

**The Health Care Divide:
Unfair Financial Burdens**

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CONSUMERS UNION
August 10, 2000

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Our health care system is characterized by divisions. The insured receive more care than the uninsured, who are often priced out of needed medical care. Even among the insured, the healthy are divided from the sick, leaving the sick to shoulder large financial burdens. The burden of paying for health care divides people by income, with those at the lower income levels paying the largest share of income for health care. Until we overcome these divisions in our health care system, the challenge of achieving affordable, universal health care coverage will continue to elude us.

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"The nation's health insurance systems, both public and private, continue to deteriorate. The country ... faces a problem that prosperity perhaps has done less to alleviate than to obscure. The health insurance system is beginning to fail even some of the better off, much less the needy. It needs to be strengthened; the strengthening, whatever form it takes, almost surely will require a major government subsidy. That's on top of the funding that will be required to shore up Social Security and Medicare, pay for national defense, etc. The estimators say there's a budget surplus and the politicians are cheerfully dispensing it. The surplus gets a lot smaller if you think, as we do, that the government has a part to play in reducing the alarming and steadily increasing number of uninsured."

-The Washington Post (editorial), July 24, 2000

"According to a World Health Organization study, the United States ranks 37th in the quality of health care, despite spending that outstrips every other nation. Nations with universal health-care systems generally had better results than the U.S. And they all spent less money to achieve those results. It's time to brush aside the insurance lobby and start working toward universal health coverage for all Americans."

- Charleston (W.V.) Gazette (editorial), June 26, 2000

"According to revised budget estimates released last month, the government can expect an extra \$1.3 trillion in revenue over the next 10 years, bringing the official surplus estimate to an astounding \$4.2 trillion. [Once you subtract the payments slated for the federal debt and current tax credits,] the next president and Congress will have slightly less than \$1 trillion of the original \$4.2 trillion to pay for new programs or tax cuts. [A] program to provide universal access to health insurance ... would probably cost between \$600 billion and \$800 billion over 10 years. Adding a decent drug benefit to Medicare would cost more than \$200 billion over 10 years."

- The New York Times (editorial), July 8, 2000

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For the past 26 years, Consumers Union's President, Rhoda H. Karpatkin, has targeted the issue of affordable health care coverage for all consumers as one of her – and Consumers Union's – highest priorities. I deeply appreciate her unwavering commitment to the goal of affordable health care for all, and her support of Consumers Union's health care advocacy.

A Note on Methodology

This report is based largely on data from the Medical Expenditures Panel Survey (1996) released earlier this year by the Agency for Healthcare Research and Quality. This consumer expenditure data were adjusted by The Lewin Group with its Health Benefits Simulation Model to reflect changes in demographics, real income and health expenditures between 1996 and 2000. The Lewin Group used a variety of data sources to impute premiums for the Medicare population, people with employer provided coverage, and people with individual coverage. Premium data (e.g. from the 1991 HIAA Survey of Employers) were adjusted for inflation, using the National Health Expenditure data for per capita private insurance spending. Details of the methodology used by The Lewin Group are included in Appendix C of *Analysis of Health Spending Across the US Population in 2000*.

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Analysis of Health Spending Across the US Population in 2000,
The Lewin Group, July 13, 2000

Executive Summary

Our health care system is characterized by divisions. People with health insurance receive more care than people without insurance, often because the uninsured cannot pay for the care they need. For those who do have insurance, the system divides the healthy from the sick, leaving the sick to shoulder large financial burdens. High-income families devote a much smaller percentage of their incomes to health care compared to lower-income families. These divisions -- of insured and uninsured, healthy and sick, and high incomes and modest incomes -- shape the choices made by sellers of health insurance, the choices made by consumers of health care, and the equity of paying for health care.

While the number of people without health insurance continues to grow, there is no sign that the private marketplace alone is capable of responding adequately to the challenge consumers face in covering health care costs. The marketplace has incentives to place the healthy and sick in different risk pools, rather than spread the risks broadly. The burden of rising costs continues to fall disproportionately on the sick and people with modest incomes.

