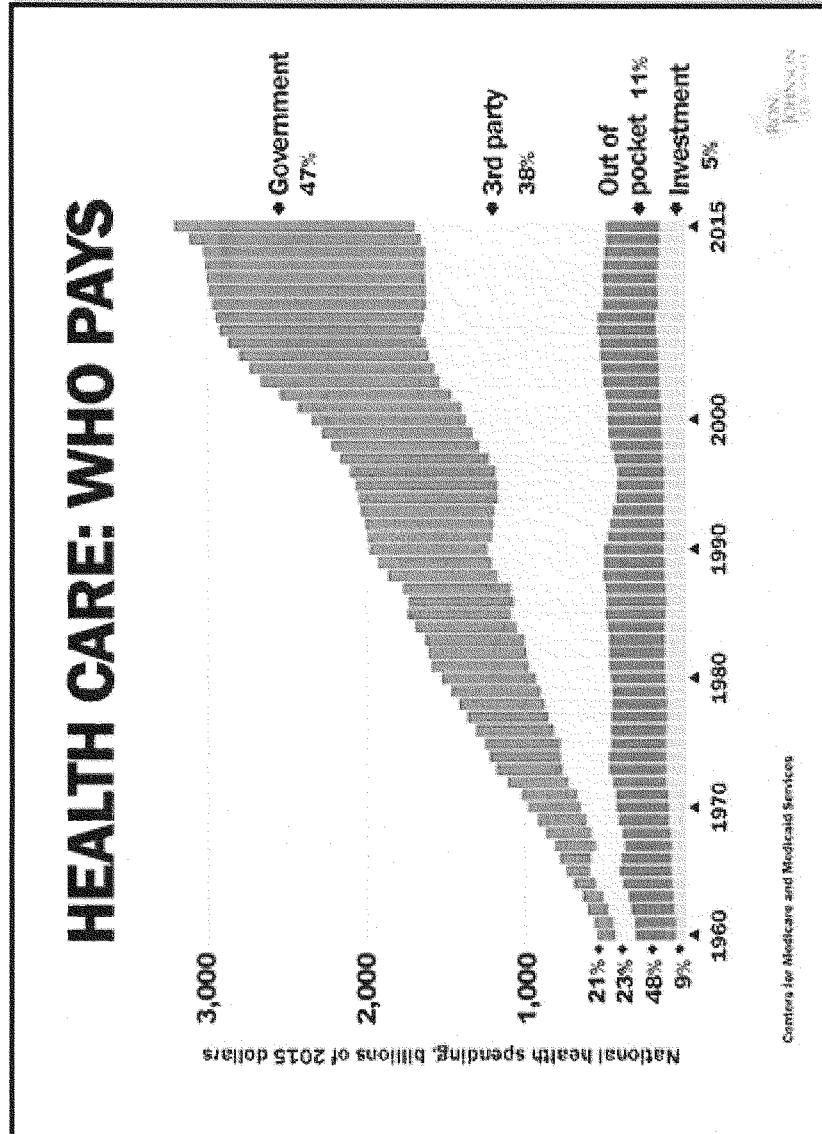
Health care spending sources

Data as of May 11, 2017.

National health expenditures

	1960	1970	1980	1990	2000	2009	2010	2011	2012	2013	2014	2015
<i>billions of nominal dollars</i>												
all non-govt	22	50	157	450	802	1,361	1,410	1,458	1,517	1,548	1,609	1,695
other govt	4	9	26	66	107	170	175	177	184	188	192	198
CHIP, DOD, VA	2	3	10	21	36	90	96	100	102	106	113	121
Medicaid	0	5	26	74	200	374	397	407	423	445	497	545
Medicare	0	8	37	110	225	499	519	546	570	590	618	646
total	27	75	255	721	1,370	2,495	2,596	2,688	2,795	2,878	3,029	3,206
<i>billions of 2015 dollars</i>												
all other spending/invest	434	653	934	1,236	1,373	1,619	1,621	1,627	1,634	1,627	1,652	1,695
other govt	78	114	153	180	184	203	201	197	198	198	197	198
CHIP, DOD, VA	34	43	58	59	61	107	110	112	110	111	116	121
Medicaid	0	70	155	202	343	445	457	454	455	468	510	545
Medicare	0	101	223	302	385	593	597	610	613	620	635	646
total	546	981	1,524	1,980	2,347	2,967	2,986	3,000	3,010	3,024	3,109	3,206
<i>percent of total</i>												
all other spending/invest	79%	67%	61%	62%	59%	55%	54%	54%	54%	54%	53%	53%
other govt	14%	12%	10%	9%	8%	7%	7%	7%	7%	7%	6%	6%
CHIP, DOD, VA	6%	4%	4%	3%	3%	4%	4%	4%	4%	4%	4%	4%
Medicaid	0%	7%	10%	10%	15%	15%	15%	15%	15%	15%	16%	17%
Medicare	0%	10%	15%	15%	16%	20%	20%	20%	20%	21%	20%	20%
total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Centers for Medicare and Medicaid Services, National Health Expenditures tables, "National Health Expenditures by type of service and source of funds, CY 1960-2015" inflation: Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers, Medical Care [CPIMEDEX]



Health care spending sources

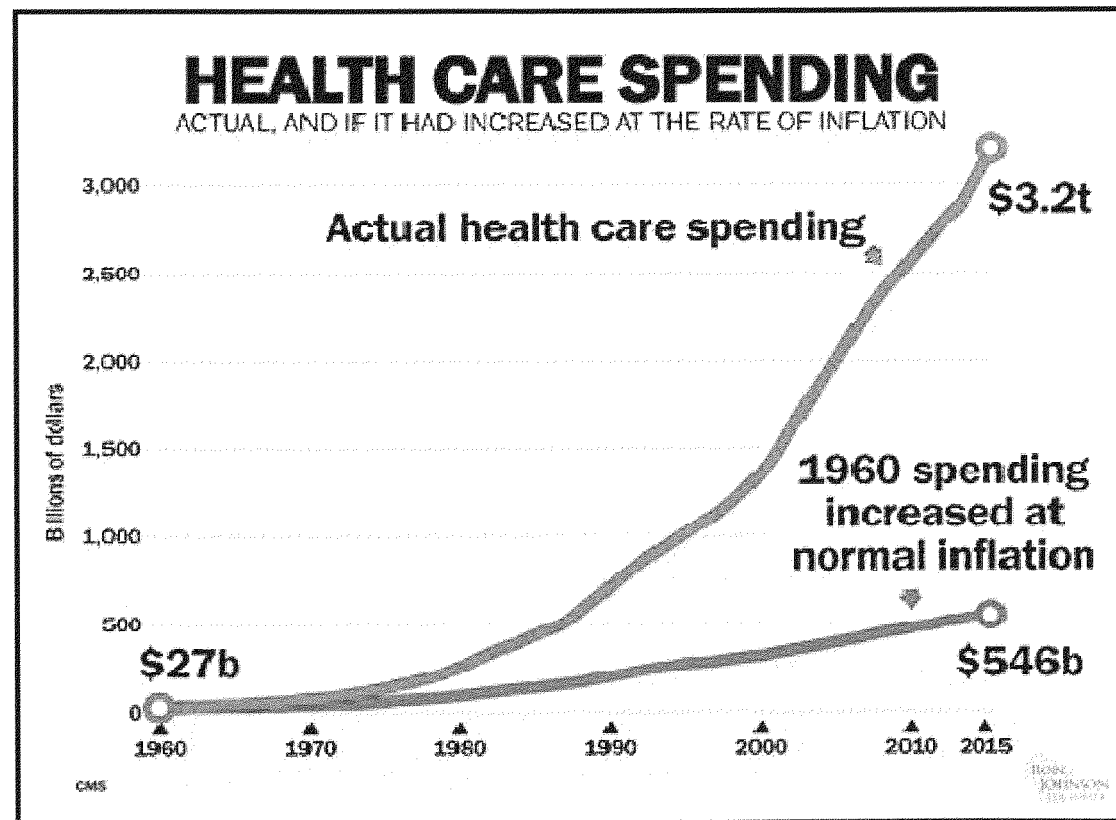
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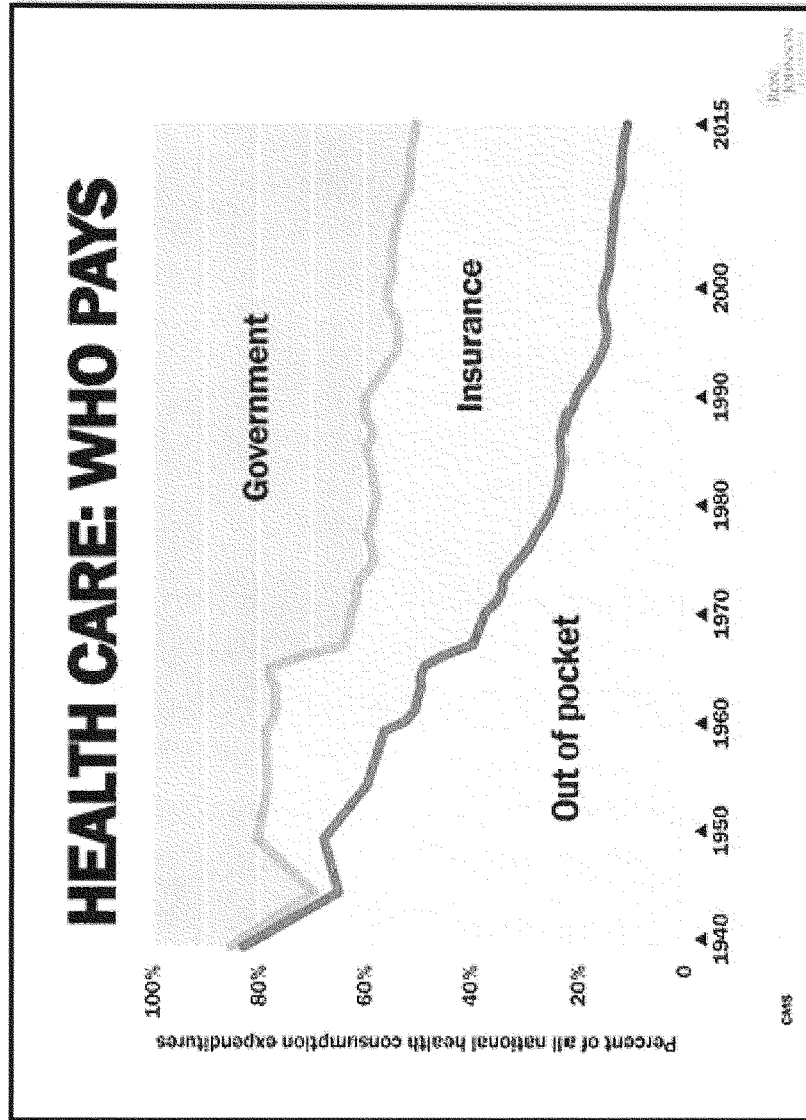
National health expenditures

	1960	1970	1980	1990	2000	2009	2010	2011	2012	2013	2014	2015
<i>billions of nominal dollars</i>												
Out-of-pocket	13	25	58	138	199	293	299	309	318	325	330	338
3rd party	6	17	79	265	519	929	968	1,000	1,046	1,070	1,129	1,202
government	6	25	99	271	568	1,134	1,187	1,230	1,278	1,330	1,420	1,510
investment	3	8	20	47	83	139	143	149	153	153	151	155
total	27	75	255	721	1,370	2,495	2,596	2,688	2,795	2,878	3,029	3,206
<i>billions of 2016 dollars</i>												
Out-of-pocket	270	341	360	393	354	362	357	357	355	355	351	351
3rd party	129	234	486	756	923	1,146	1,156	1,159	1,169	1,167	1,202	1,248
government	116	341	612	772	1,010	1,400	1,417	1,425	1,428	1,450	1,513	1,568
investment	52	103	123	135	148	172	170	173	171	167	161	161
total	567	1,018	1,582	2,055	2,436	3,080	3,099	3,114	3,124	3,139	3,227	3,327
<i>percent of total</i>												
Out-of-pocket	48%	33%	23%	19%	15%	12%	12%	11%	11%	11%	11%	11%
3rd party	23%	23%	31%	37%	38%	37%	37%	37%	37%	37%	37%	38%
government	21%	33%	39%	38%	41%	45%	46%	46%	46%	46%	47%	47%
investment	9%	10%	8%	7%	6%	6%	5%	6%	5%	5%	5%	5%

Source: Centers for Medicare and Medicaid Services, National Health Expenditures tables, "National Health Expenditures by type of service and source of funds, CY 1960-2015"

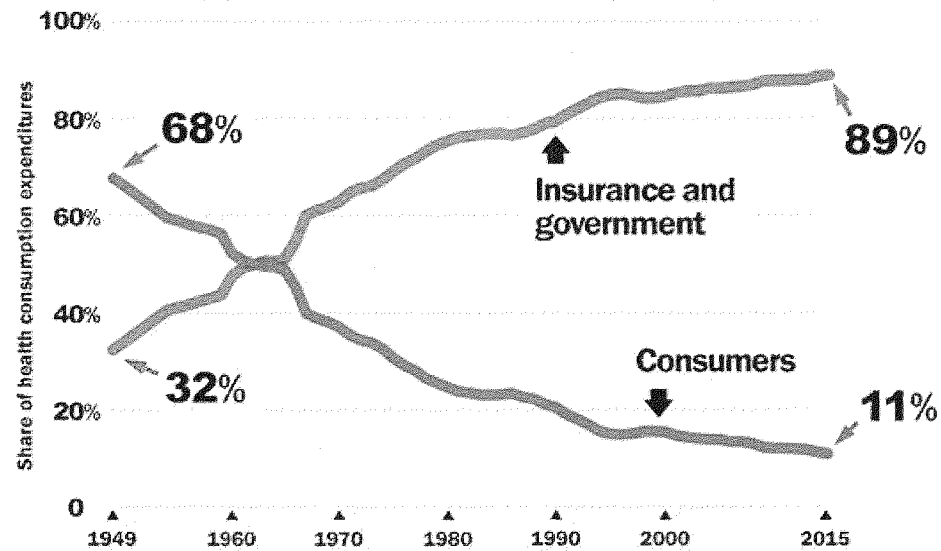
Inflation: Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care [CPIMEDSL]





HEALTH CARE: WHO PAYS

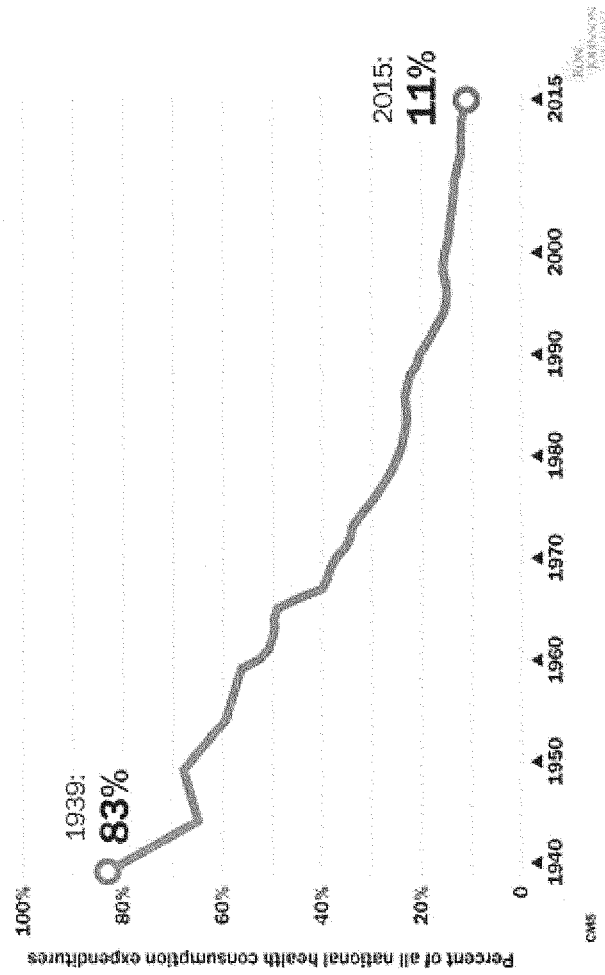
SHARE OF HEALTH CONSUMPTION EXPENDITURES



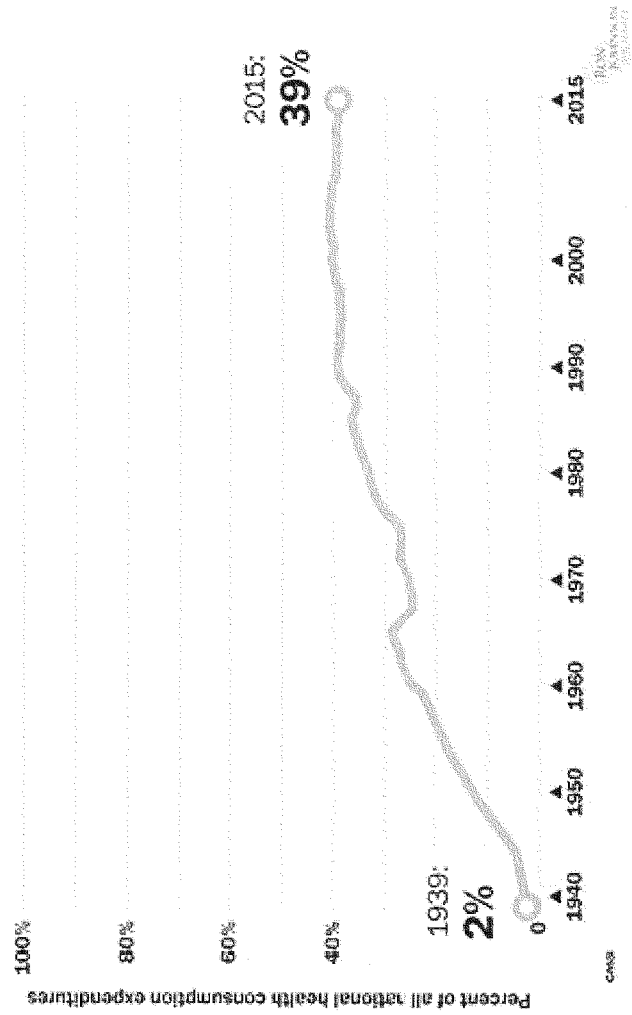
Centers for Medicare and Medicaid Services

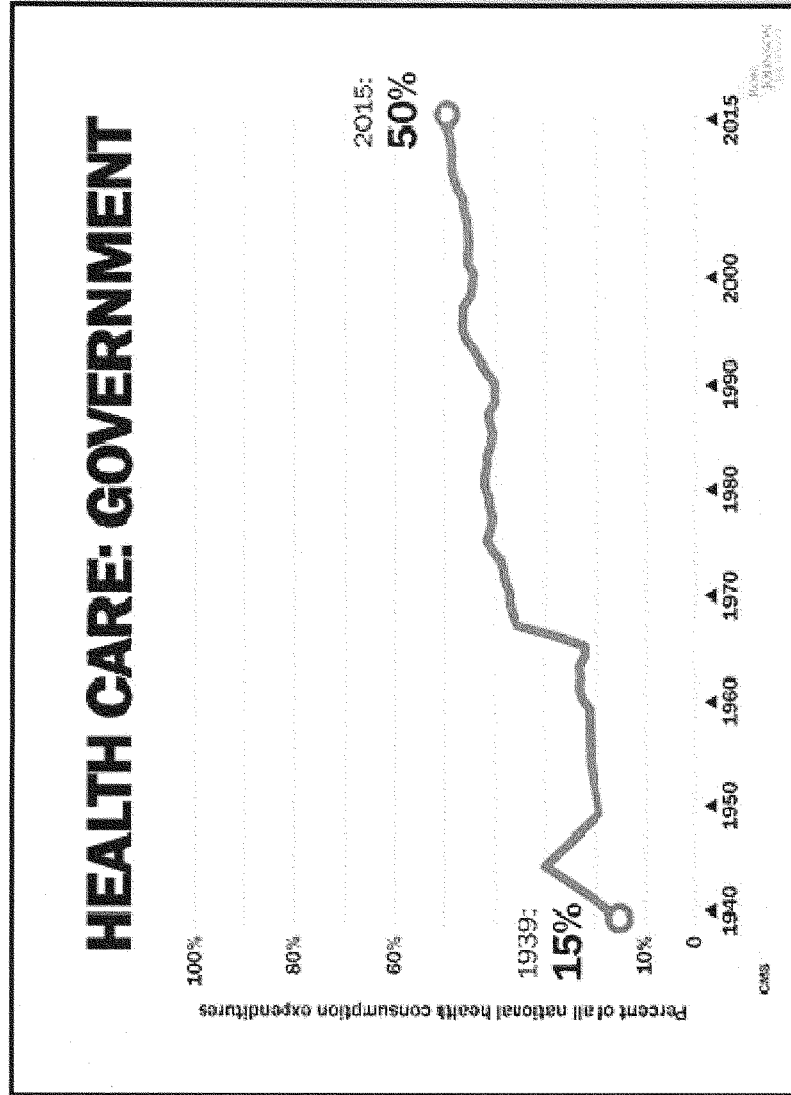
RON JOHNSON
Representative

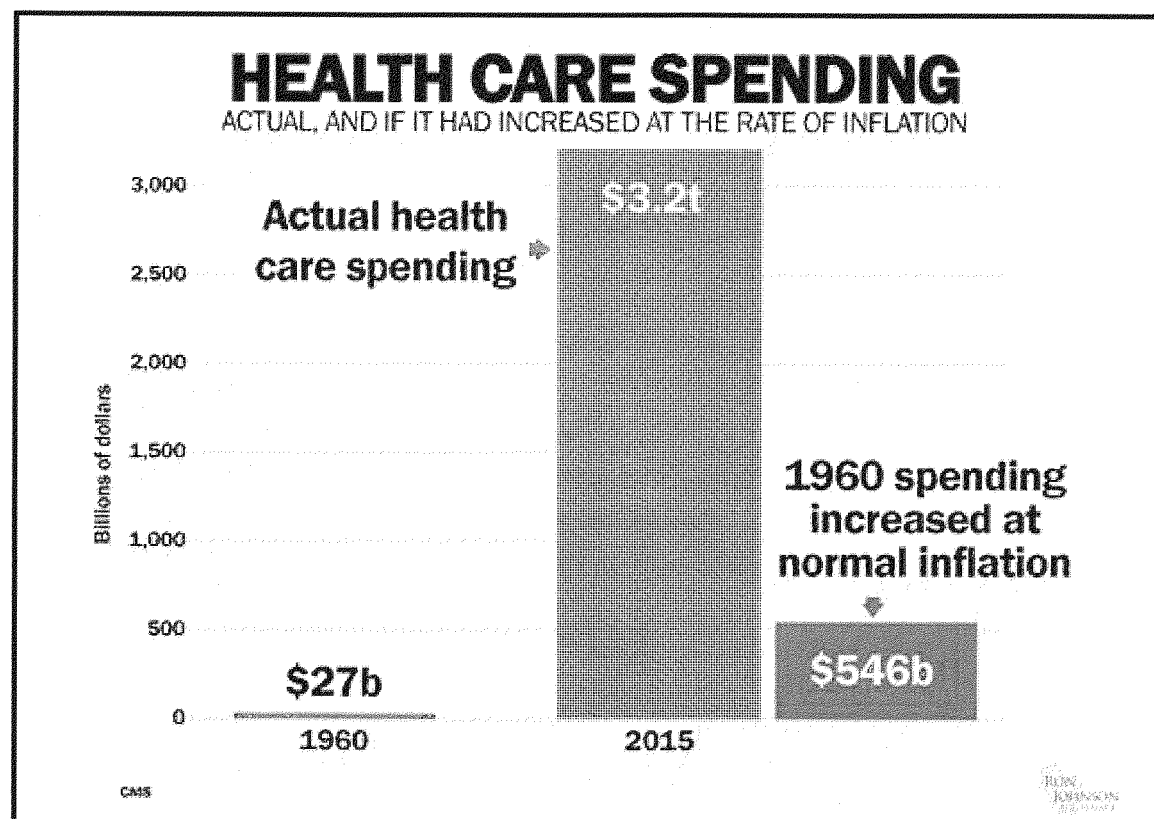
HEALTH CARE: OUT OF POCKET

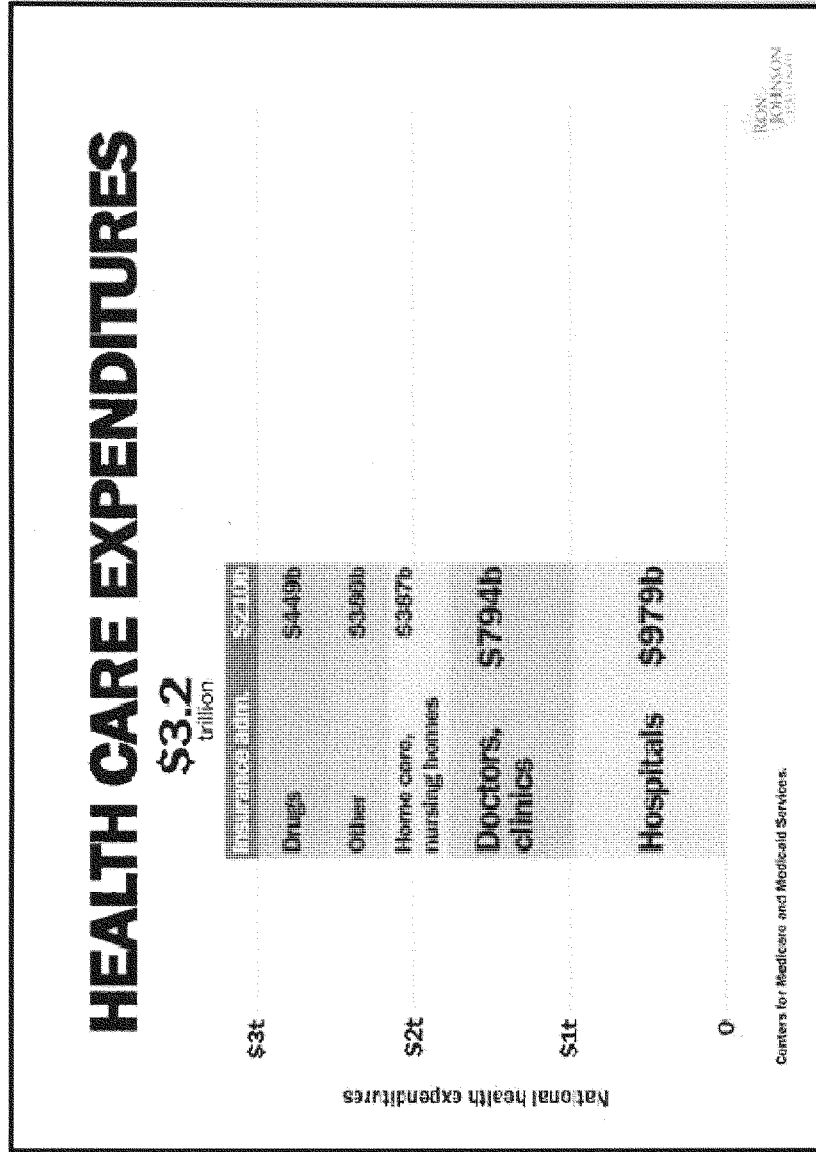


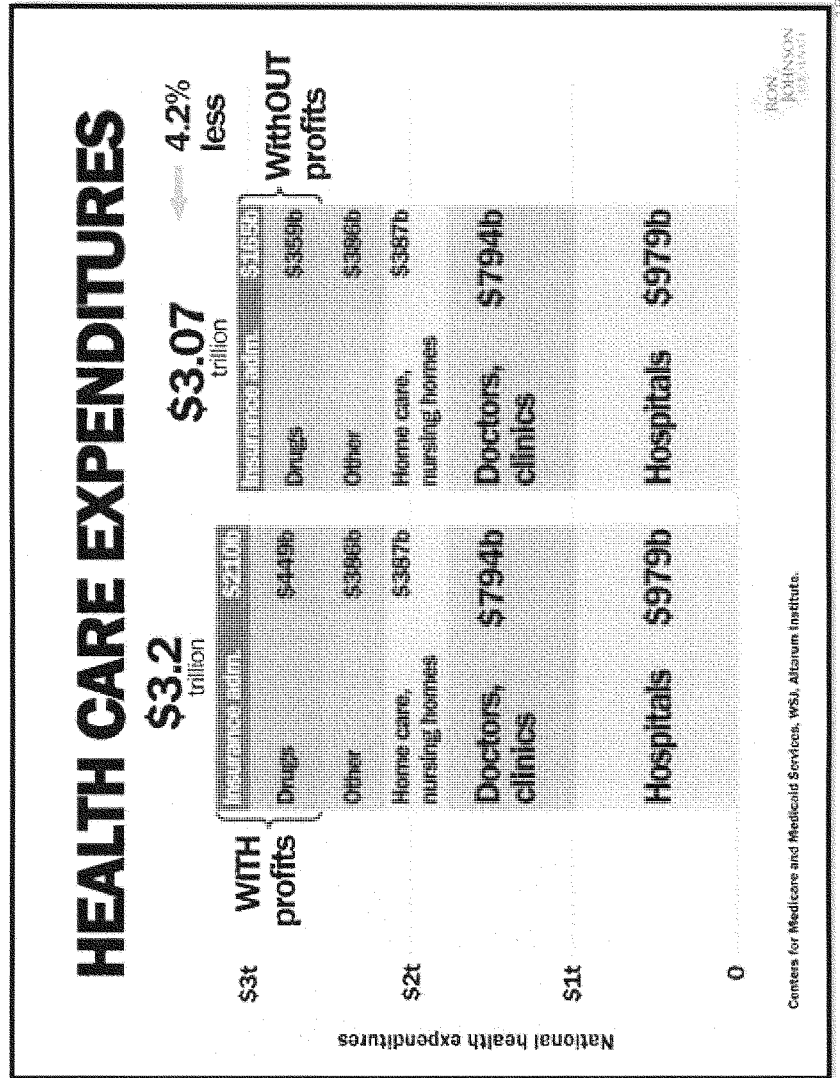
HEALTH CARE: INSURANCE



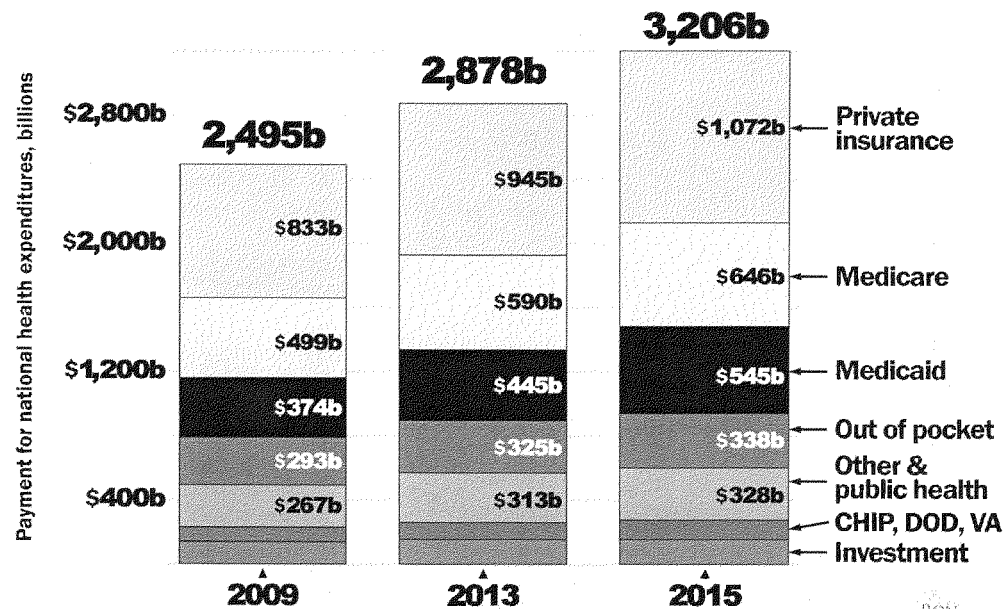








HEALTH CARE: WHO PAYS



Centers for Medicare and Medicaid Services

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U.S. SENATE

HOW INSURED?

2013
Before ACA

11 m

42 m

51 m

65 million

174 million people

Individual
Uninsured

Medicare

Medicaid

Employer,
association
or group policies

2015

3.6 m

29 m

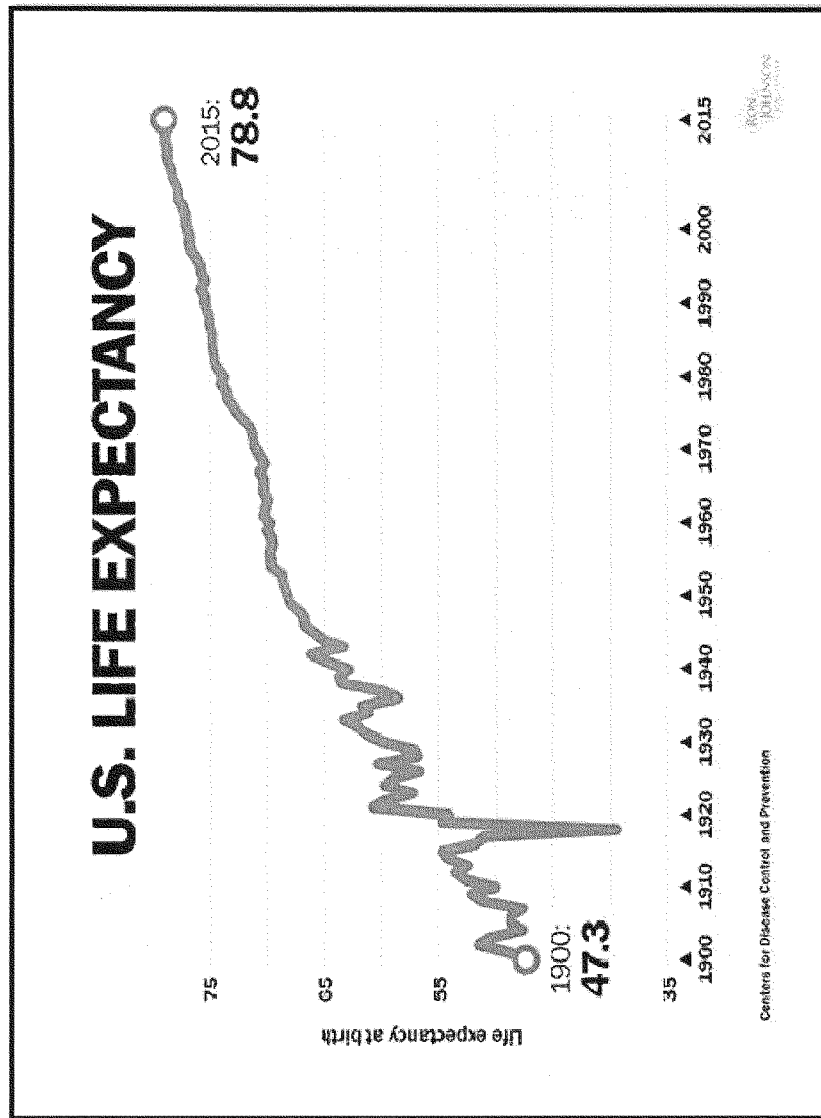
54 m

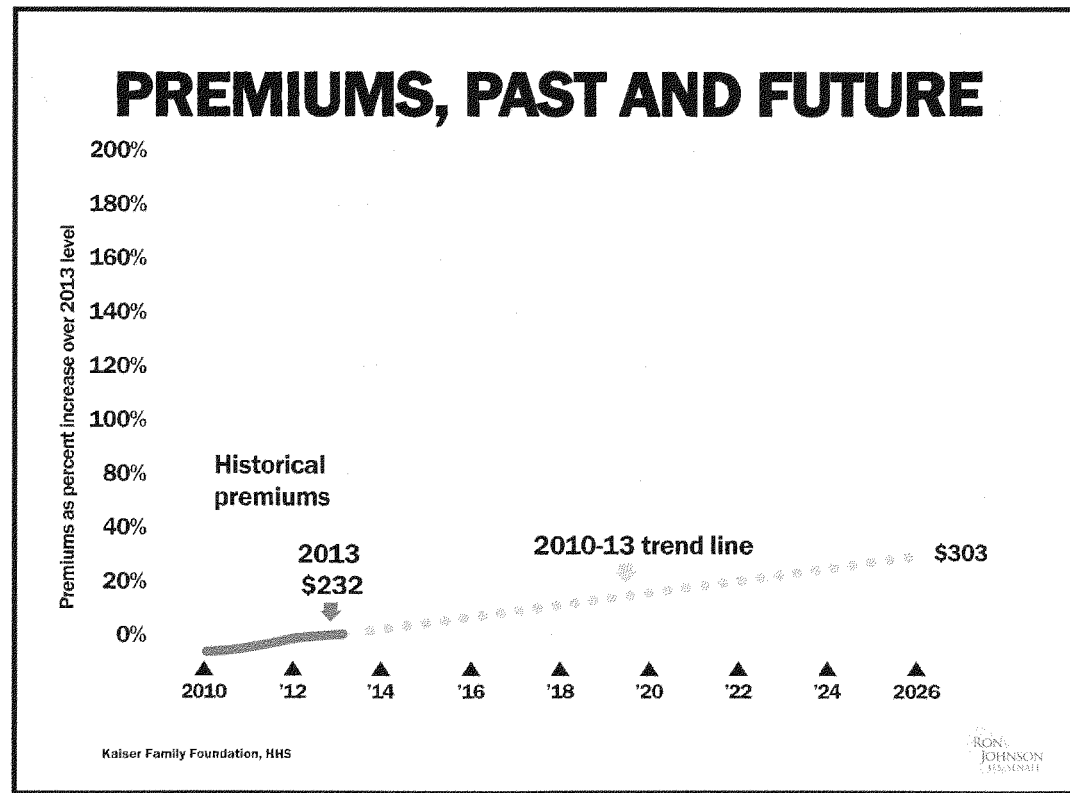
75 million

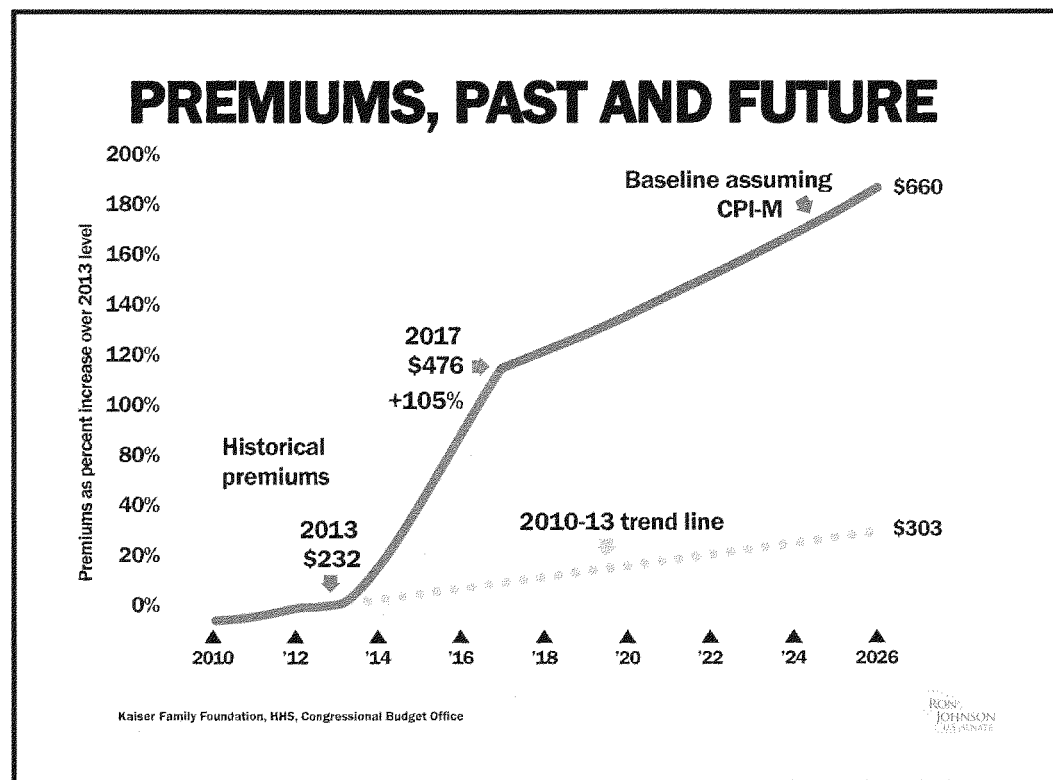
178 million people

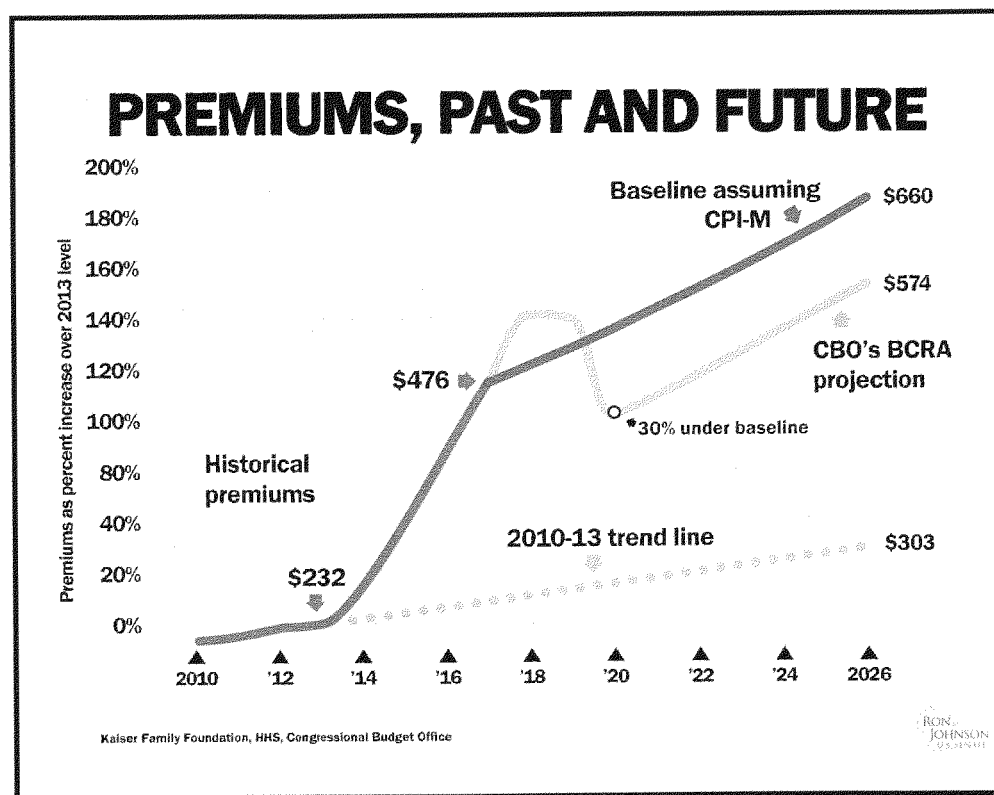
Census, CMS, NAHC. Totals exceed total population due to overlapping coverage.

