

Health Insurance Coverage in Arizona Keeps Shrinking as Premiums, Family Costs Continue Climbing

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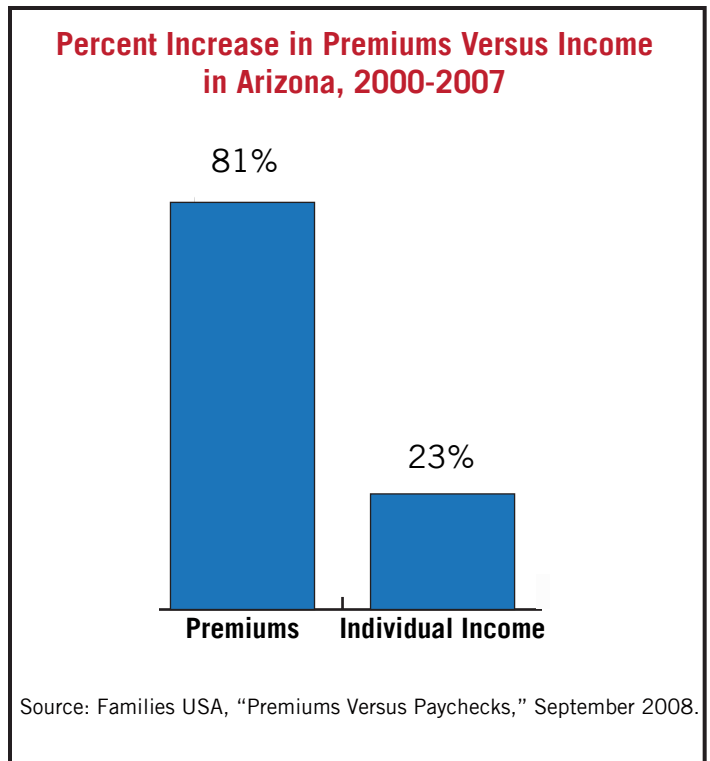
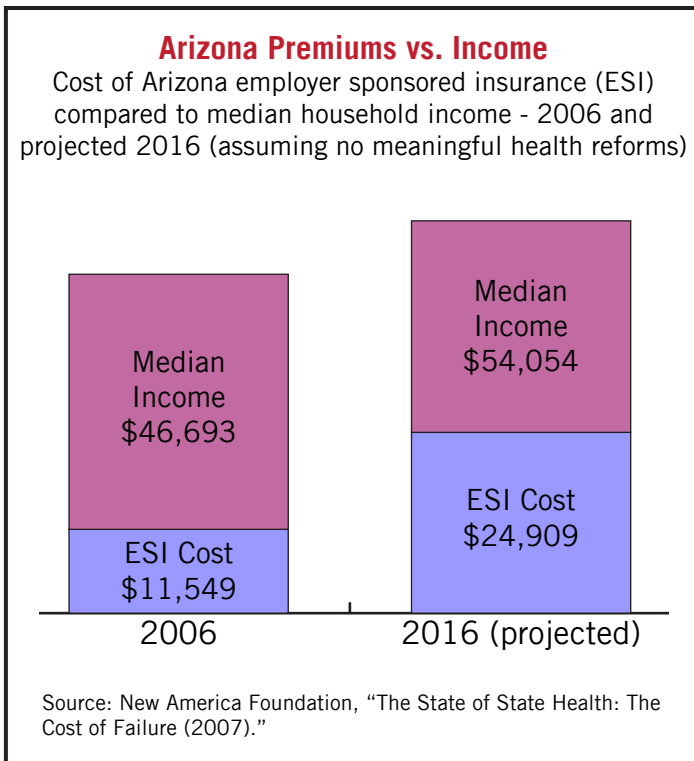
Health Insurance Coverage in Arizona Keeps Shrinking As Premiums, Family Costs Continue Climbing

Medical care has become too expensive in Arizona, leaving 1.2 million state residents uninsured and exposed to the catastrophic costs of accidents and illnesses.¹ The economic downturn that began 19 months ago has vaporized 7 million jobs across the U.S. and driven the Arizona unemployment rate to 7.7 percent from 4.3 percent.² More families are finding themselves without health benefits just as the cost of buying coverage on the open market has climbed to record levels.³

While the employed take comfort in holding on to their jobs, thousands of workers at small businesses in Arizona and millions more nationwide remain uninsured because the price of comprehensive health insurance has soared out of reach. And across the nation more than half of Americans whose jobs and benefits are intact nonetheless live in fear of becoming sudden casualties of the worst economic crisis since the Great Depression.⁴ Health insurance premiums have risen so high that experts forecast 52 million Americans will be without coverage next year.⁵ Left alone to purchase coverage directly from private health insurance companies, families often have no choice but to remain uninsured or buy policies with meager benefits.