Congress is considering a number of proposals that purport to make health care more accessible and affordable. A careful analysis of new data on health care expenditures sheds light on the likely impact of various policy proposals. It should also provide guidance for evaluating which proposals would most effectively deal with the problem of inadequate health insurance coverage.

Key Findings

- Health care spending varies substantially across the population. The sickest 10 percent of the population spends six to seven times what the average person spends on health care. The sickest 10 percent of the population accounts for 68 percent of the health care expenditures.
- Health care payments place a far greater financial burden on people with low income than those with high income. The percent of family income spent on premiums and out-of-pocket payments ranged from a high of 17 percent for families with income under \$10,000 to 3 percent for families with income of \$100,000 and more (for households with head under 65).
- One in six households headed by a person under age 65 spends 10 percent or more of its income on out-of-pocket costs plus directly paid premiums. The burden increases with age, with one out of two households headed by a person over 65 paying more than 10 percent of its income on such costs, in part because Medicare does not cover prescription drugs.

Recommendations

At a time of unprecedented budget surpluses, Congress should establish, as a matter of law, that all people in this country have a right to comprehensive, affordable, quality health care coverage.

If Congress will not undertake a comprehensive approach, it must address the most important needs of targeted populations, while guarding against market mechanisms that divide the healthy from the sick. Specifically:

- *Children:* Congress should enact legislation to assure that all children have comprehensive, quality coverage.
- *Medicare prescription drugs:* Congress should enact a universal Medicare prescription drug benefit, without dividing the healthy from the sick.
- *Medicare expansion:* Congress should expand Medicare to assure that all people 55 to 64 (including many early retirees) will have quality, affordable coverage.
- *Moderate-income and low-income adults:* Congress should extend coverage to parents of children enrolled in the State Children's Health Insurance Program (SCHIP) and Medicaid.
- *Ensuring comprehensive coverage:* Congress should take steps to reduce the ranks of the underinsured by requiring that insurance costs reflect broad spreading of risks among the healthy and the sick. Several proposals under consideration would separate the healthy from the sick, and thereby drive up premiums for those remaining in traditional coverage; they should be rejected. For example, HealthMarts, a form of voluntary purchasing cooperatives, and association health plans (AHPs), would allow small employers to join together to provide employees with health coverage. These plans would be exempt from state benefit mandates. They would be able to offer minimal benefits and would likely split the healthy from the sick, possibly leading to higher premiums for those who are not enrolled in these plans.
- *Insuring the sick with the healthy:* Congress should reject proposals such as medical savings accounts (MSAs) that combine tax-favored savings accounts with high-deductible insurance coverage. Like HealthMarts and AHPs, MSAs are expected to appeal disproportionately to relatively healthy consumers, which could increase insurance costs for others.

Part I

Paying for Health Care

Introduction

Health care is different from virtually every other product or service that is purchased by an individual or family. When an individual can't afford a product such as a television or car, quality of life might be somewhat diminished. But when an individual can't afford preventive screening, asthma medications, or a cancer operation, the inability to pay for these medical services can have a major impact on the quality of life, and can even result in premature death. One year a parent might have employer-provided comprehensive health insurance, but the next year a pink slip could bring the end of the family's health care security. Every member of a family might be healthy one year, but the next year a devastating illness can create both health care challenges and major financial hardship. When families sacrifice to pay for needed health care, the burden of paying for health care can be immense, especially for families with low or moderate income.

The financial health care burden faced by individuals and families is inextricably linked to the overall structure of our country's health care system. The United States has a hybrid health insurance system consisting of employer-based coverage, a far-from-perfect individual insurance market (with regressive premiums) for those not participating in the employer-based system, Medicare for people with disabilities and people 65 and over, Medicaid for people with very low incomes, and SCHIP for low-income children.

