



Testimony of Gail Shearer
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Before the
Joint Economic Committee

On

Impact of “Consumer-Driven” Health Care
on Consumers

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Consumers Union Testimony on “Consumer-Driven” Health Care

Introduction

Employers, who provide health insurance for about 60 percent of the U.S. population, are increasingly under pressure to constrain their spending on health insurance premiums, which have been growing in recent years at an annual rate of 5 to 8 percent. This pressure is aggravated by the recent weakness in the economy. One way to reduce the employer premiums for health insurance, and to make payments more predictable, is to switch to a “defined contribution” approach to health insurance, similar to the shift in recent decades from defined benefit pensions to defined contribution pensions. In the employer health insurance market, a key distinguishing feature of its effort to move toward a defined contribution model is high-deductible coverage. As indicated by the title of the Joint Economic Committee hearing, the term that insurers and employers have coined to name this new trend in the marketplace is “consumer-driven health care.” Consumers Union¹, which appreciates the opportunity to present our views to the committee, is troubled by this trend in the marketplace. In our testimony, **we plan to explain why we believe this type of coverage is misnamed, misguided from a policy perspective, and a dangerous distraction from the health insurance crisis that faces 43.6 million uninsured consumers and tens of millions of underinsured consumers.**

Misnomer: “Consumer-driven” health care is better called “defined contribution” health care

Defining features of so-called “consumer-driven health care” plans tend to be high deductible policies (e.g., \$5,000), combined with a contribution by the employer to a health care savings account, at a level that leaves the consumer exposed to some out-of-pocket costs before the high-deductible is met. For example, the employer might provide \$2,000 toward a family’s health reimbursement account, and offer a deductible of \$5,000. (Often, the employer provides additional access to information about health care choices, such as information about managing certain diseases.) “Consumer-driven” implies that consumers have a full range of choices, and are in the driver’s seat calling the shots. The problem with this is that too many consumers are not in control of their health care out-of-pocket costs or health coverage. An employee with a seriously, chronically ill child, for example, will not be able to accumulate a nest egg in a health reimbursement account, and will face high out-of-pocket costs each year. A consumer with an income in the range of \$25,000 to \$30,000 will suffer financial hardship if they face out-of-pocket costs as high as \$3,000 a year. An employee with existing health conditions such as high blood pressure or diabetes will face very limited choices in the individual marketplace if his employer decides to “cash out” its health insurance plan and send employees into the individual market for coverage. This type of policy appears to be driven largely by the

employer's desire to curb its health care expenditures. The term "consumer-driven" may well mislead employees and the public about the true impact of this type of coverage.

**The Medicare bill and Administration proposals
accelerate the transformation of the marketplace to one
characterized by high deductible coverage**

The year 2003 may well go down in health care history as the year that the health care system began to rapidly evolve toward a system characterized by health insurance deductibles in the range of \$1,500 to \$2,000 for individuals and \$2,500 to \$5,000 for families, instead of deductibles that are around \$250 for individuals and \$500 for families. "Consumer-driven health care" plans in the employer benefit system are one mechanism for movement toward high deductibles. The expansion of medical savings accounts (renamed as Health Savings Accounts or HSAs) in the Medicare Modernization Act is another major step toward high deductible coverage as the norm. Because employer and employee contributions to HSAs (when accompanied by a high deductible policy) will be shielded from taxes, it is likely that this financial incentive will stimulate substantial rapid expansion.

The Administration's additional proposal for making premiums paid for high deductible policies tax deductible is likely to boost the popularity in the marketplace substantially and dramatically exacerbate market segmentation. While supporters of MSAs, HSAs and "consumer driven health care" initially argued that consumers should have a choice of this type of high-deductible coverage, recently they have spoken more openly (to their credit) about their intention to transform the health care system to one in which high-deductible policies are the norm. This is a more honest approach to pretending that high-deductible and low-deductible policies can exist side-by-side in the marketplace, when the nature of varying risks in the marketplace, and adverse selection, make this impossible. This year's Economic Report of the President² clearly indicates the Administration's opposition to health insurance coverage for relatively routine health care needs; a key policy recommendation (for tax deductions for premiums for high deductible policies) clearly indicates the Administration's preference for a high-deductible health insurance system. Similarly, former House Speaker Newt Gingrich has spoken about his goal of transforming America's health care system into one characterized by high deductible coverage.