Arizona Data Points

- Health insurance premiums for Arizona working families have skyrocketed, increasing 81 percent from 2000 to 2007.⁶
- For family health coverage in Arizona during that time, the average annual combined premium for employers and employees rose from \$6,767 to \$12,253.⁷
- The combined cost to employers and workers of health insurance for an Arizona family of four is equal to 25 percent of the state's median family income. Given current trends, that share will grow to 46 percent in 2016.⁸
- The full cost of employer-sponsored health insurance in Arizona is projected to grow at an annual rate of 8 percent, compared to a 1.4 percent growth rate for income.⁹
- About 560,000 working non-elderly adults in Arizona lack health insurance. That comprises 62 percent of the non-elderly uninsured population.¹⁰
- In Arizona 7.3 percent of working adults reported spending 20 percent or more of their income on out-of-pocket health care expenses in 2004, a 70 percent increase from three years earlier.¹¹
- For family health coverage in Arizona, the average employer's portion of annual premiums rose 83 percent from 2000 to 2007, while the average worker's share grew by 76 percent.¹²
- During that time, the median earnings of Arizona workers increased 23 percent, from \$22,961 to \$28,283. Health insurance premiums for Arizona working families rose 3.5 times faster than median earnings.¹³
- In Arizona 1,237,322 people were uninsured in 2007.¹⁴
- The Bureau of Labor Statistics estimates that 7.7 percent of Arizona's labor force was unemployed in April 2009.¹⁵
- A recent report estimated that 62 percent of bankruptcies were directly related to medical bills; in Arizona there were 18,416 non-business bankruptcies in 2008.^{16,17}



Endnotes

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- ² United States Department of Labor, "Economy at a Glance," 2009. Accessed at <http://www.bls.gov/eag/>.
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- ⁵ Todd P. Gilmer, Richard G. Kronick, "Hard Times And Health Insurance: How Many Americans Will Be Uninsured By 2010?" Health Affairs 28, no. 4 (2009): w573-w577.
- ⁶ Families USA, "Premiums versus Paychecks," September 2008. Accessed at <http://www.familiesusa.org/resources/publications/reports/premiums-vs-paychecks-2008.html>.
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- ⁸ New America Foundation, "The State of State Health: The Cost of Failure (2007)." Accessed at <http://statehealth.newamerica.net/>.
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- ¹⁰ Peter Harbage, Ben Furnas, "Health Care in Crisis," Center for American Progress, May 4, 2009. Accessed at http://www.americanprogress.org/issues/2009/05/working_uninsured_map.html.
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- ¹⁵ Bureau of Labor Statistics, "Local Area Unemployment Statistics." Accessed at <http://www.bls.gov/web/lauhsthl.htm>.
- ¹⁶ David Himmelstein, et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," The American Journal of Medicine, 2009. Accessed at http://pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.
- ¹⁷ US Bankruptcy Courts, "Table F2: Business and Nonbusiness Bankruptcy Cases Commenced, by Chapter of the Bankruptcy Code: During the Twelve Month Period Ending Dec. 31 2008." Accessed at <http://www.uscourts.gov/bnkrpctstats/statistics.htm>.

Executive Summary

Skyrocketing premiums and out-of-pocket medical costs are battering family budgets, eroding U.S. competitiveness in the global economy and threatening the American standard of living,¹ once the envy of the world. As President Barack Obama and his economic advisers have repeatedly said, health costs are increasing at an unsustainable rate, and the national economy will not thrive unless they are reined in. Health care reform that guarantees quality, affordable care for everyone in the United States—and offers the choice of a public health insurance plan—can do what our private health insurance system has failed to do: provide economic security for families and the nation.

An overwhelming majority of Americans say they agree. A new survey sponsored by the independent, nonpartisan Employee Benefit Research Institute shows 83 percent² of Americans support the public health insurance plan option—despite relentless, misleading attacks by a vocal minority in Congress who misrepresent the concept and the positive impact of a public health insurance plan. Half-measures, such as those being proposed by self-interested opponents of authentic health reform, will not provide Americans with health security or enable them to afford the care they need.

This report documents the irrefutable conclusion that health care and health insurance are becoming increasingly unaffordable for a growing portion of the U.S. population.

Highlights:

- In the last nine years, the cost of health insurance has risen 120 percent while wages grew only 29 percent.
- Health insurance premiums have risen so high that experts forecast 52 million Americans will be uninsured next year.
- The lack of health insurance coverage causes 22,000 deaths each year in the U.S. People without health insurance are more likely to delay medical care, to get less care and to die when they get sick.
- Among the uninsured, 80 percent are employed.
- Total health insurance premium contributions and cash outlays for an average family of four climbed 7.4 percent this year to \$16,771.
- The average combined cost of health insurance premiums paid by employers and workers climbed to \$12,680 for family coverage in 2008.
- The number of Americans in families with problems paying medical bills in 2007 climbed to 57 million, or one in five, up from one in seven in 2003.
- Since 2004 employees have seen their cash outlays for health insurance copayments and deductibles climb by 40 percent. The monetary value of employer-based health benefits declined from 2004 to 2007 as American families were required to spend more of their own money.
- Health insurers have resorted to saving money by limiting benefits, using maneuvers such as imposing sharply higher copayments on expensive drugs needed to treat life-saving diseases.

- In bankruptcy courts, 62 percent of filers said medical bills contributed to their debts in 2007.
- About 45 percent of Americans say they are “very” worried about having to spend more on health insurance premiums and medical costs.
- Enrollment in low-premium, high-deductible health insurance products known as “consumer-directed health plans” rose to 8 million as more companies herded workers into the coverage whether they wanted it or not.

Health Care Reform Recommendations

To ensure health care reform guarantees everyone will have access to quality, affordable health care, Health Care for America Now (HCAN), a national coalition of more than 1,000 organizations, makes the following recommendations:

- For families purchasing health insurance, subsidies based on the federal poverty level must be regionally adjusted to account for drastic cost-of-living variations among urban and rural areas.
- Individuals, employers and government have a shared responsibility to contribute to the cost of extending affordable health coverage to everyone.
- The government should not tax employer-sponsored health insurance benefits.
- Benefit packages should be comprehensive and defined as a benchmark for all insurance plans.
- There should be no annual or lifetime caps on benefits payable by a health insurance plan.