The purpose of this report is to provide current data on consumer health care expenditures, with the ultimate goal of encouraging public policy changes to make our financing system fairer and more progressive. This paper presents data indicating that the lack of health insurance is likely to mean denied health care for many people. It also shows that having health insurance is no guarantee of protection against substantial financial burdens if sickness strikes. Because health insurance often has gaps, even many people with health insurance are at risk of high out-of-pocket costs. The data presented below show a system that tends to divide the healthy from the sick.

The significance of the debate on fair financing of health care was highlighted recently when the World Health Organization issued its report ranking the United States 54th out of 191 nations on the dimension of fairness of financial contributions. The World Health Organization provides a useful framework for consideration of the significance of alternate financing choices:

Choices for financing health services have an impact on how fairly the burden of payment is distributed. Can the rich and healthy subsidize the poor and sick? In order to ensure fairness and financial risk protection, there should be a high level of prepayment; risk should be spread (through cross-subsidies from low to high health risk); the poor should be subsidized (through cross-subsidies from high to low income); the fragmentation of pools or funds should be avoided....¹

In 1998, Consumers Union released the report *Hidden from View: The Growing Burden of Health Care Costs*, which measured the burden that health care costs impose on various segments of society. The 1998 report was based on data from a variety of sources, including the 1987 National Medical Expenditure Survey (NMES). The Lewin Group used its Health Benefits Simulation Model (HBSM) to estimate costs for 1996.

In January 2000, the Agency for Healthcare Research and Quality (AHRQ) released data from the 1996 Medical Expenditure Panel Survey. Consumers Union asked the Lewin Group to replicate the earlier tables using the new MEPS data for 1996 and use its microsimulation model to adjust the 1996 MEPS data to the year 2000. Tables of health care spending in 1996 and 2000 are included in the report prepared by The Lewin Group, *Analysis of Health Spending Across the US Population in 2000*, which follows this Consumers Union report. In addition, the Lewin Group used various data sources to impute premium data.² The new set of data provides an opportunity to look afresh at the burden that health care spending places on various segments of society. While there are some minor data discrepancies between the Lewin tables prepared in 1998 and 2000, for the most part the new data are consistent with the old.³

Our health care system is characterized by divisions. The insured receive more care than the uninsured, who are often priced out of needed medical care. Even among the insured, the healthy are divided from the sick, leaving the sick to shoulder large financial burdens. When health cost burden is measured as a percent of income, high-income families do better than low-income families, devoting far less of their income to cover health care costs. These divisions – of healthy and sick, insured and uninsured, and high-income from low-income – shape choices made by sellers of health insurance, choices made by consumers of health care, and the equity (or lack of equity) of paying for health care.

While the number of uninsured consumers continues to grow, there are no signs that the marketplace alone is capable of relieving the financial burden of paying health care costs. The high level of variation in health expenditures provides the marketplace with strong incentives to divide the healthy from the sick, fragmenting the risk pool. Congress is considering a number of proposals that purport to make health care more accessible and more affordable. A careful analysis of new data on health care

expenditures sheds light on the likely impact of various policy proposals, and should provide guidance for evaluating which proposals would most effectively deal with the problem of inadequate or unaffordable health insurance coverage.

Adverse selection is not merely a theoretical construct; it is a demonstrated phenomenon that regularly affects health insurance markets. For example, selection of relatively healthy people into Medicare HMOs has left the federal government struggling to avoid overpaying HMOs. Because people who need prescription drug coverage in medigap (private health insurance that supplements Medicare) are most likely to seek such coverage, this benefit (a voluntary choice in medigap) tends to be priced very high compared with the maximum possible benefit.