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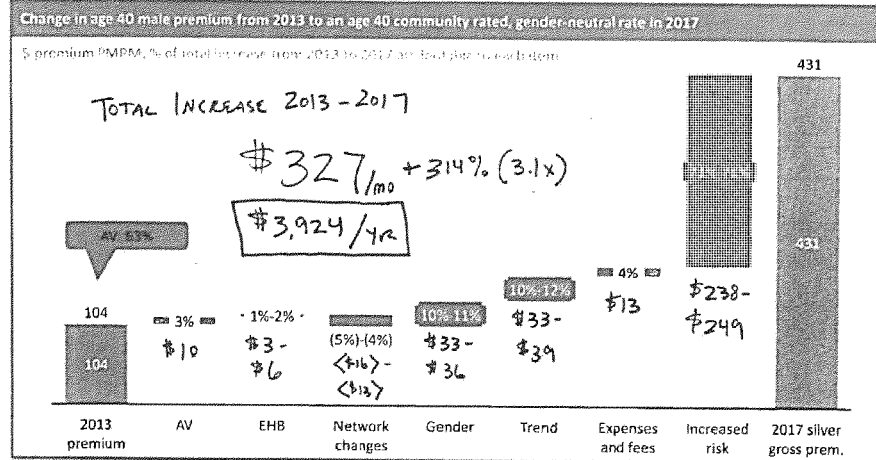








Premium reconciliation: high premium state example



INVISIBLE HIGH-RISK POOL & EXPANDED AGE BANDS: Individual Insurance Premiums Before & After Maine Reforms



Source: Foundation for Government Accountability

Fewer Americans Are Concerned About How To Pay Their Health Care Bills Under The ACA

- Cynthia Cox and Bradley Sawyer, *How Does Cost Affect Access to Health Care*, Kaiser Family Foundation (Nov. 29, 2016) (https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/?_sf_s=Affect#item-uninsured-adults-lack-usual-source-care-also-likely-forgo-preventive-care) [CHARTS]
- Cynthia Cox and Bradley Sawyer, *Despite Lower Rates of Access Barriers for Some Groups, Health Costs Remain a Concern for Many Americans*, Kaiser Family Foundation (Nov. 30, 2017) (https://www.healthsystemtracker.org/brief/despite-lower-rates-of-access-barriers-for-some-groups-health-costs-remain-a-concern-for-many-americans/?_sf_category=access-affordability#item-start) [ISSUE BRIEF]

Medicare Spending and Income

- Juliette Cubanski and Tricia Neuman, *The Facts on Medicare Spending and Financing*, Kaiser Family Foundation (July 18, 2017) (<http://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>) [ISSUE BRIEF]
- Kaiser Family Foundation, *An Estimated 52 Million Adults Have Pre-Existing Conditions That Would Make Them Uninsurable Pre-Obamacare* (Dec. 12, 2016) (<http://www.kff.org/health-reform/press-release/an-estimated-52-million-adults-have-pre-existing-conditions-that-would-make-them-uninsurable-pre-obamacare/>) [PRESS RELEASE]
- Kaiser Family Foundation, *Uninsured Rate Among the Nonelderly Population, 1972-2017* (<http://www.kff.org/uninsured/slide/uninsured-rate-among-the-nonelderly-population-1972-2016/>) [CHART]
- Gary Claxton, Larry Levitt, and Karen Pollitz, *Pre-ACA Market Practices Provide Lessons for ACA Replacement Approaches* (Feb. 16, 2017) (<http://www.kff.org/health-costs/issue-brief/pre-aca-market-practices-provide-lessons-for-aca-replacement-approaches/>) [ISSUE BRIEF]
- Gary Claxton, Matthew Rae, and Nirmita Panchal, *Consumer Assets and Patient Cost Sharing*, (Mar. 11, 2015) (<http://www.kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/>) [ISSUE BRIEF]
- Gary Claxton, Larry Levitt, Karen Pollitz, and Anthony Damico, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Feb. 6, 2013) (<http://www.kff.org/health-reform/perspective/why-premiums-will-change-for-people-who-now-have-nongroup-insurance/>) [POLICY ANALYSIS]

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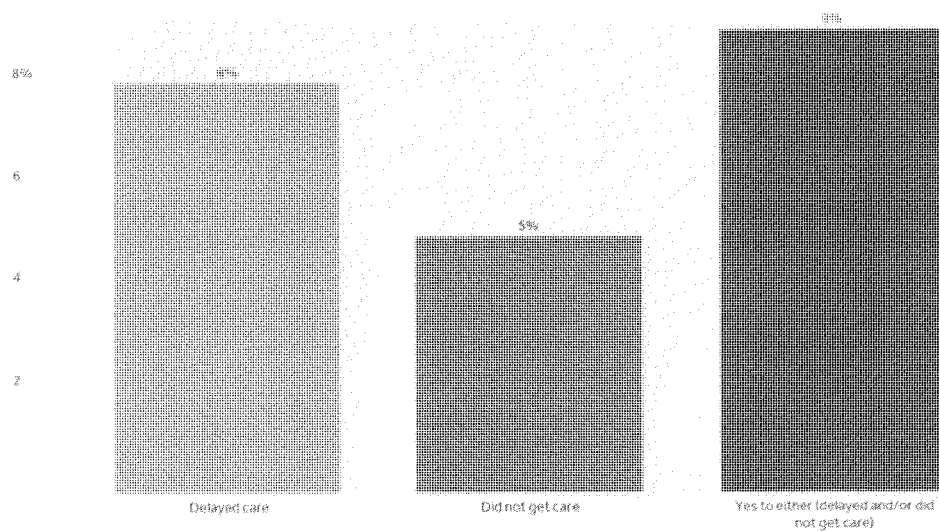
How does cost affect access to care?

By Cynthia Cox and Bradley Sawyer *Kaiser Family Foundation*

This collection of charts and a related brief explore trends in access to care in the U.S. The high cost of health care can be a barrier to access for both insured people (particularly those with high deductibles) and the uninsured, and costs can be particularly burdensome for people in worse health.

About 1 in 10 adults report that they delayed or did not get care because of its cost

Percent of adults who reported delaying or going without care due to costs, 2015



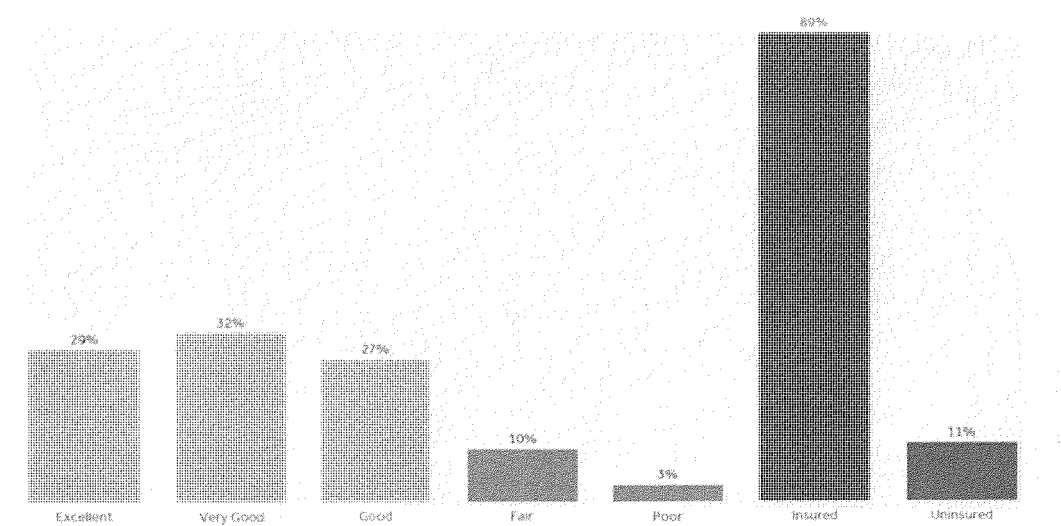
Source: Kaiser Family Foundation analysis of National Health Interview Survey

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Most Americans do not report cost-related access barriers to health care. Still, a substantial portion of the population - about one in every ten adults (9%) - said that they either delayed or did not receive medical care due to cost in 2015.

Most adults are in better health and most have health insurance

Percent of adults who reported being in worse health or without insurance, 2015



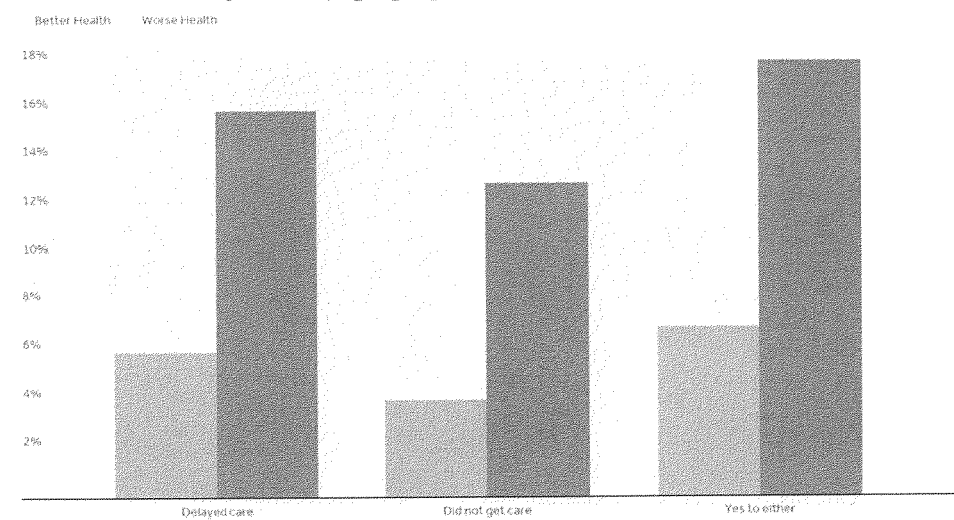
Source: Kaiser Family Foundation analysis of National Health Interview Survey

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In the U.S., most adults (89%) have health insurance and the majority (88% of adults) also report their health as at least good. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs.

Adults who are in worse health have more difficulty accessing care due to cost

Percent of adults who reported delaying or going without care due to cost, 2015



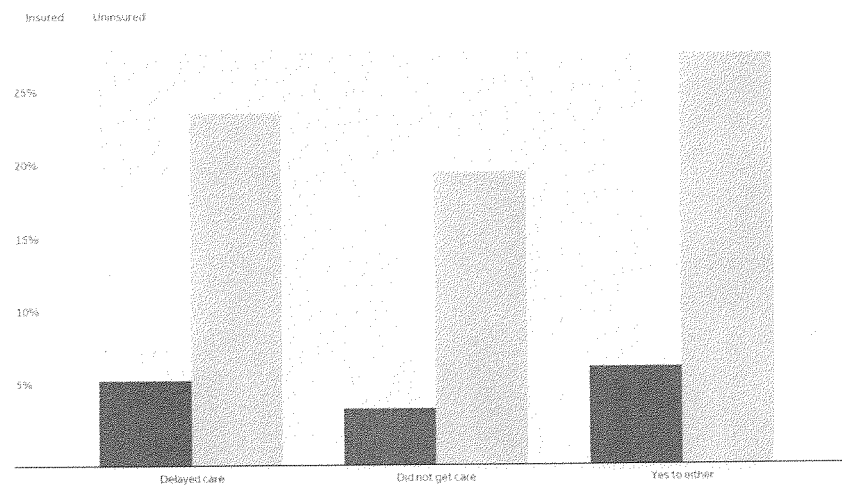
Source: Kaiser Family Foundation analysis of National Health Interview Survey

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Nearly one in five adults in worse health (18%) said they delayed or did not receive medical care due to cost barriers, while 7% of respondents in better health reported the same.

Uninsured adults are more likely to delay or go without care due to cost

Percent of adults who reported delaying or going without care due to cost, 2015



Source: Kaiser Family Foundation analysis of National Health Interview Survey [2015](#)

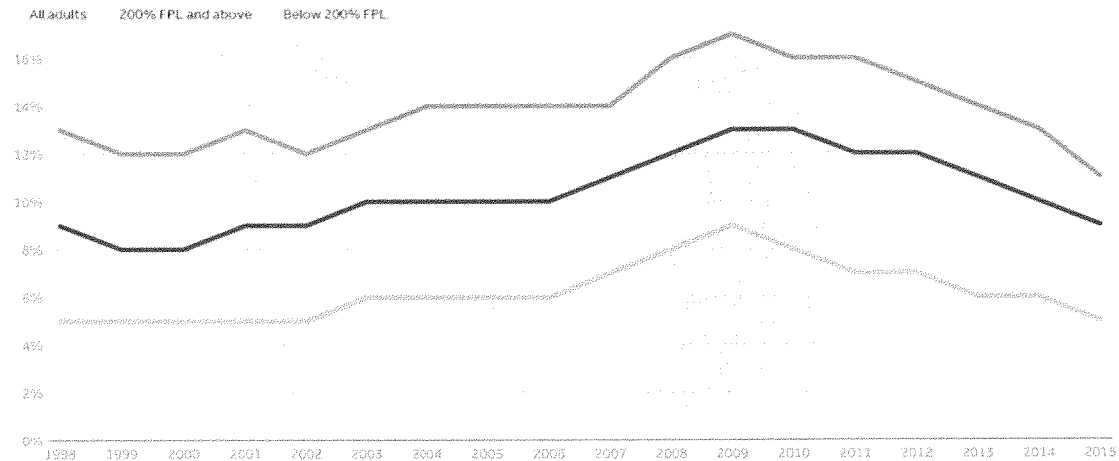
Peterson Kaiser
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More than 1 in 4 uninsured adults (28%) said they delayed or went without healthcare because of cost reasons. Meanwhile, 7% of adults who have health insurance reported encountering cost-related access barriers to care.

Low-income adults are more likely than others to have difficulty accessing medical care due to costs, but

rates have declined in recent years

Percent of adults who report delaying and/or going without medical care due to costs, 1998 - 2015



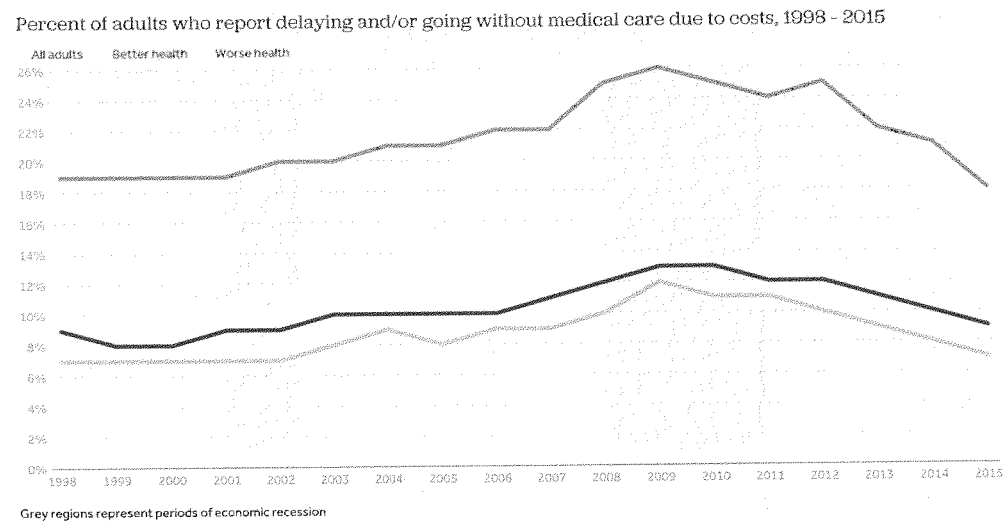
Grey region represents periods of economic recession.

Source: Kaiser Family Foundation analysis of National Health Interview Survey

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From 1998 - 2015, lower income adults have consistently reported more cost-related barriers to accessing medical care than higher income adults. Cost-related access problems generally rise during economic downturns. In 2015, rates of cost-related access barriers were lower than in any other year during this period for low-income people (11%, down from a recent high of 17% in the early years of the recent economic downturn and a low of 12% in 2002).

Adults in worse health are more likely than others to have difficulty accessing medical care due to costs, but rates have declined in recent years



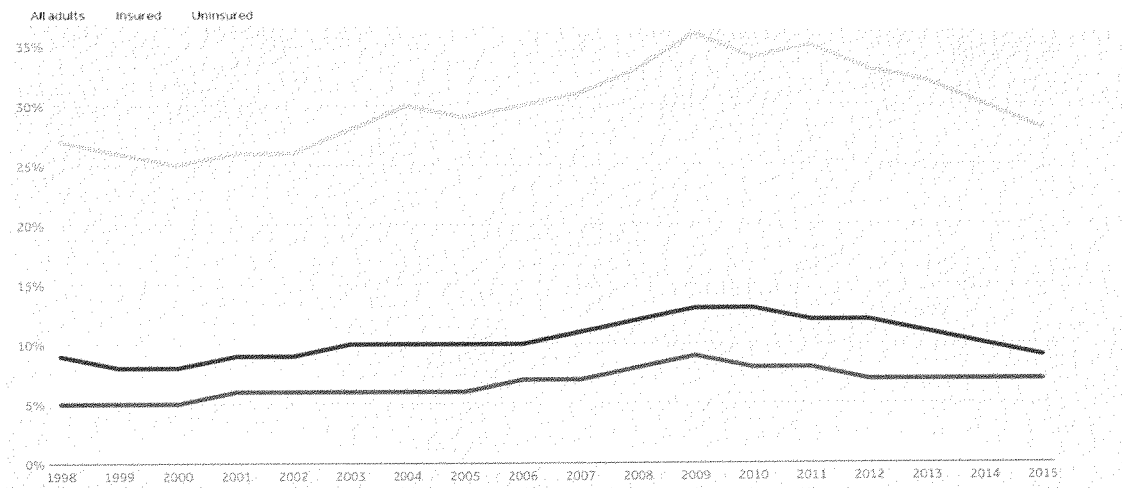
Source: Kaiser Family Foundation analysis of National Health Interview Survey ¹

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Adults in worse health have long reported more cost-related access problems than those in better health. Cost-related access problems generally rise during economic downturns. Rates of cost-related access barriers are at their lowest in 2015 for those in worse health (18%, down from a recent high of 26% in 2009, and a low of 19% in 1998).

Uninsured adults experienced more difficulty accessing care due to cost

Percent of adults who report delaying and/or going without medical care due to costs, 1998 - 2015



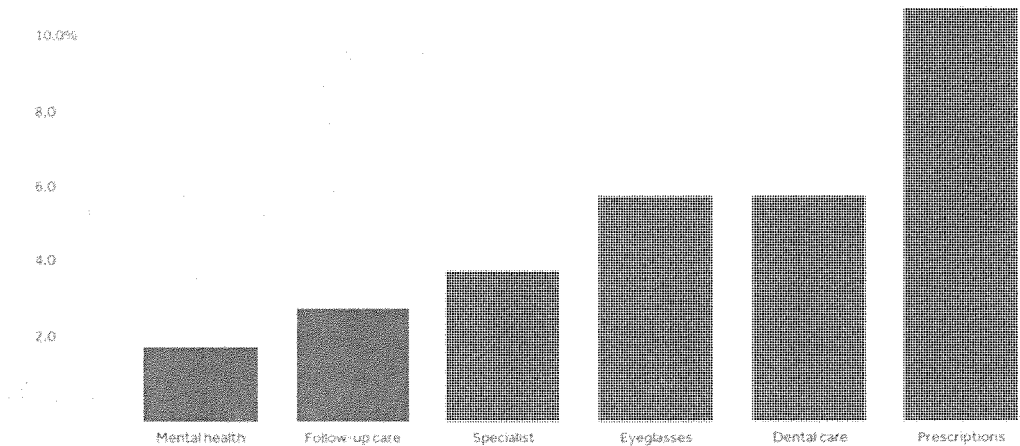
Source: Kaiser Family Foundation analysis of National Health Interview Survey

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Uninsured adults have consistently experienced more difficulty accessing health care due to cost. Cost-related access problems generally rise during economic downturns. Note that the group of people who remain uninsured in 2014 and 2015 (after the Affordable Care Act's coverage expansions) is likely different demographically from the people who were uninsured prior to 2014.

Adults are most likely to go without dental care and prescriptions because of cost reasons

Percent of adults who report delaying and/or going without medical care due to costs, by type of care, 2015



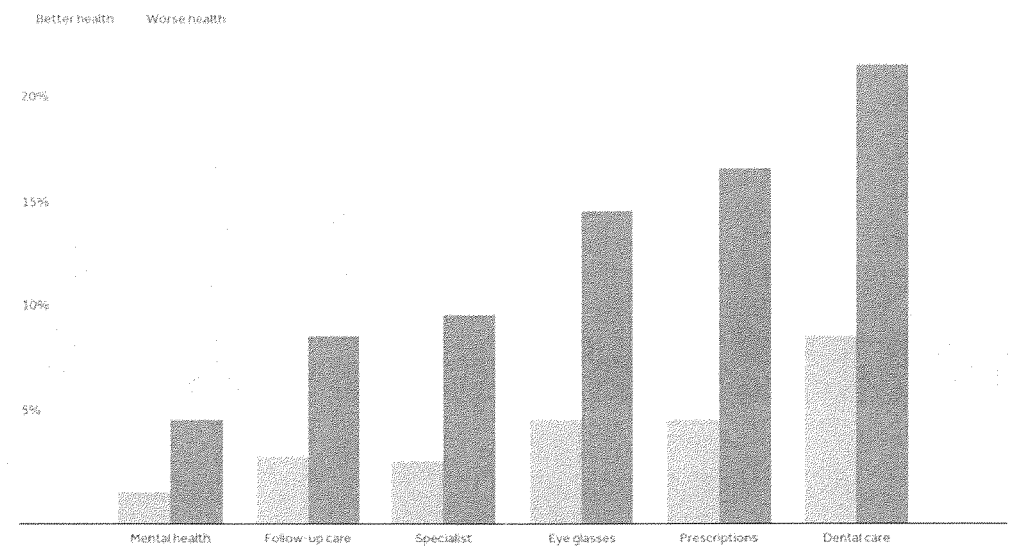
Source: Kaiser Family Foundation analysis of National Health Interview Survey

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Of the types of care that are delayed or forgone for cost reasons, dental care, prescription drugs, and eye glasses are at the top of the list, with at least 6 percent of adults reporting delaying or forgoing these types of care.

Adults in worse health report much higher rates of delayed or forgone medical care due to cost

Percent of adults who report delaying and/or going without medical care due to costs, by type of care 2015

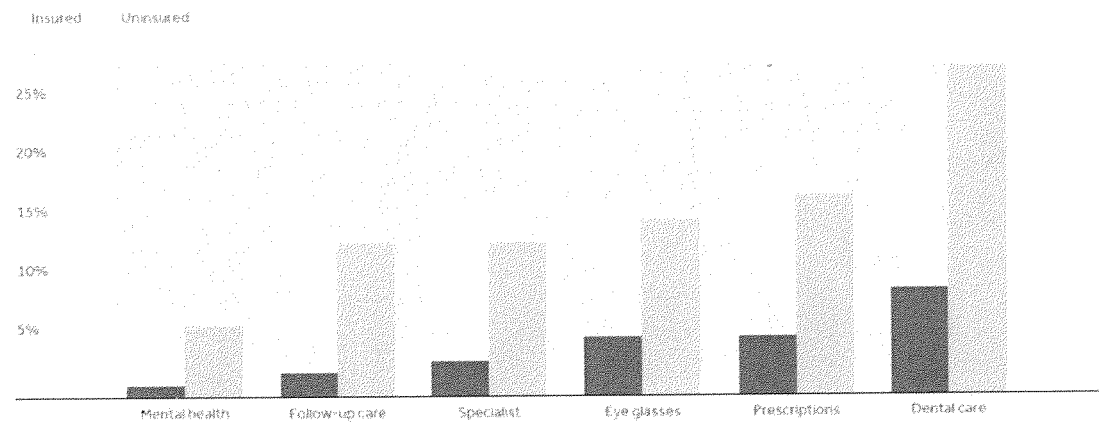


Source: Kaiser Family Foundation analysis of National Health Interview Survey [↗](#)

Adults in worse health are much more likely to delay or forgo many types of health services.

More than a fourth of uninsured adults delayed or went without needed dental care because of the cost

Percent of adults who report delaying and/or going without medical care due to costs, by type of care, 2015



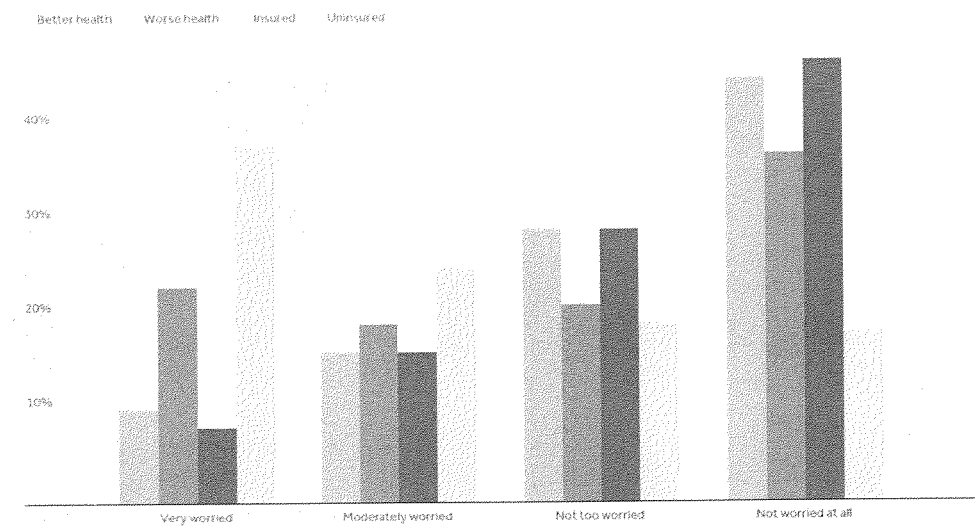
Source: Kaiser Family Foundation analysis of National Health Interview Survey ²⁰

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Similarly, uninsured adults report significantly higher rates of cost-related access problems.

Uninsured adults and those in worse health are more worried about paying bills for routine medical care

Percent of adults who worry about paying medical bills for routine care, by health and insurance status, 2015



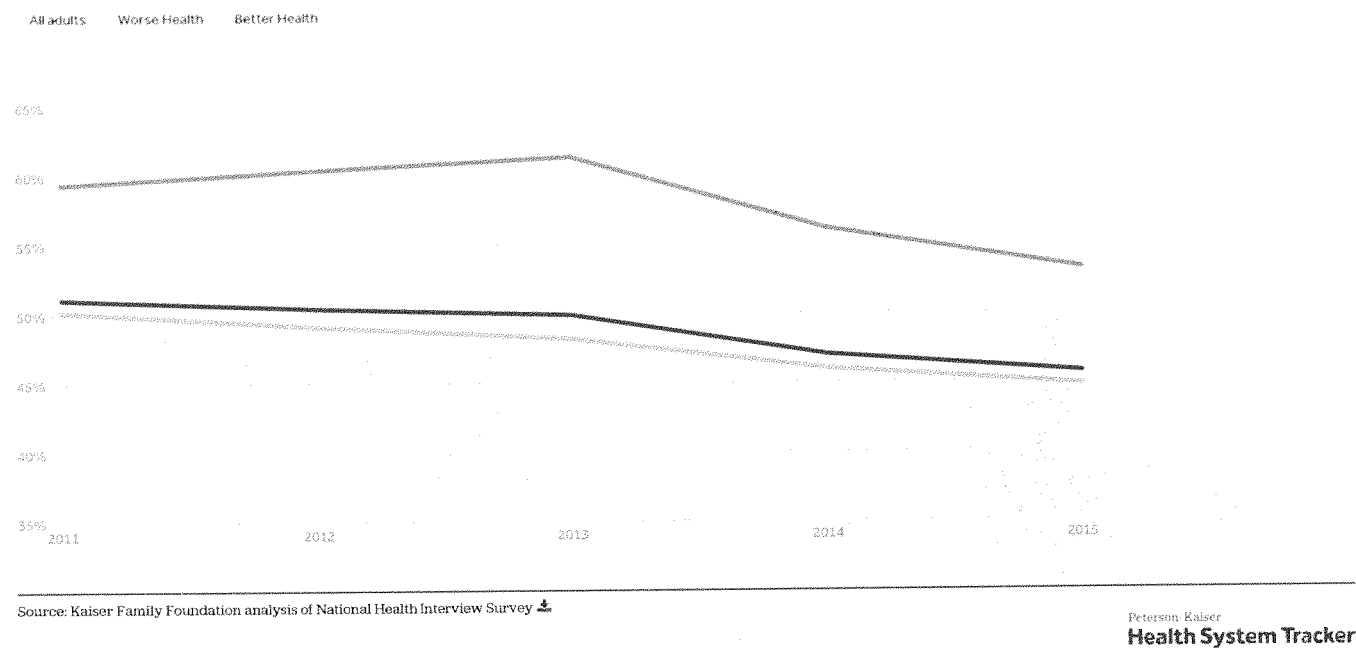
Source: Kaiser Family Foundation analysis of National Health Interview Survey [↗](#)

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Nearly two thirds (63%) of uninsured adults are very or moderately worried about paying for routine medical care. Adults in worse health care also more likely to report worries about paying for care, though the disparity is not as great as with insurance status.

Adults in worse health are less likely to worry about paying medical bills than in previous years

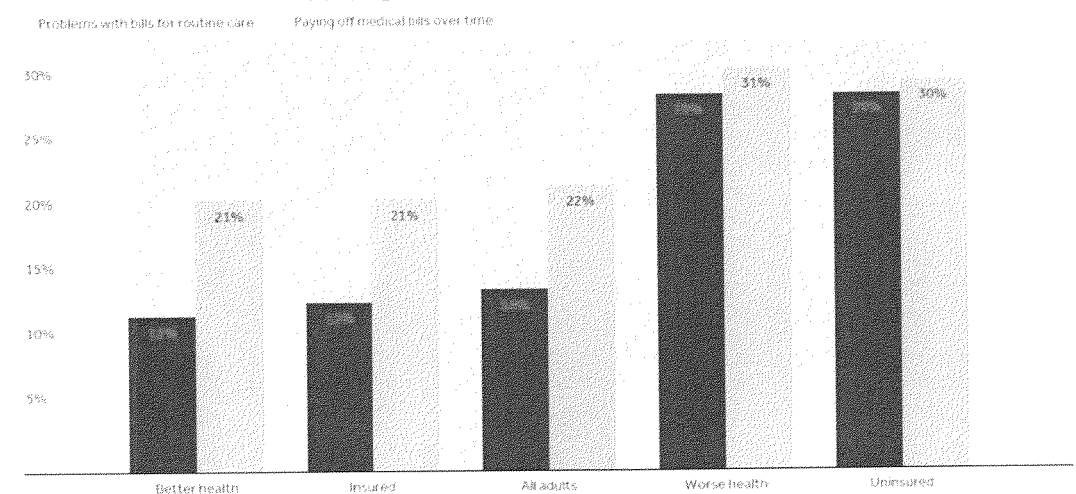
Percent of adults worried about their ability to pay medical bills if they get sick or have an accident, 2011 - 2015



Adults in worse health have long reported more cost-related access problems than those in better health.

Uninsured adults and adults in worse health report more problems paying medical bills

Percent of adults with difficulty paying medical bills, by health and insurance status, 2015



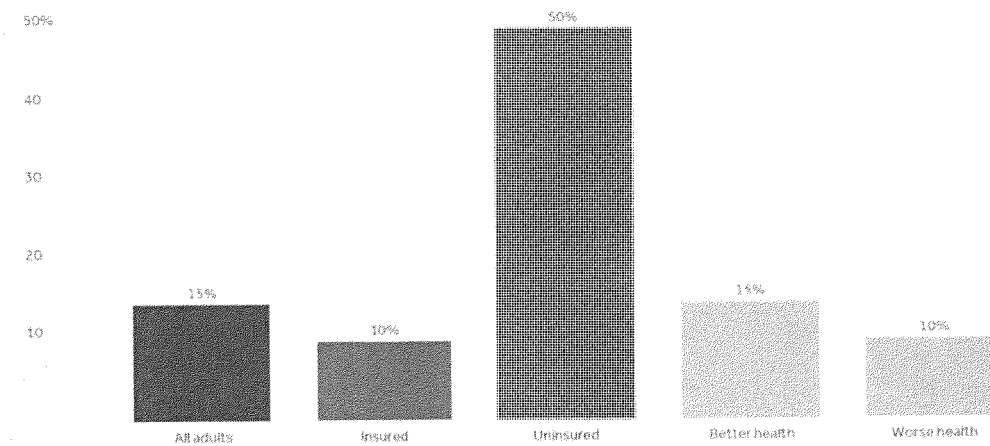
Source: Kaiser Family Foundation analysis of National Health Interview Survey


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About one in every three adults who reported being in worse health also reported problems paying bills for routine care as well as difficulty paying off medical bills over time (29% and 31% respectively). Uninsured adults had similar rates of medical bill problems.

Uninsured adults are less likely to have a usual source of care

Percent of adults without a usual source of care, by insurance and health status, 2015



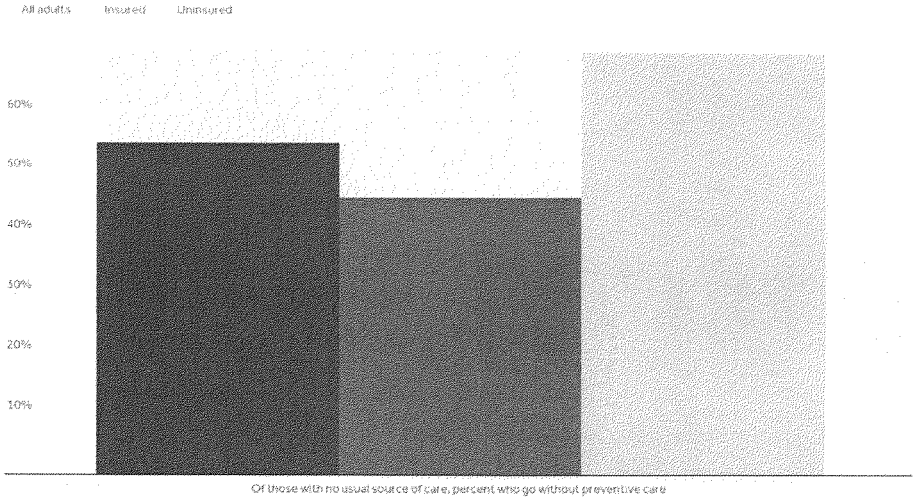
Source: Kaiser Family Foundation analysis of National Health Interview Survey 

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Compared to those in better health people (10%) in worse health more often report not having a usual source of care (15%). The uninsured, in contrast, are much less likely to report not having a usual source of care (50%) than those with insurance (10%).

Uninsured adults who lack a usual source of care are also more likely to forgo preventive care

Percent of adults who did not report a usual source of care, who reported going without preventive care, 2015



Source: Kaiser Family Foundation analysis of National Health Interview Survey [↗](#)

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Of uninsured adults who did not report having a usual source of care, the majority (70%) also said they went without preventive health care services.

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Health System Tracker**Despite lower rates of access barriers for some groups, health costs remain a concern for many Americans**By Cynthia Cox and Bradley Sawyer *Kaiser Family Foundation*

SHARE



The high cost of health care can be a barrier to access for both insured people (particularly those with high deductibles) and the uninsured. Today, a report from the National Center for Health Statistics finds that the share of adults reporting difficulty paying medical bills has declined in recent years. Similarly, a recent Commonwealth Fund survey of adults in the U.S. and 10 other countries found that fewer Americans report cost-related access barriers than did in 2013, though Americans still have more difficulty accessing care due to cost reasons than people living in the 10 other countries, on average.

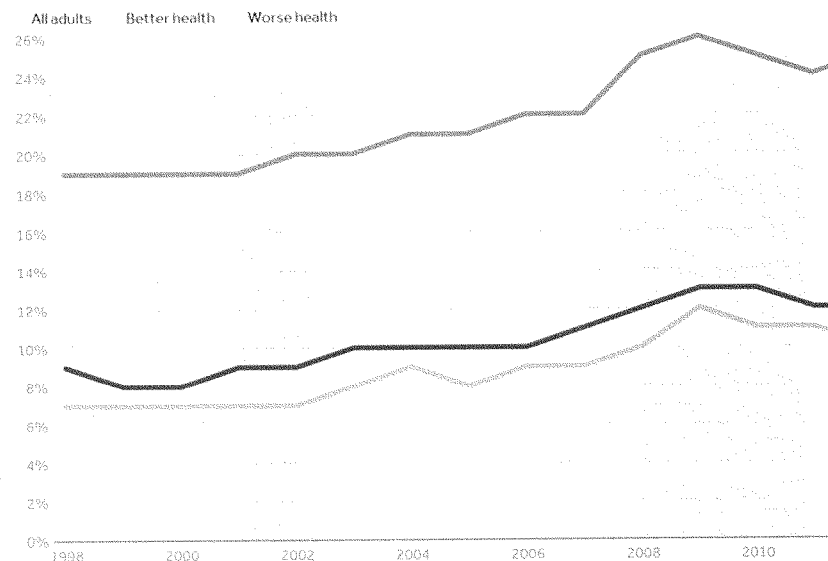
People in worse health are less likely to worry about medical bills than in past years

In this post and continuously updated chart collection, we analyze data from the U.S. CDC's National Health Interview Survey to examine trends in Americans' access to health care from 1998 through 2015. In 2015, nearly one in 10 adults (9%) reported delaying or not receiving medical care due to cost. We find that in 2015, rates of cost-related access barriers were lower than in any other year during this period for low-income people (11%, down from a recent high of 17% in the early years of the recent economic downturn and a low of 12% in 2002).


