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Addressing Underinsurance in National Health Reform

Committee on Health, Education, Labor, and Pensions

Sen. Edward M. Kennedy, Chairman
Sen. Michael B. Enzi, Ranking Member
Sen. Jeff Bingaman, Hearing Chairman

February 24, 2009

Testimony presented by
Grace-Marie Turner
President, Galen Institute

Executive Summary

Testimony by Grace-Marie Turner, Galen Institute, before the Senate Health, Education, Labor, and Pensions Committee, February 24, 2009

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

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

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

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

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

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

Addressing Underinsurance in National Health Reform

Testimony before the Senate Health, Education, Labor, and Pensions Committee
Grace-Marie Turner, president, Galen Institute
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I am most grateful to Chairman Kennedy and Ranking Member Enzi for inviting me to testify this morning before your committee on “Addressing Underinsurance in National Health Reform.” And thank you, Mr. Bingaman, for chairing this hearing today. As a native of the Land of Enchantment, it is a special privilege to speak here today.

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

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

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

As Catherine Schoen and many other experts have shown, a growing number of Americans, even those with insurance, are facing health costs that put serious financial pressure on them, especially at a time when the financial security of tens if not hundreds of millions of Americans is threatened by the nation’s economic crisis.

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

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

Flexibility in Insurance

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

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

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

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

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

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

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

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

Wal-Mart reported last week that all but 5.5 percent of its employees now have health insurance, compared with a nationwide uninsured rate of 18 percent. *The Washington Post* reported in a February 13, 2009, article² that an important tool that Wal-Mart has used to reduce its uninsured numbers is flexibility in its benefit offerings. “Employees said they wanted more choices, especially low-cost emergency coverage options. Wal-Mart responded with a menu of deductibles, co-payments and maximum out-of-pocket costs. It teamed up with the Internet site WebMD to simplify enrollment, created electronic health records and expanded its \$4 generic drug plan from the 350 medications available to customers to more than 2,000 for employees,” the *Post* reported. “Many workers have chosen low-premium, high-deductible plans that analysts say provide less coverage for preventive and primary care. The company tries to mitigate that with an upfront credit of between \$100 and \$500 that can be used on any medical expense.” And for major surgeries and other major medical treatments, Wal-Mart negotiates with providers to get the best prices on high-quality care. For example, the company has teamed up with the Mayo Clinic to provide care for employees needing transplant surgery.

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

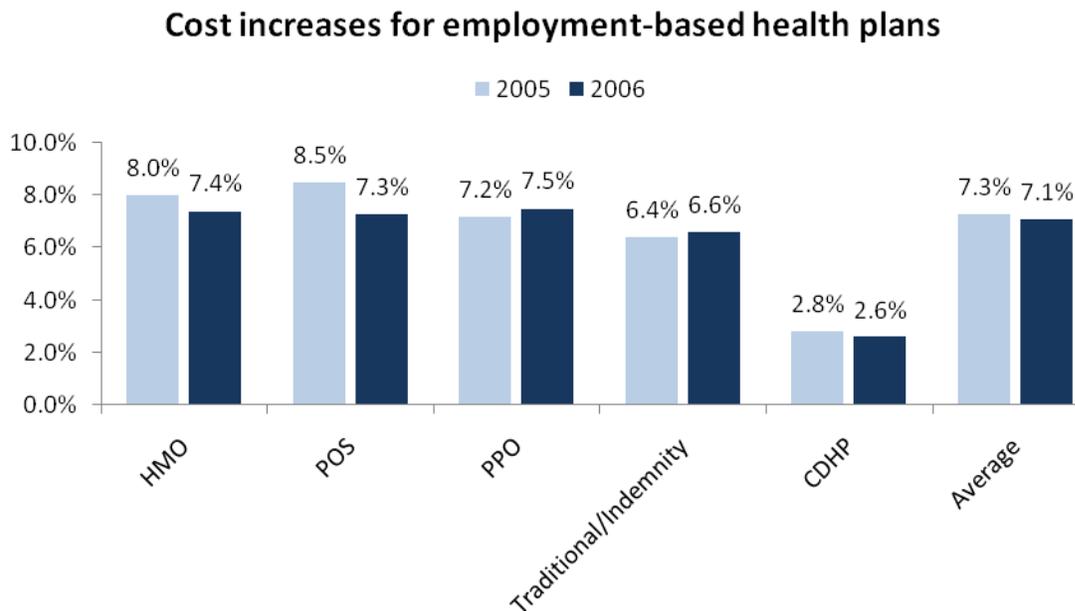
One tool is Health Savings Accounts (HSAs) that permit individuals to combine health insurance with a tax-free health spending and savings account. The account is used to pay for routine health expenses, such as doctors’ visits, for services not covered by insurance, and to create a cushion to pay premiums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

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

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

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

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



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

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

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

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

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

Challenges in public plans

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

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

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

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

Cost is the issue

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

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

The Kaiser Family Foundation reported in its latest employer benefits survey¹² that the average cost of an individual policy offered through the workplace is \$4,704, with the worker contributing \$721 and the firm, \$3,983. The average job-based family policy costs \$12,680, and the worker's contribution is significantly higher, at \$3,354 (a large reason that many employees decline the family coverage), with the employer paying \$9,325.

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

ENDNOTES

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¹⁵ Barack Obama in the second presidential debate, October 7, 2008, at <http://www.cnn.com/2008/POLITICS/10/07/presidential.debate.transcript/>.