The data in this report reveal lower spending by the uninsured (compared with the insured); a disproportionate burden on modest-income households; a heavy burden on the sick; and a growing percent of household income devoted to health care. As noted above, a new report by the World Health Organization, *The World Health Report 2000. Health Systems: Improving Performance*, provides an international context for these data. When compared with 191 countries, the United States ranks 15th on overall attainment of health goals (i.e., a combination of rankings for health level, responsiveness, and fairness in financial contribution). When the amount of resources devoted to health care in the United States (i.e., by far the highest per capita health expenditures) is also considered (attempting to get at value), the U.S. ranking falls to 72nd (performance on level of health) and 37th (performance of overall health system).⁴

Part I of this report provides an overview of the data and identifies some of the key implications for public policy. Part II uses graphs to highlight some of the important relationships, such as the burden that falls on those with modest income and the sick, and the variation of expenditures. Part III provides an in-depth analysis of the implications of the new data for discussions on adverse selection and mechanisms that undermine broad spreading of risks, splitting the healthy from the sick (e.g., medical savings accounts). Finally, following Part III, The Lewin Group's report describes the methodology and includes the tables with the data of expenditures for 1996 and 2000.

Findings and Recommendations

Finding: Health care costs as a percent of household income continue to increase, up from 7.9 percent in 1996 to 8.6 percent in 2000. The burden of paying for health care falls disproportionately on the sick and on households with modest income. The sickest uninsured people face the highest out-of-pocket costs, with average out-of-pocket costs estimated to be \$3,172 for the top decile of the uninsured. An international ranking rates the United States 54th (out of 191 countries) on fairness of financing the health care system. While the number of uninsured has grown to over 44 million people, the

percentage of people under 65 who are uninsured increased from 17.3 percent in 1994 to 18.4 percent in 1998.⁵

Recommendation: Congress should establish, as a matter of law, that all people in this country have a right to comprehensive, affordable, quality health care coverage. With the outlook for the federal budget surplus better than ever, Congress should establish a timetable that will achieve this goal in a reasonable time frame.

Finding: Per capita health care spending for children is considerably lower for people under 18 (\$1,375) than average per capita health care spending (\$3,338). Medicaid pays a quarter of the health expenditures of people 18 and under, compared with 11 percent for the entire population.

Recommendation: In times of a booming economy and growing federal budget surplus, Congress should finish the job of providing all children (regardless of age, health status, and income) with comprehensive, high-quality health care coverage. Congress should extend coverage to parents of children enrolled in SCHIP and Medicaid.

Finding: Out-of-pocket health care costs are a major financial burden on seniors, with 51 percent of families 65 and over spending more than 10 percent of their income on out-of-pocket costs plus premiums. Seniors' expenditures for prescription drugs vary considerably. While average costs are \$928 in 2000, those in the top decile of prescription drug expenditures had payments of \$4,793.⁶ If a Medicare prescription drug benefit with *unlimited choice* were adopted, adverse selection is likely to lead to higher costs for the subsidized program.

Recommendation: Congress should build a universal prescription drug benefit into Medicare, covering all beneficiaries just as Part A hospital coverage protects all enrollees. Medicare beneficiaries should have access to discount prices for the medicine; coverage should include stop-loss protection to protect those with the highest expenditures.

Finding: 24 percent of families headed by a person 55 to 64 years old have health care expenditures that total 10 percent or more of their family income.

Recommendation: Congress should expand Medicare to assure that all people 55 to 64 (including many early retirees) will have quality, affordable coverage.

Finding: Average health care expenditure figures mask the tremendous variation in risk. 10 percent of the population accounts for 68 percent of health care spending. This decile spends six to seven times as much as the average. The sickest percentile (top 1 percent) has total health care payments averaging over \$86,000. Risks vary, regardless of income or insurance status. This high level of risk variation demonstrates why it is so important to keep the healthy and the sick together in one combined risk pool. Dividing the healthy from the sick will deplete the risk pool of needed premium dollars, and will inevitably lead to higher premiums for those with higher risks. The variation of health care risks has a major bearing on the ultimate marketplace impact of medical savings accounts (MSAs, which combine tax-favored savings accounts with high-deductible insurance). MSAs will appeal disproportionately to the healthy (who can benefit from the tax shelter and the lack of need to spend their MSA funds), driving up premiums for those wishing to have -- and needing -- traditional health care coverage. In the long-term, the initial MSA option could drive low-deductible coverage out of the marketplace. Based on the 2000 health care expenditure projections and variation in spending, Consumers Union estimates that premiums could increase for those wishing to keep traditional coverage between 12 percent and 312 percent (considering various scenarios). Tripling of premiums for traditional coverage would occur if *all* of the healthy people migrated to MSAs.