Similarly, rates of cost-related access barriers are at their lowest in 2015 for those in worse health (18%, down from a recent high of 26% in 2009, and a low of 19% in 1998). Before the recent economic downturn, about 22% of adults in worse health reported cost-related access barriers to care. After peaking at 26% in 2009, the rate of cost-related access barriers for those in worse health returned to pre-recession rates by 2013, and then continued to decline to 18% in 2015 – the lowest rate since at least 1998.

Adults in worse health are more likely than others to have difficulty accessing medical care due to costs, but rates have declined in recent years

Percent of adults who report delaying and/or going without medical care due to costs, 1998 – 2015



Grey regions represent periods of economic recession

Source: Kaiser Family Foundation analysis of National Health Interview Survey | 

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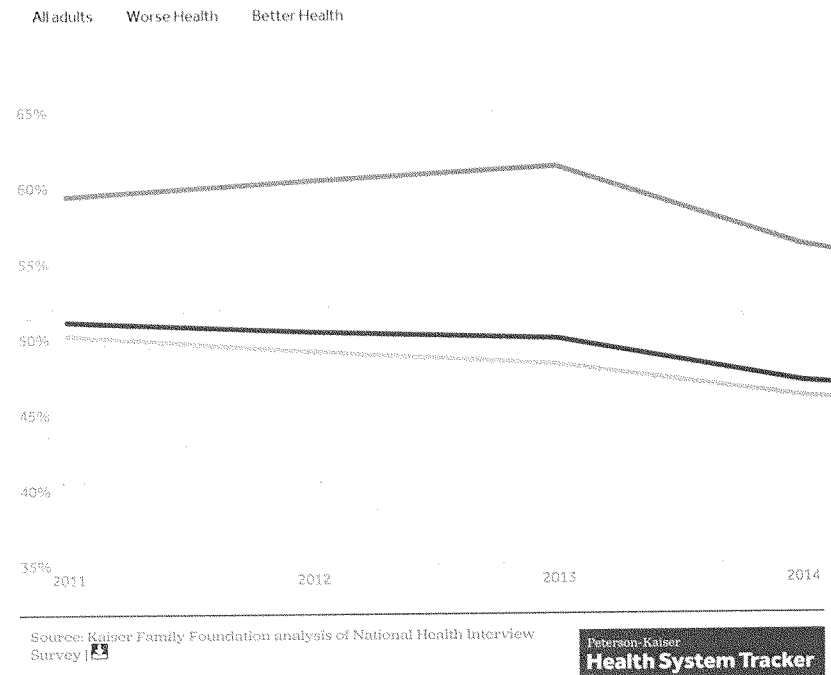
Dental care (11%), prescription drugs (6%), and eye glasses (6%) top of the list of the types of care which were delayed or forgone because of cost in 2015. The vast majority of American adults are in good or excellent health (88%) and/or have medical insurance (89%), and are thus less likely to encounter cost-related access barriers. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs:

- Nearly one in five adults (18%) who reported being in worse health said they delayed or did not receive medical care due to cost barriers, while 7% of respondents in better health reported the same.
- Without medical insurance, cost-related access problems are more common for Americans. Unaffordable medical costs caused more than 1 in 4 uninsured adults (28%) to delay or go without health care in 2015. Meanwhile, 7% of adults who have health insurance reported encountering cost-related access barriers to care.
- Lower income adults on average report more cost-related barriers to accessing medical care (11%) than higher income adults (5%). As mentioned above, 11% is the lowest rate of reported access barriers among this group since at least 1998.

Between 2011 and 2013 (the year before the major coverage expansions of the Affordable Care Act went into effect), the share of adults in worse health reporting worry about their ability to pay for medical care increased from 59% to 61%. After the coverage expansions went into effect, the share dropped to 56% in 2014, and then 53% in 2015.

Adults in worse health are less likely to worry about paying medical bills than in previous years

Percent of adults worried about their ability to pay medical bills if they get sick or have an accident, 2011 - 2015



The uninsured rate in the U.S. has fallen to an all-time low as a result of the Affordable Care Act. Still, about 28.9 million people remained uninsured in 2015. (A recent Kaiser Family Foundation analysis found that 43% of the remaining uninsured could qualify for assistance to purchase health insurance or enroll in Medicaid, but for one reason or another have not taken advantage of this assistance.) From our analysis of NHIS data, we find that half of uninsured adults (50%) report having no usual source of care, while

10% of those with insurance say the same. Similarly, of uninsured adults who did not report having a usual source of care, the majority (70%) also said they went without preventive health care services.

Following the recent election, the future of the Affordable Care Act is uncertain. One of the main objectives of the recent health care reform legislation was to increase access to care through increased affordability. In the years since its initial implementation, survey data from a variety of sources suggest that rates of cost-related access barriers have fallen, particularly for lower-income people and those in worse health, but access remains a challenge for many Americans in the early years of the health reform law.

RELATED TOPICS

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July 2017 | Issue Brief

The Facts on Medicare Spending and Financing

Juliette Cubanski and Tricia Neuman

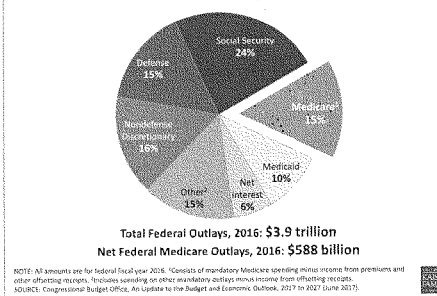
Key Facts

- Medicare spending was 15 percent of total federal spending in 2016, and is projected to rise to 17.5 percent by 2027.
- The Medicare Hospital Insurance (Part A) trust fund is projected to be depleted in 2029, one year later than the 2016 projection.
- Medicare's actuaries project that the Independent Payment Advisory Board (IPAB) process will be triggered for the first time in 2021, four years later than their 2016 forecast.
- The share of Medicare benefit spending on hospital inpatient services fell by one-third between 2006 and 2016, while spending on Medicare Advantage private health plans doubled.
- Average annual growth in Medicare per capita spending growth was 1.3 percent between 2010 and 2016, down from 7.4 percent between 2000 and 2010.
- Medicare per capita spending is projected to grow at an average annual rate of 4.5 percent over the next ten years, slightly lower than the growth rate for private insurance.

Overview of Medicare Spending

Medicare, the federal health insurance program for 57 million people ages 65 and over and younger people with permanent disabilities, helps to pay for hospital and physician visits, prescription drugs, and other acute and post-acute care services. In 2016, spending on Medicare accounted for 15 percent of the federal budget (Figure 1). Medicare plays a major role in the health care system, accounting for 20 percent of total national health spending in 2015, 29 percent of spending on retail sales of prescription drugs, 25 percent of spending on hospital care, and 23 percent of spending on physician services.¹ This issue brief includes the most recent historical and projected Medicare spending data published in the [2017 annual report](#) of the Boards of Medicare Trustees from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) and the [2017 Medicare baseline](#) and projections from the Congressional Budget Office (CBO).

Figure 1
Medicare as a Share of the Federal Budget, 2016

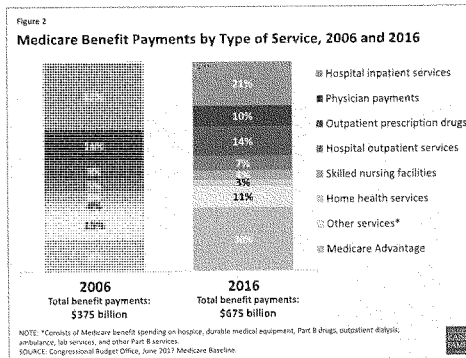


Historical Trends in Medicare Spending

TRENDS IN MEDICARE BENEFIT PAYMENTS

In 2016, Medicare benefit payments totaled \$675 billion, up from \$375 billion in 2006. The distribution of Medicare benefit payments has changed in significant ways over the past ten years (**Figure 2**).

Most notably, the share of total spending on hospital inpatient services declined by one-third between 2006 and 2016, from 32 percent to 21 percent, while payments to Medicare Advantage (private health plans which cover all Part A and Part B benefits) doubled, from 15 percent to 30 percent, as private plan enrollment has grown steadily since 2006. Thirty percent of benefit spending was for Medicare Advantage plans; in 2017, 33 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans, up from 16 percent in 2006. Over these years, spending on outpatient prescription drugs (Part D) increased from 9 percent of total benefit payments to 14 percent in 2016.

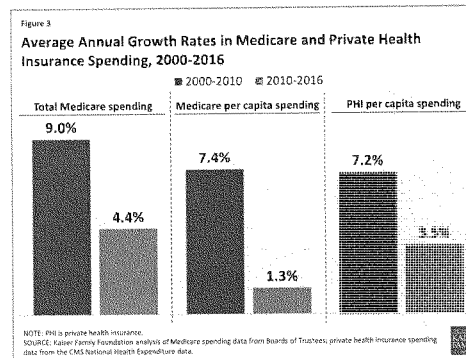


TRENDS IN TOTAL AND PER CAPITA MEDICARE SPENDING

Recent years have seen a notable reduction in the growth of Medicare spending compared to prior decades, both overall and per beneficiary.

- Average annual growth in total Medicare spending was 4.4 percent between 2010 and 2016, down from 9.0 percent between 2000 and 2010, despite faster growth in enrollment since 2011 with the baby boom generation reaching Medicare eligibility age (**Figure 3**).
- Average annual growth in Medicare spending per beneficiary was just 1.3 percent between 2010 and 2016, down from 7.4 percent between 2000 and 2010.

Slower growth in Medicare spending in recent years can be attributed in part to policy changes adopted as part of the Affordable Care Act (ACA) and the Budget Control Act of 2011 (BCA). The ACA included reductions in Medicare payments to plans and providers, increased revenues, and introduced delivery system reforms that aimed to improve efficiency and quality of patient care and reduce costs, including accountable care organizations (ACOs), medical homes, bundled payments, and value-based purchasing initiatives. The BCA lowered Medicare spending through sequestration that reduced payments to providers and plans by 2 percent beginning in 2013. Medicare spending trends in recent years have also been affected by changes



in prescription drug spending and hospital inpatient readmissions, a sharp decline in home health spending, and recoveries from program integrity efforts. In addition, although Medicare enrollment has been growing around 3 percent annually with the aging of the baby boom generation, the influx of younger, healthier beneficiaries has contributed to slower spending growth.

SPENDING TRENDS FOR MEDICARE COMPARED TO PRIVATE HEALTH INSURANCE

Over the past 25 years, Medicare spending has grown at a slightly slower rate than private health insurance spending on a per enrollee basis. With the recent slowdown in the growth of Medicare spending, the difference in growth rates between Medicare and private health insurance spending per enrollee widened.

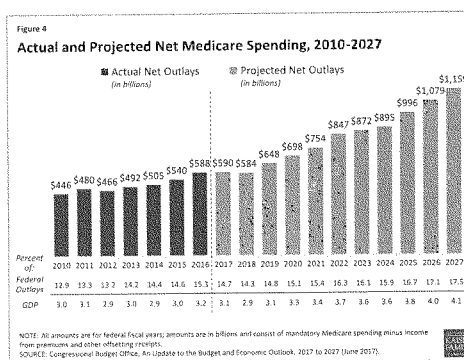
- Between 1991 and 2016, Medicare spending per enrollee grew at an average annual rate of 5.0 percent, slower than the 5.7 percent average annual growth rate in private insurance spending per enrollee.²
- Between 2000 and 2010, per enrollee spending growth rates were comparable for Medicare and private insurance (Figure 3). Between 2010 and 2016, however, Medicare per capita spending grew considerably more slowly than private insurance spending, increasing at an average annual rate of just 1.3 percent over this time period, while average annual private health insurance spending per capita grew at 3.5 percent.

Medicare Spending Projections

SHORT-TERM SPENDING PROJECTIONS FOR THE NEXT TEN YEARS

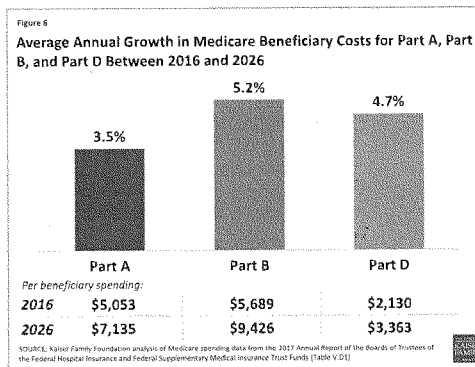
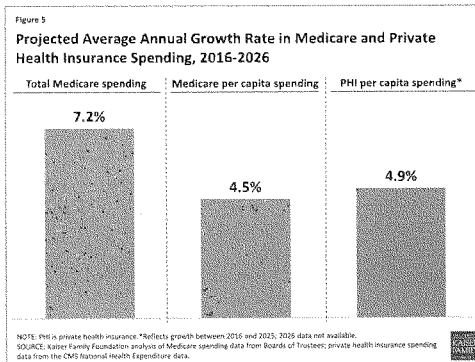
While spending is expected to continue to grow more slowly in the future compared to long-term historical trends, there are signs that spending growth is likely to increase at a faster rate than in recent years, in part due to growing enrollment in Medicare, increased use of services, and rising health care prices.³

Looking ahead, net Medicare spending (that is, mandatory Medicare spending minus income from premiums and other offsetting receipts) is projected to increase from \$590 billion in 2017 to \$1.2 trillion in 2027, according to CBO. CBO projects total Medicare spending to increase from \$708 billion to \$1.4 trillion over this time period. Net Medicare spending is projected to grow modestly as a share of the federal budget and the nation's economy over the next ten years. Between 2017 and 2027, Medicare's share of the budget is projected to increase from 14.7 percent to 17.5 percent, while Medicare spending as a share of the gross domestic product (GDP) is projected to increase from 3.1 percent to 4.1 percent (Figure 4).



SPENDING GROWTH RATE PROJECTIONS

- Average annual growth in total Medicare spending is projected to be 7.2 percent between 2016 and 2026 (**Figure 5**). This is faster than the 4.4 percent average annual growth rate between 2010 and 2016.
- On a per capita basis, Medicare spending is projected to grow at a faster rate between 2016 and 2026 (4.5 percent) than between 2010 and 2016 (1.3 percent), and slightly lower than the average annual growth in per capita private health insurance spending over this time period (4.9 percent).
- Medicare per capita spending is not expected to grow uniformly across the coming ten-year period, however. Average annual per capita spending growth is expected to be slower in the first five years of the projection period than in the last five years: 4.0 percent between 2016 and 2021, increasing to 5.0 percent between 2021 and 2026.
- OACT projects a comparatively higher per capita growth rate in the coming years for Part B than for the other parts of the program. Per capita spending growth is projected to be 5.2 percent for Part B, compared to 3.5 percent for Part A and 4.7 percent for Part D (**Figure 6**). Among the reasons for the higher growth in Part B spending is slightly higher-than-expected actual spending in 2016 for outpatient hospital services and physician-administered drugs (which are covered under Part B). OACT has revised downward somewhat the projections for Part D spending compared to 2016, primarily attributable to significantly higher drug manufacturer rebates and lower utilization of hepatitis C drugs, which was a significant driver of higher Part D spending in 2014 and 2015.



LONG-TERM SPENDING PROJECTIONS

Over the longer term (that is, beyond the next ten years), both CBO and OACT expect Medicare spending to rise more rapidly relative to GDP due to a number of factors, including the aging of the population and faster growth in health care costs than growth in the economy on a per capita basis. According to CBO's most recent [long-term projections](#), net Medicare spending will grow from 3.1 percent of GDP in 2017 to 4.2 percent in 2027, 5.3 percent in 2037, and 6.1 percent in 2047.

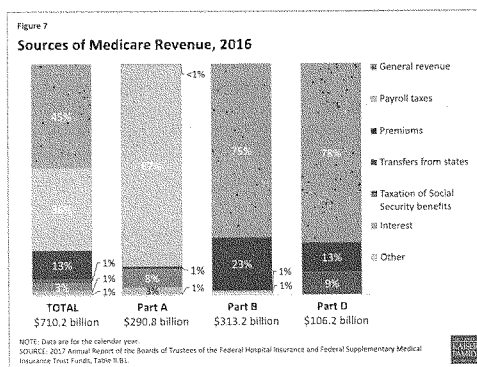
Over the next 30 years, CBO projects that "excess" health care cost growth—defined as the extent to which the growth of health care costs per beneficiary, adjusted for demographic changes, exceeds the growth of potential GDP

per person—will account for a somewhat larger share of projected growth in spending on the nation's major health care programs (Medicare, Medicaid, and subsidies for ACA Marketplace coverage) than the aging of the population. CBO cites new medical technology and rising personal income as the driving factors behind projections of rising health care costs.

How Is Medicare Financed?

Medicare is funded primarily from three sources: general revenues (45 percent), payroll taxes (36 percent), and beneficiary premiums (13 percent) (**Figure 7**).

- Part A is financed primarily through a 2.9 percent tax on earnings paid by employers and employees (1.45 percent each) (accounting for 88 percent of Part A revenue). Higher-income taxpayers (more than \$200,000/individual and \$250,000/couple) pay a higher payroll tax on earnings (2.35 percent).
- Part B is financed through general revenues (75 percent), beneficiary premiums (23 percent), and interest and other sources (2 percent). Beneficiaries with annual incomes over \$85,000/individual or \$170,000/couple pay a higher, income-related Part B premium reflecting a larger share of total Part B spending, ranging from 35 percent to 80 percent. The ACA froze the income thresholds through 2019, and beginning in 2020, the income thresholds will once again be indexed to inflation, based on their levels in 2019 (a provision in the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA⁹). As a result, the number and share of beneficiaries paying income-related premiums will increase as the number of people on Medicare continues to grow in future years and as their incomes rise.
- Part D is financed by general revenues (78 percent), beneficiary premiums (13 percent), and state payments for dually eligible beneficiaries (9 percent). As for Part B, higher-income enrollees pay a larger share of the cost of Part D coverage.
- The Medicare Advantage program (Part C) is not separately financed. Medicare Advantage plans such as HMOs and PPOs cover all Part A, Part B, and (typically) Part D benefits. Beneficiaries enrolled in Medicare Advantage typically pay monthly premiums for additional benefits covered by their plan, in addition to the Part B premium.



Assessing Medicare's Financial Condition

Medicare's financial condition can be assessed in different ways, including estimating the solvency of the Medicare Hospital Insurance (Part A) trust fund, and comparing various measures of Medicare spending—overall or per capita—to other spending measures, such as Medicare spending as a share of the federal budget or as a share of GDP. Such measures are also used in the context of broader discussions of the national budget and federal debt and in the Independent Payment Advisory Board (IPAB) process, described below.

SOLVENCY OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND

The solvency of the Medicare Hospital Insurance trust fund, out of which Part A benefits are paid, is one way of measuring Medicare's financial status, though because it only focuses on the status of Part A, it does not present a complete picture of program spending overall. The solvency of Medicare in this context is measured by the level of assets in the Part A trust fund. In years when annual income to the trust fund exceeds benefits spending, the asset level increases, and when annual spending exceeds income, the asset level decreases. When spending exceeds income and the assets are fully depleted, Medicare will not have sufficient funds to pay all Part A benefits.

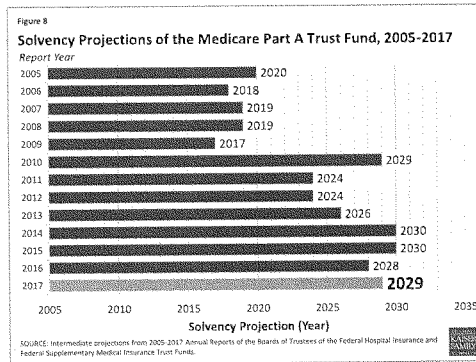
Each year, the Medicare Trustees provide an estimate of the year when the asset level is projected to be fully depleted. In their 2017 report, the Medicare Trustees project that the Part A trust fund will be depleted in 2029, one year later than was projected in 2016. The trustees attribute this to lower-than-expected hospital inpatient utilization in 2016, which affects assumptions about use of hospital services in the future (**Figure 8**).

Because of slower growth in Medicare spending in recent years, the solvency of the Part A trust fund has been extended further into the future compared to projections before the ACA was passed. Part A trust fund solvency is also affected by the level of growth in the economy, which affects Medicare's revenue from payroll tax contributions, by overall health care spending trends, and by demographic trends—of note, an increasing number of beneficiaries, especially between 2010 and 2030 when the baby boom generation reaches Medicare eligibility age, and a declining ratio of workers per beneficiary making payroll tax contributions.

Part B and Part D do not have financing challenges similar to Part A, because both are funded by beneficiary premiums and general revenues that are set annually to match expected outlays. Expected future increases in spending under Part B and Part D, however, will require increases in general revenue funding and higher premiums paid by beneficiaries.

THE INDEPENDENT PAYMENT ADVISORY BOARD

The Independent Payment Advisory Board (IPAB), authorized by the ACA, is required to recommend Medicare spending reductions to Congress if projected spending growth exceeds specified target levels. IPAB is required to propose spending reductions if the 5-year average growth rate in Medicare per capita spending is projected to exceed the per capita target growth rate, based on general and medical inflation (for determination years 2015 to 2019) or growth in the economy (2020 and beyond). The Board is to consist of 15 full-time members appointed by the President and confirmed by the Senate, but no individuals have been nominated to serve on IPAB by either former President Obama or President Trump. If there are no Board members appointed when a proposal for spending reductions is required, the Secretary of the Department of Health and Human Services is responsible for making recommendations to achieve the required spending reductions.



Based on its most recent Medicare spending growth rate projections relative to the targets, OACT has estimated that the IPAB process will first be triggered in 2021 (**Figure 9**). This would initiate a three-year cycle ending with spending reductions implemented in 2023. OACT also projects that spending growth will exceed the target growth rate in 2024, 2025, and 2026. CBO has projected that Medicare spending growth will exceed the target growth rate in 2019, 2023, 2025, and 2027. Based on its projections, CBO estimates Medicare savings of \$20 billion as a result of the IPAB process between 2019 and 2027.

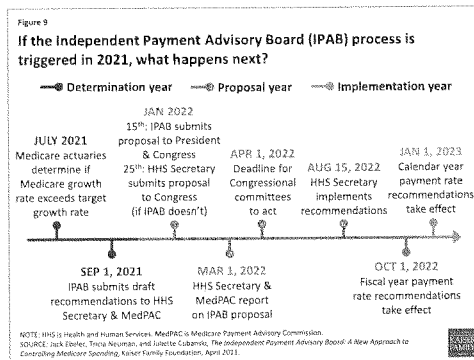
IPAB has been a source of controversy since before the enactment of the ACA, in part related to concern among members of Congress and other stakeholders about the authority granted to IPAB to make decisions about the Medicare program that are typically within the purview of Congress. There have been several attempts by Congress to repeal the IPAB since 2010, and the Trump Administration's proposed Fiscal Year 2018 budget included a provision to do the same.

The Future Outlook

While Medicare spending is on a slower upward trajectory now than in past decades, total and per capita annual growth rates appear to be edging away from their historically low levels of the past few years. This raises several questions about recent spending trends and projections for future spending growth: Can the recent slowdown in Medicare spending be sustained and can this be done without adversely affecting access to or quality of care? How are payment and delivery system reforms influencing spending levels? How will future spending be affected by Medicare's new approaches to physician payment that will be established pursuant to MACRA? What steps could be taken to moderate the projected growth in Medicare spending due to the availability of new specialty drugs and medical technology?

A number of changes to Medicare have been proposed that could help to address the health care spending challenges posed by the aging of the population, including: restructuring Medicare benefits and cost sharing; eliminating "first-dollar" Medigap coverage; further increasing Medicare premiums for beneficiaries with relatively high incomes; raising the Medicare eligibility age; shifting Medicare from a defined benefit structure to a "premium support" system; and accelerating the ACA's delivery system reforms. At the same time, changes have been proposed to improve coverage under Medicare in order to limit the financial burden of health care costs on older Americans and younger beneficiaries with disabilities, though such changes would likely require additional spending. In addition to these potential changes, which would affect future spending levels, revenue options could also be considered to help finance care for Medicare's growing and aging population.

The prospects for these and other proposals that would affect Medicare spending and financing are unknown, but few would question the importance of carefully deliberating ways to bolster the Medicare program for today's beneficiaries and for the growing number of people who will depend on Medicare in the future.



Endnotes

¹ Kaiser Family Foundation analysis based on Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditures Tables, Table 4: National Health Expenditures by Source of Funds and Type of Expenditures: Calendar Years 2009-2015 (December 2016).

² Kaiser Family Foundation analysis based on Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditures Tables, Table 21: Expenditures, Enrollment and Per Enrollee Estimates of Health Insurance: United States, Calendar Years 1987-2015 (December 2016), and Table 17: Health Insurance Enrollment and Enrollment Growth Rates, Calendar Years 2009-2025 (March 2017).

³ Sean Keehan, et al. "National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector to 20 Percent of Economy," *Health Affairs*, published online February 15, 2017.

⁴ The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Public Law 114-10) is a law to repeal and replace Medicare's Sustainable Growth Rate (SGR) formula which will establish new payment systems designed to reward quality over quantity of physician services.

An Estimated 52 Million Adults Have Pre-Existing Conditions That Would Make Them Uninsurable Pre-Obamacare

In Eleven States, 3 in 10 Non-Elderly Adults Would Likely Be Denied Individual Insurance Under Medical Underwriting Practices

Dec 12, 2016



A new Kaiser Family Foundation analysis (<http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>) finds that 52 million adults under 65 – or 27 percent of that population — have pre-existing health conditions that would likely make them uninsurable if they applied for health coverage under medical underwriting practices that existed in most states before insurance regulation changes made by the Affordable Care Act.

In eleven states, at least three in ten non-elderly adults would have a declinable condition, according to the analysis: West Virginia (36%), Mississippi (34%), Kentucky (33%), Alabama (33%), Arkansas (32%), Tennessee (32%), Oklahoma (31%), Louisiana (30%), Missouri (30%), Indiana (30%) and Kansas (30%).

States with the most people estimated to have the conditions include: California (5,865,000), Texas (4,536,000), and Florida (3,116,000).

Using data from two large government surveys, the analysis estimates the total number of nonelderly adults in each state with a health condition that could lead to a denial of coverage in the individual insurance market, based on pre-ACA field underwriting guides for brokers and agents. The results are conservative because the data don't include some declinable conditions. The estimates also don't include the number of people with other health conditions that wouldn't necessarily cause a denial, but could lead to higher insurance costs based on underwriting.

While most people with pre-existing health conditions have coverage through an employer or public program, such as Medicaid, they may intermittently seek insurance in the individual market during times when they're ineligible for other coverage, such as following a job loss or divorce. People who are self-employed, early retirees, or lower-wage workers in jobs that don't provide health benefits often are covered by individual plans for longer periods.

Before ACA protections took effect in 2014, private insurers in the individual health insurance market could use applicants' health status, health history and other risk factors to determine whether and under what terms to issue coverage. Some examples of conditions which could have led to automatic denial of coverage include cancer, diabetes, epilepsy, heart disease, and pregnancy.

In the post-election health policy debate, both political parties have expressed a desire to continue protecting people with pre-existing conditions.

The new analysis, [Pre-Existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA](http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/) (<http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>), offers a detailed look at medical underwriting practices common in the individual market before the health law's prohibitions.

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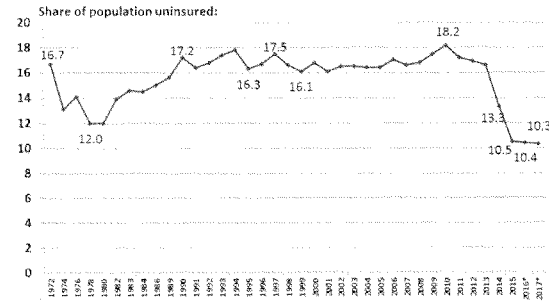
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Uninsured Rate Among the Nonelderly Population, 1972-2017

Uninsured Rate Among the Nonelderly Population, 1972-2017*



Note: 2017 data is for Q1 only.

Sources: CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm and <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf>.



<https://kaiserfamilyfoundation.files.wordpress.com/2017/02/uninsured-rate-among-the-nonelderly-population-1972-2017q1.png>



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Uninsured Rate Among the Nonelderly Population, 1972-2017

Aug 29, 2017

SOURCE

CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm
www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 (http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm) and
<https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf> (<https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf>)

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February 2017 | Issue Brief

Pre-ACA Market Practices Provide Lessons for ACA Replacement Approaches

Gary Claxton, Larry Levitt, and Karen Pollitz

Significant changes to the Affordable Care Act (ACA) are being considered by lawmakers who have been critical of its general approach to providing coverage and to some of its key provisions. An important area where changes will be considered has to do with how people with health problems would be able to gain and keep access to coverage and how much they may have to pay for it. People's health is dynamic. At any given time, an estimated 27% of non-elderly adults have health conditions that would make them ineligible for coverage under traditional non-group underwriting standards that existed prior to the ACA. Over their lifetimes, everyone is at risk of having these periods, some short and some that last for the rest of their lives.

One of the biggest changes that the ACA made to the non-group insurance market was to eliminate consideration by insurers of a person's health or health history in enrollment and rating decisions. This assured that people who had or who developed health problems would have the same plan choices and pay the same premiums as others, essentially pooling their expected costs together to determine the premiums that all would pay.

Proposals for replacing the ACA such as Rep. Tom Price's Empowering Patients First Act and Speaker Paul Ryan's "A Better Way" policy paper would repeal these insurance market rules, moving back towards pre-ACA standards where insurers generally had more leeway to use individual health in enrollment and rating for non-group coverage.¹ Under these proposals, people without pre-existing conditions would generally be able to purchase coverage anytime from private insurers. For people with health problems, several approaches have been proposed: (1) requiring insurers to accept people transitioning from previous coverage without a gap ("continuously covered"); (2) allowing insurers to charge higher premiums (within limits) to people with pre-existing conditions who have had a gap in coverage; and (3) establishing high-risk pools, which are public programs that provide coverage to people declined by private insurers.

The idea of assuring access to coverage for people with health problems is a popular one, but doing so is a challenge within a market framework where insurers have considerable flexibility over enrollment, rating and benefits. People with health conditions have much higher expected health costs than people without them (Table 1 illustrates average costs of individuals with and without "deniable" health conditions). Insurers naturally will decline applicants with health issues and will adjust rates for new and existing enrollees to reflect their health when they can. Assuring access for people with pre-existing conditions with limits on their premiums means that someone has to pay the difference between their premiums and their costs. For people enrolling in high-risk pools, some ACA replacement proposals provide for federal grants to states, though the amounts may not be sufficient. For people gaining access through continuous coverage provisions, these costs

would likely be paid by pooling their costs with (i.e., charging more to) other enrollees. Maintaining this pooling is difficult, however, when insurers have significant flexibility over rates and benefits. Experience from the pre-ACA market shows how insurers were able to use a variety of strategies to charge higher premiums to people with health problems, even when those problems began after the person enrolled in their plan. These practices can make getting or keeping coverage unaffordable.

Table 1: Average Health Costs for Non-Elderly Adults With and Without Deniable Health Conditions, by Age Range, 2014		
Age Range	Average Costs	
	With Deniable Condition	Without Deniable Condition
18-34	\$5,190	\$1,809
35-44	\$6,371	\$2,279
45-54	\$10,195	\$2,657
55-64	\$11,537	\$4,641
18-64	\$8,853	\$2,527

Source: Kaiser Family Foundation analysis of data from the Medical Expenditure Panel Survey.

The discussion below focuses on some of the issues faced by people with health issues in the pre-ACA non-group insurance market. These pre-ACA insurance practices highlight some of the challenges in providing access and stable coverage for people and some of the issues that any ACA replacement plan will need to address. Many ACA replacement proposals have not yet been developed in sufficient detail to fully deal with these questions, or in some cases may defer them to the states.

We start by briefly summarizing key differences between the ACA and pre-ACA insurance market rules for non-group coverage that affect access and continuity of coverage. We then focus on pre-ACA access and continuity issues for three different groups: (1) people transitioning from employer coverage or Medicaid to the non-group market; (2) people with non-group coverage who develop a health problem; and (3) people who are uninsured (are not considered to have continuous coverage) who want to buy non-group coverage. After that, we discuss how medical underwriting and rating practices can segment a risk pool, initially and over time, and challenges that this poses for assuring continuous coverage. We end by reviewing some of the policy choices for addressing the challenges that have been raised.

Non-Group Insurance Market Practices Before the ACA

The ACA significantly simplified the rules for health insurance enrollment, rating and benefits in the non-group market. Generally, benefits are the same for all policies offered in a state, with four levels of cost sharing (bronze, silver, gold, and platinum). Insurers cannot consider a person's health at enrollment or in determining their premium. People can enroll in any plan during an annual open enrollment period or other times under special circumstances (called special enrollment periods), such as the loss of prior coverage.

The ACA was a substantial departure from prior insurance practices in most states, where insurers had far more flexibility over enrollment, rating and benefits. State laws and practice varied -- for example, a few states required insurers to accept all applicants and prohibited rating variation based on health, similar to the ACA -- but this was not the norm. In most states, insurers were permitted to consider health in their enrollment and rating decisions. Some of the more important differences between ACA and pre-ACA market rules are described here. Their implications for providing access to coverage and assuring continuous and stable coverage are discussed in the next sections.

- 1) **Medical Screening of Applicants.** The first and most obvious difference is that insurers could ask applicants about their health and generally could deny coverage to people with health problems. They also could choose to accept the applicant at a higher premium, and, in many states, could accept the applicant but limit the terms of the coverage to exclude benefits related to a specified health condition (for example, an insurer could exclude benefits related to asthma). Underwriting decisions could vary with the type and level of coverage sought: an insurer could deny enrollment in a policy with a lower deductible to an applicant with a relatively minor condition, such as acne, but might accept them in a higher deductible plan or in a plan without drug coverage.

As will be discussed in the next section, the Health Insurance Portability and Accountability Act (HIPAA) provided access to coverage for people with at least 18 months of prior coverage, if the most immediate prior coverage was in a group health plan (generally a plan offered pursuant to employment by a public or private employer, but not Medicaid or Medicare). Insurers were required to accept these applicants (called "HIPAA-eligible" individuals) without a pre-existing condition exclusion, but generally could charge them much higher rates than other applicants. States could specify an alternative coverage mechanism for HIPAA-eligible applicants; 38 states specified an alternative, with most specifying a state high-risk pool. HIPAA-eligible individuals without health problems could choose to apply for medically-underwritten non-group policies, but doing so made them subject to preexisting condition exclusion provisions (see Medical Underwriting and Pre-existing Condition Exclusion Provisions box below).

- 2) **Multiple Rating Classes for Similar People in the Same Policy.** Another difference is that premiums for people of the same age from the same place could be quite different for the same policy. Except for a differential for smoking, people of the same age from the same place face the same (unsubsidized) premium for the same plan under the ACA. Prior to the ACA, there were many rate classifications. For example, there could be a rate for new applicants who have no health conditions, there could be several "substandard" rate tiers for people with health problems, there could be different rates for people based on how long they have had the policy (durational rating, described more below, which means that a newly issued 40 year old would pay a lower rate than a 40 year old who bought the same policy two years prior), there could be different rates based on how the policy was purchased (through an agent, directly from the insurer, through a trade group), the person's occupation, and others. Also, from year to year, the rates in each class could change by different percentages, increasing the differences for similar people in different rating classes.

- 3) **Rating by Policy or Block.** A third difference relates to how premiums are established for different policies offered by an insurer in a state. Under the ACA, where all policies cover the same essential health benefits, an average expected cost is estimated for all projected enrollees across all of an insurer's non-group products in a state, and premiums for particular policies are determined on the objective differences (i.e., cost sharing and provider network) from the average cost. In contrast, prior to the ACA, premiums were established for each policy (or a group of policies, sometimes called a block) based on the expected claims costs for the people expected to be enrolled in that policy or block, projected over current and future years. Importantly, the experience of each policy or block is developed independent of the costs or results expected in other policies or blocks, which means that two policies that are almost the same could have very different premiums associated with them based on the anticipated costs of who is projected to be enrolled (and who has actually enrolled). As discussed more below, a policy or block of policies no longer for sale to new people (called a closed policy or block) would likely have much higher premiums for the same benefits than a policy currently available to new enrollees.²
- 4) **Broad Variation in Benefits Across Policies.** Another difference is that there was significant variation in the benefits covered by pre-ACA policies, including options that excluded entire classes of benefits such as prescription drugs or mental health. Under the ACA, all policies cover the same essential health benefits, with variations largely relating to cost sharing and network. Pre-ACA policies sometimes had annual or lifetime limits on specific or total benefits: for example, a policy might limit prescription benefits to \$500 per year. Most states specified some benefits that needed to be covered or at least offered to applicants by insurers.
- 5) **Limited Ability to Switch Among Non-Group Plans.** A fifth difference relates to the ability of a person with non-group coverage to switch policies without re-submitting to medical underwriting. Before the ACA, people who were accepted into a non-group policy were not necessarily able to switch into new non-group policies, at renewal or otherwise, either from their current insurer or from others, without passing medical underwriting. Insurers sometimes offered people the ability to elect different policies at renewal (usually the ability to take a policy with higher cost sharing to moderate a rate increase), but they were not required to do so and did not have to allow current policyholders to move to different policies.

Medical Underwriting and Pre-Existing Condition Exclusion Provisions

Prior to the ACA, insurers often used the health of individual enrollees in making decisions about their coverage. **Medical underwriting** is the process by which an insurer acquires information about the health of applicants for coverage and uses the information to make decisions about whether to offer coverage, what coverage to offer, and what premium to charge. Applicants for non-group coverage generally were required to answer a long series of questions about their health and health history, and often were required to provide authorization for the insurer to obtain their medical records. In the non-group market, insurers generally were permitted to use the information to decline the application, accept the applicant for a reduced scope of coverage, or accept the applicant at a higher premium.

A **pre-existing condition exclusion provision** is a contract term that permits an insurer to exclude coverage for benefits sought by an enrollee during a defined period after the coverage begins (for example, twelve months) if the insurer can show that the claim relates to a condition that existed before the policy was issued. State laws varied in defining pre-existing conditions for non-group coverage; for example, in how far an insurer could look back to detect the condition, or in whether the condition must have been actually treated or whether a reasonable person would have sought treatment. This exclusion allowed insurers to exclude benefits for pre-existing conditions that were not necessarily detected during the medical underwriting process.

While there are many other differences between ACA and pre-ACA non-group market rules (e.g., permitted cost sharing, limits on age rating), these have the most implications for providing access to and continuous coverage for people with health problems. Most fundamentally, medical screening divides people by health at initial enrollment, and the inability to switch policies can trap people who develop health problems into much more expensive coverage. The potential implications of this are discussed below.

Issues Raised by Pre-ACA Non-Group Market Rules for Access to Coverage and Continuous Coverage

To examine the issues raised by these pre-ACA market rules, we look at three different groups of people:

- 1) People transitioning from existing coverage and applying for non-group coverage
- 2) People with non-group coverage who develop health problems
- 3) People without recent prior coverage applying for non-group coverage

PEOPLE TRANSITIONING FROM EXISTING COVERAGE TO NON-GROUP COVERAGE

Assuring access to non-group coverage for people who maintain continuous coverage has been a priority for proponents of changing the ACA. One of the attributes of the ACA is that people who lose eligibility for coverage can obtain replacement coverage in the non-group market on the same terms as others covered in the market, without consideration of their health.

A large number of people who lose their coverage might want or need access to non-group coverage. Looking at the 2012 through 2013 period (the 24 months immediately prior to the ACA coverage expansion), about 33 million people with coverage lost it and became uninsured for some period. People without health problems leaving previous coverage generally could purchase underwritten policies in the market. Some, but not all, people with health problems who had previous coverage could qualify for designated non-group policies without regard to their health.