Despite the theory (as expressed in the Economic Report of the President) that health insurance with higher deductibles will lead to consumers shopping around for health services (based on price and quality), the reality of health care needs (often requiring timely care, often requiring decisions by doctors, not patients) and inadequate information in the marketplace about health care quality and prices, precludes the workability of a "consumer-choice" type of model. Even if perfect information about price and quality were available on an instant basis, it is the

doctor who ultimately makes judgments about needed care. Another problem with the theory is that most health care expenditures are incurred in the course of very serious illness, after the deductible (and probably the stop-loss) have been met, thereby negating any curbing of expenditures that would be based on patients' financial incentives. Instead of reducing aggregate expenditures, such policies are more likely to shift even more costs to consumers.

The President's Economic Report fails to recognize the costs incurred when consumers are uninsured and underinsured

The focus of the President's Economic Report chapter on health insurance is more on the alleged problems of over-insurance rather than the problems associated with the lack of insurance and underinsurance. The chapter could be a primer for a Health Economics 101 course on the virtues of an unfettered free market for health insurance: the reader learns about different consumption choices that consumers make when they have insurance. It posits that patients might over-consume services if they face too little cost-sharing. *Insurers* might be disadvantaged because applicants know more about their health status than the company does. The lack of insurance is a matter of choice for the uninsured who opt out of employer coverage or fail to enroll in public coverage.

The report suggests that in an ideal world, the insurer would have complete information about the applicant's health status, and this would enable the insurer to more easily discriminate in pricing between the healthy and the potentially sick: "If insurers could distinguish among different types of consumers, policies could be tailored to specific types and priced accordingly." As Paul Krugman pointed out in the New York Times recently, this approach would lead to insurance companies denying coverage for dialysis if new insurance company tests indicate that they are likely to experience kidney problems later in life.³

Nowhere in this chapter is there recognition of the reality that faces millions of Americans every year: For the most part, people are not uninsured out of choice, but because they can not afford to pay health insurance premiums. Every day, uninsured and underinsured Americans are dying because of the lack of insurance. An Institute of Medicine study reported that an uninsured woman diagnosed with breast cancer is 30 to 50 percent more likely to die than a woman with private health insurance. **The record is clear: uninsured people get inadequate care.** Cancer patients die sooner when diagnosis is delayed; uninsured people with diabetes are at greater risk of uncontrolled blood sugar levels and hence are at risk of additional chronic disease and disability; and adults with mental illness who lack mental health coverage are less likely to receive mental health services consistent with clinical practice guidelines.⁴ When the marketplace shifts to one characterized by pricing to risk, as suggested by the President's Economic Report, this leads to escalating premiums for the very people who can least afford them –

people who face serious health challenges. In addition, unreimbursed health care costs are a leading cause of bankruptcy, and contribute to half of all bankruptcies.⁵

The United States is the only industrialized country in the world that would consider “pricing to risk” instead of spreading health care costs broadly across the population. A World Health Organization report found that the U.S. had the highest per capita health care spending, but rated 54th (of all the countries in the world) when it comes to fairness of financial contribution.

I would like to share a personal story that is a stark reminder of the irony that a country as rich as ours fails to provide health coverage to all. A cab driver, who came from Egypt over 20 years ago, had experienced health care in Egypt (with a per capita income about one tenth the level of the United States) with health care in America. He reported to me how a U.S. doctor marveled over his high-quality scar from stitches received in a major abdominal operation, all at no cost to him. In contrast, his wife, recently diagnosed with breast cancer, is receiving court notices for her failure to pay bills for a mastectomy, even though there had been assurances that her treatment would be covered by subsidies. He posed the question to me: how can a country this rich put such a financial burden on people who are seriously ill?