Recommendation: Congress should reject public policy proposals that fragment the risk pool, dividing the healthy from the sick. For example, Congress should end the medical savings account (MSA) demonstration and prohibit MSA expansion to broader segments of consumers.

Finding: 16 percent of families under 65 has health care costs (out-of-pocket expenditure plus directly paid premiums) that equal 10 percent or more of their income.

Recommendation: Congress should take steps to reduce the ranks of the underinsured (those who have health insurance but still face the risk of burdensome health care costs). It should ban limits on lifetime benefits that limit reimbursement to families with the most catastrophic need. It should work toward assuring that all people have comprehensive coverage that provides true security in the event of serious or chronic illness. If enacted, HealthMarts, a proposed form of voluntary purchasing cooperatives, would offer policies that are exempt from state benefit mandates. Federally-certified association health plans would allow small employers to join together to provide health coverage for employees, while creating a new exemption from state insurance regulation including state benefit mandates. Congress should reject HealthMarts and federally certified association health plans which are likely to split the healthy from the sick and drive up costs for those who *don't* enroll in these plans. HealthMarts and association health plans would be able to fragment the risk pool, in part by offering minimal benefits since they would be exempt from state benefit mandates.

Part II

Ten Measures of Burden on Consumers

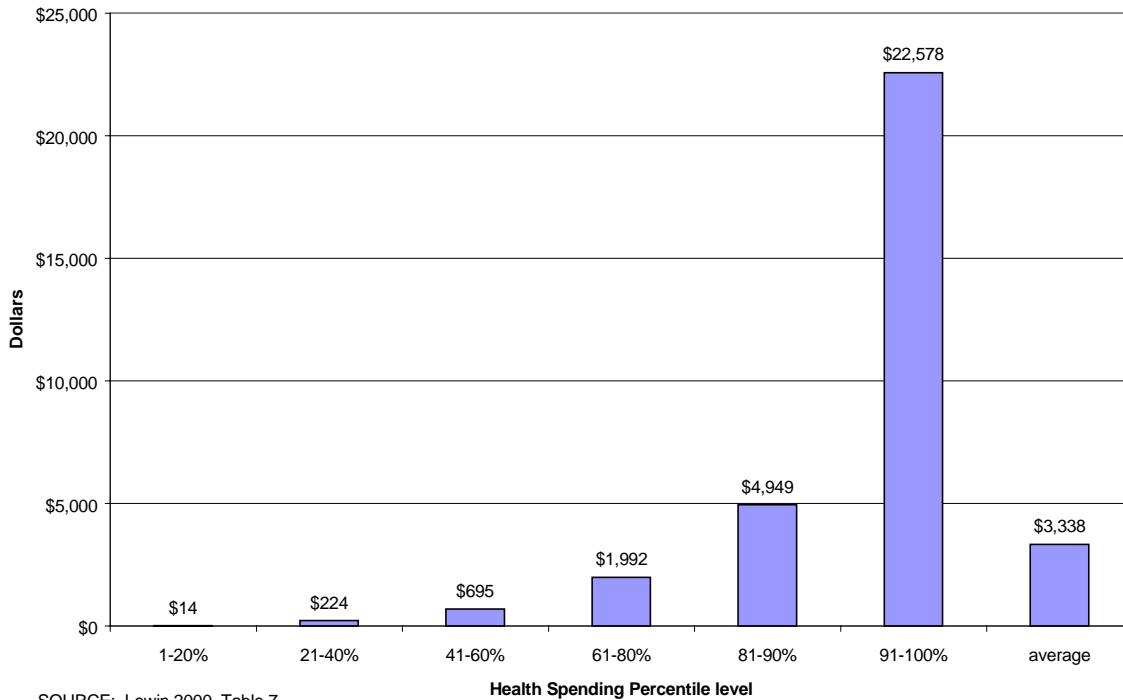
The following section shows key data from the 1996 Medical Expenditure Panel Survey⁷ (MEPS), adjusted (based on health cost trends) to the year 2000. The Lewin Group's microsimulation model adjusted the MEPS 1996 data to the year 2000. The entire set of Lewin tables (and detailed explanation of methodology) is included at the end of this report. The 1996 MEPS data and Lewin Tables for 2000 show:

- Health care spending varies substantially, with 10 percent of the population accounting for 68 percent of expenditures. (Chart 1)
- Expenditures vary considerably across all income, age, and insurance status, creating the need to keep the healthy and the sick in the same risk pool. (Chart 2)
- The sick, especially the elderly sick, face the largest burden of out-of-pocket costs. (Chart 3)
- Like other health expenditures, spending by people 65 and over on prescription drugs varies considerably. (Chart 4)
- On average, children have health care expenditures far lower than the average for the entire population, making it relatively inexpensive to cover *all* children. (Chart 5)
- A disproportionately large burden of health care spending falls on people with modest incomes. (Chart 6)
- One in six of households headed by a person under age 65 spend 10% or more of their income on out-of-pocket costs plus directly paid premiums. (Chart 7)
- One in four households headed by a person near retirement age (55-64) spends more than 10 percent of their income on out-of-pocket costs plus directly paid premium. (Chart 8)
- One out of two households headed by a person 65 or over spends more than 10 percent of their income on health care payments. (Chart 9)
- While average Medicare payments are about \$5,000, payments for the healthiest 10 percent are \$81 and the sickest 10 percent are over \$31,000. (Chart 10)

Uneven Distribution of Health Care Costs

Chart 1

Uneven Distribution of Annual Health Care Spending Across Entire US Population, 2000