As noted above, prior to the ACA, federal law provided guaranteed access to non-group coverage for people with at least 18 prior months of continuous coverage if their most recent prior coverage was an employer plan and if they did not have a gap in coverage of more than 63 days. These HIPAA-eligible individuals qualified for specified policies (most often, coverage in a state high-risk pool, but sometimes designated plans offered by non-group insurers), with no pre-existing condition exclusion. Their premiums were almost always much higher than the rates charged to applicants who could pass medical underwriting.

The HIPAA non-group market provisions were perceived generally to have fairly limited effect, primarily because the coverage made available could be expensive. Several factors limited HIPAA's effectiveness in assuring access to non-group coverage:

- 1) Eligibility. The guaranteed access and waiver of pre-existing condition exclusion provisions were available only to a limited group of people: those whose most recent previous coverage was involuntarily terminated and employment-based. Limiting the option to people leaving employer group plans left out people coming from public coverage such as Medicaid or who lost a prior non-group plan because they moved out of area served by their insurer. A few states expanded the requirement to include other types of coverage, but it was not the general rule. The provisions also left out people who wanted to switch plans within the non-group market, for example, because of network changes in their existing plan or if it had become unaffordable (discussed below).
- 2) Cost. Federal HIPAA portability provisions also did not limit the premiums that could be charged for the specified plans available to HIPAA-eligible people. Most states used a high-risk pool to serve HIPAA-eligible people, where premiums typically ranged from 125% to 200% of the estimated standard premiums for non-group coverage. With a couple exceptions, income-based subsidies were not available in high-risk pools, making it quite difficult for people with modest incomes. In states where insurers were required to make private policies available to HIPAA-eligible individuals, insurers often were able to charge much higher premiums to HIPAA-eligible individuals with health problems; for example, insurers could develop separate rating classes for HIPAA-eligible individuals who could meeting medical underwriting standards and those who could not. A few states limited the additional premium that could be charged to HIPAA-eligible individuals who could not pass medical underwriting.

In addition, HIPAA only extended guaranteed availability to people after they had exhausted their eligibility for continuation coverage under COBRA or under state continuation laws. Continuation coverage can be expensive: COBRA premiums are 102% of the full cost of the employer plan for at least 18 months. Affording COBRA can be difficult for people who lost their job and may not have new work.

The requirement to exhaust continuation coverage and the relatively high premiums served to limit the number of people who could afford to take advantage of the guaranteed availability opportunity under HIPAA. As discussed below, people who could pass medical underwriting could save these expenses and enroll in lower-cost plans, but they would not get the full benefits of having continuous coverage.

- 3) Combining Guaranteed Access and Waiver of Pre-Existing Condition Exclusion in the Same Provision. The law provided for guaranteed access to coverage and the waiver of pre-existing condition exclusion provisions only in specified policies, which tended to be quite expensive. HIPAA-eligible individuals who were healthy and could pass medical underwriting could get a non-group policy for much less than the policies offered generally to HIPAA-eligible people, but in choosing the cheaper policy they sometimes exposed themselves to a new pre-existing condition exclusion period, despite the fact that they had at least 18 months of continuous coverage. Many people may not even have understood that they were making this tradeoff.

A different kind of issue facing people leaving employer group coverage or Medicaid who wanted to maintain continuous coverage were the limits on benefits in many non-group policies. One of the significant changes in non-group coverage under the ACA was the establishment of a fairly comprehensive essential health benefit package. In particular, pre-ACA non-group policies had significant limits on mental health benefits (mental health parity requirements, which applied to employer-group plans for employers with more than 50 employees, did not apply to non-group coverage), and, unless required by states, typically excluded coverage for many policies, and also did not cover costs associated with pregnancy or routine delivery. Some state high-risk pools, which were the only options for HIPAA-eligible individuals with health problems, had tight limits on coverage for prescriptions.^{3,4}

Prior to the ACA, non-group coverage was decidedly less comprehensive than employer group coverage. Substantial shares of non-group enrollees did not have coverage for routine maternity, substance abuse or mental health services, and it was not uncommon for policies to have relatively low annual benefit limits for prescription drugs or mental health services. Even though insurers were able to medically screen applicants in most instances, they still imposed significant limits on benefits where there is a greater chance of purchasers selecting coverage based on the need for particular services. Unlike the group market, where employers select levels of benefits for all their employees, insurers are wary of non-group purchasers who are willing to pay the relatively high cost for more comprehensive benefits. These benefit limits, along with the rating issues discussed in the next section, meant that the non-group market was not a good long-term coverage option for many people, including those who wanted to start a family or who developed mental health problems.

PEOPLE ENROLLED IN NON-GROUP COVERAGE WHO DEVELOP HEALTH PROBLEMS

Another aspect of maintaining continuous coverage is being able to keep the coverage you obtain on a reasonable basis. Prior to the ACA, non-group coverage generally was guaranteed renewable, which meant that enrollees had the right to renew their coverage (with certain limited exceptions) by paying their premiums. Insurers also generally were not permitted to vary renewal premiums based on an enrollee's individual health or claims. Insurers, however, through selectively closing policies or blocks of business to new enrollees and

through certain rating approaches, were able to access higher premiums than enrollees who developed health problems after they enrolled. As discussed above, people with non-group coverage generally were not able to switch carriers or move to a new policy (in an open block of business) unless they could pass medical screening. As a result, they could find themselves essentially locked into policies with escalating premiums that could be difficult to afford.

This can happen several ways. The medical underwriting process allows insurers to protect themselves from adverse selection (see The Issue of Adverse Selection box below), but it also produces complicated dynamics that can segment risk by health even after people in good health have been accepted into coverage. Medically screening new applicants, and declining applicants who are unhealthy, produces a group of healthy new enrollees whose expected claims costs over the short term could be meaningfully below the costs for an average mix of people. Prior to the ACA, the expected low costs for these enrollees would be reinforced because the group also would generally be subject to a pre-existing condition exclusion provision for the first year that eliminated coverage for claims for pre-existing health conditions not uncovered during the medical underwriting process. Over time, however, some of the group of enrollees would develop health problems, and the average costs of the group would grow each year; by year three or four after their enrollment the expected costs for the group would roughly equal the expected costs for an average mix of people. This is sometimes referred to as “underwriting wearing off.” An insurer, at any given time, will have a group of recently underwritten enrollees, with relatively low expected costs, and other groups enrolled for varying lengths of time, with the tendency for those enrolled longer to have worse average health. If an insurer closed these older products to new enrollees – and allowed healthy enrollees in them to sign up for new, medically-underwritten products – premiums for existing enrollees would escalate over time, and those with medical conditions would essentially be trapped into paying those higher premiums because they could not switch to other coverage.

The Issue of Adverse Selection

Prior to the ACA, insurers used medical underwriting in the non-group market to protect themselves and their policyholders from adverse selection. Unlike coverage offered to large employer groups, where insurers anticipate getting a mix of better and worse health risks when they accept a new group, non-group coverage is sold person-by-person. While virtually everyone wants to have health insurance, people with high or ongoing health needs are more likely to sign up at any given price, a tendency referred to as adverse selection. Adverse selection occurs not only in the decision of whether or not to purchase coverage, but also in decisions about how much coverage to get (people in poorer health tend to want more comprehensive benefits and less cost sharing) and in decisions about whether or not to keep coverage (people in better health are more likely to drop coverage or move to less coverage in the face of premium increases). The relatively high cost of health insurance makes adverse selection more acute (premiums can be a large portion of a monthly budget, so there is a tendency for healthier people to forgo coverage if they do not think they will need it). This is particularly an issue in the non-group market where enrollees pay the full premiums.

There are several ways insurers can reflect these differences in their rating and enrollment practice rates, and this is a place where problems can occur for people who develop health problems after enrollment. One option is for insurers to combine the new and existing enrollees in blocks of business that are being actively marketed (called “open” here), so that low expected costs of new enrollees can help offset the higher costs of enrollees who have been covered longer. As long as there is a reasonable stream of people entering and leaving the block, premiums can remain reasonably spread over the entire group. Insurers also can pool the expected total claims of each durational group of enrollees over their average expected length of enrollment. This requires charging new and early-duration enrollees for more than their expected costs during their early years, setting aside a portion of the premium (i.e., creating a reserve) that can be used to offset the higher costs for those who keep their policies for longer periods.

Some insurers, however, may not want to pool the lower costs of new entrants with the higher costs of longer-term enrollees. For example, insurers with larger and older blocks of business may find that they cannot compete well for new enrollees against insurers without as much existing business, because those insurers would have a higher proportion of new healthy enrollees and could have lower rates for new business, particularly if the new carrier is not reserving for the effects of underwriting wearing off. An insurer also might develop a new group of policies based on a new approach (for example, a policy where it shares risk with an Accountable Care Organization (ACO) network) where it does not want to pool experience with its existing policies in determining rates. An insurer also may want to increase its market share by being more competitive for new enrollees, which it might do by setting the premiums for new enrollees closer to their expected first year costs.

Insurers that want to reduce the pooling of newer and longer-term enrollees have several ways to do so. One is to use the duration of enrollment as an explicit rating factor. Insurers using durational rating can set initial rates relatively low for new enrollees, but will need to raise them relatively rapidly each year (on top of

increases for rising health costs generally) for these enrollees to reflect their higher expected claims at later durations. Another option is for an insurer to stop selling policies in blocks of business to new enrollees, directing them to new policies in a new block of business without any existing enrollees. Because premiums are set based on the expected costs for specific policies or blocks of business, premiums for the new policies do not need to reflect the costs of the existing enrollees in the closed block, and future premiums for the closed block will reflect only relatively higher average costs of the existing enrollees.

Both of these practices end up harming enrollees who develop health problems. Enrollees facing the relatively higher premiums under durational rating or in a closed block will look for lower cost alternatives. Healthier enrollees who can pass medical screening will move to lower cost policies (essentially starting over as new entrants), while people with health problems who cannot move will have to stay and pay the higher premiums being charged. The new round of higher premiums will cause more of the healthier enrollees to leave, resulting in higher expected costs for those remaining and higher premiums, a cycle that will continue until most enrollees have left the block.

PEOPLE WITHOUT RECENT PRIOR COVERAGE APPLYING FOR NON-GROUP COVERAGE

There was a substantial number of people without health insurance prior to the ACA, many of whom had been without coverage for long periods of time.⁵ The primary reason people went without coverage was its cost, although in some cases people were unable to qualify for coverage due to their health.⁶ The two factors sometimes worked together; many states had high-risk pools or similar options for people with health problems who were denied non-group coverage, but the high premiums and other limitations could make these options difficult for people to afford and the pools had fairly low enrollment.

High-risk pools are being discussed as an important part of ACA replacement proposals. About 227,000 people were enrolled in 35 state high-risk pools at the end of 2011, including HIPAA-eligible individuals, which was equal to just over 2% of non-group market enrollment nationally.⁷ A few states with relatively lower premiums, such as Maryland, Wisconsin, Minnesota, and Oregon, covered somewhat higher shares of their people.⁸ Enrollment in state high-risk pools tapered off with the opening of the federal Pre-Existing Condition Insurance Pool, created and funded under the ACA, which served many of the people who previously would have been covered in the state pools.

State high-risk pools varied in terms of benefits, premiums, and funding.⁹ As noted above, in many states the high-risk pool served as the state-designated mechanism to cover HIPAA-eligible individuals. There were a few common themes: premiums generally were calculated as a percentage of estimated standard premiums in the non-group market (typically 125% to 200% of standard premiums); coverage for pre-existing conditions was limited for a period after enrollment; pools generally offered several benefit options, most states had lifetime benefit limits and a few had annual limits; premiums did not cover the cost of benefits, with the difference subsidized by state and federal payments (a few states had dedicated revenue sources) or assessments on insurers.

A combination of factors limited the attractiveness of pre-ACA state high-risk pools. The relatively high premiums made coverage difficult to afford for people with low or modest incomes, and only a couple of states had subsidies for lower-income enrollees. In addition, pools generally had pre-existing condition exclusion

periods for enrollees who were not HIPAA-eligible individuals, which means that people were required to pay for coverage that would not cover the illnesses that had made them eligible for the high-risk pool in the first place for six months to a year or more (depending on the state). A few state pools also had annual limits on some or all benefits, and the majority had lifetime benefit limits. Given the populations served, these limits could affect those with high cost chronic conditions, such as the ongoing need for expensive prescriptions.

A few states addressed access for people with health problems by requiring all insurers (or in some cases, one or more designated insurers) to accept applicants even if they were in poor health. Premiums in these states tended to be much higher than premiums in states that permitted medical underwriting, which limited participation in non-group coverage significantly and made coverage even more difficult to afford for people with modest incomes.

Discussion

There were many aspects of the pre-ACA non-group market that made it difficult for people with health problems to get and keep non-group coverage. Any proposal for replacing the ACA will have to determine which, if any, of these previous insurance practices will once again be permitted. Medical screening was the most obvious barrier, combined with high premium costs for people who were HIPAA-eligible. Even people who purchased coverage when they were healthy sometimes were unable to keep it because certain rating approaches could cause their premiums to spiral. Returning to a less structured, less regulated non-group market raises questions about how people with health problems will be treated in terms of access to and cost of coverage. Health insurance underwriting and rating is complex, and reviewing how the pre-ACA market operated provides information about the types of issues that people with health problems may confront if the ACA market structure is replaced.

Endnotes

- ¹ Proposals to Replace the Affordable Care Act. The Henry J. Kaiser Family Foundation, 2017. <http://kff.org/health-reform/issue-brief/proposals-to-replace-the-affordable-care-act/>
- ² American Academy of Actuaries. (2004). Report on Potential Regulatory Solutions for Closed Block Problem. <http://actuary.org/content/report-potential-regulatory-solutions-closed-block-problem>
- ³ National Association of State Comprehensive Health Insurance Plans. Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2010/2011.
- ⁴ Annual maximum pharmacy benefits by state: AL: \$10,000; MS: \$100,000; NH: \$10,000; NC: \$100,000 applies to injectable drugs.
- ⁵ Congressional Budget Office. (2003). How Many People Lack Health Insurance and For How Long? <https://www.cbo.gov/publication/14426>
- ⁶ Kaiser Health Tracking Poll – August 2011. The Henry J. Kaiser Family Foundation. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/89121.pdf>
- ⁷ National Association of State Comprehensive Health Insurance Plans. Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012. Pool Membership-2011. <http://www.naship.org/2012/Quick%20Checks/Pool%20Membership%202011.pdf>
- ⁸ Ibid.
- ⁹ National Association of State Comprehensive Health Insurance Plans. Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012.



February 2015 | Issue Brief

Consumer Assets and Patient Cost Sharing

Gary Claxton, Matthew Rae and Nirmita Panchal

Higher cost sharing in private insurance has been credited with helping to slow the growth of health care costs in recent years. Plans with higher deductibles and other point of service costs provide health plan enrollees with incentives to make more cost conscious health care choices. For families with limited resources, however, high cost sharing can be a potential barrier to care and may lead these families to significant financial difficulties. Many current policies expose individual enrollees to thousands of dollars in cost sharing expenses and family expenses can easily top ten thousand dollars when someone becomes seriously ill.

While concerns about cost sharing are not new, the recent coverage expansions under the ACA put a new focus on what it means for coverage to be affordable. The goal of the law was to cover more of the uninsured, many of whom have limited means. The law requires most people to have health insurance, if they can afford to pay the premium, or to pay a penalty. The issue for some families, however, is that the policies with affordable premiums may have cost sharing requirements that would be difficult for them to meet when they access services. Many of the policies in the state and federal marketplaces have significant cost sharing, as do many policies provided to people at work [\[here\]](#). The ACA provides cost-sharing assistance to some, primarily to those with incomes below 200 percent of poverty purchasing through a state or the federal marketplace (see sidebar). Others potentially face much higher out-of-pocket expenses

We use information from the 2013 Survey of Consumer Finances to look at how household resources match up against potential cost-sharing requirements. We assume that households pay premiums out of current income, but that they may need to use savings or other assets if they become seriously ill in order to meet the deductible or the out-of-pocket limit under their health insurance policies. We show that many households, in particular those with lower incomes or where someone lacks insurance, have low levels of resources that would make it difficult for them to meet health insurance cost sharing demands.

Survey of Consumer Finances

The Survey of Consumer Finances (SCF) is a triennial, nationally representative household survey conducted by the Federal Reserve Board. The 2013 SCF provides a snapshot of household finances, including detailed information on households' debts, assets, income and other characteristics, including the types of health insurance present in the household.¹

The SCF collects information for households, which in some cases will be different than the group of people considered to be a family in other surveys. Most of the information from the SCF, including the financial information, is designed to describe the “primary economic unit” (PEU), which is the economically dominant single person or couple (living together as spouses or partners) in a household and all of the other people living in the household who are financially dependent on that individual or couple. For this analysis, we limit the households to be more representative of those who are likely to rely on private health insurance by excluding (1) households where a dominant economic individual or his or her spouse/partner if either are over age 64 and (2) households with incomes under poverty.

Results are shown for all these households as well as for households where someone had private insurance and for households where someone was uninsured. Although we are looking at cost sharing

The Affordable Care Act, Accessibility and Coverage Options

The ACA extended access to coverage to all citizens and legal residents and requires most people to either have health coverage or pay a penalty. People who are offered coverage at work are generally expected to get their coverage there, and the ACA has complementary policies that require employers with more than 50 workers to offer coverage meeting minimum standards in terms of cost and value to their full time workers or to pay a financial penalty. All citizens and legal residents not eligible for Medicare also may purchase coverage in a state or the federal marketplace, and those with incomes below 400% of poverty who are not offered coverage at work meeting minimum requirements and who are not eligible for Medicaid or CHIP also may qualify for tax credits to reduce their premiums.

The ACA addresses cost sharing in private policies in several ways:

- Most policies are required to have an out-of-pocket limit that limits the amount of cost sharing enrollees must pay in a year for covered services received from network providers. The maximum limits for 2015 are \$6,600 for single coverage and \$13,200 for family coverage. For policies offered in the non-group and small group markets, the limits apply to all cost sharing for the essential health benefits. In the larger group market, federal guidance provides employers with flexible to exclude otherwise covered services from the limit, permitting unlimited cost sharing [\[for more information\]](#).
- Most private policies are prohibited from requiring cost sharing for specified preventive services [\[listed here\]](#). Federal regulations define “minimum value” for coverage offered by employers. Large employers must offer coverage that meets the minimum value standard or they may face financial penalties if one of their full-time employees receives subsidized coverage in a state or the federal marketplace. In addition, workers and their family members who are coverage by an employer that meets the minimum value requirement (as well as a separate requirement related to affordability of premium contributions) are not eligible for premium tax credits or cost sharing assistance.

Minimum value is defined in relation to the cost of benefits for a standard population covered by typical self-funded group health plans. Basically, the cost sharing under an employer plan must pay for at least 60% of the anticipated costs for covering a standard population; taking into account the plan's cost sharing. The federal government has provided a minimum value calculator to allow employers to test their plans, but alternative methods are also available. Generally, the minimum value requirement does not provide a meaningful check on cost sharing in employer plans. The large majority of plans have values that would exceed the 60% requirements [\[for more information\]](#), and the calculation does not reduce cost sharing much if at all beyond the maximum permitted out-of-pocket limits. This means that in many cases a plan with a deductible of \$6,000 with the maximum out-of-pocket limit would meet the minimum value requirement.

- For those who are not eligible for job-based coverage or Medicaid, the ACA allows people to enroll in non-group plans. New market rules establish four tiers of cost sharing and limit out-of-pocket expenses for patient cost sharing to the same limits as described above. In addition, people with incomes below 250% of poverty who purchase coverage through the marketplace are eligible to enroll in silver plans with reduced cost sharing. Those with the lowest incomes are eligible for greater reductions; the impact of the reductions on cost-sharing requirements is shown [\[here\]](#)

for people with insurance, we included households with people who were uninsured in 2013 because they are prime targets for coverage expansion under the ACA, either through expanded coverage at work or through new coverage options. For each groups results are further broken out by household size (one person or households of more than one person) and by poverty categories.

Using the information from the survey on household assets and debts, we developed two measures of resources that households may have to meet health insurance cost sharing. The measures used here could be considered conservative because they assume that a household can bring a large share of its saved resources to bear to pay one-year's cost sharing in a health insurance policy.²

- The first category is liquid financial assets, which are those most easily converted to cash. The category includes checking and saving accounts, money market accounts, certificates of deposit, savings bonds, non-retirement mutual funds, stocks and bonds, but excludes the value of dedicated retirement accounts (such as 401k accounts) and the cash value of life insurance.
- The second category is net financial assets, which is a broader measure of the household's total resources. This category includes total all financial assets, including assets dedicated to retirement, reduced by the household's unsecured debts. For this measure, the value of assets is reduced by credit-card debt and other unsecured loans, but debts secured by real property (such as mortgage debt) and loans for vehicles and education are not counted against assets. This category measures how much money a household has to pay medical expenses after meeting debt obligations.

We look at the median amount (one-half of households have more and one-half have less) for each measure to paint a basic picture of the financial resources available to households. Median asset levels, rather than averages, are used because assets, like income, are unevenly distributed and the high asset levels of wealthier households skew the distribution. We also calculate the percentages of households with the resources to meet specified deductibles and out-of-pocket cost sharing limits. We assume that a household meets medical cost sharing when they spend all of their net-financial assets or liquid financial assets; this assumption would leave households with no additional assets for savings or other emergencies and does not account for the complex financial picture many households face.

Health Insurance Cost Sharing

Private health insurance policies have several forms of cost sharing, including general deductibles that must be met before most services are covered, and specified dollar amounts (copayments) or percentage contributions (coinsurance) that plan enrollees must pay when they receive covered services. Most plans are required to have limits on annual enrollee cost sharing; the maximum allowed limits for 2015 are \$6,600 for single coverage and \$13,200 for family coverage.

Cost sharing requirements vary widely from policy to policy. Looking at plans offered by employers, about 80% of workers with employer plans have a general annual deductible and, among those, average deductibles for single coverage are almost \$1,800 in smaller firms (3 to 199 workers) and about \$970 in large firms³. Among all workers enrolled in a plan with a deductible in 2014, the average is \$1,217.

There is considerable variation in deductibles that covered workers face. Around these averages, 25% of workers enrolled in a plan with a deductible at smaller firms have a single deductible of \$894 or less while 25% have a single deductible of \$2,500 or more. In larger firms, 25% of workers who are enrolled in a plan with a deductible have a single deductible of \$500 or less while 25% have a single deductible of \$1,265 or more. For all covered workers, 25% are in a plan with a deductible of 500 or less and 75% are in a plan with a deductible of \$1,500 or more. Out-of-pocket limits for workers in single coverage in plans offered by employers average about \$3,500 in small firms and about \$3,000 in larger firms; 25% of workers in smaller firms have an out-of-pocket limit of \$5,000 or more for single coverage; the comparable amount for larger firms is \$4,000. Deductibles and out-of-pocket limits in family plans are usually about twice the single amounts, but some plans may have a different structure, such as a per enrollee limit which make them harder to characterize. A more complete picture of deductibles, out-of-pocket limits are other cost sharing in employer plans is available [\[here\]](#).

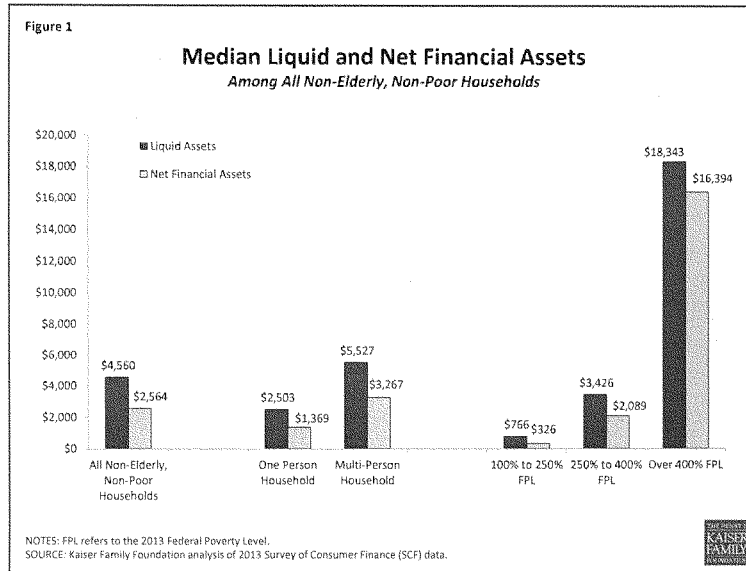
Cost sharing also varies significantly in nongroup plans both across and within metal tiers. For example, average single deductibles for plans with a combined deductible for medical and prescription drugs offered in the federal marketplace range from \$69 for platinum plans to \$5,328 in bronze plans⁴. As with employer plans, there is significant variation around the averages, for example 13% of silver plans on the federal marketplaces have a combined deductible of less than \$1,500 dollars and seven percent have a deductible of \$4,000 or more. Out-of-pocket limits also have a large range: \$1,975 for platinum plans and \$6,359 for bronze plans⁵. For more information on cost sharing in the federal exchanges see [\[here\]](#). Many lower income purchasers in the federal and state marketplaces also are eligible for subsidies that reduce the cost sharing in their policies [\[here\]](#).

For this analysis, we compare household resources against two deductible levels: \$1,200 single/\$2,400 family (referred to as the lower deductible amounts) and \$2,500 single/\$5,000 family (referred to as the higher deductible amounts); and against two out-of-pocket limits: \$3,000 single/\$6,000 family (referred to as the lower out-of-pocket limits) and \$6,000 single/\$12,000 family (referred to as the higher out-of-pocket limits). We chose these levels to represent the mid to high range of cost sharing. While there are plans with less cost sharing and plans with more cost sharing, these levels should provide a reasonably good measure of the ability of families to meet of the typical cost sharing requirements available in the market. Households with one member are measure against the single amounts and households with more than one member are measured against the family amounts.

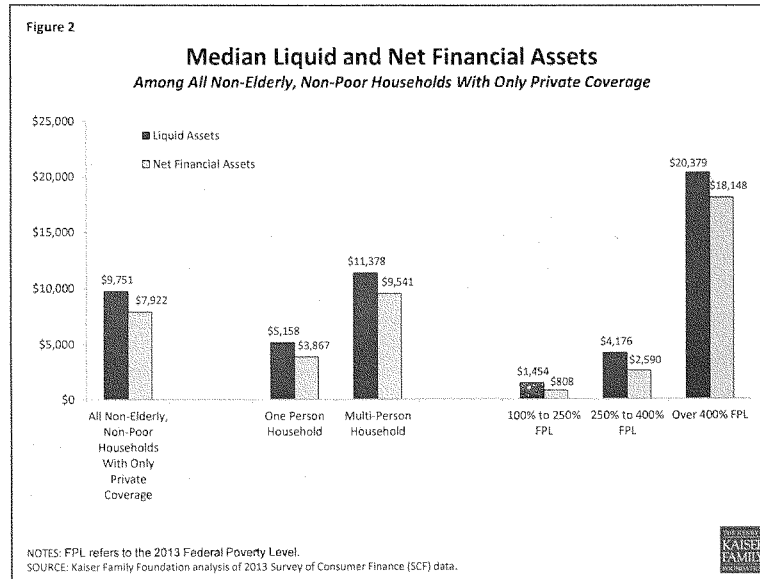
Median Financial Resources

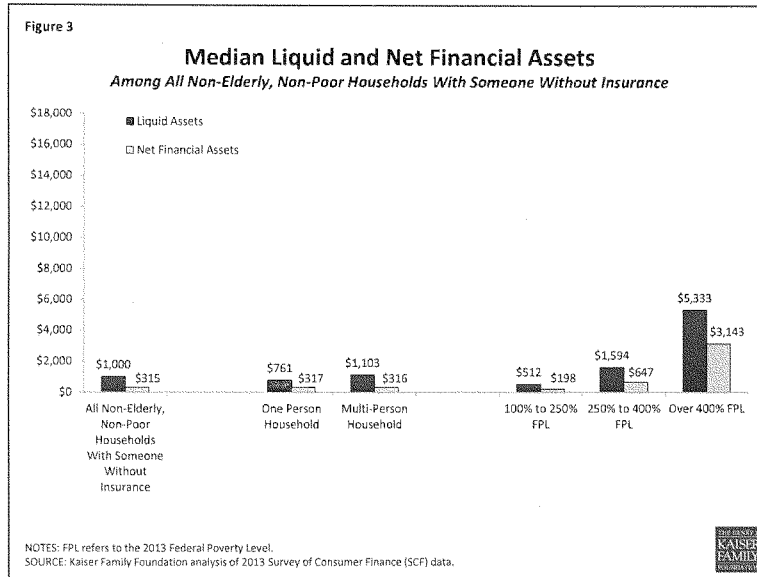
Among non-elderly, non-poor households, the median amount of liquid financial assets is \$4,560 and the median amount of net financial assets is \$2,564. Liquid financial and net financial assets are lower among single households than among households of two or more members, and are much lower in households with incomes below 400% of poverty than above (Figure 1). Households with incomes between 100% and 250% of poverty have quite low levels: the median for liquid financial assets is just over \$700 and median for net financial assets is just over \$300. The poverty categories are defined based upon the poverty level established by the Department of Health and Human Service for 2013. In 2015, a family of four earning \$24,250 would be 100% of poverty and households at \$60,625 and

\$97,000 would be 250% and 400% of poverty, respectively. For a single individual, the poverty level in 2015 is \$11,770, individuals earning \$29,425 and \$47,080 would be at 250% and 400% of poverty respectively⁶.



Asset levels vary when everyone in the household is covered by private insurance and when someone in the household is without insurance. In households where the only form of coverage was private health insurance, median liquid financial assets are \$9,751 and median financial assets are \$7,922 (Figure 2). The distribution is similar to that of all households: median asset levels are higher among households with one member than among those with one-member and households with incomes under 400% of poverty have much lower assets than those with higher incomes. In contrast, households where at least one member was uninsured have lower asset levels: the median level of liquid financial assets is \$1,000 and the median level of net financial assets is \$315. Households with lower incomes have particularly low asset levels (Figure 3).





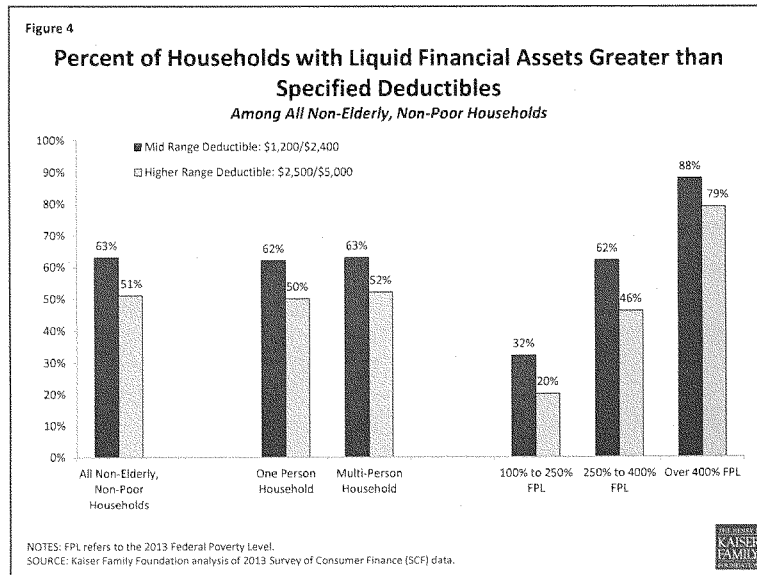
The figures above show that many households may have difficulty meeting health insurance cost-sharing requirements with existing resources. Median assets levels for households with incomes below 400% of poverty, and particularly those between 100 and 250% of poverty, are low when compared to the higher deductible amounts and out-of-pocket limits in health insurance policies. Families where someone lacked health insurance, a primary target for coverage expansion under the ACA, have relatively low assets across the board.

Assets to Meet Cost-Sharing Requirements

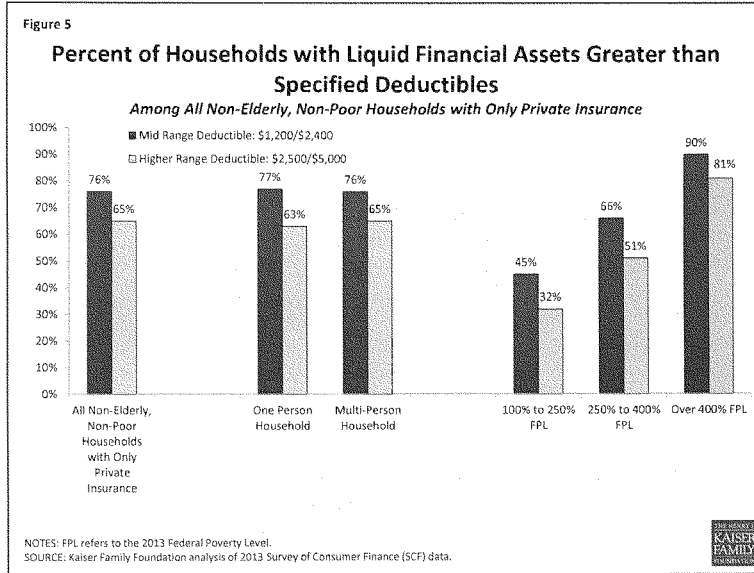
In this section we look at the percent of households that have sufficient assets to meet the specified deductible amounts and out-of-pocket limits. The discussion here focuses on liquid financial assets because for most households they are the higher measure. Similar figures using the net financial asset measure are shown in the appendix. In general, many households, and particularly those with lower incomes or with someone who was uninsured, do not have sufficient liquid financial assets to cover the deductibles amounts. Looking at the out-of-pocket limits, most households do not have sufficient liquid financial assets to meet either the lower or the higher limit. The percentage of households who have both low incomes and enough assets to meet either of the out-of-pocket limits is very low.

DEDUCTIBLES

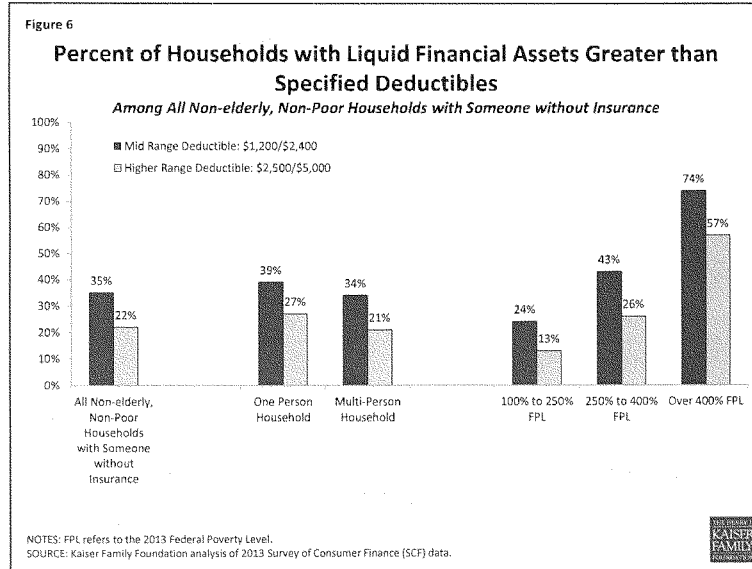
Overall, three in five (63%) households have enough liquid financial assets to meet the lower deductible amounts while one-half (51%) can meet the higher deductible amounts (Figure 4). These percentages are similar for single-member and multi-member households, but vary significantly by family income. Only 32% of households with incomes between 100% and 250% of poverty can meet the lower deductible amounts, while one-in-five can meet the higher deductible amounts. In contrast, 88% of households with incomes over 400% of poverty can meet the lower deductible amounts and three-in-four (79%) can meet the higher amounts.



Deductibles are easier to meet for households with only private coverage, where 76% have sufficient liquid financial assets to meet the lower deductible amounts and 65% can meet the higher amounts (Figure 5). Again there is significant variation across income. Among households with only private coverage and incomes between 100% and 250% of poverty, two in five (45%) have enough liquid financial assets to meet the lower deductible amounts and 32% can meet the higher amounts; in contrast, for households with incomes above 400% of poverty, 90% have enough liquid financial assets to meet the lower deductible amounts and 81% can meet the higher amounts.

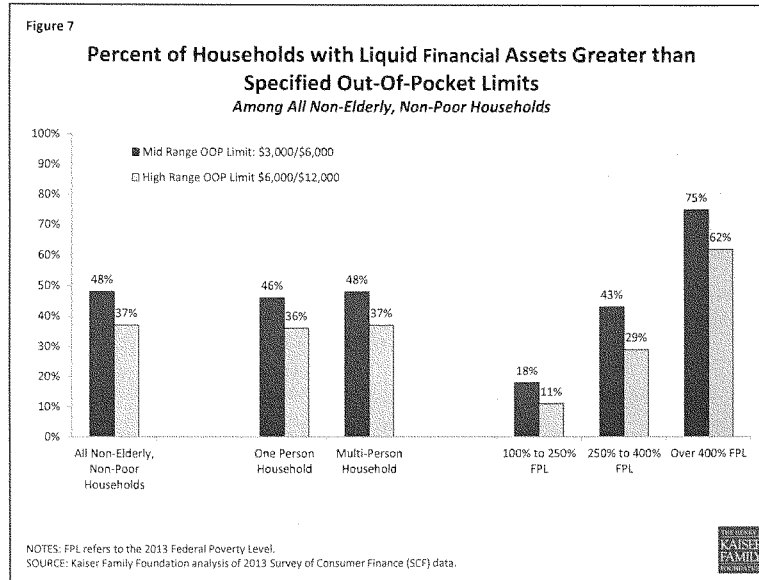


Households with at least one person who was uninsured have a particularly hard time meeting the deductible amounts. Only about one-in-three (35%) of these households have enough liquid financial assets to meet the lower deductible amounts and only 22% can meet the higher amounts. Among households with incomes between 100% and 250% of poverty, about a quarter (24%) have enough liquid financial assets to meet the lower deductible amounts and only 13% can meet the higher amounts. Among households with incomes over 400% of poverty, 74% have enough liquid financial assets to meet the lower deductible amounts while just about one-half (57%) can meet the higher deductible amounts.

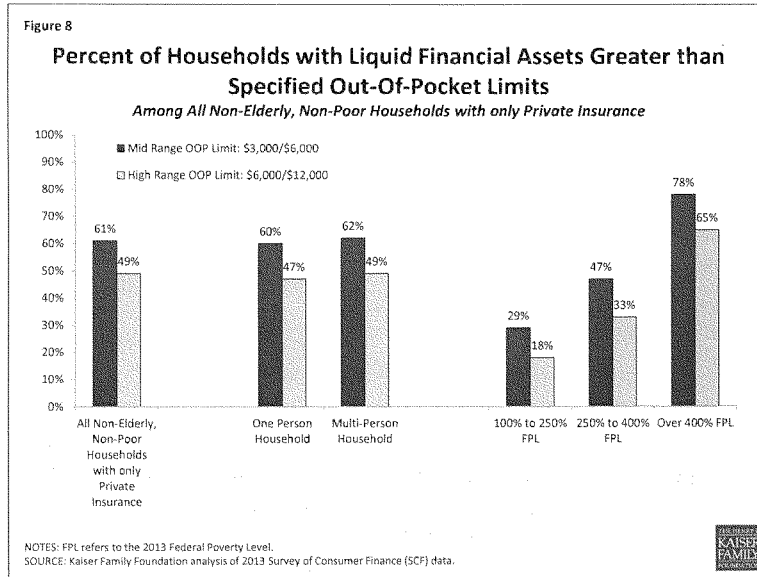


OUT-OF-POCKET LIMITS

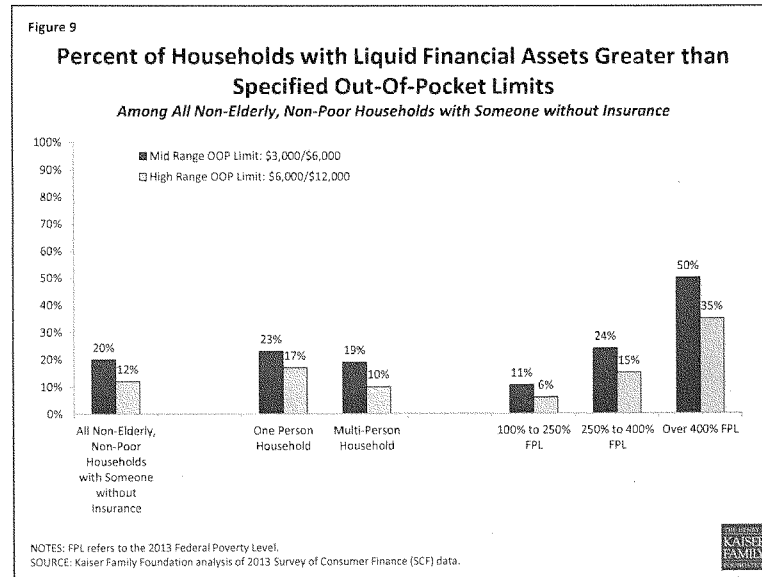
Out-of-pocket limits are higher than deductibles and meeting them is more difficult for many families. Forty-eight percent of households have enough liquid financial assets to meet the lower out-of-pocket limits and 37% can meet the higher limits (Figure 7). The percentages are quite low for households with incomes between 100% and 250% of poverty, with 18% having enough liquid financial assets to meet the lower out-of-pocket limits and 11% being able to meet the higher limits. Among households with incomes over 400% of poverty, 75% have enough liquid financial assets to meet the lower out-of-pocket limits while just 62% can meet the higher limits.