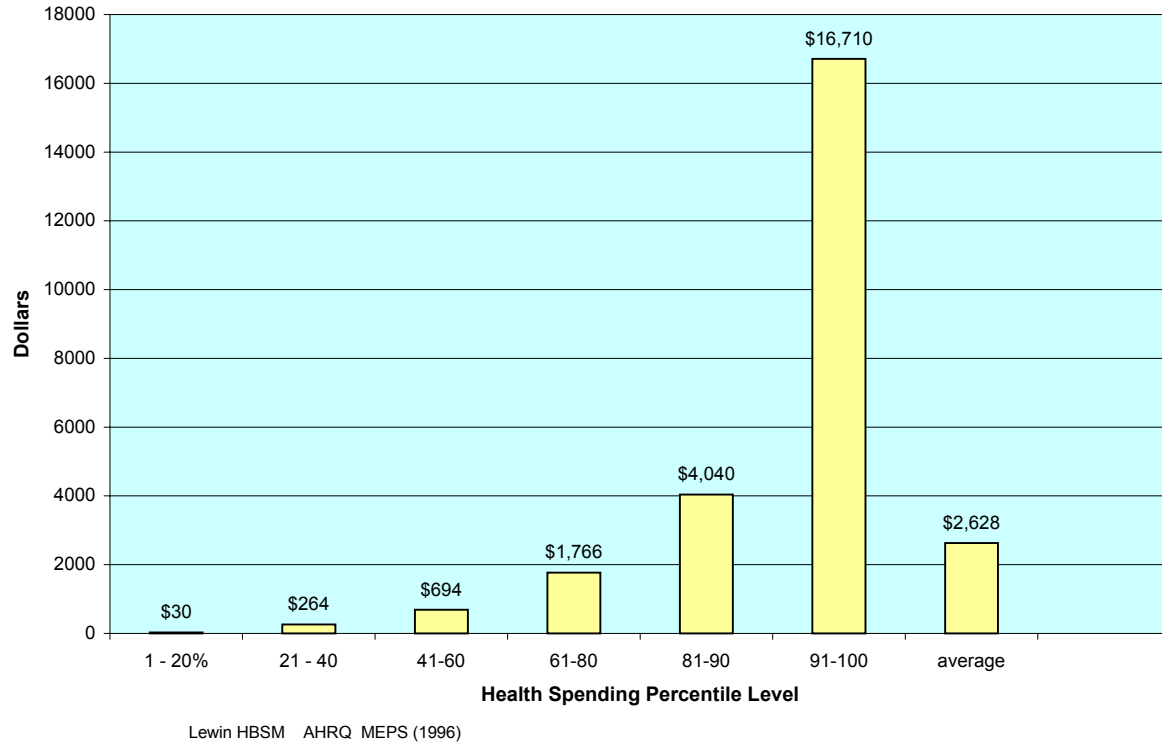
The Administration’s proposals, which boost “consumer-driven” health care, by design, shift more costs to those who are sick. The result will ultimately be a health care system that distributes costs of health care *even less fairly than it does today.*

Health insurance risks vary

There is tremendous variation in health care costs incurred by those covered by employer health insurance, as shown in the Figure below. Based on survey data from the Medical Expenditure Panel Survey (MEPS) and adjusted to 2000 levels (by the Lewin microsimulation model), the average health care costs of those with employer based coverage was \$2,628 in 2000. However, the average masks a large degree of variation: those in the lowest fifth of spending incurred on average \$30 of health care expenditures, while those in the top tenth of spending incurred costs of \$16,710.⁶ This variation of risk goes to the heart of the need to find a way to spread costs broadly in order to keep costs affordable to those at the highest risk level.

Figure

Variation in Health Care Costs of People with Employer Coverage, 2000



Studies show that those with pre-existing conditions do not fare well in the health insurance marketplace

In one form of “consumer-driven health care,” and in the model suggested in the President’s Economic Report and proposal for tax deductibility of insurance premiums for high deductible coverage, employers would “cash out” health benefits, providing employers with a cash contribution for health insurance. Employees would go out and shop on their own for health insurance. **The problem with this approach is that it undermines the spreading of costs across the population, just as Medicare spreads the cost of senior and disabled health care, and other countries spread the cost and spare the sick with large financial burdens.**

A study by the Kaiser Family Foundation (using hypothetical consumers shopping for coverage) found that individuals with existing health conditions do not fare well in the individual health insurance market⁷:

- A 62-year-old overweight smoker with high blood pressure was rejected 55 percent of the time, and was offered coverage with benefit limits or premium surcharges 42 percent of the time, at average premiums of \$9,936/year.
- A 48-year old breast cancer survivor was rejected 44 percent of the time, and was offered coverage with benefit limits or premium surcharges 38 percent of the time.
- Even a 24-year old with hay fever faced rejection 8 percent of the time, and benefit limits or premium surcharges 87 percent of the time.