A National Solution for a National Crisis

Skyrocketing premiums and out-of-pocket medical costs are battering family budgets, eroding U.S. competitiveness in the global economy and threatening the American standard of living,¹ once the envy of the world. As President Barack Obama and his economic advisers have repeatedly said, health cost growth is unsustainable, and the national economy will not thrive if the growth of medical spending is not reined in.^{2,3} Health care reform that guarantees quality, affordable care for everyone in the United States—and provides the choice of a public health insurance plan—can do what our private health insurance system has failed to do: provide economic security for families and the nation. The Commonwealth Fund recently recommended the creation of a public health insurance plan to play “a central role in harnessing markets for positive change.”⁴

An overwhelming majority of Americans say they agree. A new survey sponsored by the independent, nonpartisan Employee Benefit Research Institute shows 83 percent of Americans support the public health insurance plan option⁵—despite relentless, misleading attacks by a vocal minority in Congress who misrepresent the concept and the positive impact of a public health insurance plan.

As people lose jobs in the economic downturn, they lose health coverage. Each 1 percent jump in unemployment results in 1.1 million people becoming uninsured.⁶ At the current rate of job loss, 14,000 people are losing coverage each day.⁷ People without health insurance are more likely to delay care, to get less care, and to die when they fall ill.⁸ An estimated 137,000 people died from 2000 through 2006 because they lacked health insurance, including 22,000 people in 2006.⁹ Four out of five people who are uninsured are in working families whose employers offer no health coverage or unaffordable coverage, or they are part-time or self-employed workers.¹⁰

In the last nine years, the cost of health insurance in the United States has risen 120 percent while wages grew only 29 percent.¹¹ The average total cost of workplace health benefits for employers and workers has increased relentlessly for 10 years, reaching \$12,680 for family Figure 1.



coverage in 2008¹² and forcing some employers to slash benefits to stave off job cuts. The total cost of insurance and out-of-pocket medical costs for a typical American family of four in 2009 is \$16,771, compared with the 2008 figure of \$15,609, a 7.4 percent increase.^{13,14}

Powerful Special Interest Groups Fighting Change

Washington lawmakers have plunged into the debate over how to retool the \$2.5 trillion-a-year U.S. health

system¹⁵ by extending affordable coverage to everyone, improving the nation's health, curbing the growth of medical costs and devising a way to pay for it all. Special interest groups, determined to preserve traditional revenue streams that have made them rich and powerful, are fiercely resisting many of these changes. Congress and President Obama will make a number of critical decisions about how best to structure health care reform.

They must decide the extent of subsidies to help low-income people buy coverage. Health Care for America Now (HCAN), a national coalition of more than 1,000 organizations, believes that if the program is to be effective, subsidies based on the federal poverty level must be regionally adjusted to account for drastic cost-of-living variations among urban and rural areas.

Congress will have to set employer responsibility standards for contributing to the costs of their workers' health plans. HCAN believes individuals, employers and government have a shared responsibility to contribute to the cost of extending affordable health coverage to everyone. Legislators are considering whether to tax employer-sponsored health insurance benefits, a policy that increases the cost of insurance for people with employer coverage and that HCAN opposes.

Lawmakers must decide whether insurers should be permitted to keep selling inexpensive policies with flimsy benefits that run out long before major medical costs are covered. Washington-based lobbyists for the \$800 billion-a-year health insurance industry¹⁶ want insurers to retain "flexibility" in designing their benefit packages—a euphemism for continuing to sell high-deductible plans with low premiums and shoddy coverage to people of modest means. HCAN has called on Congress to set a defined, comprehensive benefit package as a threshold for all insurance plans and to outlaw any annual or lifetime limit on benefits payable by the health insurance plan.

This report documents the irrefutable conclusion that health care and health insurance are becoming increasingly unaffordable for a growing portion of the U.S. population. HCAN believes that half-measures, such as those being proposed by self-interested opponents of authentic health reform, will not address the unsustain-

able growth in health care costs, provide Americans with health security or enable them to afford the care they need. Americans with health security or enable them to afford the care they need.

At the heart of the affordability problem lies the rapidly consolidating health insurance industry, which rigs the system to extract huge profits from customers who pay skyrocketing premiums for a shrinking array of benefits. Private insurers cannot or will not bargain as effectively as Medicare to hold down prices for medical services, according to the Medicare Payment Advisory Commission, an independent expert panel appointed by Congress.¹⁷ As a result, spending on member health benefits has grown substantially faster for private plans than it has for Medicare in the last decade.¹⁸ Private insurance outlays per enrollee grew an average of 7.6 percent a year between 1983 and 2006, compared with 5.9 percent growth for Medicare—a substantial 22 percent rate differential. That gap has become even bigger in recent years. Between 1997 and 2006, private health insurance spending per enrollee rose at an annual rate of 7.3 percent, compared with 4.6 percent under Medicare—a hefty 37 percent difference. Medicare more successfully restrained the spending growth rate; the rate of growth is also on a steeper downward trajectory under Medicare than under private insurance (Fig. 2).¹⁹

It's no coincidence that private insurers who abide by the code of paying providers significantly more than Medicare pays have been able to finance a mergers-and-acquisition binge for the past 15 years. Consolidation has enabled a small number of giant insurance companies to put hammerlocks on state and metropolitan area markets nationwide.²⁰ A public health insurance plan would introduce competition on cost and quality, inject "a new competitive dynamic in insurance markets and provide a strong foundation for payment and system reforms,"²¹ Commonwealth said. A public health insurance plan option would force private insurers to compete—bringing down costs, guaranteeing quality, and setting benchmarks for coverage and accountability. It would break the near-monopoly power of the private insurance companies' cartel, which is motivated by a single-minded focus on meeting or exceeding the profit expectations of their masters on Wall Street.