Things are somewhat better for households with only private health insurance, where 61% of households have enough liquid financial assets to meet the lower out-of-pocket limit and 49% can meet the higher limit (Figure 8). Still, only 29% of these households with incomes between 100% and 250% of poverty can meet the lower out-of-pocket limit and only 18% can meet the higher amount. The percentages for those over 400% of poverty are similar to those for households overall.



A large share of households in which someone was uninsured lacks enough resources to meet the out-of-pocket limits (Figure 9). Only 20% of these households have enough liquid financial assets to meet the lower out-of-pocket limit and only 12% can meet the higher limit. Even among households with incomes above 400% of poverty, only 50% have liquid financial assets that meet the lower out-of-pocket limit and 35% can meet the higher limit.



Additional Financial Support

Faced with medical bills, people may turn to friends and relatives to help them meet expenses. The SCF asks respondents whether in an emergency they could obtain \$3,000 of financial assistance from friends or relatives⁷. Among non-elderly, non-poor households, 69% respond affirmatively to this question. Households with higher incomes are more likely to say that they can obtain \$3,000 from family or friends in an emergency: 82% for households with incomes over 400% of poverty compared with 51% for households with incomes between 100% and 250% of poverty. Similarly, just over one-half (55%) of households that have liquid financial assets below the lower out-of-pocket limits (\$3,000 single/\$6,000 family) say that they could do so.

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Roughly half of those with liquid financial assets below the cost sharing measures say they could obtain \$3,000 in an emergency from friends or relatives.

The higher cost sharing in private insurance has been credited with helping to slow the rate of health care cost growth. Asking enrollees to pay a portion of costs at the point of service may encourage them to make consumer health care more wisely and to weigh the costs and benefits of alternative treatment options and providers. At the same time, cost sharing that seriously stresses family budgets may act as an impediment to seeking needed care, frustrating a primary reason people seek to be insured in the first place. For these families, having coverage would certainly reduce the ultimate financial consequences of serious illness, which is important both for the family and for providers delivering care, but this is a bargain that may look better in hindsight, after an illness has occurred, than it does when the family is trying to decide whether or not to pay for such a plan in the first place. Particularly as we extend private coverage to more families with lower incomes and limited resources, we need to be cognizant of their financial capacity to use the coverage that they are being asked to buy.

Methods:

The 2013 Survey of Consumer Finances (SCF) is a triennial, nationally representative household survey conducted by the Federal Reserve Board. The survey has a dual frame, with respondents selected both from a national area probability design and a sample of households with high income tax returns.⁸ The 2013 SCF is the most current survey available and is based on 6,015 households.⁹ For this analysis, we excluded households in which (1) a financially dominant individual or his or her spouse was over age 64 or (household income was less than 100% of poverty). These limitations reduce the number of households to 4,080.

The SCF defines a family as a “primary economic unit (PEU),” or all of the individuals living in a household who are financially interdependent with the dominant individual or couple.¹⁰ Income and assets are measured for the PEU in the household. The definitions of the different types of assets and debts are available [\[here\]](#) and [\[here\]](#). The analysis uses median rather than mean measures of assets to account for the skewed distribution of household financial characteristics. Weights were applied to ensure medians were representative of the population.

The SCF provides information about the types of insurance present in each household, and also about whether each member had coverage or not. Unlike financial characteristics, insurance questions are asked of all members of a household, including members that are not part of the PEU, which could be a relative who is financially independent or a financially independent nonrelative living in the household. This creates some potential ambiguity when we look at households in which someone has private coverage because it is possible that the only people with private coverage are not part of the PEU. To check if this was biasing results, we also looked at households where everyone had private coverage and no other type of coverage and found that the quartiles for liquid and net financial assets were similar. Because we have information about whether or not each person in the household has some coverage or not, we were better able to target the members of the PEU in identifying households where someone was uninsured. We selected only households where the financially dominant individual, his or her spouse or

partner, or his or her financially dependent children (regardless of the child's age) were uninsured. Households with only private insurance are covered those in which all the members are covered by employer coverage, private non-group coverage, Tri-care and/or a union sponsored plan.



Appendix:

Percent of Households with Net Financial Assets Greater than Specified Deductibles and Out of Pocket Maximums				
Threshold:	Mid Range Deductible:	High Range Deductible:	Mid Range Out-of-Pocket Maximum:	High Range Out-of-Pocket Maximum:
Single/Family Coverage	(\$1,200- Single and \$2,400- Family)	(\$2,500- Single and \$5,000- Family)	(\$3,000- Single and \$6,000- Family)	(\$6,000- Single and \$12,000- Family)
Among All Non-elderly, Non-Poor Households				
All Households	53%	45%	43%	35%
<i>Size of Household</i>				
One Person Households	51%	43%	41%	34%
Multi-Person Households	53%	45%	43%	35%
<i>Poverty Level</i>				
100% to 250% FPL	26%	18%	17%	10%
250% to 400% FPL	51%	39%	37%	28%
Over 400% FPL	76%	70%	67%	59%
Among All Non-Elderly, Non-Poor Households with Only Private Insurance				
All Households	65%	57%	54%	46%
<i>Size of Household</i>				
One Person Households	64%	55%	52%	44%
Multi-Person Households	66%	57%	55%	47%
<i>Poverty Level</i>				
100% to 250% FPL	38%	28%	27%	18%
250% to 400% FPL	54%	42%	39%	32%
Over 400% FPL	78%	72%	69%	61%
Among All Non-Elderly, Non-Poor Households with Someone without Insurance				
All Households	27%	19%	17%	11%
<i>Size of Household</i>				
One Person Households	30%	24%	21%	16%
Multi-Person Households	27%	17%	16%	9%
<i>Poverty Level</i>				
100% to 250% FPL	18%	12%	11%	5%
250% to 400% FPL	34%	22%	21%	14%
Over 400% FPL	59%	45%	40%	30%
NOTES: FPL (federal poverty level). Households with only private insurance are covered by employer coverage, non-group coverage, Tri-care and/or a union sponsored plan. Figures reported are percent of households meeting family thresholds for households with more than one member and single-coverage threshold for individual households.				
SOURCE: Kaiser Family Foundation analysis of 2013 Survey of Consumer Finance (SCF) data.				

Endnotes:

¹ The survey asks whether anyone in the household has health insurance and if so, what types of insurance people have. The survey also ascertains whether everyone in the household is covered by the same type of health insurance, whether everyone is uninsured, and who in the household is uninsured.

² Jacobs, Paul, and Gary Claxton. "Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans." *Health Affairs* 27.3 (2008): W214-221. Web. 14 Jan. 2013.
<http://content.healthaffairs.org/content/27/3/w214.full.pdf.html>.

³ Kaiser Family Foundation. "Employer Health Benefits Survey". Sept 2015. <http://kff.org/report-section/chbs-2014-section-seven-employee-cost-sharing/>

⁴ Averages and distributions are not weighted by enrollment. For more information see: Claxton, Gary; Cox, Cynthia and Rae, Matthew. "The Cost of Care with Marketplace coverage". Kaiser Family Foundation. February 11, 2015.
<http://kff.org/health-reform/issue-brief/the-cost-of-care-with-marketplace-coverage/>

⁵ Averages and distributions are not weighted by enrollment. For more information see: Claxton, Gary; Cox, Cynthia and Rae, Matthew. "The Cost of Care with Marketplace coverage". Kaiser Family Foundation. February 11, 2015.
<http://kff.org/health-reform/issue-brief/the-cost-of-care-with-marketplace-coverage/>

⁶ U.S. Department of Health & Human Services. "2015 Poverty Guidelines." <http://aspe.hhs.gov/poverty/15poverty.cfm>

⁷ The exact question wording is: "In an emergency could you (or your {husband/wife/partner}) get financial assistance of \$3,000 or more from any friends or relatives who do not live with you?". "Codebook for the 2013 Survey of Consumer Finances." Federal Reserve. <http://www.federalreserve.gov/consumersdata/scf/scfindex.htm>

⁸ Kennickell, Arthur B. "Wealth Measurement in the Survey of Consumer Finances: Methodology and Directions for Future Research". May 2000. Web. 23 Jan. 2013. <http://www.federalreserve.gov/consumersdata/scf/files/measurement.pdf>

⁹ Kennickell, Arthur. "Codebook for the 2013 Survey of Consumer Finances." Division of Research and Statistics Board of Governors of the Federal Reserve System. Web. 23 Jan. 2013.
<http://www.federalreserve.gov/consumersdata/scf/files/codebk301.txt>

¹⁰ Brian K. Bucks, Arthur B. Kennickell, Traci L. Mach and Kevin B. Moore. "Changes in U.S. Family Finances from 2004 to 2007: Evidence from the Survey of Consumer Finances." *Federal Reserve Bulletin*, vol. 95 (February 2009), pp. A53.

Why Premiums Will Change for People Who Now Have Nongroup Insurance

Feb 06, 2013 | **Gary Claxton** (<http://www.kff.org/person/gary-claxton/>), **Larry Levitt** (<http://www.kff.org/person/larry-levitt/>) (https://twitter.com/larry_levitt), **Karen Pollitz** (<http://www.kff.org/person/karen-pollitz/>), and **Anthony Damico** (<http://www.kff.org/person/anthony-damico/>)



The federal government recently released [draft regulations that address the benefits, market rules, and rating practices for nongroup coverage](http://www.kff.org/healthreform/8399.cfm) (<http://www.kff.org/healthreform/8399.cfm>). Before reform, the nongroup market was widely acknowledged to be broken, with restricted access, limited benefits, high administrative costs, and frequent and large premium increases subject to inadequate oversight. Recent requests for large premium hikes for nongroup coverage in some states, at a time when the group market is experiencing very low increases, have revived [concerns](http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?ref=reedabelson) (<http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?ref=reedabelson>) about current pricing practices and the effectiveness of regulatory oversight. The ACA seeks to address many of these issues, essentially remaking the nongroup market starting in 2014 by instituting new rules and a platform for increased transparency and price competition. Newly available premium and cost-sharing subsidies will vastly expand the number of people who will get coverage there. With so many changes and new participants, there understandably is a great deal of speculation about what the products will look like and how premiums in 2014 will compare to premiums in the nongroup market.

Overall, we expect that average, unsubsidized premiums for nongroup coverage will be somewhat higher under reform than they are today (as does the [Congressional Budget Office](http://www.cbo.gov/publication/41792) (<http://www.cbo.gov/publication/41792>)). This is because many people will be getting better insurance. The law requires that all nongroup insurance provide a package of essential benefits, which includes items like maternity care and mental health that often are not covered in nongroup policies now. And, while [patient cost sharing will still be quite high](http://www.kff.org/healthreform/8303.cfm) (<http://www.kff.org/healthreform/8303.cfm>), everyone's out-of-pocket costs will be capped, which is not always the case today.

In addition, guaranteed access to coverage for people with pre-existing conditions may very well increase average premiums as well, as people with higher health costs come into the insurance system. Hopefully this will be balanced by attracting reasonably healthy young, uninsured enrollees also, using the carrot of premium subsidies in exchanges and the stick of the individual mandate.

The ACA also redistributes the premium burden among different enrollees by eliminating premium differences for gender and limiting variation premiums due to age to a maximum of three to one. Compared with existing practice, the new rules will lower premiums for older people and many women, while raising premiums for young people (particularly young men). This has led to concerns that these young people will suffer “rate shock,” though as we discuss below, the potential for premium increases among young people is mitigated by the fact that many of them will be eligible for premium subsidies. People under age 30 also are able to enroll in a special catastrophic plan that will provide coverage roughly similar to bronze plans and with rates that may be much less affected by the age limitation.

Each of the insurance market changes in the ACA that may raise or lower premiums overall or redistribute them among different groups of people is explained below.

Access to coverage

The ACA addresses access to coverage in two fundamental and related ways. First, insurers must accept all applicants, including those with pre-existing conditions, during open enrollment periods and charge sick people and healthy people the same premium. Second, the ACA provides significant premium and cost-sharing subsidies to assist low- and moderate-income people with the cost of coverage.

These provisions will change the population covered by nongroup insurance when they take effect in 2014. Health plans now offering nongroup coverage can exclude people with health problems, and the high turnover that market now experiences means that a significant portion of nongroup enrollment is made up of people who have recently passed health screening. Many nongroup policies also limit benefits for the first year or so for any pre-existing health issues that enrollees may have. Other industry practices, such as durational rating and opening and closing policies to new enrollees, can also be used to keep premiums for new enrollees low, but can mean significant increases for policyholders who keep their coverage for longer periods, particularly if they develop health problems. All of these techniques work together to produce low premiums for those who can pass underwriting and an overall risk pool of nongroup enrollees today that is healthier than the population who will be eligible in 2014.

Eliminating medical screening and other current industry practices, without other policy changes, would markedly increase premiums: this can be seen from the high premiums and low enrollment in the handful of states where insurers must accept all applicants today. The ACA, however, provides significant financial assistance that will help many of the current uninsured afford coverage. Cost is the primary reason people do not have health insurance, and new premiums subsidies (combined with cost-sharing assistance so that lower income families can use the coverage) will significantly reduce financial barriers to coverage in 2014. New premium subsidies will attract large numbers of new applicants to the nongroup market, many in good health. The individual responsibility provision will add an additional incentive for healthy people to purchase coverage, and restricting access to annual and special enrollment periods will reduce the likelihood that people will wait until they develop health problems before seeking coverage. In addition, to address transitions issues (i.e., the concern that the less healthy will be the first to enroll), the ACA provides for \$20 billion (a meaningful amount given the size of the market) in transitional reinsurance to offset adverse selection in the first three years of the program.

The ACA design is intended to open access to the now restrictive nongroup market, and with a combination of market rules, tax credits and tax penalties, to produce stable risk sharing with risk pools that have a reasonable mix of people in good and poor health. It will probably not produce the “healthier-than-average” nongroup risk pools that seem to exist now in some states, which means that premiums for nongroup coverage under reform will need to be higher to reflect the cost of covering a more average mix of healthy and less healthy people.

Essential health benefits

A second set of factors affecting premium change is the benefit design and associated cost sharing. The ACA defines essential health benefits that must be offered in the nongroup market beginning in 2014. While there will be some variation from state to state, the benefits generally will be based on benefits provided now in the small group market, with a couple of small additions (e.g., habilitation and pediatric dental). This, combined with ACA requirements to cover preventive services and for mental health parity, will result in nongroup benefits under reform that will be more protective than those in many nongroup policies today. Nongroup policies offered in the market now often have no coverage for routine maternity care and impose limitations on mental health and prescription drug benefits that will not be permitted when reform rules take effect in 2014. The more complete benefits will increase premiums when compared to current nongroup policies because there is more coverage.

The ACA also specifies five levels of cost sharing for nongroup policies, defined in most cases by an actuarial value, which is the average percentage of costs for covered benefits that the health plan will pay for. The ACA allows for a wide range of actuarial values, from 60% (bronze) to 90% (platinum), plus a somewhat lower level of coverage (catastrophic) which will be available to people under age 30 and others who find other coverage offerings unaffordable. Policies after reform still will be able to have significant cost sharing; the actuarial value calculator recently proposed by HHS shows that a single policy with a \$5,900 deductible, 10% patient cost-sharing and a \$6,350 out-of-pocket limit will meet the requirements of the bronze actuarial value level, and a family policy could have a deductible and an out-of-pocket limit twice as high. While a policy with this much cost sharing would hardly qualify as generous (e.g., most employer-based plans have deductibles that are thousands of dollars lower than this (<http://www.kff.org/insurance/snapshot/chcm110212oth.cfm>), there certainly are nongroup policies currently available that require enrollees to pay even higher shares of their expenses. Setting a minimum actuarial value (in most cases) of 60% will, by itself, increase premiums for current nongroup enrollees with very high cost sharing.

The benefit and cost-sharing changes for nongroup coverage under the ACA move that market from one largely defined by coverage limitations to one with a more complete level of benefits and catastrophic protection, similar to the level of protection that people with group coverage enjoy. Nongroup cost sharing will still be higher on average, but with real limits on catastrophic expenses. This additional protection will increase premiums for current enrollees with more limited benefits and very high cost sharing, but will also lower their out-of-pocket expenses when they need care.

Premium rating rules

Another set of factors that affects premium change under reform is how risk will be pooled. The ACA changes the way that health plans use an individual's demographic and health characteristics when setting premiums, and also requires plans to pool the risk of all enrollees with nongroup coverage in a market when setting rates. Unlike the access and benefit provisions discussed above, which change the average cost of coverage in a market, changes in how rates are set primarily affect how costs are distributed across different enrollees within a market, which means that some people will pay less and others more. Age rating in particular has received a good deal of attention recently, but these other factors matter as well.

Demographic factors

Health plans under reform will be able to vary the premium for a nongroup policy only to reflect a policyholder's family size, age (with a 3 to 1 limitation), location, and tobacco use. Premiums in the current market vary much more widely based on demographics,

so these limitations, by themselves, will result in some people paying more and some paying less. Two of the more important relate to age and gender. It is now common for health plans to use age as a rating factor because older people, on average, have many more claims than younger people. Premium differences for the same coverage between a 21-year-old male and a 64-year-old male can easily be 500 percent. The premium difference in current policies between women of those ages is less, because younger women are generally charged higher premiums than men their same age (even when routine maternity is excluded) and older women are often charged lower premiums than men their same age. The gender and age-rating limitations in the ACA, by themselves, will have the effect of raising premiums for younger people and lowering them for older people. Younger men in markets where health plans vary rates by age and gender will be most affected, because premiums will adjust both to reflect the limit on age rating and the elimination of gender rating. The premium impact of the gender and age limitations (assuming the same benefit and cost-sharing) may be quite large (an increase of maybe 65% to 75%, or perhaps more, for younger men), before taking into account any premium subsidies discussed below.

Health status rating and single risk pool

Beginning in 2014, health plans will no longer be able to surcharge new enrollees with health problems, and will be required to pool the experience of all nongroup enrollees in a market when setting rates. Current practices can cause less healthy people to pay more for the same coverage, even if their health issues developed after enrollment. In many states nongroup health plans can charge new entrants higher premiums. Insurers also are able to set premiums for a policy (i.e., distinct group of benefits) or group of policies based on who enrolls or is projected to enroll, which means that policies with similar benefits can have very different premiums depending on how they were sold, when they were sold and whether they are still being actively marketed. These practices can lead to less healthy people being disproportionately concentrated in certain policies, and the high premium increases they face can cause people to give up coverage (<http://actuary.org/content/report-potential-regulatory-solutions-closed-block-problem>). Ending these practices will tend to lower premiums for some current nongroup enrollees with health problems and will increase them for enrollees who are healthy.

Marketplace changes

The ACA changed not only the coverage that will be offered in the nongroup market but also the environment in which it will be offered. Several provisions should reduce costs associated with selling coverage, but some new fees will work in the opposite direction. Two ACA provisions already in effect, enhanced review of nongroup premiums and higher minimum loss ratios (enforced through required rebates) have put pressure on health plans to reduce their administrative costs and lower their rate requests.

(<http://www.kff.org/healthreform/8376.cfm>). Beginning in 2014, new health insurance exchanges will make nongroup coverage offerings more transparent, and provisions establishing a common essential health benefits package and standard cost sharing tier will make coverage much easier to understand. These changes will allow consumers to more easily compare premiums and benefits and will focus competition more squarely on price and value. The variety of benefit constructs, coverage limits and cost sharing differences in the market today make meaningful comparisons quite difficult.

Price competition in exchanges will be enhanced by the premium tax credit structure, which ties the amount of the tax credits to the premium for the second lowest-cost silver plan in each market. Health plans with premiums above this level will be much less attractive to the millions of new and existing purchasers expected to receive premium tax credits, putting strong pressure on insurers to create more efficient networks and lower costs in order to be more price competitive. Health plans report pursuing strategies to reduce their costs through tighter, lower-cost networks to be offered through exchange plans¹². These efforts should complement the broader payment and delivery system reforms (spurred on by the Medicare provisions under the ACA) that health plans are pursuing in their other commercial and government lines of business.

There also are several ACA provisions that increase the cost of selling coverage. These include a new tax on health insurers, a small fee (\$2 per member per month) to help fund the Patient-Centered Outcome Research Trust Fund, fees on medical devices that may be passed on to patients and purchasers, and fees (3.5% of premium) to fund the insurance exchanges.

The net impact of these changes is unknown, but there is a strong argument that they should result in lower premiums. The incentives for more efficient delivery and lower administrative costs, reinforced by the minimum loss ratio and rate review provisions, should set the stage for a more robust effort by the industry to limit costs and cost increases in this market. The large number of new enrollees also will provide greater incentive for the health plans to invest in cost control programs for the nongroup market.

The issue of rate shock for younger people who now have nongroup coverage

Recent discussion about premium rates under health reform have focused in on the potential rate shock for younger enrollees who will pay higher premiums under reform with suggestions that phasing in the 3:1 age limitation could moderate the impact. As discussed above, there are a number of factors that will affect the premiums that nongroup enrollees will see under reform. Some will affect all buyers: the coverage is better; the limits on cost-sharing, while hardly generous, are more protective than some

of the policies currently available, and the risk pool will more likely reflect the general population rather than a select, healthy one. Other changes, such as the elimination of gender rating and the limits on age variation, largely redistribute the premium burden advantaging some populations and disadvantaging others (particularly younger men). The suggested phase-in of the 3:1 age rating limit is intended to address one part of the rate shock concern, at least temporarily, but it would not affect changes in premiums due to better benefits and cost-sharing protections and a more inclusive marketplace.

So does a phase-in make sense to at least partially mitigate the premium impact on younger enrollees? There are a few additional factors that might be considered in answering that question.

The first is that most current nongroup enrollees will be eligible for premium tax credits, which will limit the share of the premium that they will be required to pay to a percentage of family income. We used income and coverage data from the Survey of Income and Program Participation to estimate

(http://kaiserfamilyfoundation.files.wordpress.com/2013/02/age_rate_analysis_method_020613.pdf) the differences in the amounts that current nongroup enrollees would pay for the same silver plan under a 3:1 limit and the unlimited age rating that exists in the market today. We estimate that 80% of current nongroup enrollees would pay less under the 3:1 limit for equivalent coverage, once premium subsidies are taken into account. While many younger enrollees would see higher premiums under the 3:1 age limit, they would not pay more because they would receive a tax credit that caps their premium obligation as a percentage of their income. It is important to note that this is not an estimate of the percentage of current nongroup enrollees who might pay more for coverage under reform, taking all factors into account; we only looked at the impact of the different age-rate limits because that is a policy that has been advanced by some in the industry and others. This analysis does not consider premium increases because the coverage is better or because the risk pool is more representative of the general population.

A second consideration is that catastrophic plans available under reform may accomplish much of what the advocates of phasing in the 3:1 age limit are trying to accomplish: a low-cost plan with rates that reflect the medical spending of younger enrollees. The ACA permits health plans to offer a catastrophic health plan to people under age 30 and to people who otherwise would be required to pay more than 8% of their income for a health plan. While the catastrophic plans are part of the single risk pool that health plans must have for each market, the proposed regulations from CMS allow plans to adjust premiums for the catastrophic plans to reflect the demographics of its enrollees. Enrollment in catastrophic plans is likely to be younger, on average, than enrollment in the other tiers, because under the proposed rules people under age 30 can easily enroll in a catastrophic plan but people who are older must first get a

certification from an exchange that premiums for other available coverage would exceed 8% of their income. The certification requirement will likely slow any enrollment of older people into catastrophic plans, leaving a younger risk pool. Catastrophic plans also will be treated separately under risk adjustment, which means that catastrophic premiums will not go up if enrollees in catastrophic plans are healthier on average than enrollee in other tiers.

This all means that the catastrophic plans, if implemented as proposed, may have premiums that are more reflective of a younger and healthier population than plans in other tiers. Since the actuarial value of the catastrophic plans is very close to that of bronze plans (57% v. 60%), the premiums for younger people in catastrophic plans may be quite close to what you would get if you permitted unlimited premium variation for age in bronze plans. We estimate that the premium for a younger person in their twenties may be as much as 29% less in a catastrophic plan than in a bronze plan, assuming that catastrophic enrollment is primarily under age 30. This would cushion the potential rate shock for existing, young nongroup enrollees with low cost coverage, particularly those who would not receive a premium tax credit or who would rather pay a very low price for less coverage.

A third consideration is the high turnover in the current market. A fairly high percentage of people who buy nongroup policies have their coverage for a year or less, which means that many of the people who the age rating phase-in is designed to help may not be planning to keep their current health plans anyway. A [project](http://www.kff.org/insurance/7133.cfm) (<http://www.kff.org/insurance/7133.cfm>) that the Foundation did with the online broker eHealthInsurance found that, among nongroup purchasers aged 18 to 24, 38% of males and 44% of females had given up their policies by the end of their first year of coverage and 60% have given up their policies by the end of the second year. This study is a little old and involved on-line purchasers, so it may not be representative of all younger purchasers. But given these high lapse rates, policy makers may want to get additional information about the purchase and retention of patterns of younger purchasers to help them understand how many current nongroup policyholders would actually benefit from a phase-in of the age rating limit. The availability of premium tax credits and the catastrophic plan already limit the number of current nongroup policyholders who would actually benefit from a phase-in; the high lapse rates only further reduce that number.

In the big picture, the ACA addresses many of the shortcomings of the current nongroup market by providing access to a complete set of health benefits with protections against catastrophic out-of-pocket costs. The higher level of benefits, the better protection against catastrophic costs and wider access to coverage each tend to increase the average level of premiums, although out-of-pocket costs for enrollees will go down due to the better protection they receive. The more competitive marketplace created under

the ACA, greatly enhanced by the structure of the premium tax credits, will push in the other direction, forcing health plans to become more efficient and better managers of the premiums they receive. There already is some evidence that plans are working to create less costly, more efficient networks to offer with plans sold in exchanges.

Limiting premium variation for age to 3:1 will increase premiums for younger people when compared to current rating practices, but several policies in the ACA limit the impact. The premium tax credits will protect many current nongroup enrollees from paying more due to their age, and the manner in which the federal government has proposed to implement the catastrophic health plan may blunt the impact of the age constraint, providing younger people with access to a low-cost policy that is more reflective of their age and relative health.

—Gary Claxton, Larry Levitt, and Karen Pollitz (with analysis by Anthony Damico)

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1. Justin Lake, Andrew Valen, Michael Newshel, J.P. Morgan Securities LLC, “Managed Care and Providers Wrap-Up,” *J.P. Morgan Health Conference*, (January 2013).
 2. Christine Arnold, Cowen and Company, “4Q12 Hospital Survey Results Suggest Mixed Views on Reform Impact,” *Health Care*, (February 2013).
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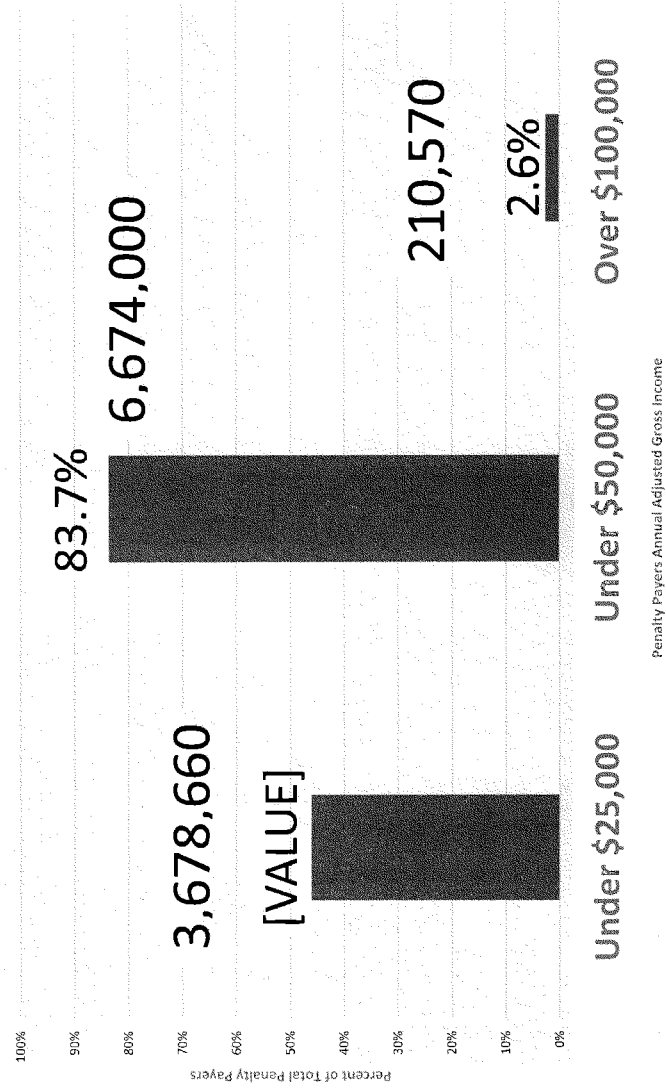
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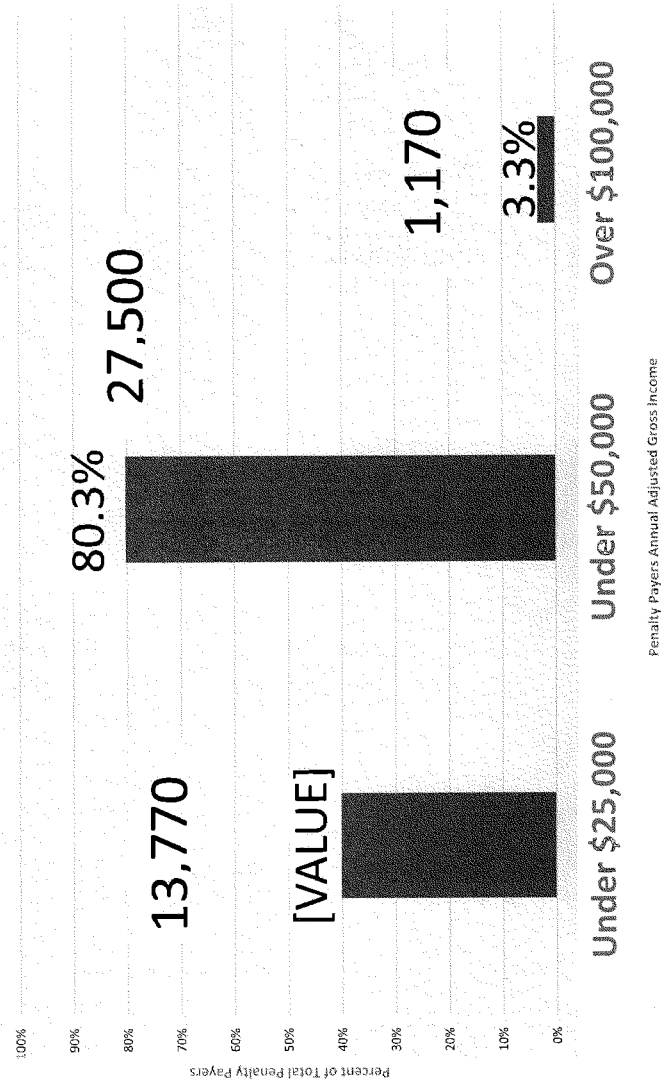
Obamacare's Poverty Tax

USA (7,973,490)



source: Internal Revenue Service: <https://www.irs.gov/iaac/oi-tax-stats-historic-table-2>

Obamacare's Poverty Tax Montana (34,250)



Source: Internal Revenue Service: <https://www.irs.gov/uac/soi-tax-stat-historic-table-2>

HOW DOCTORS DIE

It's Not Like the Rest of Us, But It Should Be

BY KEN MURRAY | NOVEMBER 30, 2011

Years ago, Charlie, a highly respected orthopedist and a mentor of mine, found a lump in his stomach. He had a surgeon explore the area, and the diagnosis was pancreatic cancer. This surgeon was one of the best in the country. He had even invented a new procedure for this exact cancer that could triple a patient's five-year-survival odds—from 5 percent to 15 percent—albeit with a poor quality of life. Charlie was uninterested. He went home the next day, closed his practice, and never set foot in a hospital again. He focused on spending time with family and feeling as good as possible. Several months later, he died at home. He got no chemotherapy, radiation, or surgical treatment. Medicare didn't spend much on him.

It's not a frequent topic of discussion, but doctors die, too. And they don't die like the rest of us. What's unusual about them is not how much treatment they get compared to most Americans, but how little. For all the time they spend fending off the deaths of others, they tend to be fairly serene when faced with death themselves. They know exactly what is going to happen, they know the choices, and they generally have access to any sort of medical care they could want. But they go gently.

Of course, doctors don't want to die; they want to live. But they know enough about modern medicine to know its limits. And they know enough about death to know what all people fear most: dying in pain, and dying alone. They've talked about this with their families. They want to be sure, when the time comes, that no heroic measures will happen—that they will never experience, during their last moments on earth, someone breaking their ribs in an attempt to resuscitate them with CPR (that's what happens if CPR is done right).

Almost all medical professionals have seen what we call “futile care” being performed on people. That's when doctors bring the cutting edge of technology to bear on a grievously ill person near the end of life. The patient will get cut open, perforated with tubes, hooked up to machines, and assaulted with drugs. All of this occurs in the Intensive Care Unit at a cost of tens of thousands of dollars a day. What it buys is misery we would not inflict on a terrorist. I cannot count the number of times fellow physicians have told me, in words that vary only slightly, “Promise me if you find me like this that you'll kill me.” They mean it. Some medical personnel wear medallions stamped “NO CODE” to tell physicians not to perform CPR on them. I have even seen it as a tattoo.

To administer medical care that makes people suffer is anguishing. Physicians are trained to gather information without revealing any of their own feelings, but in private, among fellow doctors, they'll vent. “How can anyone do that to their family members?” they'll

ask. I suspect it's one reason physicians have higher rates of alcohol abuse and depression than professionals in most other fields. I know it's one reason I stopped participating in hospital care for the last 10 years of my practice.

How has it come to this—that doctors administer so much care that they wouldn't want for themselves? The simple, or not-so-simple, answer is this: patients, doctors, and the system.

To see how patients play a role, imagine a scenario in which someone has lost consciousness and been admitted to an emergency room. As is so often the case, no one has made a plan for this situation, and shocked and scared family members find themselves caught up in a maze of choices. They're overwhelmed. When doctors ask if they want "everything" done, they answer yes. Then the nightmare begins. Sometimes, a family really means "do everything," but often they just mean "do everything that's reasonable." The problem is that they may not know what's reasonable, nor, in their confusion and sorrow, will they ask about it or hear what a physician may be telling them. For their part, doctors told to do "everything" will do it, whether it is reasonable or not.

The above scenario is a common one. Feeding into the problem are unrealistic expectations of what doctors can accomplish. Many people think of CPR as a reliable lifesaver when, in fact, the results are usually poor. I've had hundreds of people brought to me in the emergency room after getting CPR. Exactly one, a healthy man who'd had no heart troubles (for those who want specifics, he had a "tension pneumothorax"), walked out of the hospital. If a patient suffers from severe illness, old age, or a terminal disease, the odds of a good outcome from CPR are infinitesimal, while the odds of suffering are overwhelming. Poor knowledge and misguided expectations lead to a lot of bad decisions.

But of course it's not just patients making these things happen. Doctors play an enabling role, too. The trouble is that even doctors who hate to administer futile care must find a way to address the wishes of patients and families. Imagine, once again, the emergency room with those grieving, possibly hysterical, family members. They do not know the doctor. Establishing trust and confidence under such circumstances is a very delicate thing. People are prepared to think the doctor is acting out of base motives, trying to save time, or money, or effort, especially if the doctor is advising against further treatment.

Some doctors are stronger communicators than others, and some doctors are more adamant, but the pressures they all face are similar. When I faced circumstances involving end-of-life choices, I adopted the approach of laying out only the options that I thought were reasonable (as I would in any situation) as early in the process as possible. When patients or families brought up unreasonable choices, I would discuss the issue in layman's terms that portrayed the downsides clearly. If patients or families still insisted

on treatments I considered pointless or harmful, I would offer to transfer their care to another doctor or hospital.

Should I have been more forceful at times? I know that some of those transfers still haunt me. One of the patients of whom I was most fond was an attorney from a famous political family. She had severe diabetes and terrible circulation, and, at one point, she developed a painful sore on her foot. Knowing the hazards of hospitals, I did everything I could to keep her from resorting to surgery. Still, she sought out outside experts with whom I had no relationship. Not knowing as much about her as I did, they decided to perform bypass surgery on her chronically clogged blood vessels in both legs. This didn't restore her circulation, and the surgical wounds wouldn't heal. Her feet became gangrenous, and she endured bilateral leg amputations. Two weeks later, in the famous medical center in which all this had occurred, she died.

It's easy to find fault with both doctors and patients in such stories, but in many ways all the parties are simply victims of a larger system that encourages excessive treatment. In some unfortunate cases, doctors use the fee-for-service model to do everything they can, no matter how pointless, to make money. More commonly, though, doctors are fearful of litigation and do whatever they're asked, with little feedback, to avoid getting in trouble.

Even when the right preparations have been made, the system can still swallow people up. One of my patients was a man named Jack, a 78-year-old who had been ill for years and undergone about 15 major surgical procedures. He explained to me that he never, under any circumstances, wanted to be placed on life support machines again. One Saturday, however, Jack suffered a massive stroke and got admitted to the emergency room unconscious, without his wife. Doctors did everything possible to resuscitate him and put him on life support in the ICU. This was Jack's worst nightmare. When I arrived at the hospital and took over Jack's care, I spoke to his wife and to hospital staff, bringing in my office notes with his care preferences. Then I turned off the life support machines and sat with him. He died two hours later.

Even with all his wishes documented, Jack hadn't died as he'd hoped. The system had intervened. One of the nurses, I later found out, even reported my unplugging of Jack to the authorities as a possible homicide. Nothing came of it, of course; Jack's wishes had been spelled out explicitly, and he'd left the paperwork to prove it. But the prospect of a police investigation is terrifying for any physician. I could far more easily have left Jack on life support against his stated wishes, prolonging his life, and his suffering, a few more weeks. I would even have made a little more money, and Medicare would have ended up with an additional \$500,000 bill. It's no wonder many doctors err on the side of overtreatment.

But doctors still don't over-treat themselves. They see the consequences of this constantly. Almost anyone can find a way to die in peace at home, and pain can be managed better than ever. Hospice care, which focuses on providing terminally ill

patients with comfort and dignity rather than on futile cures, provides most people with much better final days. Amazingly, studies have found that people placed in hospice care often live longer than people with the same disease who are seeking active cures. I was struck to hear on the radio recently that the famous reporter Tom Wicker had “died peacefully at home, surrounded by his family.” Such stories are, thankfully, increasingly common.

Several years ago, my older cousin Torch (born at home by the light of a flashlight—or torch) had a seizure that turned out to be the result of lung cancer that had gone to his brain. I arranged for him to see various specialists, and we learned that with aggressive treatment of his condition, including three to five hospital visits a week for chemotherapy, he would live perhaps four months. Ultimately, Torch decided against any treatment and simply took pills for brain swelling. He moved in with me.