Yet the Economic Report of the President suggests that instead of spreading risks broadly so that health coverage will be affordable to those with existing conditions, “pricing to risk” is a primary goal of the health insurance marketplace. This approach sacrifices any notion of community and sharing of our neighbor’s burden, in favor of marketplace efficiency. Clearly, a shift of the insurance market away from employers and toward the individual insurance market, as encouraged by the President’s proposal, will add financial burdens and challenges to all those that have any existing health conditions.

Health Savings Accounts (HSAs) disproportionately benefit the healthy and wealthy and fragment the risk pool

Expansion of medical savings accounts (MSAs) under the new name of Health Savings Accounts (HSAs) add a new wrinkle to “consumer-driven health care” plans by making the contributions to the health reimbursement account tax deductible. This new tax policy, combined with high deductible health coverage, is likely to appeal disproportionately to the healthy and wealthy⁸.

- The healthy benefit because they have the new prospect of a tax-sheltered investment in which money is not taxed when put in or when withdrawn.
- The wealthy, with higher tax brackets, benefit disproportionately because the tax savings are larger at higher tax brackets than lower tax brackets.

Because of the divisive impact of high-deductible health insurance, it is also likely to aggravate already serious health marketplace disparities that result in inferior health care for blacks and Latinos, another troubling possibility at a time when the nation is finally beginning to address these problems. **Because of the variation of risks, and different selections made by people of different health status, high deductible plans can not exist in the long-term in a marketplace that offers low-deductible plans as well. Ultimately, low-deductible plans will be driven out of the market, with “premium spirals” driving out comprehensive coverage.**⁹

At the same time that this type of policy drives low-deductible coverage out of the marketplace, it is expected to do so with considerable federal expenditures. While the 10-year estimate of the HSA provision in the Medicare bill is \$16 billion, adding the cost of the President's proposal to make premiums deductible brings the 10-year cost to \$41 billion.¹⁰ Beyond draining the federal treasury (and these cost estimates may well be low), it is important to keep in mind what other experts have said about the impact of such high deductible coverage:

“Fundamentally, those who would likely win from shifting to MSA/catastrophic arrangements are the healthy who will ‘take back’ some of their ‘excess’ contributions that effectively help to subsidize others.”¹¹

“The great savings will be for the employees who have little or no health care expenditures. The greatest losses will be for employees with substantial health care expenditures.”¹²

“Insurers view high deductible plan enrollees as presenting a lower claims risk than enrollees in traditional low deductible plans Insurers expect relatively better health status and lower service utilization by enrollees selecting high deductible plans and price their products accordingly.”¹³

“If MSAs become widely popular among consumers with relatively better health, an adverse selection cycle could be triggered that would drive up the cost of conventional, more comprehensive insurance. The resulting premium increases are likely to be large enough to make such insurance unaffordable and unavailable for substantial numbers of Americans.”¹⁴

A recent study of “consumer-directed health benefits” concluded that the young and healthy are potential winners, and that older people are less likely to choose high-deductible plans.¹⁵

Another concern about the President's proposal to make premiums for high-deductible health insurance policies tax deductible is the likely erosion of employer-based health coverage. When employers realize that employees have alternatives to employee coverage (i.e., through tax credits or deductions on the individual market), they may decide to discontinue offering their employees health insurance. Economists have estimated (in the case of tax credits) that for every 100 individuals who become newly insured through tax credits, 42 individuals would become uninsured because their employer dropped coverage.¹⁶

In sum, high deductible coverage, combined with the new tax shelter, drive up premiums for those wanting low deductible coverage, are likely to lead to elimination of low-deductible coverage, strain the federal treasury, and will lead to

shifting of costs to those who are sick while benefiting the healthy and those in high tax brackets.

“Consumer Driven Health Care” will not solve the problem of the uninsured while aggravating the problem of the underinsured

Approximately one in six (16 percent) families (with head of household under 65) incurred out-of-pocket health care costs (including premiums they pay directly) that exceed 10 percent of their income.¹⁷ Economists have used a risk-based definition of the underinsured – in which individuals are “underinsured” if they have private insurance and yet, because it is not comprehensive, run the risk of having out-of-pocket costs exceeding 10 percent of their income if they face a catastrophic illness.¹⁸ **As the President’s Economic Report clearly points out, high-deductible (and “consumer-driven”) health care plans are designed to increase out-of-pocket costs for those who have health care expenditures.** The gap between money in a health savings account and the high-deductible (this gap could be very high, in a range of \$2,000 to \$5,000 for families) is likely to cause a large number of families with relatively modest income to fall into the category of being “underinsured”: they are at increased risk (especially when including premiums and health care expenses not even covered by their policy) of having out-of-pocket costs exceeding 10 percent of their income. This concern is aggravated by the fact that many costs (e.g., charges that exceed allowed rate levels, charges for non-covered services) will not count toward meeting the deductible or toward any stop-loss in the policy. In our view, shifting this kind of financial burden to families with moderate incomes is undesirable. This segment of the population is also at risk of facing loss of employer coverage (if employers drop out of the health care market) and higher premiums for low-deductible coverage (if high-deductible policies are available).