When genuine competition comes to the market, it won't be soon enough for millions of Americans like Jim Knopeck, a farmer from Belgrade, Nebraska, who has trouble paying his medical bills. "Health insurance – just for my wife and I – is running over \$15,000 a year... our income fluctuates, because we're farmers... [but] that could be half of our income in most years."²²

In 2003, nearly 50 million people, or 19 percent of the U.S. non-elderly population, lived in families that spent more than 10 percent of income on health care. That includes 19 million people in families paying more than

Figure 2.



20 percent of household income on health care.²³ The threshold over which financial pressures from medical bills increase sharply is 2.5 percent of family income, according to a new report by the Center for Studying Health System Change.²⁴ In 2007, one in five Americans struggled to meet medical costs, up from one in seven only four years earlier.²⁵ From 2003 to 2007 the percentage of Americans in families with problems paying medical bills increased from 15 to 19 percent—or 57 million Americans.²⁶

Rising Out-of-Pocket Costs Rattle Nearly Half of Americans

Across the economic spectrum of families, the upward march of premiums and out-of-pocket costs has been unnerving. No less than 45 percent of Americans say they are "very" worried about having to pay more for their health insurance or medical care, the highest proportion measured in Kaiser Family Foundation polls since 2006. The most recent survey,²⁷ reported in February, found 38 percent were very worried about being able to afford needed medical services. The "very worried" rate rose to 56 percent among those who expect someone in their household to lose a job. One-third of those with existing coverage are fearful about losing it. While these concerns are more prevalent in lower-income families, middle class Americans are also susceptible to health-insurance anxiety, Kaiser found. One-third of people in households making \$30,000 to \$75,000 a year fear they may lose their health benefits. Not surprisingly, angst is surging among the uninsured; seven in 10 are very worried about affording the medical care they need, Kaiser said.

The need for quality health coverage doesn't go away during an economic crisis. Americans still get sick, still need treatment for expensive chronic diseases and still depend on insurance companies to pay for the care they need. But experts report that the temporary downturn is fomenting lasting structural changes in the health insurance marketplace. As financial pressures force businesses to reduce their share of benefit costs or to reduce benefits to save money, more on-the-job health plans are shifting costs and risks from employer to employee. Insurers have capitalized on this movement, maximizing their own profits by reconfiguring health plan offerings in the face of medical costs that have expanded faster than most other components of national spending. In the last year alone, employers increased U.S. workers' premium contributions by 15 percent and raised out-of-pocket medical costs 5.4 percent. Since 2004, employees have seen their cash outlays for copayments and deductibles climb 40 percent, according to a survey by the benefits consulting firm Milliman Inc.²⁸

Report: Health care costs to rise 9 percent in 2010

By TOM MURPHY Associated Press June 18, 2009

INDIANAPOLIS — Employers who offer health insurance coverage could see a 9 percent cost increase next year, and their workers may face an even bigger hit, according to a report from consulting firm PricewaterhouseCoopers.

Costs will rise in part because workers worried about losing their jobs are using their health care more while they still have it, the firm said in the report released to The Associated Press. The report also said rising unemployment is driving up medical costs.

Health care reform legislation currently being hashed out in Congress likely will have little impact on next year's costs, said PWC principal Michael Thompson. But he noted that the intense focus on health care may slow price increases.

"Nobody wants to be front page news when all the lights are shining on your industry," he said.

The report projects the expected cost increase per person for employee benefits plans, and it factors in things such as price increases, as well as utilization changes.

Businesses confronted with increases will likely pass some of the burden to employees via higher premiums, deductibles or copays, Thompson said.

"If the underlying costs go up by 9 percent, employees' costs actually go up by double digits," he said, noting that will have a "major, major impact" when many employers also are freezing or cutting pay.

A total of 42 percent of employers surveyed said they would increase employees' share of costs.

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A disturbing case in point involves the amounts patients must pay when their doctors prescribe expensive drugs to treat life-threatening diseases. In 2009, Medicare prescription drug plans are forcing people with cancer to pay more for their drugs and face increased restrictions on access to them, according to research from Avalere Health and the American Cancer Society Cancer Action Network. Their study found that the private health insurers who run Medicare drug plans increasingly have been shifting name-brand oral cancer drugs to higher formulary tiers over the last four years. Consumers have had to pay more for those drugs with each succeeding year.

In 2009, the large majority of Medicare drug plans placed name-brand oral oncology products – including Gleevec, Sutent, Tarceva, Thalomid, and Tykerb – on specialty tiers that require cost-sharing of 26 to 35 percent per prescription, Avalere found. For example, 84 percent of drug plan members are in plans that put Gleevec – a name-brand drug used to treat leukemia and other forms of cancer – in their most expensive