We spent the next eight months doing a bunch of things that he enjoyed, having fun together like we hadn’t had in decades. We went to Disneyland, his first time. We’d hang out at home. Torch was a sports nut, and he was very happy to watch sports and eat my cooking. He even gained a bit of weight, eating his favorite foods rather than hospital foods. He had no serious pain, and he remained high-spirited. One day, he didn’t wake up. He spent the next three days in a coma-like sleep and then died. The cost of his medical care for those eight months, for the one drug he was taking, was about \$20.

Torch was no doctor, but he knew he wanted a life of quality, not just quantity. Don’t most of us? If there is a state of the art of end-of-life care, it is this: death with dignity. As for me, my physician has my choices. They were easy to make, as they are for most physicians. There will be no heroics, and I will go gentle into that good night. Like my mentor Charlie. Like my cousin Torch. Like my fellow doctors.

Ken Murray, MD, is Clinical Assistant Professor of Family Medicine at USC.

**Post-Hearing Questions for the Record
Submitted to Melissa Thomasson
From Senator Claire McCaskill**

“The History and Current Reality of the U.S. Health Care System”

September 6, 2017

See attached document for responses.

Market Stability (CSRs)

Despite claims that the Affordable Care Act market is in a death spiral, a report released by the non-partisan Kaiser Family Foundation in July found that the “individual market has been stabilizing and insurers are regaining profitability.” The Foundation’s report found that “insurer financial results show no sign of a market collapse,” noting that, although some insurers have exited the market in recent years, “others have been successful and expanded their footprints, as would be expected in a competitive marketplace.”

Many economists believe that the greatest risk to the stability of the individual market stems from the uncertainty surrounding the Administration’s intention to continue making Cost Sharing Reduction or “CSR” payments to insurers.

1. Please explain the relationship between CSR payments and market stability.
2. How is the uncertainty surrounding CSR payments currently affecting the individual market?
3. Would making the CSR payments mandatory have any effect on the stability of the individual insurance market?
4. Are there additional mechanisms for stabilizing the individual insurance market that we should consider?

The ACA – Coverage and Gaps

Although there are still large gaps in coverage in the current system of health insurance in the United States, the uninsured rate for the first three months of 2017 was at an all-time low with only 8.8 percent of Americans uninsured, according to the Centers for Disease Control and Prevention. The Affordable Care Act is far from perfect, but it has made health insurance accessible for millions of Americans who otherwise would have remained uninsured.

5. Is there a benefit to providing access to health care insurance to as many people as possible?
6. What are the economic reasons for providing access to comprehensive coverage to as

many people as possible?

7. Expansion of coverage is not strictly an economic argument. Can you provide this Committee with some public policy arguments that support the need for more people to have access to comprehensive health care?

Over the years, various administrations have succeeded in passing incremental reforms to fill gaps left by our employer based system. Medicare and Medicaid provide insurance coverage to the elderly as well as the poor and disabled, respectively. CHIP extended Medicaid coverage to low-income children. However, there are still millions of Americans without any health care coverage, and millions more who have insufficient coverage and high deductibles that preclude them from accessing health care services.

8. What are the largest gaps that remain under our current system? Are there certain holes left by the employer-based system that the Affordable Care Act does not address?
9. Are there steps that we, or our counterparts on the state level, can take to increase coverage?

Defense of Insurance Coverage

The majority's staff memorandum states: "[t]he current health care debate is centered on a misguided, albeit appealing, principle of providing health care coverage to as many uninsured Americans as possible. While expanding healthcare insurance coverage may be viewed as a laudable goal, it ignores one of the most significant problems within the current U.S. health care system—the cost of health care is sky rocketing."

Although I absolutely agree that costs needs to be contained, we must also continue to strive to provide access to health care coverage to every American.

10. Can you explain how access to comprehensive health care coverage can provide economic stability to a patient facing a serious medical event?
11. Is there recent data on the number of families who say they are having problems paying medical bills?
12. Are there studies demonstrating how Medicaid expansion has impacted medical debt?
13. Can you explain the benefits of coverage expansions related to hospital-based uncompensated care?

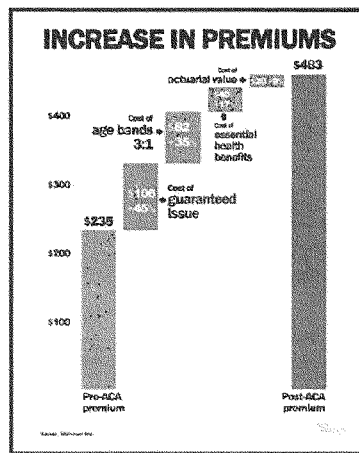
On February 13, 2017, your article entitled, "A lesson from history: Repealing the ACA will make health insurance more expensive" was published by Stat News. In your article, the ACA's individual mandate addresses the problem of "adverse selection."

14. Please explain the problem of “adverse selection” in our health care system.
15. How does the individual mandate address the problem of “adverse selection”?
16. What other components of the ACA address the problem of “adverse selection”?
17. Why would repealing the ACA make health care more expensive?
18. What groups would be most adversely impacted by repeal of the ACA?

Explanation of Premium Increases

Many critics of the current state of the health care system assign blame on increased costs to greater coverage. In the staff memo you distributed at the last hearing, you included a chart that showed that increases in premium costs following enactment of the Affordable Care Act.

I note that this information only related to the primary cost drivers for premiums in the individual health insurance market.



This chart shows that there was an increase of 45 percent due to guaranteed issue.

19. Explain what “guaranteed issue” is and why it was included as a market reform in the Affordable Care Act.

The chart shows an increase of 35 percent due to age bands being 3 to 1.

20. What do “age bands” mean and why was it an important market reform?

The chart shows an increase of 17 percent for essential health benefits.

21. What are “essential health benefits” and why was this a necessary reform included in the Affordable Care Act?

The chart shows an increase of nine percent for actuarial value.

22. What is “actuarial value?” Is this a market reform under the Affordable Care Act, or some kind of cost driver separate from health reform?

Recent Cost Drivers

There are a number of cost drivers that are currently causing health care costs to rise dramatically that are not based on the insurance markets. Over the last two decades, the health care industry has experienced significant consolidation.

23. How much has the cost of hospital care increased?
24. Has hospital consolidation resulted in increased costs?
25. How can we as policymakers address hospital consolidation to decrease costs?
26. To what extent has decreased competition among health care providers contributed to higher health care costs for consumers?
27. How can we reform payments for physician services to contain costs?
28. How does the cost of prescription drugs impact overall health spending?
29. What steps can we take to control the high cost of prescription drugs?

Historical Cost Drivers

The original Blue Cross Blue Shield insurance providers were non-profit organizations that generally offered health care coverage at a “community rate” and provided coverage to all members of the groups regardless of the employees’ ages or health status.

30. How did the adoption of “experience rating” and “underwriting” by for-profit insurance providers change the risk pool for the insured groups?
31. How did this change in the risk pool affect the costs of health care coverage?

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Post-Hearing Questions for the Record

Submitted by: Melissa A. Thomasson, Ph.D.

“The History and Current Reality of the U.S. Health Care System”

October 11, 2017

1. Under the Affordable Care Act (ACA), insurance companies are required to offer reduced enrollee cost sharing in the form of lower deductibles and co-pays to people insured in the silver-level plans with incomes 100-250% of the federal poverty level (FPL). Despite the greater generosity of these plans, these individuals pay the same premiums as higher-income individuals enrolled in silver-level plans. To compensate insurance companies for the added cost of these Cost-Sharing Reductions (CSRs), the federal government agreed to reimburse insurers directly. If the CSR payments end, insurers will face higher costs and may exit the individual marketplace.
2. Some insurance companies claim that uncertainty surrounding CSR payments will lead them to exit the market.
3. Making CSR payments mandatory would stop the exit of insurance companies generated by CSR uncertainty.
4. Other mechanisms that could be used to enhance market stability would be reinsurance and high risk pools.
5. The primary function of health insurance is to provide financial protection for individuals who experience an adverse shock to their health. Health insurance may help to prevent medical bankruptcy, for example, see Himmelstein *et al.* (2005, 2009); Dranove & Millenson (2006); Dobkin *et al.* (2016); Hu *et al.* (2016). Other studies find a less conclusive link (see Morrison *et al.* (2013); Gupta *et al.* (2015)). Because insured individuals are better able to afford medical care, they may enjoy better health outcomes than uninsured individuals (for greater discussion see Baicker *et al.* (2013); Finkelstein *et al.* (2012); Long & Baicker (2014); Finkelstein & McKnight (2008)).
6. See the answer to number (5).
7. As an economist, I leave this answer to my public policy school colleagues to answer.
8. Under the ACA, employers are not required to provide affordable coverage for families – this is the so-called “family glitch”. Low-to-moderate income families cannot qualify for premium tax credits to reduce the cost of a plan on the exchange if an individual employee in the family has access to “affordable” employer based coverage. This can lead to coverage gaps for family members. Without reauthorization of the Children’s Health Insurance Program (CHIP), some children will remain uninsured and have no private market path for health insurance.
9. In the short-run, Congress must reauthorize payments to states to support CHIP. In the longer run, the ACA would need to be modified to correct the “family glitch.”
10. I answered how insurance protects individuals in my response to question (5).
11. I am not familiar with recent studies.

12. See Hu *et al.* (2016) for a detailed answer of how Medicaid expansions affect financial wellbeing.
13. When hospitals treat uninsured individuals, they do not receive payment. In response, they may charge insured patients more to recover their losses.
14. Adverse selection in health insurance refers to the situation in which individuals who are more likely to be sick are more likely to want insurance coverage at an average premium. Individuals who suspect they are likely to be more sick than average enroll, and individuals who believe they are healthier than average do not buy coverage. As a result, the average premium rises. Over time, this process continues until the premium becomes unaffordable.
15. The individual mandate reduces the problem of adverse selection by making health individuals enroll, thus keeping average premiums down.
16. Other mechanisms that offset the higher cost of less healthy consumers that may help to reduce adverse selection include premium adjustments allowed based on age and tobacco use.
17. Repealing the ACA will make health care more expensive for people with pre-existing conditions and less healthy people for several reasons. It will take away the individual mandate so that adverse selection occurs and increases premiums. Ending the ACA would also end end risk-selection protections such as guaranteed issue. Guaranteed issue and limits on medical underwriting prevent insurance companies from “cherry picking” the healthiest enrollees so that less healthy individuals cannot find affordable health insurance coverage. Since repealing the ACA would increase the number of uninsured individuals, repealing the ACA would also mean that providers face more unpaid claims, so they may increase their charges for people who are able to pay. Finally, uninsured individuals who forego early treatment may end up paying more later to treat conditions at a more advanced stage.
18. The groups most likely to be impacted would be those people without access to employer-based coverage or Medicare, particularly individuals with pre-existing conditions.
19. “Guaranteed issue” is a requirement that insurers sell health insurance to any individual or family who seeks coverage, regardless of age or health status.
20. Older people are more likely to face higher medical costs than younger people. If insurance companies experience rate policies (that is, charge people a premium associated with their expected health expenditures), older people would face much higher premiums than younger people and have difficulty paying for health insurance coverage. To mitigate this and keep insurance affordable for older Americans, the ACA mandates that insurance companies can charge older people no more than three times what they charge younger people. However, younger people face premium increases with age band rating, so the individual mandate is very important to make sure they buy coverage and prevent adverse selection.

21. Essential health benefits are a standardized set of services that insurance companies must cover under the ACA. It is important to specify a standard set of services so individuals can comparison shop for plans. Premiums reflect both the amount of benefits that are covered by a plan and administrative and other fees. If the benefits differ across plans, it makes it more difficult for people to determine which plans offer better value.
22. Actuarial value is a term used to refer to the expected payments an insurance company expects to pay to an individual who has a policy. It is a standard insurance term and is not related to the ACA nor is it a separate driver of the cost of health care.
23. Answering this question is difficult because the best sources of data on hospital costs over time only come from Medicare. The *share* of hospital expenditures in overall health care expenditures has remained fairly steady over the past 20 years, between 30 and 33 percent (Peterson-Kaiser Health System Tracker, 2017). There is an extensive literature in economics on hospital costs. See Cooper *et al.* (2015); Ho & Lee (2015) for an overview.
24. For discussion of this see Dafny (2014); Gaynor & Vogt (2003); Gowrisankaran *et al.* (2015); Tay (2003).
25. Consolidation could be reduced with enforcement of antitrust policy and full staffs at the Federal Trade Commission and the Department of Justice. Medicare payments are also a huge lever. For example, see White (2013).
26. This is an excellent question. The references cited in questions 23 through 25 above will help shed light on this. More importantly, recent trends of hospitals merging and acquiring physician practices will further concentrate the health care market and likely lead to reduced competition and further costs, but I am not aware of a study that has yet looked at these issues.
27. Reimbursement methods based on fee-for-service payment have historically driven health care costs. Congress can use Medicare and the ACA as mechanisms for payment reform, and focus on value-based reimbursement instead of reimbursement on a fee-for-service schedule. For evidence of Medicare's influence on private physician payments, see Clemens & Gottlieb (2013). In addition, letting physicians determine their own reimbursement in a closed-door setting may not be efficient. (see: <https://www.axios.com/amas-doctor-panel-still-operates-behind-closed-doors-2493775917.html>).
28. Over the past 25 years, the share of health care spending on prescription drugs has nearly doubled, from 5.5 percent in 1995 to over 10 percent today (Peterson-Kaiser Health System Tracker, 2017). Spending is driven by costs and utilization, but I am not aware of economic analysis that specifically focuses on cost alone.
29. There is not a single cause of rising prescription drug costs. Price controls and policies intended to limit government spending can have unintended consequences. For example, when a federal govern-

ment audit of Average Wholesale Prices (AWP) in the Medicaid program led states to reduce Medicaid reimbursement for many drugs, pharmacies switched to dispensing higher priced drugs instead (see Alpert 2013). Another example of this comes from a Medicare reform in 2003 that led oncologists to switch to much higher cost drugs (see Gatesman & Smith (2011)). Investigation into industry consolidation, the role of Pharmacy Benefit Managers (PBMs) and greater incentives for transparent pricing would shed light on the costs in the pharmaceutical industry.

30. The adoption of modified experience rating led the plans that still engaged in community rating to suffer from adverse selection. To compete, these plans eventually had to convert to modified experience rating as well. See Thomasson (2004) for greater discussion.
31. To my knowledge, no research has been done about how this affected the costs of health care coverage.

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**Post-Hearing Questions for the Record
Submitted to Katherine Baicker
From Senator Claire McCaskill**

“The History and Current Reality of the U.S. Health Care System”

September 6, 2017

Questions Below, Responses Enclosed

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12. Are there studies demonstrating how Medicaid expansion has impacted medical debt?
13. Can you explain the benefits of coverage expansions related to hospital-based uncompensated care?

You were a co-author of the Oregon Medicaid experiment, which is often referenced as evidence that health outcomes under Medicaid coverage are "no better than being uninsured."

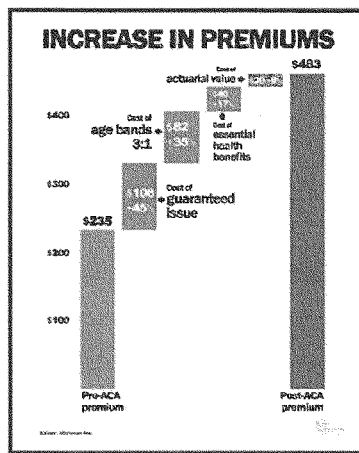
14. Did the Oregon Medicaid experiment indicate that individuals with Medicaid coverage were no better off than their uninsured counterparts?

15. Is Medicaid coverage better for individuals than remaining uninsured? If so, why?
16. Are there any economic or non-medical benefits to having access to health insurance?
17. Are there any psychological benefits to having access to affordable health care coverage?

Explanation of Premium Increases

Many critics of the current state of the health care system assign blame on increased costs to greater coverage. In the staff memo you distributed at the last hearing, you included a chart that showed that increases in premium costs following enactment of the Affordable Care Act.

I note that this information only related to the primary cost drivers for premiums in the individual health insurance market.



This chart shows that there was an increase of 45 percent due to guaranteed issue.

18. Explain what “guaranteed issue” is and why it was included as a market reform in the Affordable Care Act.

The chart shows an increase of 35 percent due to age bands being 3 to 1.

19. What do “age bands” mean and why was it an important market reform?

The chart shows an increase of 17 percent for essential health benefits.

20. What are “essential health benefits” and why was this a necessary reform included in the Affordable Care Act?

The chart shows an increase of nine percent for actuarial value.

21. What is “actuarial value?” Is this a market reform under the Affordable Care Act, or some kind of cost driver separate from health reform?

Recent Cost Drivers

There are a number of cost drivers that are currently causing health care costs to rise dramatically that are not based on the insurance markets. Over the last two decades, the health care industry has experienced significant consolidation.

22. How much has the cost of hospital care increased?
23. Has hospital consolidation resulted in increased costs?
24. How can we as policymakers address hospital consolidation to decrease costs?
25. To what extent has decreased competition among health care providers contributed to higher health care costs for consumers?
26. How can we reform payments for physician services to contain costs?
27. How does the cost of prescription drugs impact overall health spending?
28. What steps can we take to control the high cost of prescription drugs?

Historical Cost Drivers

The original Blue Cross Blue Shield insurance providers were non-profit organizations that generally offered health care coverage at a “community rate” and provided coverage to all members of the groups regardless of the employees’ ages or health status.

29. How did the adoption of “experience rating” and “underwriting” by for-profit insurance providers change the risk pool for the insured groups?
30. How did this change in the risk pool affect the costs of health care coverage?



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RESPONSES TO QUESTIONS FOR THE RECORD

Submitted as follow-up to "The History and Current Reality of the U.S. Health Care System"

Thank you for the opportunity to testify, and for these additional questions. As several of the 30 questions are closely related, and some fall outside my area of expertise, I will group my answers by topic and focus on those where I believe I can provide the best information. I have attached some supplemental material (including pieces that I have co-authored) that speak to these questions in greater depth, and have referenced my original testimony when relevant.

The Effects of Medicaid Coverage

Several of the questions focused on the effects of Medicaid coverage on health care use, financial stability, and health outcomes. One of the pieces that I have attached synthesizes my reading of the evidence on these points, which is very much informed by my work on the Oregon Health Insurance Experiment.¹ In that work, we found that people on Medicaid are substantially better off than if they were uninsured, with better self-reported health, lower rates of depression, and more financial stability (including reduced risk of having unpaid medical bills sent to collection) – although we found no evidence that Medicaid coverage results in substantial improvements in several chronic physical health conditions such as high blood pressure.^{2,3} There is also a broader set of evidence speaking to the health improvements associated with insurance.⁴ The benefits to Medicaid enrollees relative to being uninsured comes along with an increase in health care utilization (and a commensurate increase in program costs that must be borne by taxpayers) – including primary and preventive care, prescription drugs, hospitalizations, and emergency department visits.^{2,5-7}

Data on Coverage and Spending

The attached chart (also appearing as Figure 3 in my written testimony) draws on data from the CMS Office of the Actuary's National Health Statistics Group to show the increase in spending on hospitals, prescription drugs, physicians, and other types of care over time.

Estimates of the share of the uninsured who are eligible for public insurance programs such as Medicaid or CHIP vary substantially, but are often in the range of ¼, meaning that most of the uninsured are not eligible for these programs.⁸ (An additional share of the uninsured are eligible for tax credits.) Many people who are eligible for public insurance are thus not enrolled, whether it is because of lack of information or low valuation of the coverage. There is evidence that facilitating the Medicaid enrollment process, such as through clearer communications, appreciably increases enrollment – suggesting that valuation of the coverage is not the sole driver of enrollment patterns.⁹

Health Care and Health Insurance Markets

I touched briefly in my written and oral testimony on two topics related to health markets. First, there is evidence that hospital consolidation leads to higher hospital prices, provider consolidation leads to higher provider prices, and insurer consolidation leads to higher premiums.¹⁰⁻¹³ These effects should be taken into account by regulators assessing potential mergers.

Second, as several witnesses highlighted, insurance markets are likely to be more stable when insurers have clear information about rate-setting regimes, subsidies, and market participation. Higher enrollments will facilitate risk-pooling.

Last, I believe that there is considerable potential for payment reform to increase the value of health care delivered and the financial sustainability of our health care system. Like patients, providers respond to financial incentives.^{14,15} Private insurers have experimented with “value-based” payments and accountable care organizations, along with alternative payment models introduced in Medicare’s payment schedule for physicians and other services, but the effectiveness of these and alternative payments systems is still being explored.¹⁶⁻¹⁹

Terminology

My usage of technical terms like “actuarial value,” “guaranteed issue,” and “ratings bands” is intended to be consistent with standard utilization, such as that summarized at <https://www.healthcare.gov/glossary>.

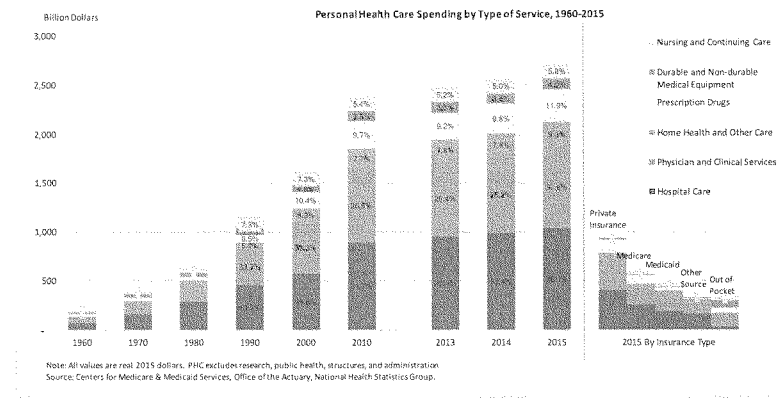
I thank the committee for the opportunity to testify. Please do not hesitate to let me know if I can be of service in the future.

Sincerely,



Katherine Baicker

Figure



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SOUNDING BOARD

Health Insurance Coverage and Health — What the Recent Evidence Tells Us

Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H.,
and Katherine Baicker, Ph.D.

The national debate over the Affordable Care Act (ACA) has involved substantial discussion about what effects — if any — insurance coverage has on health and mortality. The prospect that the law's replacement might lead to millions of Americans losing coverage has brought this empirical question into sharp focus. For instance, politicians have recently argued that the number of people with health insurance is not a useful policy metric¹ and that no one dies from a lack of access to health care.² However, assessing the impact of insurance coverage on health is complex: health effects may take a long time to appear, can vary according to insurance benefit design, and are often clouded by confounding factors, since insurance changes usually correlate with other circumstances that also affect health care use and outcomes.

Nonetheless, over the past decade, high-quality studies have shed light on the effects of coverage on care and health. Here, we review and synthesize this evidence, focusing on the most rigorous studies from the past decade on the effects of coverage for nonelderly adults. Previous reviews have provided a thorough discussion of older studies.³ We concentrate on more recent experimental and quasi-experimental studies of the ACA and other expansions of public or private insurance. The effects of coverage probably vary among people, types of plans, and settings, and these studies may not all directly apply to the current policy debate. But as a whole, this body of research (Table 1) offers important insights into how coverage affects health care utilization, disease treatment and outcomes, self-reported health, and mortality.

FINANCIAL PROTECTION AND THE ROLE OF INSURANCE

Before we assess these effects, it is worth recognizing the role of insurance as a tool for managing financial risk. There is abundant evidence that

having health insurance improves financial security. The strongest evidence comes from the Oregon Health Insurance Experiment, a rare randomized, controlled trial of health insurance coverage.⁴¹ In that study, people selected by lottery from a Medicaid waiting list experienced major gains in financial well-being as compared with those who were not selected: a \$390 average decrease in the amount of medical bills sent to collection and a virtual elimination of catastrophic out-of-pocket expenses.⁴⁸ Studies of other insurance expansions, such as Massachusetts' 2006 health care reform,⁷ the ACA's 2010 "dependent-coverage provision" enabling young adults to stay on a parent's plan until age 26,⁶ and the ACA's 2014 Medicaid expansion,⁵ have all revealed similar changes, including reduced bill collections and bankruptcies, confirming that insurance coverage reduces the risk of large unpredictable medical costs.

But from a policy perspective, health insurance is viewed differently from most other types of insurance: there is no push, for example, for universal homeowners' or renters' insurance subsidized by the federal government. We contend that there are two reasons for this difference. First, policymakers may value publicly subsidized health insurance as an important part of the social safety net that broadly redistributes resources to lower-income populations. Second, policymakers may view health insurance as a tool for achieving the specific policy priority of improved medical care and public health. Evaluating the impact of insurance coverage on health outcomes — and whether these benefits justify the costs of expanding coverage — is our focus.

ACCESS TO CARE AND UTILIZATION

For coverage to improve health, insurance must improve people's care, not just change how it's paid for. Several observational studies have found

Table 1. Evidence on the Effects of Health Insurance on Health Care and Health Outcomes, 2007–2017.

Domain and Findings	Insurance or Policy Examined ^a	Studies
Financial security		
Reduction in medical bills sent to collection and in catastrophic medical spending	Medicaid	Baicker et al. 2013 ⁴ ; Hu et al. 2016 ⁵
Reduced out-of-pocket medical spending	DCP, Medicaid	Chua and Sommers 2014 ⁶ ; Baicker et al. 2013 ⁴
Reduced personal bankruptcies and improved credit scores	MA	Mazumder and Miller 2016 ⁷
Access to care and utilization		
Increased outpatient utilization and rates of having a usual source of care/personal physician	Medicaid, MA	Finkelstein et al. 2012 ⁸ ; Sommers et al. 2014 ⁹ ; Simon et al. 2017 ¹⁰
Increased preventive visits and some preventive services including cancer screening and lab tests	Medicaid, MA	Baicker et al. 2013 ⁴ ; Sommers et al. 2014 and 2016 ^{9,11} ; Simon et al. 2017 ¹⁰
Increased prescription drug utilization and adherence	Medicaid	Ghosh et al. 2017 ¹² ; Sommers et al. 2016 ¹¹
Mixed evidence on emergency department use, with some studies showing an increase and others a decrease	Medicaid, DCP, MA	Taubman et al. 2014 ¹³ ; Akosa Antwi et al. 2015 ¹⁴ ; Miller 2012 ¹⁵ ; Sommers et al. 2016 ¹¹
Improved access to surgical care	DCP, MA	Scott et al. 2016 ¹⁶ ; Loehrer et al. 2016 ¹⁷
Chronic disease care and outcomes		
Increased rates of diagnosing chronic conditions	Medicaid	Baicker et al. 2013 ⁴ ; Wherry and Miller 2016 ¹⁸
Increased treatment for chronic conditions	Medicaid	Baicker et al. 2013 ⁴ ; Sommers et al. 2017 ⁹
Improved depression outcomes	Medicaid	Baicker et al. 2013 ⁴
No significant change in blood pressure, cholesterol, or glycated hemoglobin	Medicaid	Baicker et al. 2013 ⁴
Mixed evidence on cancer stage at time of diagnosis	MA, DCP	Keating et al. 2013 ¹⁹ ; Robbins et al. 2015 ²⁰ ; Loehrer et al. 2016 ¹⁷
Well-being and self-reported health		
Improved self-reported health in most studies	Medicaid, MA, DCP, ACA	Baicker et al. 2013 ⁴ ; Sommers et al. 2012 ²¹ ; Van Der Wees et al. 2013 ²² ; Chua and Sommers 2014 ⁶ ; Sommers et al. 2015 ¹⁴ ; Simon et al. 2017 ¹⁰ ; Sommers et al. 2017 ¹⁹
Some ACA-specific studies have shown limited or nonsignificant changes	Medicaid, ACA	Courtemanche et al. 2017 ²³ ; Miller and Wherry 2017 ²⁴
Mortality		
Conflicting observational studies on whether lack of insurance is an independent predictor of mortality	Private insurance	Kronick 2009 ²⁵ ; Wilper et al. 2009 ²⁶
Highly imprecise estimates in randomized trial, unable to rule out large mortality increases or decreases	Medicaid	Finkelstein et al. 2012 ⁸
Significant reductions in mortality in quasi-experimental analyses, particularly for health care–amenable causes of death	Medicaid, MA	Sommers et al. 2012 ²⁷ ; Sommers et al. 2014 ⁹ ; Sommers 2017 ²⁸

* “Medicaid” includes pre-ACA expansions of Medicaid in selected states and the ACA’s 2014 Medicaid expansion. ACA denotes Affordable Care Act (specifically applies here to the 2014 coverage expansions including Medicaid and subsidized marketplace coverage), DCP dependent-coverage provision (the ACA policy enacted in 2010 that allows young adults to remain on their parents’ plan until the age of 26 years), and MA Massachusetts statewide health care reform (enacted 2006).

that the ACA's coverage expansion was associated with higher rates of having a usual source of care and being able to afford needed care,^{32,33} factors typically associated with better health outcomes.³⁴ Stronger experimental and quasi-experimental evidence shows that coverage expansions similarly lead to greater access to primary care,^{11,24} more ambulatory care visits,⁸ increased use of prescription medications,^{4,12} and better medication adherence.¹¹

There is also strong evidence that coverage expansion increases access to preventive services, which can directly maintain or improve health. Studies of Massachusetts' health care reform⁹ and the ACA's Medicaid expansion found higher rates of preventive health care visits,¹¹ and although the utility of the "annual exam" is uncertain, such visits may facilitate more specific evidence-based screening. For instance, the ACA Medicaid expansion has led to significant increases in testing for diabetes,¹¹ hypercholesterolemia,¹⁸ and HIV,³⁵ and the Oregon study revealed a 15-percentage-point increase in the rate of cholesterol screening and 15- to 30-percentage-point increases in rates of screening for cervical, prostate, and breast cancer.⁴

The connection between health outcomes and use of other services, such as surgery, emergency-department (ED) care, and hospitalizations, tends to be more complicated. Much of this utilization serves critical health needs, though some may represent low-value care or reflect poor outpatient care. Thus, it is perhaps not surprising that the evidence on the effects of coverage on ED use and hospitalizations is mixed.³⁵ Both types of utilization went up in the Oregon study,^{8,13} whereas studies of other coverage expansions found reductions in ED use,^{11,14,15} and changes in hospital use have not been significant in several ACA studies^{11,26} — though these studies may not have had an adequate sample size to examine this less common outcome. Meanwhile, studies of Massachusetts' reform and the ACA's dependent-coverage provision indicate that insurance improves access to some high-value types of surgical care.^{16,17}

CHRONIC DISEASE CARE AND OUTCOMES

The effects of coverage are particularly important for people with chronic conditions, a vulnerable

high-cost population. Here, the Oregon experiment found nuanced effects. After 2 years of coverage, there were no statistically significant changes in glycated hemoglobin, blood pressure, or cholesterol levels.⁴ On the basis of these results, some observers have argued that expanding Medicaid does not improve health and is thus inadvisable.³⁶ However, the study revealed significant increases in the rate of diagnosis of diabetes that were consistent with findings in two recent post-ACA studies,^{18,37} along with a near-doubling of use of diabetes medications,⁴ again consistent with more recent data on the ACA's Medicaid expansion.¹² Glycated hemoglobin levels did not improve, but, as the authors note, the confidence intervals are potentially consistent with these medications' working as expected.⁴ The investigators did not detect significant changes in diagnosis of or treatment for high cholesterol or hypertension. One recent quasi-experimental study, however, showed that the ACA's Medicaid expansion was associated with better blood-pressure control among community health center patients.³⁸

Meanwhile, the Oregon study found substantial improvements in depression, one of the leading causes of disability in the United States.³⁹ It also found an increased rate of diagnosis, a borderline-significant increase in the rate of treatment with antidepressant medication, and a 30% relative reduction in rates of depressive symptoms.⁴

Other studies have assessed the effects of insurance coverage on cancer, the leading cause of death among nonelderly adults in the United States.⁴⁰ Though not all cancer results in chronic illness, most cancer diagnoses necessitate a period of ongoing care, and approximately 8 million U.S. adults under age 70 are currently living with cancer.⁴¹ Beyond increases in cancer screening, health insurance may also facilitate more timely or effective cancer care. However, evidence on this front is mixed. A study of Massachusetts' reform did not find any changes in breast-cancer stage at diagnosis,²⁰ whereas the ACA's dependent-coverage provision was associated with earlier-stage diagnosis and treatment of cervical cancer among young women.²¹ Another Massachusetts study revealed an increase in rates of potentially curative surgery for colon cancer among low-income patients after cover-

age expansion, with fewer patients waiting until the emergency stage for treatment.¹⁷

Coverage implications for many other illnesses such as asthma, kidney disease, and heart failure require additional research. Studies do show that for persons reporting any chronic condition, gaining coverage increases access to regular care for those conditions.^{19,30} Overall, the picture for managing chronic physical conditions is thus not straightforward, with coverage effects potentially varying among diseases, populations, and delivery systems.

WELL-BEING AND SELF-REPORTED HEALTH

Although the evidence on outcomes for some conditions varies, evidence from multiple studies indicates that coverage substantially improves patients' perceptions of their health. At 1 year, the Oregon study found a 25% increase in the likelihood of patients reporting "good, very good, or excellent" health, and more days in good physical and mental health.⁸ Evidence from quasi-experimental studies indicates that self-reported health and functional status improved after Massachusetts' reform²³ and after several pre-ACA state Medicaid expansions,²² and that self-reported physical and mental health improved after the ACA's dependent-coverage provision went into effect.⁵

Recent studies of the ACA's 2014 coverage expansion provide more mixed evidence. Multiple analyses have found improved self-reported health after the ACA's coverage expansion, either in broad national trends²⁴ or Medicaid expansion studies,^{20,11} whereas one found significant changes only for select subpopulations²⁵ and another not at all.²⁶ Larger coverage gains have generally been associated with more consistent findings of improved self-reported health.¹⁹

Does self-reported health even matter? It squarely fits within the World Health Organization's definition of health as "a state of complete physical, mental, and social well-being," and improved subjective well-being (i.e., feeling better) is also a primary goal for much of the medical care delivered by health care professionals. In addition, self-reported health is a validated measure of the risk of death. People who describe their health as poor have mortality rates 2 to 10 times as high as those who report being in the healthiest category.^{42,43}

MORTALITY

Perhaps no research question better encapsulates this policy debate than, "Does coverage save lives?" Beginning with the Institute of Medicine's 2002 report *Care without Coverage*, some analyses have suggested that lack of insurance causes tens of thousands of deaths each year in the United States.⁴⁴ Subsequent observational studies had conflicting findings. One concluded that lacking coverage was a strong independent risk factor for death,²⁸ whereas another found that coverage was only a proxy for risk factors such as socioeconomic status and health-related behaviors.²⁷ More recently, several studies have been conducted with stronger research designs better suited to answering this question.

The Oregon study assessed mortality but was limited by the infrequency of deaths in the sample. The estimated 1-year mortality change was a nonsignificant 16% reduction, but with a confidence interval of -82% to +50%, meaning that the study could not rule out large reductions — or increases — in mortality. As the authors note, the study sample and duration were not well suited to evaluating mortality.

Several quasi-experimental studies using population-level data and longer follow-up offer more precise estimates of coverage's effect on mortality. One study compared three states implementing large Medicaid expansions in the early 2000s to neighboring states that didn't expand Medicaid, finding a significant 6% decrease in mortality over 5 years of follow-up.²² A subsequent analysis showed the largest decreases were for deaths from "health-care-amenable" conditions such as heart disease, infections, and cancer, which are more plausibly affected by access to medical care.²⁹ Meanwhile, a study of Massachusetts' 2006 reform found significant reductions in all-cause mortality and health-care-amenable mortality as compared with mortality in demographically similar counties nationally, particularly those with lower pre-expansion rates of insurance coverage.⁹ Overall, the study identified a "number needed to treat" of 830 adults gaining coverage to prevent one death a year. The comparable estimate in a more recent analysis of Medicaid's mortality effects was one life saved for every 239 to 316 adults gaining coverage.²⁹

How can one reconcile these mortality findings with the nonsignificant cardiovascular and

diabetes findings in the Oregon study? Research design could account for the difference: the Oregon experiment was a randomized trial and the quasi-experimental studies were not, so the latter are susceptible to unmeasured confounding despite attempts to rule out alternative explanations, such as economic factors, demographic shifts, and secular trends in medical technology. But — as coauthors of several of these articles — we believe that other explanations better account for this pattern of results.

First, mortality is a composite outcome of many conditions and factors. Hypertension, dyslipidemia, and elevated glycated hemoglobin levels are important clinical measures but do not capture numerous other causes of increased risk of death. Second, the studies vary substantially in their timing and sample sizes. The Massachusetts and Medicaid mortality studies examined hundreds of thousands of people gaining coverage over 4 to 5 years of follow-up, as compared with roughly 10,000 Oregonians gaining coverage and being assessed after less than 2 years. It may take years for important effects of insurance coverage — such as increased use of primary and preventive care, or treatment for life-threatening conditions such as cancer, HIV–AIDS, or liver or kidney disease — to manifest in reduced mortality, given that mortality changes in the other studies increased over time.^{9,22}

Third, the effects on self-reported health — so clearly seen in the Oregon study and other research — are themselves predictive of reduced mortality over a 5- to 10-year period.^{42,43} Studies suggest that a 25% reduction in self-reported poor health could plausibly cut mortality rates in half (or further) for the sickest members of society, who have disproportionately high rates of death. Finally, the links among mental health, financial stress, and physical health are numerous,⁴⁵ suggesting additional pathways for coverage to produce long-term health effects.

DIFFERENT TYPES OF COVERAGE

In light of recent evidence on the benefits of health insurance coverage, some ACA critics have argued that private insurance is beneficial but Medicaid is ineffective or even harmful.⁴⁶ Is there evidence for this view? There is a greater body of rigorous evidence on Medicaid's effects — from studies of pre-ACA expansions, from

the Oregon study, and from analyses of the ACA itself — than there is on the effects of private coverage. The latter includes studies of the ACA's dependent-coverage provision, which expanded only private insurance, and of Massachusetts' reform, which featured a combination of Medicaid expansion, subsidies for private insurance through Medicaid managed care insurers, and some increase in employer coverage. But there is no large quasi-experimental or randomized trial demonstrating unique health benefits of private insurance. One head-to-head quasi-experimental study of Medicaid versus private insurance, based on Arkansas's decision to use ACA dollars to buy private coverage for low-income adults, found minimal differences.^{11,19} Overall, the evidence indicates that having health insurance is quite beneficial, but from patients' perspectives it does not seem to matter much whether it is public or private.⁴⁷ Further research is needed to assess the relative effects of various insurance providers and plan designs.

Finally, though it is outside the focus of our discussion, there is also quasi-experimental evidence that Medicare improves self-reported health⁴⁸ and reduces in-hospital mortality among the elderly,⁴⁹ though a study of older data from Medicare's 1965 implementation did not find a survival benefit.⁵⁰ However, since universal coverage by Medicare for elderly Americans is well entrenched, both the policy debate and opportunities for future research on this front are much more limited.

IMPLICATIONS AND CONCLUSIONS

One question experts are commonly asked is how the ACA — or its repeal — will affect health and mortality. The body of evidence summarized here indicates that coverage expansions significantly increase patients' access to care and use of preventive care, primary care, chronic illness treatment, medications, and surgery. These increases appear to produce significant, multifaceted, and nuanced benefits to health. Some benefits may manifest in earlier detection of disease, some in better medication adherence and management of chronic conditions, and some in the psychological well-being born of knowing one can afford care when one gets sick. Such modest but cumulative changes — which one of us has called “the heroism of incremental

care⁵¹ — may not occur for everyone and may not happen quickly. But the evidence suggests that they do occur, and that some of these changes will ultimately help tens of thousands of people live longer lives. Conversely, the data suggest that policies that reduce coverage will produce significant harms to health, particularly among people with lower incomes and chronic conditions.

Do these findings apply to the ACA? Drawing on evidence from recent coverage expansions is, in our view, the most reasonable way to estimate future effects of policy, but this sort of extrapolation is not an exact science. The ACA shares many features with prior expansions, in particular the Massachusetts reform on which it was modeled. But it is a complex law implemented in a highly contentious and uncertain policy environment, and its effects may have been limited by policies in some states that reduced take-up.⁵² Congress's partial defunding of the provisions for stabilizing the ACA's insurance marketplaces,⁵³ and plan offerings with high patient cost sharing. Furthermore, every state's Medicaid program has unique features, which makes direct comparisons difficult. Finally, coverage expansions and contractions will not necessarily produce mirror-image effects. For these reasons, no study can offer a precise prediction for the current policy debate. But our assessment, in short, is that these studies provide the best evidence we have for projecting the impact of the ACA or its repeal.