Focusing on transforming our health care marketplace into a high-deductible marketplace is a dangerous distraction from the urgent national goal of extending affordable, quality health coverage to all.

¹ Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the state of New York to provide consumers with information, education and counsel about goods, services, health and personal finance, and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of *Consumer Reports*, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports* with more than 4 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support

² p. 200, Economic Report of the President, February 2004.

³ Paul Krugman, “The Health of Nations,” New York Times, February 17, 2004.

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- ⁴ *Care without Coverage: Too Little, Too Late*, Institute of Medicine, 2002, pages 3-11.
- ⁵ *Consumer Bankruptcy: Issues Summary*, Leo Gottlieb Professor of Law Elizabeth Warren, Harvard Law School, January 7, 2003.
- ⁶ Gail Shearer, Consumers Union, *The Health Care Divide: Unfair Financial Burdens*, August 10, 2002, Table 10.
- ⁷ How Accessible is Individual Health Insurance for Consumers in less-than-perfect health? The Henry J. Kaiser Family Foundation, June 2001, www.kff.org.
- ⁸ Edwin Park and Robert Greenstein, Center on Budget and Policy Priorities, President Proposes to Make Tax Benefits of Health Savings Accounts More Lucrative for Higher-Income Individuals, February 9, 2004.
- ⁹ Daniel Zabinski, Thomas M. Selden, John F. Moeller, Jessica S. Banthin, Center for Cost and Financing Studies, Agency for Health Care Policy and Research, "Medical Savings Accounts: Microsimulation Results from a Model with Adverse Selection," *Journal of Health Economics* 18 (1999) 195-218.
- ¹⁰ The \$25 billion estimate is from: General Explanations of the Administration's FY2005 Revenue Proposals," Department of Treasury, February 2004, p. 26. The HSA provision of the Medicare Modernization Act was initially estimated (by the Joint Committee on Taxation) to cost \$6.4 billion over 10 years. The Administration budget estimated this cost to be \$16 billion. OMB, *Analytical Perspective: Fiscal Year 2005*, p. 292, cited in Edwin Park and Robert Greenstein, Center on Budget and Policy Priorities, *President Proposes to Make Tax Benefits of Health Savings Accounts more Lucrative for Higher-Income Individuals*, February 9, 2004, p. 3.
- ¹¹ Len M. Nichols, Marilyn Moon & Susan Wall, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A numerical Analysis of Winners and Losers," The Urban Institute, Washington DC, April 1996, p. 12.
- ¹² American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," May 1995.
- ¹³ "Medical Savings Accounts: Results from Surveys of Insurers," U.S. General Accounting Office, December 31, 1998, GAO/HEHS-999-34, Appendix, p 14.
- ¹⁴ Iris J. Lav, Center of Budget and Policy Priorities, "MSA Expansions in Patients' Bill of Rights Could Drive up Health Insurance Premiums and Create New Tax Shelter," February 23, 2000.
- ¹⁵ Dwight McNeill, "Do Consumer-Directed Health Benefits Favor the Young and Healthy?" *Health Affairs*, January/February 2004, p. 186 – 196.
- ¹⁶ Estimate calculated based on Jonathan Gruber's testimony before the Subcommittee on Health, House Ways and Means Committee, February 13, 2002. See also: Edwin Park, Center on Budget and Policy Priorities, *Administration's Proposed Tax Credit for the Purchase of Health Insurance Could Weaken Employer-Based Health Insurance*, February 18, 2004. www.cbpp.org.
- ¹⁷ Gail Shearer, Consumers Union, *The Health Care Divide: Unfair Financial Burdens*, August 10, 2002, p. 14.
- ¹⁸ Pamela Farley Short and Jessica S. Banthin, *New Estimates of the Underinsured Younger than 65*, JAMA, 274: 1302-1306.