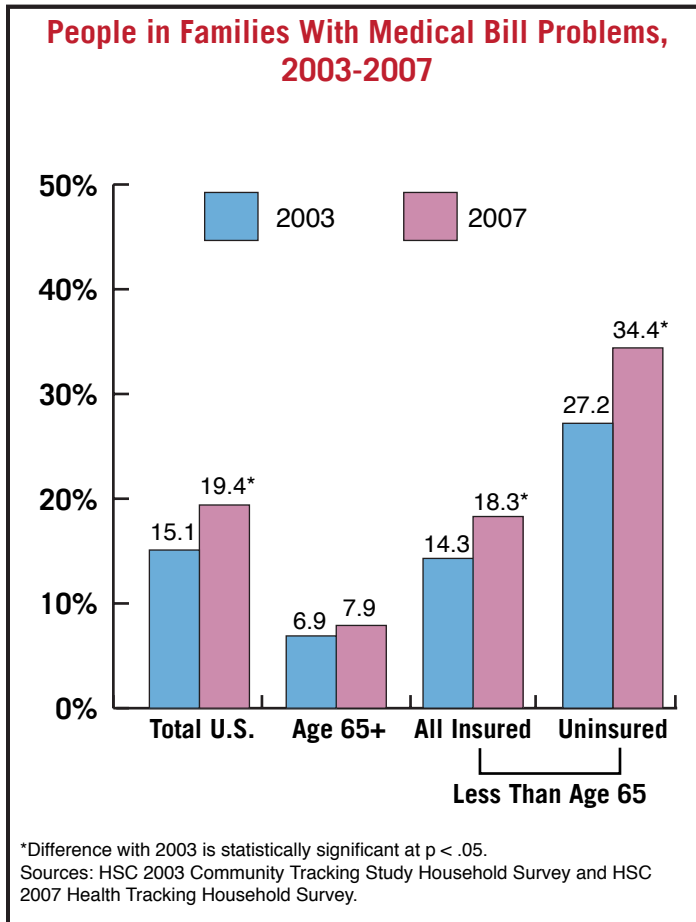
tiers (fourth or higher) in 2009, up from 39 percent in 2006. "This pattern of shifting the costs of brand-ed medications to patients needs to be scrutinized, especially in light of the economic difficulty being experienced by so many," said Valerie Barton, an Avalere vice president, in a statement released by the firm. The cancer group said the price increases are reducing financially strapped patients' treatment options or halting treatment entirely.

Surging insurance and medical costs have left millions of Americans uninsured and unable to afford preventive or nonemergency care. The growth in per-capita health care spending has outpaced personal income since 1979, and extensive research has linked that disparity to the decline in health coverage among workers.^{29,30,31} By 2007, about 49.5 million Americans were uninsured, according to an estimate by researchers who concluded that the U.S. Census Bureau has understated that population.³² Projections indicate that without meaningful reform, that number will grow to 52 million people by next year.³³ Four in five uninsured people are in working families.³⁴

Medical Bills Inflict Stress on Working Families

One doesn't have to be uninsured to experience economic disaster from the cost of medical care. In 2007, more than 57 million Americans of all ages had difficulty paying medical bills. They were in families that were contacted by a collection agency, struggling to pay for necessities, putting off purchases, dipping into savings, borrowing

Figure 3.



money, seeking bankruptcy protection or being denied medical care. That was an increase of more than 14 million people from 2003.³⁵ According to a 2007 Health Tracking Household Survey of 18,000 respondents, 60 percent attributed these financial challenges to illnesses, 29 percent to accident or injury, and about 8 percent to the birth of a child.³⁶ Three quarters of people with medical bill problems have health insurance.³⁷

Burdensome medical bills can prevent people from paying for necessities or force them into debt. The

increase in problems paying for medical bills—especially among insured people—is the main reason why more people reported unmet medical needs because of cost in 2007 than in 2003. About one-third of respondents were saddled with medical debt for more than two years, and about 45 percent said they did not expect to be able to pay off the debt in the next year.³⁸ In the most extreme scenarios, high medical bills drive both the insured and the uninsured into bankruptcy.

Medical Debt and Bankruptcy

The problems associated with medical debt are squeezing families just as the economic recession limits their capacity to cope. This is especially worrisome since, “in 2007, before the current economic downturn, an American

Figure 4.

Financial Consequences of Medical Bill Problems		
Results of National Survey of Bankruptcy Filers		
	2003	2007
Problems paying for other necessities	61.2%	65.0%
Put off major purchase	50.5	52.2
Contacted by collection agency	62.4	62.2
Took money out of savings	57.3	61.7
Borrowed money	44.8	53.4
Thought about filing for bankruptcy	N/A	20.4
Percentage of those who considered bankruptcy that actually filed for bankruptcy	N/A	19.3

Source: David Himmelstein, et al., “Medical Bankruptcy in the United States, 2007: Results of a National Study,” *The American Journal of Medicine*, 2009.

family filed for bankruptcy in the aftermath of illness every 90 seconds; three quarters of them were insured,” wrote Harvard Medical School Professor David Himmelstein in a peer-reviewed study.³⁹ His national survey of 2,314 bankruptcy filers in 2007 found that 62 percent were forced to seek the court’s protection at least partly because of medical debt.^{40,41} In 2008 there were 1.07 million non-business bankruptcies filed across the United States.⁴² Most adults with medical debt had college degrees, owned homes, and had middle-class occupations; three quarters had health insurance. The rest fell into bankruptcy because they lost significant income

Figure 5.