The many benefits of coverage, though, come at a real cost. Given the increases in most types of utilization, expanding coverage leads to an increase in societal resources devoted to health care.⁸ There are key policy questions about how to control costs, how much redistribution across socioeconomic groups is optimal, and how trade-offs among federal, state, local, and private spending should be managed. In none of these scenarios, however, is there evidence that covering more people in the United States will ultimately save society money.

Are the benefits of publicly subsidized coverage worth the cost? An analysis of mortality changes after Medicaid expansion suggests that expanding Medicaid saves lives at a societal cost of \$327,000 to \$867,000 per life saved.²⁰ By comparison, other public policies that reduce mortality have been found to average \$7.6 million

per life saved, suggesting that expanding health insurance is a more cost-effective investment than many others we currently make in areas such as workplace safety and environmental protections.^{20,54} Factoring in enhanced well-being, mental health, and other outcomes would only further improve the cost-benefit ratio. But ultimately, policymakers and other stakeholders must decide how much they value these improvements in health, relative to other uses of public resources — from spending them on education and other social services to reducing taxes.

There remain many unanswered questions about U.S. health insurance policy, including how to best structure coverage to maximize health and value and how much public spending we want to devote to subsidizing coverage for people who cannot afford it. But whether enrollees benefit from that coverage is not one of the unanswered questions. Insurance coverage increases access to care and improves a wide range of health outcomes. Arguing that health insurance coverage doesn't improve health is simply inconsistent with the evidence.

Disclosure forms provided by the authors are available at NEJM.org.

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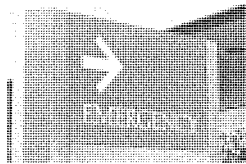
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INSURING THE UNINSURED

The Oregon Health Insurance Experiment found that covering the uninsured with Medicaid increased the use of health care, including primary care, hospitalizations, and emergency room visits; diminished financial strain; and reduced depression. There was no statistically significant impact on physical health measures, employment, or earnings.

Featuring an evaluation by principal investigators Katherine Baicker and Amy Finkelstein



The impact of extending health insurance coverage to the uninsured persists as a topic of debate in the United States, but there is limited rigorous evidence on the effects of expanding health insurance, and Medicaid in particular, on health care use, health outcomes, financial hardship, and employment.

Prevailing theories offer conflicting predictions for the impact of expanding Medicaid, the public health insurance program in the United States for low-income adults and children. For example, by reducing the costs patients face in seeking care, Medicaid may increase health-care use, improve health, and reduce financial hardship from large, out-of-pocket health expenditures. However, these effects could be negligible in magnitude if the program does not in fact afford newly insured individuals access to health-care services, or if these individuals had already been able to receive comparable cost-free services through public-health clinics or uncompensated care. In these cases, the magnitude of the expected change is uncertain.

In some cases, both the direction and the magnitude of changes caused by Medicaid are unclear. For example, expanded Medicaid coverage could either increase or decrease emergency-department use. On the one hand, by reducing the costs the patient faces for emergency-department care, expanding Medicaid could increase use and total health-care costs. On the other hand, if Medicaid increases primary-care access or improves health, expanding Medicaid could reduce emergency-department use and perhaps even total health-care costs.

In 2008, the state of Oregon expanded Medicaid coverage to a limited number of individuals selected by a lottery. This provided a rare opportunity for researchers to use the random selection of lottery winners to better examine and understand the effects of extending Medicaid to the uninsured.

Medicaid increased the use of health-care services. It increased hospitalizations, emergency-department visits, outpatient visits, prescription-drug use, and preventive-care use. Medicaid also improved access to medical-care services.

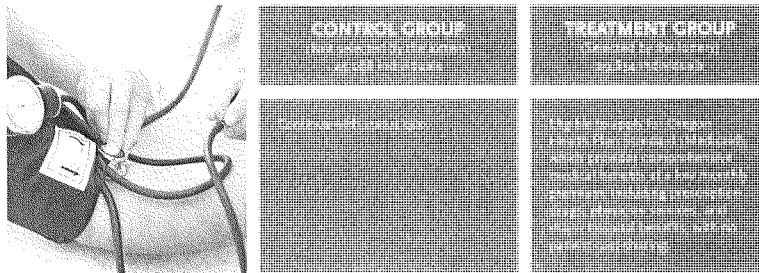
Medicaid decreased financial strain. It reduced medical debts sent to collection agencies, lowered the likelihood of borrowing money or skipping other bill payments to cover medical expenses, and virtually eliminated catastrophic out-of-pocket medical expenditures.

Medicaid improved self-reported health and reduced rates of depression, but had no statistically significant effect on physical health outcomes. Clinical measures included screenings of blood pressure, cholesterol, and glycated hemoglobin.

Medicaid had no statistically significant effect on employment or earnings.

EVALUATION

The state of Oregon offers a Medicaid expansion program for low-income, able-bodied, uninsured adults aged 19–64 years who are not eligible for other public health insurance. This program, called Oregon Health Plan Standard, had capacity for new enrollment in 2008 after being closed since 2004 due to budgetary constraints. Correctly anticipating excess demand for the available new enrollment slots, the state conducted a lottery, randomly selecting individuals from a list of those who signed up in early 2008. Lottery winners and members of their households were able to apply for Medicaid. Applicants who met the eligibility requirements¹ were then enrolled in Oregon Health Plan Standard.



The Oregon Health Insurance Experiment is a series of ongoing studies in which a team of researchers is using assignment to the program by a lottery to study the impact of this Medicaid expansion. It is the only randomized evaluation that has ever been conducted on the impact of Medicaid.

Researchers estimated the effects of expanding Medicaid coverage by comparing the outcomes of those selected by the lottery and those who were not selected, using a combination of survey and administrative data.² They collected administrative data on Medicaid enrollment, hospital and emergency-department use, credit reports, participation in other public programs, and labor-market outcomes. Researchers also conducted a mail survey about one year after the lottery, which contained information on self-reported financial strain, health, and health-care access and use. All individuals in the treatment group and a similar number of individuals in the control group were sent a survey. About two years following the lottery, researchers conducted more detailed in-person interviews and physical-health exams for a subset of about twelve thousand treatment and control group individuals in the Portland metro area. This included measurements of cholesterol, blood pressure, and glycated hemoglobin (a measurement used to diagnose and gauge control of diabetes), and screenings for depression, in addition to a catalog of medications.

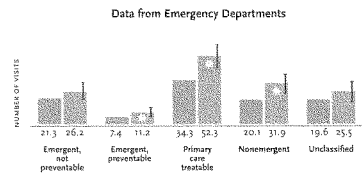
¹ Eligible candidates were 19–64 years of age, US citizens or legal immigrants, ineligible for other public health insurance (including the traditional Medicaid program available to children, the disabled, and cash welfare recipients), uninsured for the past six months, had income under 100 percent of the federal poverty level, and possessed assets of less than \$2,000. In contrast, traditional Medicaid in most states in 2008 did not cover adults with income under 100 percent of the federal poverty level who did not meet certain other eligibility criteria.

² The state of Oregon kept the barriers for signing up for the lottery low and did not screen for Medicaid eligibility at lottery sign-up. Not everyone who won the lottery ended up on Medicaid because only about 60 percent of those who won filled out the paperwork to receive Medicaid coverage, and, among this group, only about half met the eligibility requirements for Medicaid coverage. The results in the following text and figures measure the impact of Medicaid coverage by comparing the individuals who won the lottery to the individuals not selected by the lottery (the control group), under the assumption that the only reason these groups differ is because of the increased Medicaid coverage among those selected by the lottery. Because only about one-quarter of lottery winners actually ended up on Medicaid, the effect of Medicaid coverage is found by multiplying the effect of winning the lottery by approximately four.

RESULTS

Medicaid increased the use of health-care services. Administrative hospital and emergency department records showed that, over about an 18-month period, Medicaid increased the probability of hospital admission by 2.1 percentage points (a 30 percent increase relative to the control group³) and the number of emergency-department visits per person by 0.41 visits (a 40 percent increase). This included, in particular, increases in visits to the emergency department for conditions considered likely to be nonemergent and treatable by primary care (Figure 1). Survey results indicated that Medicaid also increased outpatient visits and prescription-drug use.

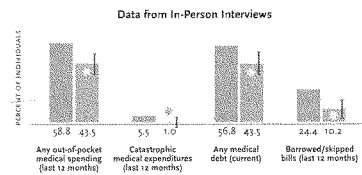
FIGURE 1: EFFECT ON EMERGENCY-DEPARTMENT USE



Medicaid increased the use of recommended preventive-care services as well. For example, Medicaid more than doubled the likelihood of mammograms for women over forty years of age. Self-reported access to and quality of care also improved with Medicaid coverage.

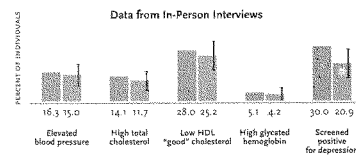
Medicaid diminished financial hardship. Medicaid reduced the likelihood of having any unpaid medical bills that were sent to collection agencies by 6.4 percentage points (a 23 percent decrease). It also reduced several other measures of financial hardship (Figure 2). Catastrophic out-of-pocket expenditures, defined as out-of-pocket medical expenditures in excess of 30 percent of household income, were nearly eliminated.

FIGURE 2: EFFECT ON FINANCIAL HARDSHIP



Medicaid reduced rates of depression and improved self-reported health, but had no statistically significant effect on physical health measures. Specifically, Medicaid did not have a statistically significant effect on measured blood pressure, cholesterol, or glycated hemoglobin (Figure 3). However, Medicaid did increase the diagnosis of diabetes and use of diabetes medication. Given limits in the sample size of diabetic people, the study was not able to rule out potential improvements in glycated hemoglobin (a measure of diabetes) one would have expected to see with the increased medication use. On the other hand, the study was able to rule out declines in blood pressure one would have expected to see based on prior quasi-experimental evaluations of the effects of Medicaid.

FIGURE 3: EFFECT ON CLINICAL MEASURES



While long-run effects may differ from those found over this two-year study period, these physical health measures were chosen explicitly because clinical trials have shown them to respond to medication within this time frame.

Medicaid reduced rates of depression by 9 percentage points (a 31 percent decrease) and increased the likelihood of self-reporting health as good, very good, or excellent (as opposed to fair or poor) by 13 percentage points (a 24 percent increase).

Medicaid had no statistically significant effect on individuals' employment or earnings. The employment rate among the control group was about 55 percent and the study was able to rule out a decline in employment due to Medicaid of greater than 4.4 percentage points or an increase greater than 1.2 percentage points.



³All reported percent changes indicate the percent increase or decrease caused by Medicaid relative to the control group.

On the one hand, numerous commentators claimed that many Medicaid patients would be better off with no health insurance because Medicaid patients have difficulty accessing care and often have worse health outcomes than the uninsured. However, this evaluation demonstrated measurable benefits: within the first one to two years, Medicaid reduced exposure to major financial risk, reduced depression, improved diabetes detection and treatment, and improved self-reported health and happiness.

While further research is needed to understand the most effective and efficient means of providing health care and insurance, these results can help inform ongoing policy discussions regarding the costs and benefits of expanding Medicaid coverage to the uninsured.

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Perspective

The Effects of Medicaid Coverage — Learning from the Oregon Experiment

Katherine Baicker, Ph.D., and Amy Finkelstein, Ph.D.

There has been much debate, especially in light of the health insurance expansions in the Affordable Care Act and the current fiscal crisis, about the costs and benefits of Medicaid. Some have

argued that Medicaid doesn't deliver much in the way of real benefits, either because it pays providers so little that beneficiaries have trouble gaining access to care, or because the low-income uninsured already have reasonable access to care through clinics, uncompensated care, emergency departments, and out-of-pocket spending. Others have argued that providing Medicaid coverage to the uninsured would reduce total health care spending by improving health and reducing inefficient use of hospitals and emergency rooms. Ultimately, the costs and benefits of Medicaid are empirical questions.

One might think that these questions would have been set-

tled with data long ago, but they are notoriously difficult to resolve.^{1,2} Comparisons of the insured and the uninsured can yield misleading results, because the two groups differ in many ways (such as income and baseline health) that are difficult to control for fully and that affect the outcomes of interest, such as health and the use of health care. For example, if less healthy people are more likely to find a way to obtain Medicaid, one might perversely conclude from comparing the health of those with and without Medicaid that Medicaid is bad for one's health.

Working with a team of researchers, we have taken advantage of an unprecedented oppor-

tunity to gauge the effects of Medicaid coverage on low-income, previously uninsured adults, using the gold standard of medical and scientific research: a randomized, controlled trial. In 2008, Oregon used a lottery to allocate a limited number of Medicaid spots for low-income adults (19 to 64 years of age) to people on a waiting list for Medicaid. Those selected by random lottery draw won the opportunity to apply for Medicaid. In total, about 30,000 people were selected from the 90,000 on the waiting list. Approximately 10,000 of those selected ended up being enrolled in Medicaid; not everyone who was selected successfully filled out the required application and met the eligibility criteria.

The lottery provides an opportunity to estimate the causal effects of being allowed to apply for Medicaid (intention to treat). It also allows us to estimate the

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causal effects of being enrolled in Medicaid relative to being uninsured (the effects of “treatment on the treated,” which we focus on below), under the assumption that selection by the lottery to be able to apply for Medicaid affects the outcomes we studied only through its role in increasing insurance coverage.

We now have evidence of the effects of the first year of Medicaid coverage after the lottery.³ These results are based on administrative data from hospital discharges, credit reports, and death records, in addition to mail surveys we conducted. We found that Medicaid coverage increases the use of health care. In particular, it raises the probability of using outpatient care by 35%, of using prescription drugs by 15%, and of hospital admission by 30%. We did not detect a statistically significant change in emergency room utilization, although our estimates were imprecise. Overall, we estimate that the increased health care use from enrollment in Medicaid translates into about a 25% increase in total annual health care expenditures.

That Medicaid increases health care use makes economic sense, since insurance reduces the price of care for the insured (in this program, there are no copayments). The increase in health care use is associated with more consistent primary care: people with Medicaid coverage were 70% more likely to report having a regular place of care and 55% more likely to report having a usual doctor; Medicaid coverage also increased the use of preventive care such as mammograms (by 60%) and cholesterol monitoring (by 20%). Although it's possible that improved efficiency

of care delivery could reduce overall spending, that does not appear to have happened in Oregon, at least in the short run.

What benefits accrue along with this increase in spending? We examined two potential benefits: financial protection and improved health and well-being. The financial protection aspects of insurance are too often overlooked in academic and public policy discussions. Just as fire insurance is designed not to prevent fires but to help financially when fire creates catastrophic financial losses, a key purpose of health insurance is to reduce the financial risk posed by catastrophic medical expenditures.

We found that Medicaid improves financial security. Medicaid reduces by 40% the probability that people report having to borrow money or skip payment on other bills because of medical expenses. Although it does not appear to reduce their risk of bankruptcy (at least in the first year), it decreases by 25% the probability that they will have unpaid medical bills that are sent to a collection agency. This effect benefits not only the insured but, since the vast majority of bills sent to a collection agency are never paid, also those who may ultimately help to finance this unpaid care, including health care providers and the public sector.

We also found that being covered by Medicaid improves self-reported health as compared with being uninsured. Medicaid enrollees are 25% more likely to indicate that they're in good, very good, or excellent health (vs. fair or poor health). They are 25% less likely to screen positive for depression. They are even 30% more likely to report that they

are pretty happy or very happy (vs. not too happy).

It's hard to tell from the current data whether objective, physical health has improved. The evidence we have to date suggests that at least some of the improvements in self-reported health probably reflect a more general sense of improved well-being and reduced stress; for example, the improvements in self-reported health start to show up after only a month of insurance coverage and before health care use has started to increase. Of course, our findings of increased health care use and increased access to care suggest that physical health may also have improved or will improve. We will know more when we have data from the second year, when we collected information on physical health measures such as blood pressure, obesity, cholesterol, and blood sugar control. (Currently our only objective health measure is mortality, on which we were unable to detect an effect.) Whether it was health or general well-being (or both) that improved, both represent potentially important benefits of Medicaid, along with the reductions in financial strain.

There are, of course, limits to the lessons that can be drawn from this experiment. For example, the results are naturally specific to the study's population, insurance plan, and health care environment. Coverage by private insurance, in different settings, or of people with very different characteristics than those who enrolled in Oregon's Medicaid program might have very different effects. Moreover, the Oregon lottery insured only 10,000 adults. The system-level effects of insuring millions of people at once, including strain on the provider

network and any changes in the delivery of care, might be quite different. In addition, our current results cover only the effects of the first year of insurance coverage. The long-run costs and benefits of Medicaid coverage may well be different.

That said, we believe that these results provide the best evidence to date on the effects of Medicaid expansions. Our results cast considerable doubt on both the optimistic view that Medicaid can reduce health care spending, at least in the short run, and the

pessimistic view that Medicaid coverage won't make a difference to the uninsured. We expect ongoing data collection to provide even more information about the longer-run costs and benefits of Medicaid coverage.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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SPECIAL ARTICLE

The Oregon Experiment — Effects of Medicaid on Clinical Outcomes

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Mira Bernstein, Ph.D., Jonathan H. Gruber, Ph.D., Joseph P. Newhouse, Ph.D.,
Eric C. Schneider, M.D., Bill J. Wright, Ph.D., Alan M. Zaslavsky, Ph.D.,
and Amy N. Finkelstein, Ph.D., for the Oregon Health Study Group*

ABSTRACT

BACKGROUND

Despite the imminent expansion of Medicaid coverage for low-income adults, the effects of expanding coverage are unclear. The 2008 Medicaid expansion in Oregon based on lottery drawings from a waiting list provided an opportunity to evaluate these effects.

METHODS

Approximately 2 years after the lottery, we obtained data from 6387 adults who were randomly selected to be able to apply for Medicaid coverage and 5842 adults who were not selected. Measures included blood-pressure, cholesterol, and glycated hemoglobin levels; screening for depression; medication inventories; and self-reported diagnoses, health status, health care utilization, and out-of-pocket spending for such services. We used the random assignment in the lottery to calculate the effect of Medicaid coverage.

RESULTS

We found no significant effect of Medicaid coverage on the prevalence or diagnosis of hypertension or high cholesterol levels or on the use of medication for these conditions. Medicaid coverage significantly increased the probability of a diagnosis of diabetes and the use of diabetes medication, but we observed no significant effect on average glycated hemoglobin levels or on the percentage of participants with levels of 6.5% or higher. Medicaid coverage decreased the probability of a positive screening for depression (−9.15 percentage points; 95% confidence interval, −16.70 to −1.60; $P=0.02$), increased the use of many preventive services, and nearly eliminated catastrophic out-of-pocket medical expenditures.

CONCLUSIONS

This randomized, controlled study showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.

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*Members of the Oregon Health Study Group are listed in the Supplementary Appendix, available at NEJM.org.

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IN 2008, OREGON INITIATED A LIMITED expansion of its Medicaid program for low-income adults through a lottery drawing of approximately 30,000 names from a waiting list of almost 90,000 persons. Selected adults won the opportunity to apply for Medicaid and to enroll if they met eligibility requirements. This lottery presented an opportunity to study the effects of Medicaid with the use of random assignment. Earlier, nonrandomized studies sought to investigate the effect of Medicaid on health outcomes in adults with the use of quasi-experimental approaches.¹⁻³ Although these approaches can be an improvement over observational designs and often involve larger samples than are feasible with a randomized design, they cannot eliminate confounding factors as effectively as random assignment. We used the random assignment embedded in the Oregon Medicaid lottery to examine the effects of insurance coverage on health care use and health outcomes after approximately 2 years.

METHODS

RANDOMIZATION AND INTERVENTION

Oregon Health Plan Standard is a Medicaid program for low-income, uninsured, able-bodied adults who are not eligible for other public insurance in Oregon (e.g., Medicare for persons 65 years of age or older and for disabled persons; the Children's Health Insurance Program for poor children; or Medicaid for poor children, pregnant women, or other specific, categorically eligible populations). Oregon Health Plan Standard closed to new enrollment in 2004, but the state opened a new waiting list in early 2008 and then conducted eight random lottery drawings from the list between March and September of that year to allocate a limited number of spots.

Persons who were selected won the opportunity — for themselves and any household member — to apply for Oregon Health Plan Standard. To be eligible, persons had to be 19 to 64 years of age and Oregon residents who were U.S. citizens or legal immigrants; they had to be ineligible for other public insurance and uninsured for the previous 6 months, with an income that was below 100% of the federal poverty level and assets of less than \$2,000. Persons who were randomly selected in the lottery were sent an application. Those who completed it and met the eligibility criteria were enrolled in the plan. Oregon Health

Plan Standard provides comprehensive medical benefits, including prescription drugs, with no patient cost-sharing and low monthly premiums (\$0 to \$20, based on income), mostly through managed-care organizations. The lottery process and Oregon Health Plan Standard are described in more detail elsewhere.⁴

DATA COLLECTION

We used an in-person data-collection protocol to assess a wide variety of outcomes. We limited data collection to the Portland, Oregon, metropolitan area because of logistical constraints. Our study population included 20,745 people: 10,405 selected in the lottery (the lottery winners) and 10,340 not selected (the control group). We conducted interviews between September 2009 and December 2010. The interviews took place an average of 25 months after the lottery began.

Our data-collection protocol included detailed questionnaires on health care, health status, and insurance coverage; an inventory of medications; and performance of anthropometric and blood-pressure measurements. Dried blood spots were also obtained.⁵ Depression was assessed with the use of the eight-question version of the Patient Health Questionnaire (PHQ-8),⁶ and self-reported health-related quality of life was assessed with the use of the Medical Outcomes Study 8-Item Short-Form Survey.⁷ More information on recruitment and field-collection protocols are included in the study protocol (available with the full text of this article at NEJM.org); more information on specific outcome measures is provided in the Supplementary Appendix (available at NEJM.org). Multiple institutional review boards approved the study, and written informed consent was obtained from all participants.

STATISTICAL ANALYSIS

Virtually all the analyses reported here were prespecified and publicly archived (see the protocol).⁸ Prespecification was designed to minimize issues of data and specification mining and to provide a record of the full set of planned analyses. The results of a few additional post hoc analyses are also presented and are noted as such in Tables 1 through 5. Analyses were performed with the use of Stata software, version 12.⁹

Adults randomly selected in the lottery were given the option to apply for Medicaid, but not all persons selected by the lottery enrolled in

Medicaid (either because they did not apply or because they were deemed ineligible). Lottery selection increased the probability of Medicaid coverage during our study period by 24.1 percentage points (95% confidence interval [CI], 22.3 to 25.9; $P<0.001$). The subgroup of lottery winners who ultimately enrolled in Medicaid was not comparable to the overall group of persons who did not win the lottery. We therefore used a standard instrumental-variable approach (in which lottery selection was the instrument for Medicaid coverage) to estimate the causal effect of enrollment in Medicaid. Intuitively, since the lottery increased the chance of being enrolled in Medicaid by about 25 percentage points, and we assumed that the lottery affected outcomes only by changing Medicaid enrollment, the effect of being enrolled in Medicaid was simply about 4 times (i.e., 1 divided by 0.25) as high as the effect of being able to apply for Medicaid. This yielded a causal estimate of the effect of insurance coverage.¹⁰ (See the Supplementary Appendix for additional details.)

All analyses were adjusted for the number of household members on the lottery list because selection was random, conditional on household size. Standard errors were clustered according to household to account for intrahousehold correlation. We fitted linear probability models for binary outcomes. As sensitivity checks, we showed that our results were robust when the average marginal effects from logistic regressions for binary outcomes were estimated and when demographic characteristics were included as covariates (see the Supplementary Appendix). All analyses were weighted for the sampling and field-collection design; construction of the weights is detailed in the Supplementary Appendix.

RESULTS

STUDY POPULATION

Characteristics of the respondents are shown in Table 1. A total of 12,229 persons in the study sample responded to the survey, for an effective response rate of 73%. There were no significant differences between those selected in the lottery and those not selected with respect to the response rates to either the full survey (0.28 percentage points higher in the group selected in the lottery, $P=0.86$) or specific survey measures, each of which had a response rate of at least 97% among people who completed any part of the survey. Just over

Table 1. Characteristics of the 12,229 Survey Respondents.*

Characteristic	Controls (N=5842)	Lottery Winners (N=6387)†	P Value
	percent		
Female sex	56.9	56.4	0.60
Age group‡			
19–34 yr	36.0	35.1	0.38
35–49 yr	36.4	36.6	0.87
50–64 yr	27.6	28.3	0.43
Race or ethnic group§			
Non-Hispanic			
White	68.8	69.2	0.68
Black	10.5	10.6	0.82
Other	14.8	14.8	0.97
Hispanic	17.2	17.0	0.82
Interview conducted in English	88.2	88.5	0.74

* Values for the control group (persons not selected in the lottery) are weighted means, and values for the lottery-winner group are regression-adjusted weighted means. P values are for two-tailed t-tests of the equality of the two means.

† Lottery winners were adults who were randomly selected in the lottery to be able to apply for Medicaid coverage.

‡ The data on age are for the age of the respondent at the time of the in-person interview. The study sample was restricted to persons who were between 19 and 64 years of age during the study period.

§ Race and ethnic group were self-reported. The categories of non-Hispanic race (white, black, and other) were not mutually exclusive; respondents could report as many races or ethnic groups as they wished.

half the participants were women, about a quarter were 50 to 64 years of age (the oldest eligible age group), and about 70% were non-Hispanic white. There were no significant differences between those selected in the lottery and those not selected with respect to these characteristics (F statistic, 0.20; $P=0.99$) or to the wide variety of prerandomization and interview characteristics examined (see the Supplementary Appendix).

CLINICAL MEASURES AND HEALTH OUTCOMES

Table 2 shows estimated effects of Medicaid coverage on blood-pressure, total and high-density lipoprotein (HDL) cholesterol, and glycated hemoglobin levels and depression. In the control group, 30% of the survey respondents had positive screening results for depression, and we detected elevated blood pressure in 16%, a high total cholesterol level in 14%, and a glycated hemoglobin level of 6.5% or more (a diagnostic criterion for

diabetes) in 5%. Medicaid coverage did not have a significant effect on measures of blood pressure, cholesterol, or glycated hemoglobin. Further analyses involving two prespecified subgroups — persons 50 to 64 years of age and those who reported receiving a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery (all of which were balanced across the two study groups) — showed similar results (see the Supplementary Appendix).

The predicted 10-year risk of cardiovascular events was measured with the use of the Framingham risk score, which estimates risk among persons older than 30 years of age according to sex, age, levels of total cholesterol and HDL cholesterol, blood pressure and use or nonuse of blood-pressure medication, status with respect to diabetes, and smoking status, with the predicted risk of a cardiovascular event within 10 years ranging from less than 1% to 30%.¹¹ The

10-year predicted risk did not change significantly with Medicaid coverage (−0.21 percentage points; 95% CI, −1.56 to 1.15; $P=0.76$).

We investigated whether Medicaid coverage affected the diagnosis of and use of medication for hypertension, hypercholesterolemia, or diabetes. Table 2 shows diagnoses after the lottery and current medication use. We found no effect of Medicaid coverage on diagnoses after the lottery or on the use of medication for blood-pressure and high cholesterol levels. We did, however, find a greater probability of receiving a diagnosis of diabetes (3.83 percentage points; 95% CI, 1.93 to 5.73; $P<0.001$) and using medications for diabetes (5.43 percentage points; 95% CI, 1.39 to 9.48; $P=0.008$). These are substantial increases from the mean rates of diagnosis and medication use in the control group (1.1% and 6.4%, respectively).

A positive result on screening for depression was defined as a score of 10 or more on the PHQ-8 (which ranges from 0 to 24, with higher

Table 2. Mean Values and Absolute Change in Clinical Measures and Health Outcomes with Medicaid Coverage.*

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI)†	P Value
Blood pressure			
Systolic (mm Hg)	119.3±16.9	−0.52 (−2.97 to 1.93)	0.68
Diastolic (mm Hg)	76.0±12.1	−0.81 (−2.65 to 1.04)	0.39
Elevated (%)‡	16.3	−1.33 (−7.16 to 4.49)	0.65
Hypertension			
Diagnosis after lottery (%)§¶	5.6	1.76 (−1.89 to 5.40)	0.34
Current use of medication for hypertension (%)§	13.9	0.66 (−4.48 to 5.80)	0.80
Cholesterol**			
Total level (mg/dl)	204.1±34.0	2.20 (−3.44 to 7.84)	0.45
High total level (%)	14.1	−2.43 (−7.75 to 2.89)	0.37
HDL level (mg/dl)	47.6±13.1	0.83 (−1.31 to 2.98)	0.45
Low HDL level (%)	28.0	−2.82 (−10.28 to 4.64)	0.46
Hypercholesterolemia			
Diagnosis after lottery (%)§¶	6.1	2.39 (−1.52 to 6.29)	0.23
Current use of medication for high cholesterol level (%)§	8.5	3.80 (−0.75 to 8.35)	0.10
Glycated hemoglobin			
Level (%)	5.3±0.6	0.01 (−0.09 to 0.11)	0.82
Level ≥6.5% (%)‡††	5.1	−0.93 (−4.44 to 2.59)	0.61
Diabetes			
Diagnosis after lottery (%)§¶	1.1	3.83 (1.93 to 5.73)	<0.001
Current use of medication for diabetes (%)§	6.4	5.43 (1.39 to 9.48)	0.008

Table 2. (Continued.)

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI) [†]	P Value
Depression			
Positive screening result (%) ^{‡,§}	30.0	-9.15 (-16.70 to -1.60)	0.02
Diagnosis after lottery (%) ^{§¶}	4.8	3.81 (0.15 to 7.46)	0.04
Current use of medication for depression (%) ^{§§}	16.8	5.49 (-0.46 to 11.45)	0.07
Framingham risk score (%) ^{§§}			
Overall	8.2±7.5	-0.21 (-1.56 to 1.15)	0.76
High-risk diagnosis	11.6±8.3	1.63 (-1.11 to 4.37)	0.24
Age of 50–64 yr	13.9±8.2	-0.37 (-2.64 to 1.90)	0.75

* Plus-minus values are weighted means ±SD. Where means are shown without standard deviations, they are weighted means. The effect of Medicaid coverage was estimated with the use of two-stage least-squares instrumental-variable regression. All regressions include indicators for the number of household members on the lottery list, and all standard errors were "clustered," or adjusted to allow for arbitrary correction of error terms within households. For the blood-pressure measures, all regressions also included controls for age (with dummies for age decile) and sex. All analyses were weighted with the use of survey weights. The sample size was all 12,229 survey respondents for all measures except for the Framingham risk score. HDL denotes high-density lipoprotein.

† For variables measured as percentages, the change is expressed as percentage points.

‡ Elevated blood pressure was defined as a systolic pressure of 140 mm Hg or more and a diastolic pressure of 90 mm Hg or more.

§ This analysis was not prespecified.

¶ A participant was considered to have received a diagnosis of a certain condition after the lottery if he or she reported a first diagnosis after March 2008 (the start of the lottery). A participant who received a diagnosis before March 2008 was not considered to have a diagnosis after the lottery.

§§ A participant was considered to have received medication for the condition if one or more of the medications recorded during the interview was classified as relevant for that condition.

** A high total cholesterol level was defined as 240 mg per deciliter (6.2 mmol per liter) or higher. A low HDL cholesterol level was defined as less than 40 mg per deciliter (1.03 mmol per liter). There was no separate measurement of low-density lipoprotein cholesterol.

†† A glycated hemoglobin level of 6.5% or higher is a diagnostic criterion for diabetes.

‡‡ A positive result on screening for depression was defined as a score of 10 or higher on the Patient Health Questionnaire 8 (PHQ-8). Scores on the PHQ-8 range from 0 to 24, with higher scores indicating more symptoms of depression.

§§§ The Framingham risk score was used to predict the 10-year cardiovascular risk. Risk scores were calculated separately for men and women on the basis of the following variables: age, total cholesterol and HDL cholesterol levels, measured blood pressure and use or nonuse of medication for high blood pressure, current smoking status, and status with respect to a glycated hemoglobin level ≥6.5%. Framingham risk scores, which are calculated for persons 30 years of age or older, range from 0.99 to 30%. Samples sizes for risk scores were 9525 participants overall, 3099 participants with high-risk diagnoses, and 3372 participants with an age of 50 to 64 years. A high-risk diagnosis was defined as a diagnosis of diabetes, hypertension, hypercholesterolemia, myocardial infarction, or congestive heart failure before the lottery (i.e., before March 2008).

scores indicating more symptoms of depression). Medicaid coverage resulted in an absolute decrease in the rate of depression of 9.15 percentage points (95% CI, -16.7 to -1.60; $P=0.02$), representing a relative reduction of 30%. Although there was no significant increase in the use of medication for depression, Medicaid coverage led to an absolute increase in the probability of receiving a diagnosis of depression after the lottery of 3.81 percentage points (95% CI, 0.15 to 7.46; $P=0.04$), representing a relative increase of about 80%.

HEALTH-RELATED QUALITY OF LIFE AND HAPPINESS

Table 3 shows the effects of Medicaid coverage on health-related quality of life and level of happiness. Medicaid coverage led to an increase in the proportion of people who reported that their health was the same or better as compared with their health 1 year previously (7.84 percentage points; 95% CI, 1.45 to 14.23; $P=0.02$). The physical-component and mental-component scores of the health-related quality of life measure are based on different weighted combinations of the eight-question battery; each ranges from 0 to 100,

Table 3. Mean Values and Absolute Change in Health-Related Quality of Life and Happiness with Medicaid Coverage.^a

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI) [†]	P Value
Health-related quality of life			
Health same or better vs. 1 yr earlier (%)	80.4	7.84 (1.45 to 14.23)	0.02
SF-8 subscale [‡]			
Mental-component score	44.4±11.4	1.95 (0.03 to 3.88)	0.05
Physical-component score	45.5±10.5	1.20 (-0.54 to 2.93)	0.18
No pain or very mild pain (%)	56.4	1.16 (-6.94 to 9.26)	0.78
Very happy or pretty happy (%)	74.9	1.18 (-5.85 to 8.21)	0.74

^a Plus-minus values are weighted means ±SD. Where means are shown without standard deviations, they are weighted means. The effect of Medicaid coverage was estimated with the use of two-stage least-squares instrumental-variable regression. All regressions included indicators for the number of household members on the lottery list, and all standard errors were clustered on household. All analyses were weighted with the use of survey weights. The sample was all 12,229 survey respondents.

[†] For variables measured as percentages, the change is expressed as percentage points.

[‡] Scores on the Medical Outcomes Study 8-Item Short-Form Health Survey (SF-8) range from 0 to 100, with higher subscale scores indicating better self-reported health-related quality of life. The scale is normalized to yield a mean of 50 and a standard deviation of 10 in the general U.S. population.

with higher scores corresponding to better health-related quality of life. Medicaid coverage led to an increase of 1.95 points (95% CI, 0.03 to 3.88; $P=0.05$) in the average score on the mental component; the magnitude of improvement was approximately one fifth of the standard deviation of the mental-component score. We did not detect a significant difference in the quality of life related to physical health or in self-reported levels of pain or happiness.

FINANCIAL HARDSHIP

Table 4 shows that Medicaid coverage led to a reduction in financial strain from medical costs, according to a number of self-reported measures. In particular, catastrophic expenditures, defined as out-of-pocket medical expenses exceeding 30% of income, were nearly eliminated. These expenditures decreased by 4.48 percentage points (95% CI, -8.26 to -0.69; $P=0.02$), a relative reduction of more than 80%.

ADDITIONAL OUTCOMES

Table 5 shows the effects of Medicaid coverage on health care utilization, spending on health care, preventive care, access to and quality of care, smoking status, and obesity. Medicaid coverage resulted in an increase in the number of prescription drugs received and office visits made in the previous year; we did not find significant changes in visits to the emergency department or hos-

pital admissions. We estimated that Medicaid coverage increased annual medical spending (based on measured use of prescription drugs, office visits, visits to the emergency department, and hospital admissions) by \$1,172, or about 35% relative to the spending in the control group. Medicaid coverage also led to increases in some preventive care and screening services, including cholesterol screening (an increase of 14.57 percentage points; 95% CI, 7.09 to 22.04; $P<0.001$) and improved perceived access to care, including a usual place of care (an increase of 23.75 percentage points; 95% CI, 15.44 to 32.06; $P<0.001$). We found no significant effect of Medicaid coverage on the probability that a person was a smoker or obese.

DISCUSSION

This study was based on more than 12,000 in-person interviews conducted approximately 2 years after a lottery that randomly assigned access to Medicaid for low-income, able-bodied, uninsured adults — a group that comprises the majority of persons who are newly eligible for Medicaid under the 2014 expansion.¹² The results confirm that Medicaid coverage increased overall health care utilization, improved self-reported health, and reduced financial strain; these findings are consistent with previously published results based on mail surveys conducted approximately 1 year af-

Table 4. Mean Values and Absolute Change in Financial Hardship with Medicaid Coverage.*

Variable	Mean Value in Control Group	Change with Medicaid Coverage [95% CI]†	P Value
Any out-of-pocket spending (%)	58.8	-15.30 (-23.28 to -7.32)	<0.001
Amount of out-of-pocket spending (\$)	552.8±1219.5	-215.35 (-408.75 to -21.95)	0.03
Catastrophic expenditures (%)‡	5.5	-4.48 (-8.26 to -0.69)	0.02
Any medical debt (%)	56.8	-13.28 (-21.59 to -4.96)	0.002
Borrowed money to pay bills or skipped payment (%)	24.4	-14.22 (-21.02 to -7.43)	<0.001

* Plus-minus values are weighted means ±SD. Where means are shown without standard deviations, they are weighted means. The effect of Medicaid coverage was estimated with the use of two-stage least-squares instrumental-variable regression. All regressions include indicators for the number of household members on the lottery list, and all standard errors were clustered on household. All analyses were weighted with the use of survey weights. The sample was all 12,229 survey respondents.

† For variables measured as percentages, the change is expressed as percentage points.

‡ Persons with catastrophic expenditures had out-of-pocket medical expenses that exceeded 30% of their household income.

ter the lottery.⁴ With these new data, we found that increased health care utilization observed at 1 year persisted, and we present new results on the effects of Medicaid coverage on objectively measured physical health, depression, condition-specific treatments, and other outcomes of interest.

Medicaid coverage had no significant effect on the prevalence or diagnosis of hypertension or high cholesterol levels or on the use of medication for these conditions. It increased the probability of a diagnosis of diabetes and the use of medication for diabetes, but it had no significant effect on the prevalence of measured glycated hemoglobin levels of 6.5% or higher. Medicaid coverage led to a substantial reduction in the risk of a positive screening result for depression. This pattern of findings with respect to clinically measured health — an improvement in mental health but not in physical health (Table 2) — was mirrored in the self-reported health measures, with improvements concentrated in mental rather than physical health (Table 3). The improvements appear to be specific to depression and mental health measures; Medicaid coverage did not appear to lead to an increase in self-reported happiness, which is arguably a more general measure of overall subjective well-being.

Hypertension, high cholesterol levels, diabetes, and depression are only a subgroup of the set of health outcomes potentially affected by Medicaid coverage. We chose these conditions because they are important contributors to morbidity and mortality, feasible to measure, prevalent in the low-income population in our study, and plausibly modifiable by effective treatment within a

2-year time frame.¹³⁻¹⁶ Nonetheless, our power to detect changes in health was limited by the relatively small numbers of patients with these conditions; indeed, the only condition in which we detected improvements was depression, which was by far the most prevalent of the four conditions examined. The 95% confidence intervals for many of the estimates of effects on individual physical health measures were wide enough to include changes that would be considered clinically significant — such as a 7.16-percentage-point reduction in the prevalence of hypertension. Moreover, although we did not find a significant change in glycated hemoglobin levels, the point estimate of the decrease we observed is consistent with that which would be expected on the basis of our estimated increase in the use of medication for diabetes. The clinical-trial literature indicates that the use of oral medication for diabetes reduces the glycated hemoglobin level by an average of 1 percentage point within as short a time as 6 months.¹⁵ This estimate from the clinical literature suggests that the 5.4-percentage-point increase in the use of medication for diabetes in our cohort would decrease the average glycated hemoglobin level in the study population by 0.05 percentage points, which is well within our 95% confidence interval. Beyond issues of power, the effects of Medicaid coverage may be limited by the multiple sources of slippage in the connection between insurance coverage and observable improvements in our health metrics; these potential sources of slippage include access to care, diagnosis of underlying conditions, prescription of appropriate med-

Table 5. Mean Values and Absolute Change in Health Care Utilization and Spending, Preventive Care, Access to and Quality of Care, and Smoking and Obesity with Medicaid Coverage.*

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI) [†]	P Value
Utilization (no. of visits or medications)			
Current prescription drugs	1.8±2.8	0.66 (0.21 to 1.11)	0.004
Office visits in past 12 mo	5.5±11.6	2.70 (0.91 to 4.49)	0.003
Outpatient surgery in past 12 mo	0.1±0.4	0.03 (−0.03 to 0.09)	0.28
Emergency department visits in past 12 mo	1.0±2.0	0.09 (−0.23 to 0.42)	0.57
Hospital admissions in past 12 mo	0.2±0.6	0.07 (−0.03 to 0.17)	0.17
Estimate of annual health care spending (\$)‡	3,257.3	1,171.63 (199.35 to 2,143.91)	0.018
Preventive care in past 12 mo (%)			
Cholesterol-level screening	27.2	14.57 (7.09 to 22.04)	<0.001
Fecal occult-blood test in persons ≥50 yr	19.1	1.26 (−9.44 to 11.96)	0.82
Colonoscopy in persons ≥50 yr	10.4	4.19 (−4.25 to 12.62)	0.33
Flu shot in persons ≥50 yr	35.5	−5.74 (−19.31 to 7.83)	0.41
Papanicolaou smear in women	44.9	14.44 (2.64 to 26.24)	0.016
Mammography in women ≥50 yr	28.9	29.67 (11.96 to 47.37)	0.001
PSA test in men ≥50 yr	21.4	19.18 (1.14 to 37.21)	0.037
Perceived access to and quality of care (%)			
Had a usual place of care	46.1	23.75 (15.44 to 32.06)	<0.001
Received all needed care in past 12 mo	61.0	11.43 (3.62 to 19.24)	0.004
Care was of high quality, if received, in past 12 mo	78.4	9.85 (2.71 to 17.00)	0.007
Smoking status and obesity (%)			
Current smoker	42.8	5.58 (−2.54 to 13.70)	0.18
Obese	41.5	0.39 (−7.89 to 8.67)	0.93

* Plus-minus values are weighted means ±SD. Where means are shown without standard deviations, they are weighted means. The effect of Medicaid coverage was estimated with the use of two-stage least-squares instrumental-variable regression. All regressions include indicators for the number of household members on the lottery list, and all standard errors were clustered on household. All analyses were weighted with the use of survey weights. The sample size was all 12,229 survey respondents. For some prevention measures, the sample was limited to the 3374 survey respondents who were at least 50 years of age, the 1864 female survey respondents who were at least 50 years of age, or the 1509 male survey respondents who were at least 50 years of age. The sample for quality of care was limited to the 9694 survey respondents who received care in the previous 12 months. PSA denotes prostate-specific antigen.

† For variables measured as percentages, the change is expressed as percentage points.

‡ Annual spending was calculated by multiplying the numbers of prescription drugs, office visits, visits to the emergency department, and hospital admissions by the estimated cost of each. See the Supplementary Appendix for details.

ications, compliance with recommendations, and effectiveness of treatment in improving health.¹⁷

Anticipating limitations in statistical power, we prespecified analyses of subgroups in which effects might be stronger, including the near-elderly and persons who reported having received a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery. We did not find significant changes in any of these subgroups. To try to improve statistical power, we used the

Framingham risk score as a summary measure. This allowed us to reject a decrease of more than 20% in the predicted 10-year cardiovascular risk or a decrease of more than 10% in predicted risk among the participants with high-risk diagnoses before the lottery. Our results were thus consistent with at best limited improvements in these particular dimensions of physical health over this time period, in contrast with the substantial improvement in mental health.

Although changes in health status are of great

interest, they are not the only important potential benefit of expanded health insurance coverage. Health insurance is a financial product that is aimed at providing financial security by protecting people from catastrophic health care expenses if they become injured or sick (and ensuring that the providers who see them are paid). In our study, Medicaid coverage almost completely eliminated catastrophic out-of-pocket medical expenditures.

Our estimates of the effect of Medicaid coverage on health, health care utilization, and financial strain apply to able-bodied, uninsured adults with incomes below 100% of the federal poverty level who express interest in insurance coverage — a population of considerable interest for health care policy, given the planned expansion of Medicaid. The Patient Protection and Affordable Care Act of 2010 allows states to extend Medicaid eligibility to all adults with incomes of up to 138% of the federal poverty level. However, there are several important limits to the generalizability of our findings. First, the low-income uninsured population in Oregon differs from the overall population in the United States in some respects, such as the proportions of persons who are members of racial and ethnic minority groups. Second, our estimates speak to the effect of Medicaid coverage on the subgroup of people who signed up for the lottery and for whom winning the lottery affected their coverage status; in the Supplementary Appendix we provide some additional details on the characteristics of this group. Medicaid coverage may have different effects for persons who seek insurance through the lottery than for the general population affected by coverage mandates. For example, persons who signed up for the lottery may have expected a greater health benefit from insurance coverage than those who did not sign up. Of course, most estimates suggest imperfect (and selective) Medicaid take-up rates even under man-

dates.³⁸ Third, the newly insured participants in our study constituted a small share of all uninsured Oregon residents, limiting the system-level effects that insuring them might generate, such as strains on provider capacity or investment in infrastructure. Fourth, we examined outcomes in people who gained an average of 17 months of coverage (those insured through the lottery were not necessarily covered for the entire study period); the effects of insurance in the longer run may differ.

Despite these limitations, our study provides evidence of the effects of expanding Medicaid to low-income adults on the basis of a randomized design, which is rarely available in the evaluation of social insurance programs. We found that insurance led to increased access to and utilization of health care, substantial improvements in mental health, and reductions in financial strain, but we did not observe reductions in measured blood-pressure, cholesterol, or glycated hemoglobin levels.

The findings and conclusions expressed in this article are solely those of the authors and do not necessarily represent the views of the funders.

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The NEW ENGLAND JOURNAL of MEDICINE

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Effect of Medicaid Coverage on ED Use — Further Evidence from Oregon's Experiment

Amy N. Finkelstein, Ph.D., Sarah L. Taubman, Ph.D., Heidi L. Allen, Ph.D., Bill J. Wright, Ph.D., and Katherine Baicker, Ph.D.

The effect of Medicaid coverage on health and the use of health care services is of first-order policy importance, particularly as policymakers consider expansions of public health insurance.

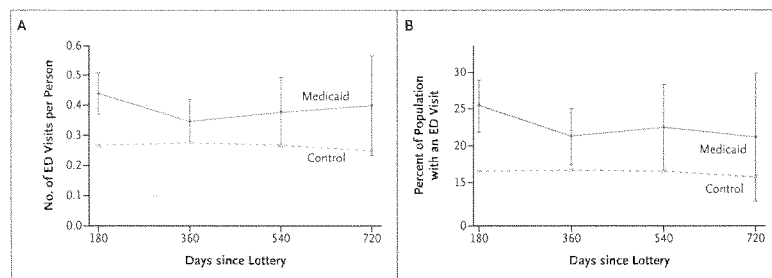
Estimating the effects of expanding Medicaid is challenging, however, because Medicaid enrollees and the uninsured differ in many ways that may also affect outcomes of interest. Oregon's 2008 expansion of Medicaid through random-lottery selection of potential enrollees from a waiting list offers the opportunity to assess Medicaid's effects with a randomized evaluation that is not contaminated by such confounding factors. In a previous examination of the Oregon Health Insurance Experiment, we found that Medicaid coverage increased health care use across a range of settings, improved financial security, and reduced rates of depression among enrollees, but it produced no detectable changes in several mea-

sures of physical health, employment rates, or earnings.^{1,4}

A key finding was that Medicaid increased emergency department (ED) visits by 40% in the first 15 months after people won the lottery.³ This finding was greeted with considerable attention and surprise, given the widespread belief that expanding Medicaid coverage to more uninsured people would encourage the use of primary care and thereby reduce ED use. Many observers speculated that the increase in ED use would abate over time as the newly insured found alternative sites of care or as their health needs were addressed and their health improved. One commentator, for example, raised the question, "But why did these patients

go to the ED and not to a primary care office?" He hypothesized that "Despite the earlier finding that coverage increased outpatient use, many of these newly insured patients probably had not yet established relationships with primary care physicians. If so, the excess ED use will attenuate with time."⁵

We have now analyzed additional data in order to address these questions: Does the increase in ED use caused by Medicaid coverage represent a short-term effect that is likely to dissipate over time? And does Medicaid coverage encourage the newly insured to substitute physician office visits for ED visits? We used the lottery to implement a randomized, controlled evaluation of the causal effect of Medicaid coverage on health care use, applying a standard instrumental variables approach. More detail on the lottery, data, and methods is available elsewhere¹⁻³ as well as in the Supplementary Appendix



Estimated Effect of Medicaid Coverage on ED Use over Time.

Emergency department (ED) discharge data from January 2007 through September 2010 for the 12 EDs in the Portland area were probabilistically matched to lottery-list members. There were 24,646 lottery-list members living in the catchment area comprehensively covered by these EDs. Error bars indicate 95% confidence intervals. See the Supplementary Appendix for details. The "Medicaid" line is the mean in the control group plus the estimated effect of Medicaid coverage from the two-stage least-squares regression analysis described in the Supplementary Appendix.

(available at NEJM.org), which also provides additional results.

Extending our ED administrative data by a year to span the 2007–2010 period, we analyzed the pattern of the effect of Medicaid coverage on ED use over a 2-year period after the 2008 lottery. The graphs show the effect of Medicaid coverage over time — both in terms of the mean number of ED visits per person (Panel A) and whether a person had any ED visits (Panel B) — measured separately for the four 6-month periods after lottery notification. There is no statistical or substantive evidence of any time pattern in the effect on ED use on either variable. Medicaid coverage increased the mean number of ED visits per person by 0.17 (standard error, 0.04) over the first 6 months or about 65% relative to the mean in the control group of individuals not selected in the lottery; over the subsequent three 6-month periods, the point estimates are similar and, for the most part, statistically indistinguishable from each other. For example, we cannot reject ($P=0.80$) the hypothesis that the 0.17 in-

crease in ED visits attributable to Medicaid coverage in the first 6 months is the same as the 0.15 increase in visits in months 18 to 24. Thus, using another year of ED data, we found no evidence that the increase in ED use due to Medicaid coverage is driven by pent-up demand that dissipates over time; the effect on ED use appears to persist over the first 2 years of coverage. We repeated a similar analysis for hospital admissions and once again found no evidence of any time patterns in the effects of Medicaid coverage over the first 2 years (see the Supplementary Appendix for details).

In our previous work, we found that Medicaid increased both physician office visits and ED use.^{1,3} To investigate whether Medicaid coverage affects the relationship between office visits and ED use, we analyzed data on annual office visits from our 2010 in-person survey, combined with administrative records on ED use for the same people over the same 12-month look-back period. We estimated that Medicaid coverage increased the joint probability of a person's having both an ED visit and an

office visit by 13.2 percentage points (standard error, 3.5).

We estimated separately the effect of Medicaid coverage on whether the person had an office visit and whether he or she had an ED visit; we used these estimates, together with Bayes' rule, to predict the effect that Medicaid coverage would have on the joint probability of having both types of visits if the increases in the two types of visits were independent of each other. The predicted increase in the joint probability under the assumption of independence is 9.9 percentage points (standard error, 3.5), which is less than the estimate of the actual increase in the joint probability. We thus found no evidence that Medicaid coverage makes use of the physician's office and use of the ED more substitutable for one another. If anything, the results suggest that it makes them complementary.

One possible reason for this finding is that the type of people who use more care when they gain Medicaid coverage are likely to increase use across multiple settings, including both the ED and

the physician's office. Another possible reason is that by increasing the use of primary care, Medicaid coverage may end up driving greater use of emergency care. For example, primary care providers may sometimes encourage patients to seek such care. One study participant we interviewed told us, "I went to the doctor's office one time and they said, no, you need to go to the ER because your blood sugar is way too high. It's going to take us hours to get it down. So you need to go to the ER."

For policymakers deliberating about Medicaid expansions, our results, which draw on the strength of a randomized, controlled design, suggest that newly insured

people will most likely use more health care across settings — including the ED and the hospital — for at least 2 years and that expanded coverage is unlikely to drive substantial substitution of office visits for ED use.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Economics (A.N.F.) and the Abdul Latif Jameel Poverty Action Lab (J-PAL) (A.N.F., K.B.), Massachusetts Institute of Technology (A.N.F.), and the National Bureau of Economic Research (A.N.F., S.L.T., K.B.), Cambridge, and the Department of Health Policy and Management, Harvard T.H. Chan School of Public Health, Boston (K.B.) — all in Massachusetts; Columbia University School of Social Work, New York (H.L.A.); and Providence Health and Services, Portland, OR (B.J.W.).

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The United States and Cuba — Turning Enemies into Partners for Health

C. William Keck, M.D., M.P.H.

In June 2016, the U.S. Department of Health and Human Services (HHS) and Cuba's Ministry of Public Health signed an umbrella accord that promises to make health a cornerstone of the new era of cooperation between the two countries. The memorandum of understanding (MOU), signed by HHS Secretary Sylvia Mathews Burwell and Minister Roberto Morales Ojeda, is the latest expression of goodwill since the December 2014 rapprochement that renewed diplomatic relations and reopened embassies in Washington and Havana. According to the HHS announcement, the MOU "establishes coordination across a broad spectrum of public health issues, including global health security, communicable and non-communicable diseases, research and development, and information technology."¹ Fi-

nally the door has been opened for bilateral collaboration aimed at preventing and controlling diseases that affect people in both countries — including infectious threats such as Zika as well as cancer and other chronic conditions that are the main causes of death in the United States and Cuba.

Somewhat lost in the attention received by the MOU and the general progress of negotiations — which allow for expanded travel to Cuba for Americans — is the fact that Washington's six-decade embargo against Cuba is still in place. Although President Barack Obama's executive actions have reduced its reach, only Congress has the power to end the embargo altogether. Its restrictions seriously hamper the full collaboration promised in the MOU.

Why should Americans care? Although Cuba is relatively poor,

it has managed to make prevention-oriented primary care, as well as secondary and tertiary care, available to all its citizens. Today, markers of population health in Cuba compare favorably with those in the United States, and there are fewer geographic and urban-rural health disparities. Cut off from pharmaceuticals, medical devices, and other technology developed in the United States, Cuba has also invested heavily and successfully in biotechnology and related fields, as well as in strategies to address tropical and infectious diseases and chronic conditions common in its aging population.

As a result, the United States can learn a number of lessons from Cuba's experience — about the organization of medical services, the establishment of community-based programs to pro-



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The Veiled Economics of Employee Cost Sharing

This year, once again, millions of people in the United States who get health insurance through their employers received the unwelcome news that cost sharing would increase. Harvard University, where both of us work and get our health insurance, increased cost-sharing for its employees, raising a hue and cry from faculty.¹ There were charges that the changes were regressive and particularly harmful for lower-wage employees.¹ The critiques implicitly presumed that it is possible to have high wages, lower premiums, and no cost sharing. But this presumption misses the fundamental economic connections between wages, premiums, and cost sharing.

Cost sharing has certainly increased, from copayments for physician office visits and prescription drugs to deductibles; the fraction of workers in a plan with at least a \$1000 deductible for coverage of a single person increased from 10% in 2006 to 41% in 2014.² Higher cost sharing feels like a decrease both in the generosity of coverage and in compensation. It seems particularly unfair to lower-wage workers who face the same deductibles and copayments as their higher-paid counterparts and who may be discouraged from seeking needed care. But increases in cost sharing are not necessarily regressive nor necessarily associated with lower compensation.

The reality of who actually pays for health insurance drives the different impacts of changes in insurance plans on low-wage and high-wage employees. Despite the hand-wringing over increases in employee premium contributions, the employee share of premiums has stayed between 27% and 29% for the last 2 decades, although the dollar amounts have increased because total premiums have increased. The premium for a family policy more than doubled from approximately \$8000 in 2002 to \$16 800 in 2014.² This is far from transparent to employees, most of whom do not see their employer's share of the premium. More important—but even more opaque—is the fact that employees ultimately pay not only their share of premiums but their employer's share as well.³ This is driven by the economics of labor markets. Employers are largely indifferent between paying an employee \$40 000 in wages and \$20 000 in benefits and paying \$50 000 in wages and \$10 000 in benefits—in both cases, total compensation is \$60 000. When the cost of health insurance increases, less money is left available for wages. This “wage-fringe” trade-off is well documented and applies to nonprofit and for-profit employers alike. Increases in health insurance premiums do not get absorbed by an unlimited reservoir of profits or endowments—they are paid for by employees taking home smaller paychecks.^{4,5} The trade-off does not occur instantaneously for each individual, however. So increases in premiums are much more visible and salient than their effect on take-home pay.

The trade-off between wages and fringe benefits is central to understanding the distributional effects of increases in health care costs. Employers provide a similar menu of insurance options to workers with different wages and salaries. Health insurance premiums represent a much larger share of compensation for a family taking home \$40 000 than for a family that makes \$150 000—and a premium increase of \$1000 takes a much bigger percentage bite out of take-home pay for the lower-income family. A lower-income family might prefer to have less generous health insurance and more compensation, so that more money was available for rent, gas, and other priorities. So why do they have this compensation package?

A key reason that employers provide a similar menu of insurance options, regardless of an employee's income, is that the tax code in the United States favors health insurance benefits relative to wages as long as employers offer their high- and low-wage workers the same plans. This tax preference fosters compensation packages that are skewed toward health insurance rather than wages. The skewing has 2 insidious effects: it is both regressive and inefficient.

The tax preference for health insurance is regressive because it gives a greater tax benefit to higher-income workers: an employee in the 40% marginal tax bracket with a \$10 000 tax-free policy saves \$4000 in taxes avoided, whereas an employee in the 15% tax bracket saves only \$1500. Higher-income workers are also more likely to have jobs that offer expensive insurance plans. As a result, lower-wage workers have slow or nonexistent wage growth because of the growing share of their compensation devoted to health insurance instead of wages, and their insurance plans cater more to the preferences of higher-wage workers than to theirs. Remedying this regressive aspect of the tax code is one of the motivations for the “Cadillac tax”: starting in 2018, health insurers have to pay a tax on employer health insurance plans with premiums greater than \$10 200 for individuals or \$27 500 for families.⁶ These dollar amounts increase only as quickly as inflation, so if health insurance premiums increase more quickly, more and more plans will be subject to the tax over time. The Cadillac tax provides a motivation for employers to slow premium growth.

Another reason to reduce the tax subsidy for expensive employer-sponsored health insurance is that the subsidies encourage the proliferation of plans with minimal cost sharing, which in turn encourages the inefficient use of medical care. At first blush, it might seem that cost sharing is just a way of dividing up whether employers or employees pay the bills, but decades of evidence show that lower cost sharing leads patients to consume more care of limited health value—such as unnecessary tests—and that this consumption leads to

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higher health insurance premiums.^{7,8} Cost sharing can thus mitigate the premium increases that would be needed to expand coverage to new services—many of which may particularly benefit patients with serious illnesses.

The potential usefulness of cost sharing does not, however, mean that we would all be better off with across-the-board increases in cost sharing.⁹ First, insurance provides crucial financial protection against potentially catastrophically high health expenditures. Patient cost sharing erodes the value of the risk protection that health insurance provides. The benefit of reducing the overuse of medical services that is inherent in subsidizing health care must be balanced against the cost of losing financial protection when it really matters. A disproportionate share of health spending is for a relatively small number of people requiring very expensive care. Any insurance plan with adequate protection against catastrophic out-of-pocket spending (such as an annual out-of-pocket maximum of \$10 000) will leave a substantial share of health care expenditures in excess of that maximum, and thus not subject to cost sharing. Second, as we have discussed, a given dollar amount of cost sharing has different implications for people with different incomes, suggest-

ing that optimal cost sharing might increase with income. At present, this feature is seen more in cost-sharing subsidies for low-income enrollees in some public plans than in employer-sponsored health insurance. Third, patients facing higher deductibles and copays may reduce care of high value (such as adherence to effective medications) along with the care of low value (such as tests that are not recommended).^{8,10} The evidence suggests that more sophisticated cost sharing, such as higher copays for care of questionable health benefit, might encourage higher-value health care spending and stem the growth of health insurance premiums. Examples are “carve-outs” that protect preventive care from copayments and “value-based” insurance plans that subsidize medications that help keep patients out of the hospital.¹⁰

These caveats do not mean that cost sharing should be eschewed as a tool to improve value—but rather that cost sharing should be deployed in a more nuanced way than it is now. If enabled by regulatory changes and health care system reforms, cost sharing based on the value of care and scaled by income could improve health, slow increases in health insurance premiums, and increase take-home pay.

ARTICLE INFORMATION

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Alternative Alternative Payment Models

Katherine Baicker, PhD, Michael E. Chernew, PhD

Some of the most promising strategies for controlling spending and improving the quality of care delivered in the United States are payment reforms that aim to give health care providers an incentive to improve value. Health care providers are often in the best position to identify ways to reduce waste and help their patients choose the most efficient sites and types of care. Giving health care providers a financial stake in driving value can be much more effective and palatable than runaway health care spending, pushing the risk onto patients, or subjecting them to one-size-fits-all insurer rules.

There are several types of payment reforms. Some approaches target total population spending, such as Accountable Care Organizations. These models typically provide incentives for physician groups or delivery systems to reduce per-capita spending and improve quality. The savings are generally shared with the organization that employs the primary care physician. Other payment models focus on episodes (bundles) of care, creating incentives for providers to limit spending during the episode while achieving quality benchmarks. The savings typically accrue to the organization that controls the hospital or specialist responsible for the episode. Medicare is currently experimenting with both approaches.

In this issue of *JAMA Internal Medicine*, Navathe et al¹ study the effect of episode payment on lower extremity joint replacement in a single hospital system. Their findings are striking: After approximately 5 years under 2 different bundled payment programs for these procedures, spending at the Baptist Health System was about 20% lower. Much of that stems from savings on postacute care, suggesting the importance of whether postacute care is included in the bundle. The changes they document are much larger than most of those seen in other studies of similar bundles. For example, an earlier study² examining all participants in 1 of the 2 bundled payment demonstrations studied by Navathe et al at Baptist Health System found average savings of about 4%.² This could reflect differences in the duration of the episode (shorter in the study by Navathe and colleagues), experience with episode payment (greater in the study by Navathe and colleagues), research methodology (Navathe and colleagues do not formally incorporate an external control group), or variation across program participants (Navathe and colleagues examine 1 system). While the results of the study by Navathe et al are promising, further research will be needed to assess how well this comparison of spending before vs after the reform captures the causal effect of the payment reform and how broadly these results would generalize to other hospital systems. The headline results may not capture all of the other dimensions along which providers may respond. For example, there is some evidence from the study by Dummit et al³ that health care providers paid through episode models select healthier patients:

the number of patients staying at a skilled nursing facility or using home health care before joint replacement decreased after an episode payment model was introduced. Moreover, Dummit et al reported that the number of lower extremity joint replacement episodes per hospital increased enough to offset savings per episode.^{2,3} Navathe et al also report large increases in volume. Some of this may reflect broad trends for greater use or shifts in care toward the participating facilities. Much more work is needed to assess how health status changes affect calculated savings and the extent to which volume increases offset per episode savings.

More broadly, the effectiveness of these alternative payment models in improving quality and lowering spending hinges on design and implementation choices. How the benchmarks against which spending is evaluated are set and updated is crucial to generating the right targets and attracting the right participants. The share of savings providers get to keep (including upside vs downside risk) is a key determinant of the strength of the incentives to reduce resource use. The scope of services covered (such as whether postacute care is included) and the range of conditions covered affect not only the incentives to save, but the magnitude of the potential system-level savings.

So which is more promising, episode-based or population-based payment reforms? Either could be better than the fee-for-service system that dominates Medicare now—particularly with broad scope and real financial stakes—but both seem likely to generate only modest savings in their current incarnations. The greater share of spending potentially covered by population-based payments suggests that, absent broader reach of episode-based models, population-based approaches might eventually have a bigger impact system-wide, although savings to date have been modest; estimates suggest that ACOs cover about 25% of Medicare Parts A and B spending and generate 1% to 2% savings (potentially rising over time).⁴ Even if episode-based models result in somewhat higher savings for covered spending, as currently constituted they are likely to cover a smaller fraction of spending than population-based payments could. Moreover, savings to date have been driven by a small subset of episode types, suggesting expansions of the program may yield even lower returns, further eroded by any increase in the number of episodes.^{5,6}

It is also important to note that the Medicare program does not capture all of the savings in either model—that is the “shared” part of shared savings. The population-based saving programs share a large portion of savings with health care providers. Over time, savings to Medicare would grow if benchmarks rose more slowly than they otherwise would. In the episode-based models, benchmarks are set a few percent below estimated spending, guaranteeing that Medicare will reap some savings, but any greater savings go entirely to health care providers.

The good news is that neither type of reform seems to lower the quality of care thus far and both have the potential to be dialed up to increase savings to the Medicare program and overall.^{5,7} Ideally, both could be deployed in concert, designed so that the strengths of each complement the weaknesses of the other. But there are concerns that they compete to capture savings, and there are currently so many different options and demonstrations in play that the effective-

ness of each may be dulled by the discordant incentives and systems with which health care providers must grapple. The existence of so many competing options—even leaving aside other Medicare programs like the Merit-based Incentive Payment System, Medicare Advantage, and Medicaid—may well undermine the potential for payment reform to drive health care providers toward real delivery-system improvements.

ARTICLE INFORMATION

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**Post-Hearing Questions for the Record
Submitted to Sabrina Corlette
“The History and Current Reality of the U.S. Health Care System”
September 6, 2017**

Market Stability (CSRs)

Despite claims that the Affordable Care Act market is in a death spiral, a report released by the non-partisan Kaiser Family Foundation in July found that the “individual market has been stabilizing and insurers are regaining profitability.” The Foundation’s report found that “insurer financial results show no sign of a market collapse,” noting that, although some insurers have exited the market in recent years, “others have been successful and expanded their footprints, as would be expected in a competitive marketplace.”

Many economists believe that the greatest risk to the stability of the individual market stems from the uncertainty surrounding the Administration’s intention to continue making Cost Sharing Reduction or “CSR” payments to insurers.

1. Please explain the relationship between CSR payments and market stability.

CSR payments are payments made from the federal government to insurance companies in return for offering reduced cost-sharing plans for individuals between 100-250% of the Federal Poverty Level (FPL). Without these payments, insurers could lose as much as \$10 billion in 2018 and \$16 billion by 2027, leading insurance companies to significantly raise premiums to make up for the cost, or pull out of the individual market altogether.

2. How is the uncertainty surrounding CSR payments currently affecting the individual market?

Most insurance companies have dramatically increased premiums for 2018, citing the loss of CSR reimbursement as a primary cause. Others have decided to leave the individual health insurance markets in 2018 because of continued policy uncertainty at the federal level.

3. Would making the CSR payments mandatory have any effect on the stability of the individual insurance market?

Yes. Making CSR payments mandatory would give certainty to insurers, allowing them to decrease their premiums. It will also help reassure insurers that they are working with a reliable federal partner that will keep its commitments.

4. Are there additional mechanisms for stabilizing the individual insurance market that we should consider?

The government should commit to making CSR payments, enforce the individual mandate, conduct robust marketing outreach efforts to enroll the remaining uninsured, re-establish a reinsurance program, provide incentives to keep insurers in rural areas, and fix the “family glitch”.

The ACA – Coverage and Gaps

Although there are still large gaps in coverage in the current system of health insurance in the United States, the uninsured rate for the first three months of 2017 was at an all-time low with only 8.8 percent of Americans uninsured, according to the Centers for Disease Control and Prevention. The Affordable Care Act is far from perfect, but it has made health insurance accessible for millions of Americans who otherwise would have remained uninsured.

5. Is there a benefit to providing access to health care insurance to as many people as possible?

Yes. Generally, whether someone pays for health care or not, they still use resources, such as hospitals and clinics. Given that everyone uses the health care system, providing access to health insurance helps avoid preventable conditions and more efficiently treat existing conditions. Furthermore, it protects families from financial hardship and even personal bankruptcy in case of an unexpected health event.

5. What are the economic reasons for providing access to comprehensive coverage to as many people as possible?

Providing access to comprehensive coverage affords people protection from financial problems and even personal bankruptcy resulting from an unexpected medical episode. Access to coverage also enables people the ability to use preventive services and avoid more acute (and often more expensive) conditions. This contributes to a healthier population and thus a healthier workforce.

Expanding access to health coverage is also an important driver of economic activity and employment in thousands of communities across the country. People who have insurance coverage are able to pay hospital, doctor, and other providers for health care services they receive. In turn, these providers use those payments to pay their employees and buy goods and services. This can have a significant effect on the economic vitality of a community, as those employees use their income to purchase homes and other consumer goods.

7. Expansion of coverage is not strictly an economic argument. Can you provide this Committee with some public policy arguments that support the need for more people to have access to comprehensive health care?

Countless studies have demonstrated that lack of access to health insurance coverage leads to poorer health outcomes and premature disability and death. Conversely, expanding coverage can improve access to services and better health outcomes. For example, since the ACA, the percent of Americans reporting that they didn't see a doctor or fill a prescription because they couldn't afford it has declined by more than one-third. Further, more people are reporting that they have a primary care doctor or had a check-up in the last 12 months.

The research to date also strongly suggests that expanding access to coverage leads to better health outcomes. For example, studies of the reforms in Massachusetts, upon which the ACA was modeled, have found that coverage expansion in that state led to reported improvements in physical and mental health, as well as reductions in mortality. The early data on changes in health outcomes due to the ACA's coverage expansions are consistent with these findings.

Over the years, various administrations have succeeded in passing incremental reforms to fill gaps left by our employer based system. Medicare and Medicaid provide insurance coverage to the elderly as well as the poor and disabled, respectively. CHIP extended Medicaid coverage to low-income children. However, there are still millions of Americans without any health care coverage, and millions more who have insufficient coverage and high deductibles that preclude them from accessing health care services.

8. What are the largest gaps that remain under our current system? Are there certain holes left by the employer-based system that the Affordable Care Act does not address?

According to the Kaiser Family Foundation, the largest gaps in insurance rates in our current system are mostly nonelderly adults in working families with low incomes. Most uninsured remain in the South and West due to lack of Medicaid expansion in some states. Seventy-five percent of the uninsured in 2016 had at least one full-time worker in their family, and 11 percent had a part-time worker in their family. These families either do not receive employer-sponsored insurance, or cannot afford their share of the premiums.

9. Are there steps that we, or our counterparts on the state level, can take to increase coverage?

States can expand Medicaid, giving access to coverage to low-income families in their states that are currently left in the Medicaid gap. Additionally, the federal government should enforce the individual mandate, conduct robust marketing outreach efforts to enroll the remaining uninsured, provide incentives to keep insurers in rural areas, and fix the "family glitch".

Defense of Insurance Coverage

The majority's staff memorandum states: "[t]he current health care debate is centered on a misguided, albeit appealing, principle of providing health care coverage to as many uninsured Americans as possible. While expanding healthcare insurance coverage may be viewed as a laudable goal, it ignores one of the most significant problems within the current U.S. health care system—the cost of health care is sky rocketing."

Although I absolutely agree that costs needs to be contained, we must also continue to strive to provide access to health care coverage to every American.

10. Can you explain how access to comprehensive health care coverage can provide economic stability to a patient facing a serious medical event?

Comprehensive coverage is a critical tool for financial security, particularly in the event of a large, unanticipated medical expense. Health care in this country is expensive. For example, the average cost of a MRI today is \$1,119. An uncomplicated hospital-based labor and delivery costs an average of \$10,808, while a C-section will average over \$16,000. One course of treatment for colon cancer will cost you roughly between \$21,000 and \$52,000. Yet almost half of American families report that they would not be able to afford to pay just \$400 in cash for an unanticipated medical event.

11. Is there recent data on the number of families who say they are having problems paying medical bills?

Yes. Survey data show that the number of families who say they're having problems paying medical bills has fallen dramatically since 2013, particularly among low- and moderate-income families. Other studies have demonstrated that the ACA's Medicaid expansion has led to reductions in the amount of debt sent to collection agencies and improvements in credit scores.

12. Are there studies demonstrating how Medicaid expansion has impacted medical debt?

An article published in Health Affairs in July 2017 shows that Medicaid expansion reduced unpaid medical debt and increased financial security. One study shows Medicaid expansion states having significant reductions in unpaid non-medical bills, suggesting that the financial protection from insurance leads to better financial stability. Another study shows a decrease in non-medical debt sent to third-party collection agencies in low-income areas in states that expanded Medicaid. Lastly, another study finds low-income adults in states that expanded Medicaid had fewer issue with paying and worrying about medical bills.

13. Can you explain the benefits of coverage expansions related to hospital-based uncompensated care?

Coverage expansions decrease the amount of uncompensated care, saving money for hospitals and eventually consumers. The Commonwealth Fund found that from 2013-2015, uncompensated care burdens fell from 3.9% to 2.3% of operating costs in states that expanded Medicaid, resulting in \$6.2 billion in savings.

Explanation of Premium Increases

Many critics of the current state of the health care system assign blame on increased costs to greater coverage. In the staff memo you distributed at the last hearing, you included a chart that showed that increases in premium costs following enactment of the Affordable Care Act.

I note that this information only related to the primary cost drivers for premiums in the individual health insurance market.

This chart shows that there was an increase of 45 percent due to guaranteed issue.

14. Explain what “guaranteed issue” is and why it was included as a market reform in the Affordable Care Act.

The guaranteed availability provision of the ACA requires individual market insurers to accept any individual who applies during open enrollment or special enrollment if eligible. It went into effect on January 1, 2014. Prior to the ACA, insurers in most states engaged in underwriting, in which they would require individual market applicants to undergo a health screening before agreeing to issue them a policy. A 2011 report by the GAO found that, on average, 19 percent of applicants were denied a policy due to their health status, but that figure varied widely from market to market, from 6 percent to 40 percent of applicants. This meant that individuals with pre-existing conditions were often unable to obtain insurance coverage, meaning that their health condition either went untreated or they were forced to pay out-of-pocket.

The chart shows an increase of 35 percent due to age bands being 3 to 1.

15. What do “age bands” mean and why was it an important market reform?

Age bands represent a range for which insurers can charge higher premiums from older consumers over younger consumers to cover the increased medical costs of older populations. Before the ACA’s 3:1 ratio, most states allowed a 5:1 ratio, meaning an insurance company could charge an older consumer up to five times as much as a younger consumer. The purpose of the ACA’s 3:1 ratio was to more equitably spread health care costs.

The chart shows an increase of 17 percent for essential health benefits.

16. What are “essential health benefits” and why was this a necessary reform included in the Affordable Care Act?

Essential Health Benefits (EHBs) are ten categories of health care services that individual and small-group market health plans are required to cover. States are given flexibility to choose a benchmark plan from existing health plans in their state. The EHBs were included in the ACA to ensure that all health plans covered a basic set of medical services, modeled on a typical employer group policy. Prior to the ACA, many critical services were excluded from health plan benefits, such as maternity care, mental health, prescription drugs, and substance use treatment.

The chart shows an increase of nine percent for actuarial value.

17. What is “actuarial value?” Is this a market reform under the Affordable Care Act, or some kind of cost driver separate from health reform?

Actuarial value is the percentage of medical services that an insurance plan will cover. For example, a “silver” plan on the individual market has an actuarial value of 70%, meaning the insurer will cover, on average 70% of health care expenses for an individual enrolled in such a plan. The actual expenditure may vary depending on the particular needs of the enrollee.

Under the ACA, individual and small-group market insurers are required to offer plans that have a minimum actuarial value of 60 percent, meaning that, on average, the insurer covers 60 percent of enrollees’ costs. These are called bronze plans.

Recent Cost Drivers

There are a number of cost drivers that are currently causing health care costs to rise dramatically that are not based on the insurance markets. Over the last two decades, the health care industry has experienced significant consolidation.

18. How much has the cost of hospital care increased?

According to the CMS, hospital expenditures grew 5.6% to \$1,036.1 billion in 2015, faster than the 4.6% growth in 2014.

19. Has hospital consolidation resulted in increased costs?

Research from the Robert Wood Johnson Foundation finds that hospital consolidation increases prices, and can cause a price increase exceeding 20% in already concentrated markets.

20. How can we as policymakers address hospital consolidation to decrease costs?

Experts recommend robust anti-trust enforcement at the federal and state level. Additionally, policymakers should consider state licensing requirements that may limit new market entrants and/or discourage health care professionals from performing to their full training and expertise, restrictions on the use of telemedicine, as well as the oversight of anti-competitive provider contracts that increase consumer costs or hinder payment reform or quality improvement efforts.

21. To what extent has decreased competition among health care providers contributed to higher health care costs for consumers?

Decreased competition among providers has been documented to increase prices paid by insurance companies, leading to higher premiums for consumers and other purchasers.

22. How can we reform payments for physician services to contain costs?

Experts recommend shifting away from fee-for-service reimbursement, starting with Medicare and Medicaid.

23. How does the cost of prescription drugs impact overall health spending?

Prescription drug costs are growing faster than any other health care sector. Prescription drugs represented 10% of national health expenditures, or \$325 billion, in 2015.

24. What steps can we take to control the high cost of prescription drugs?

Key policy solutions include:

- Greater transparency of drug prices, including a drug's unit price and the projected cost to the federal government before allowing FDA approval.
- Annual reports on increases in a drug's list price.
- Disclosure of actual research and development costs for drugs, including how much was supported by public dollars, such as through NIH.
- Improving competition by speeding FDA approval of generic alternatives and reducing monopolies by encouraging new market entrants.
- Support independent, objective research that assesses a drug's value relative to its price.
- Expand value-based pricing in public programs such as Medicare and Medicaid.

Historical Cost Drivers

The original Blue Cross Blue Shield insurance providers were non-profit organizations that generally offered health care coverage at a "community rate" and provided coverage to all members of the groups regardless of the employees' ages or health status.

25. How did the adoption of "experience rating" and "underwriting" by for-profit insurance providers change the risk pool for the insured groups?

Before the advent of the non-profit Blue Cross/Blue Shield plans, traditional commercial insurers had not been in health insurance business because of their concerns about adverse selection. In general, the only people willing to pay for such insurance were those with high health care costs. Also, the administrative costs of selling insurance directly to individuals was very high.

Blue Cross plans demonstrated that if you could target the coverage to employer groups, you could make health insurance a viable business enterprise. Targeting large employer groups meant creating a naturally balanced risk pool – an individual's coverage was tied to their employment, not their need for health care services. It also came with lower marketing costs.

As employer-sponsored coverage expanded in the middle of the last century, other important insurance market changes were also taking place. The early Blue Cross Blue Shield plans were non-profit organizations and in general offered coverage at a "community rate," meaning that all employer groups paid the same price, regardless of the age or health status of their employees.

But soon, for-profit commercial insurers entered the market and realized they could make more money if they cherry picked: They would offer certain employers a lower rate if they had younger, healthier workers. Effectively, they used health status underwriting to "experience rate" their employer customers. Blue Cross Blue Shield was left with sicker employee groups and ultimately adopted their competitors' rating practices in order to survive.

Similarly, before the ACA, insurers found they could make money in the individual market if they engaged in health status "underwriting," or the practice of deterring the enrollment of individuals considered to pose a health risk. These tactics included outright denials of coverage, pre-existing condition benefit exclusions, and premium surcharges based on factors such as health status, age, and gender.

26. How did this change in the risk pool affect the costs of health care coverage?

While the use of underwriting and health status or experience rating can help lower premiums for young, healthy individuals and employer groups, it increases premiums and makes coverage less accessible for people with pre-existing conditions and sicker employer groups.