Demographic Characteristics of 2,314 Bankruptcy Filers and Comparison of Medical and Non-medical Filers, 2007*				
	All Bankruptcies	Medical Bankruptcies	Non-medical Bankruptcies	P Value Medical vs. Non-medical Bankruptcies
Mean age	44.4 years	44.9 years	43.3 years	.01
Debtor or spouse/partner male	44.5%	44.9%	44.3%	NS
Married	43.9%	46.3%	40.1%	.02
Mean family size - debtors + dependents	2.71	2.79	2.63	.02
Attended college	61.9%	60.3%	65.8%	.02
Homeowner or lost home within 5 years	66.7%	66.4%	67.8%	NS
Current homeowner	52.3%	52.0%	53.2%	NS
Occupational prestige score>20	87.3%	86.1%	89.8%	.01
Mean (median) monthly household income at time of bankruptcy filing	\$2,676 (\$2,299)	\$2,586 (\$2,225)	\$2,851 (\$2,478)	.002
Debtor or spouse/partner currently employed	79.2%	75.5%	85.0%	.001
Debtor or spouse/partner active duty military or veteran	19.4%	20.1%	18.4%	NS
Market value of home (mean)	\$147,776	\$141,861	\$159,145	.03
Mean net worth (assets - debts)	-\$41,474	-\$44,622	-\$37,650	NS

*Bankruptcies meeting at least one of the following criteria: illness, injury or medical bills listed as specific reason for filing OR uncovered medical bills >\$5000 or > 10% of annual family income OR, lost ≥ 2 weeks of work-related income due to illness/injury, OR depleted home equity to pay medical bills.

Source: David Himmelstein, et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine*, 2009.

due to illness or borrowed money against a home to pay medical bills. Himmelstein found that the share of bankruptcies attributable to medical problems rose by 50 percent from 2001 to 2007. Many of these people once considered themselves "protected" by health insurance in effect when they became ill.

Side Effects of Medical Costs

The increasing cost of health insurance doesn't merely affect people's finances and lead to greater stress; being uninsured also makes them physically sick, according to the Institute of Medicine, an independent advisory body of the federally chartered National Academy of Sciences.⁴³ People whose benefits don't shield them from large out-of-pocket costs can experience the same problems getting needed care.⁴⁴ Underinsured individuals are more likely to forgo needed medical services because of cost, according to the Commonwealth Fund.⁴⁵ Among those with the greatest medical expenses and the flimsiest benefit plans, two-thirds went without necessary care because of cost.⁴⁶ About half of those people have

chronic conditions and attempted to save money by disregarding doctors' orders.⁴⁷ In a recent Kaiser Family Foundation survey, insured individuals reported that concerns about affording needed medical care led them to postpone or cancel a recommended medical visit or treatment, to leave prescriptions unfilled, or to skip doses or cut pills in half to extend their supply of pills.⁴⁸

High medical costs, decreased benefits, and rising costs have real effects on the quality of care available to families, who often face "overwhelming financial problems at the very point they are coping with overwhelming medical conditions," health policy expert Judy Feder, of the Center for American Progress, testified to Congress this year.⁴⁹ A recent report prepared by the Kaiser Family Foundation and the American Cancer Society illustrates how people are "spending to survive;" they are having trouble finding adequate and affordable health insurance or struggling to pay for health care despite being insured.⁵⁰ Even patients with insurance coverage can pay more than \$100,000 for treatment because of high deductibles, high cost-sharing, and limited lifetime

spending caps as well as inadequate benefits that shift the financial risk to the individual. Adding insult to injury, health insurance underwriting and rating practices leave many individuals with cancer or other serious conditions unable to obtain insurance against future illness.^{51,52}

Employers Scale Back on Benefit Packages

A recent study found statistically significant declines in the monetary value of employer-based health insurance benefits from 2004 to 2007.⁵³ People are paying more for less. A growing number of employers that once offered traditional health insurance plans—including major for-profit health insurers themselves—have herded their workers into so-called “consumer-directed” health plans, which are linked to tax-advantaged health savings accounts. Some of these plans purport to provide good benefits at relatively low premiums, but participants must satisfy annual deductibles as high as \$10,000 before benefits kick in. The number of people with these consumer-directed plans rose to 8 million this year, a point of pride among publicly traded health insurance companies.⁵⁴

Perhaps the most insidious sign that benefit costs are spiraling out of control is the insurance industry’s aggressive marketing of health plans that provide inadequate protections to members, particularly people with costly and complex health care needs. Many people end up buying “low-cost” limited-benefit plans and other inexpensive coverage, which pay little in health claims. Insurers use these relatively inexpensive programs to attract unwitting enrollees who don’t realize how restrictive the benefits are until they get sick.

Soon after Darlene Henderson of Penn Valley, Calif., was diagnosed with cancer, her husband David needed emergency surgery. They believed they were protected by a health plan with \$1 million in catastrophic coverage, but they soon learned that it would cover only 20 percent of the bills, which topped \$210,000.⁵⁵ Because private insurers are not required to disclose how they make coverage or denial decisions, the only way to find out the actual extent of one’s benefits is to file claims. But by then it’s too late to switch.

“An insured person who becomes seriously ill might have to pay thousands, or tens of thousands, of dollars out-of-pocket for needed care,” wrote Karen Pollitz, a health insurance specialist at the Georgetown University Health Policy Institute, in a recent report. “For many consumers that range represents the difference between health security and financial catastrophe. Consumers compare the prices of health insurance policies, but cannot always reliably tell if they are comparing like products. The affordability of health insurance premiums cannot be considered independently of the adequacy of coverage health insurance provides. At a minimum, the difference in protection health insurance offers should be readily available for all to see.”⁵⁶

In recent testimony in Congress, Pollitz said the erosion of benefits inflicts severe financial pain on those with the misfortune of getting sick. “Coverage erosion leaves the under-insured in circumstances very similar to the uninsured—they forgo or delay needed medical care due to costs, experience poorer quality care, and suffer financial burdens,” she said.⁵⁷ For example, a study of the effect of doubling prescription drug co-pays from \$6 to \$12 for generic drugs and from \$12 to \$25 for brand-name medicines found that patients with diabetes, hypertension, and depression reduced use of their respective medications by nearly one-quarter.⁵⁸ Failure to properly manage such chronic conditions often leads to the development of more serious and expensive medical complications.

Families are being forced to endure financial hardship or forgo needed medical care in a health system that seems to be stacked against them. Even opponents of President Obama’s policy prescriptions acknowledge that our current health care system is dysfunctional⁵⁹ and no longer burdens only the sickest. With no guaranteed back-up coverage available, workers who are older or have common medical conditions often remain in jobs they would prefer to leave simply to retain access to employer-sponsored health benefits. American productivity suffers when experienced workers stay in jobs for the health coverage long after they wish to move on, perhaps to pursue entrepreneurial goals that might create jobs and expand the U.S. economy.

The herculean political efforts devoted to reforming the health system will be wasted unless Congress provides adequate health coverage to everyone based on each family's ability to pay and without limits on payments for covered services.

HCAN Recommendations to Ensure Affordable, Quality Health Care for Everyone

The evidence cited in this report describes the heavy toll that unaffordable health care can have on a family's health and financial security. Reforming our health care system through half-measures that leave the private insurance industry in control will not provide Americans with health security or enable them to afford the care they need.

HCAN urges Congress to adopt health reform legislation that gives people a choice of a public health insurance plan competing on a level playing field with private insurance companies.

A package of defined, comprehensive benefits for all should be created and funded by contributions from individuals, employers and government. Individuals and families should pay no more than a defined, maximum percent of income on total health care costs, with those having the lowest incomes paying a substantially lower share of income. An annual limit should be placed on total enrollee cost-sharing requirements (deductibles, co-insurance, and co-payments) for covered services. Only minimal deductibles should be permitted.

The federal poverty level (FPL) is currently \$22,050 a year for a family of four. For such families who earn less than 200 percent of the FPL (\$44,100), protections and standards should be no less than current Medicaid protections and standards that are applied to people with income below the poverty line. Those include barring premium contribution requirements and allowing only nominal cost-sharing requirements. Individuals who are in groups currently with cost-sharing exemptions or caps should maintain this protection.

Subsidies should be made available to assist lower- and middle-income individuals and families with paying

for health care costs. Proposals that limit assistance to families at or below 400 percent of the FPL may not be adequate for families with higher incomes depending on considerations such as cost-sharing requirements, premiums, and employer contributions.

Subsidies should be administered without application of an assets test, and proven administrative mechanisms should be employed that ensure successful and efficient outreach and timely application of the affordability protections and subsidies (e.g., prior to premiums being due.) Affordability standards that are established (particularly those not expressed as a percent of income) should include mechanisms to ensure that the standards will continue to adequately protect individuals and families over time from rising health care costs.

No family should be required to pay more than it can afford. The defined benefit package should be paid for by individuals and families on a sliding scale based on income and with a regional adjustment factor that accounts for wide geographic variations in living costs. Adjustment is necessary because the federal poverty level is the main national benchmark for the United States. States and areas within states have different costs of living and purchasing power; this means that a subsidy calculated with the FPL would not have the same value in a low-cost area of the country, such as rural Alabama, and a high cost area such as New York City.

Cost-sharing rules should be designed to foster prevention, primary care and effective treatment of chronic conditions, with no cost-sharing for preventive care services and for chronic disease-management services. No annual or lifetime limits should be allowed on payments for covered services.

Employers should be responsible for paying a meaningful portion of their employees' health care costs. Contribution levels should be at least proportional to the number of hours worked and not based on the immigration status of the worker. Large employers should be responsible for funding at least 80 percent of the cost of individual coverage and 75 percent of family coverage for the defined benefit. These rates reflect current average employer premium contribution

Figure 6.

What a Family of Four Would Need to Earn in Selected Urban Areas to Have Purchasing Power Equal to 300% of the U.S. Federal Poverty Level (\$63,600), 2008 (in dollars)⁶⁰			
	Lowest Cost Urban Area	Middle Cost Urban Area	Highest Cost Urban Area
Alabama	\$55,651	\$57,638	\$62,465
Alaska	\$80,479	\$80,932	\$87,879
Arizona	\$62,893	\$67,998	\$75,313
Arkansas	\$54,808	\$56,202	\$58,995
California	\$67,458	\$86,573	\$110,411
Colorado	\$55,032	\$64,223	\$83,459
Connecticut	\$72,126	\$75,310	\$92,928
Delaware	\$62,137	NA	\$65,368
District of Columbia	NA	\$87,385	NA
Florida	\$59,420	\$63,202	\$78,033
Georgia	\$52,672	\$58,798	\$62,004
Hawaii	NA	\$104,073	NA
Idaho	\$56,446	\$60,230	\$60,239
Illinois	\$56,239	\$61,054	\$73,341
Indiana	\$57,659	\$58,638	\$62,809
Iowa	\$54,992	\$59,444	\$64,130
Kansas	\$56,153	\$57,039	\$64,461
Kentucky	\$56,402	\$57,820	\$60,330
Louisiana	\$57,615	\$59,761	\$63,028
Maine	NA	NA	NA
Maryland	\$78,430	NA	\$83,792
Massachusetts	\$66,963	NA	\$84,173
Michigan	\$60,130	\$60,281	\$64,187
Minnesota	\$61,537	\$63,179	\$71,327
Mississippi	\$54,384	\$59,403	\$61,318
Missouri	\$52,898	\$57,431	\$61,746
Montana	\$65,579	\$67,418	\$69,374
Nebraska	\$55,080	NA	\$59,583
Nevada	\$67,996	NA	\$70,306
New Hampshire	NA	\$75,570	NA
New Jersey	\$79,936	\$81,432	\$83,669
New Mexico	\$62,075	\$63,198	\$70,783
New York	\$60,898	\$65,988	\$142,593
North Carolina	\$56,171	\$60,922	\$67,382
North Dakota	\$59,003	\$60,956	\$61,042
Ohio	\$55,006	\$59,673	\$62,118
Oklahoma	\$53,676	\$56,469	\$58,495
Oregon	\$72,038	NA	\$72,505
Pennsylvania	\$59,365	\$62,977	\$80,019
Rhode Island	NA	\$76,318	NA
South Carolina	\$58,315	\$59,083	\$70,204
South Dakota	NA	\$58,625	NA
Tennessee	\$53,644	\$56,047	\$57,712
Texas	\$54,965	\$58,072	\$60,750
Utah	\$58,868	\$60,326	\$64,147
Vermont	NA	\$74,772	NA
Virginia	\$54,994	\$63,710	\$68,674
Washington	\$56,527	\$67,161	\$79,277
West Virginia	\$55,435	\$59,297	\$64,050
Wisconsin	\$58,060	\$59,539	\$64,449
Wyoming	\$65,054	NA	\$66,081

Source: Kaiser Family Foundation, statehealthfacts.org, "What a Family of Four Would Need to Earn in Selected Urban Areas to Have Purchasing Power Equal to 300% of the U.S. Federal Poverty Level (\$63,600), 2008."

levels for employer-based health insurance. Contribution requirements for small and medium employers should be scaled based on size of payroll, wage levels, and number of workers.

Insurers should be responsible for tracking enrollee out-of-pocket expenditures for covered services and automatically applying affordability protections for enrollees. A final evaluation of the affordability provisions of a legislative proposal must be considered within the overall context of the legislative proposal, especially as to the comprehensiveness of the benefit package.

Insurers should be barred from continuing to discriminate against women, older adults and people with chronic or “pre-existing” health conditions. Health plans must not be permitted to deny coverage, limit benefits or charge higher rates based on health status, age or any other demographic or personal characteristic, or on definitions of the word “family” that are not inclusive.

Regulatory Reforms Inadequate to Guarantee Affordable Health Care

The health insurance industry and its friends in Congress have argued strenuously that regulatory reforms are sufficient to solve the nation’s health cost and guarantee quality, affordable health care for everyone. Families USA surveyed state insurance regulators and compiled information on the laws that each state has in place to protect consumers. It found that protections “vary greatly across the country, and in many states, because of a lack of consumer protections, insurance companies can deny people coverage, raise premiums significantly, refuse to cover treatment for certain conditions, and even revoke the coverage of policyholders who have been paying premiums for years.”⁶¹

The disappointing reality is that even the most diligent state insurance regulators have failed to keep insurers in check so that they stop denying medical care inappropriately to boost their bottom lines. For example, when insurers in California were wrongfully canceling people’s coverage because they got sick, regulators fined

several plans for the infraction. But California regulators who imposed a \$1 million fine against one large insurer did not follow through with legal proceedings to actually collect the money because the insurer was “too powerful to take on.”⁶² Regulation is not enough to curb the private health insurance industry. The only way to make private insurance companies accountable to the public is to have a public health insurance plan competing with them on a level playing field. Americans should be given the choice of keeping their private plan and doctor, choosing a different private plan, or opting for a quality public health insurance plan.

Even before the economic crisis began, it was apparent that health insurers are more interested in protecting profits and executive pay than in improving the health of customers or making it easier for people to afford coverage. Without comprehensive health reform, including a public health insurance option, private insurers will continue to exert their near-monopoly power and game the system to bolster profits and protect the status quo.

“Private insurance and public insurance have distinct strengths and weaknesses, and thus should be encouraged to compete side by side to attract enrollees on a level playing field that rewards plans that deliver better value and health to their enrollees,”⁶³ said political scientist Jacob Hacker, of the University of California at Berkeley, in a paper for the Institute for America’s Future. “Public insurance can be a benchmark for private plans and a source of stability for enrollees, especially those with substantial health needs. Private plans can provide an alternative for those who feel that public insurance does not serve their needs and a source of continuing pressure for innovation in benefit design and care management strategies. Both should have a chance to prove their strengths and improve their weaknesses in a competitive partnership. If, as many critics of public plan choice contend, the private sector can provide greater value than the public sector, then private plans should have nothing to fear from competing on a level playing field with a new public plan. The alarm bells ringing among private insurers suggest that they recognize some of the key advantages of public insurance too.”⁶⁴

A competing public plan will neither destroy the private insurance market nor lead to a government takeover, as the health insurance industry asserts, according to a recent report by the Urban Institute. Private insurers will thrive because of their ability to be responsive to consumer demands for choice and innovations arising from the profit motive and the desire to attract more customers, the report concluded. A public plan will offer better access to necessary care for diverse populations, reduce administrative costs, and function as a large-scale purchaser with a strong negotiating position with providers, wrote authors John Holahan and Linda Blumberg.

“The presence of a well-run public plan would constrain private spending, as the plans would have to compete on price, which does not frequently occur today,” they wrote. “Private insurers who are not adding much value and lack clout are likely to disappear in the face of public competition. But at the same time, those that are able to offer a superior product through high levels of efficiency, satisfaction in consumer preferences and ease of access to quality medical services will survive in a reformed market. Incentives for them to innovate in the areas of cost containment and service delivery will be enhanced by the presence of a well-run and effective public plan.”⁶⁵

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