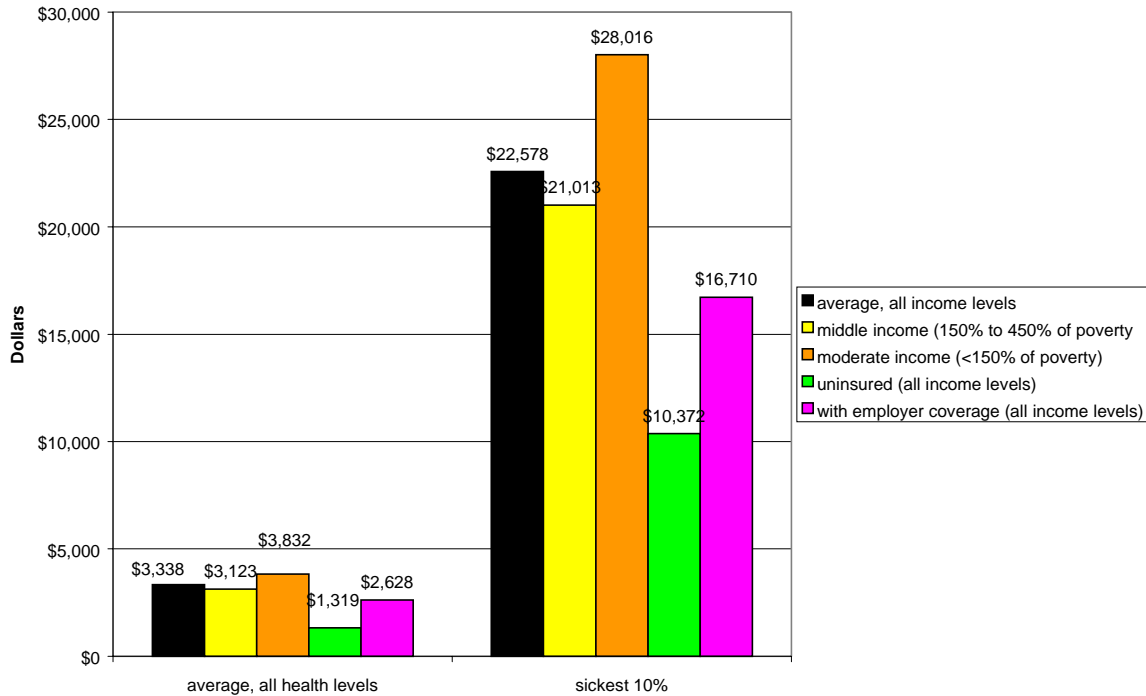


- Figures for annual per capita health care spending mask the variation in health care spending. The healthiest 20 percent spend \$14 on average, while the sickest 10 percent spend \$22,578. The average per capita health care payments in 2000 for all ages is \$3,338.
- 10 percent of the population accounts for 68 percent of health care spending (Lewin 2000, Table 7).
- Public policy solutions that divide the healthy majority from the relatively costly sicker minority will lead to higher, unaffordable premiums for the sick, unless new risk spreading schemes are adopted.
- The sickest one percent of the population has expenditures of \$86,322. (Lewin 2000, Table 16)
- Per capita health expenditures increased from \$2,805 in 1996 to \$3,338 in 2000. Spending by the sickest decile increased from \$19,724 to \$22,578 in this period.

Variation in Expenditures Across Various Incomes and Insurance Statuses

Chart 2

High Expenditures of the Sickest Decile, Annual Per Capita Spending, 2000



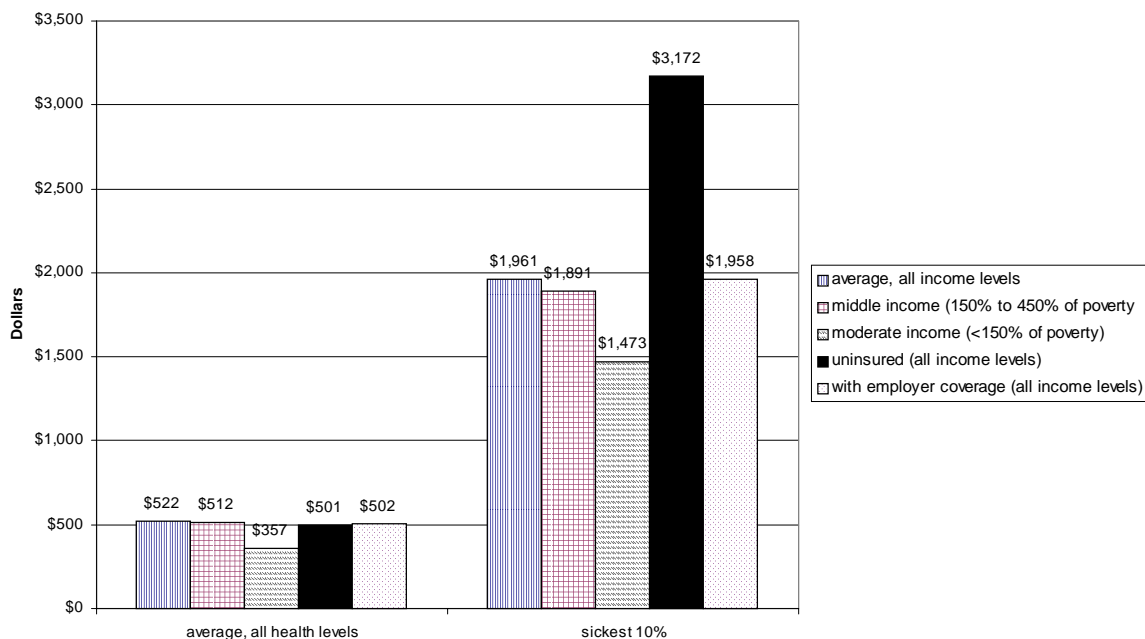
Source: Lewin 2000. Tables 7. 10. 14

- Expenditures for the sickest 10 percent are six to seven times higher than average expenditures, across all income levels and various insurance statuses.
- People who are uninsured spend 60 percent less than the average person. The sickest 10 percent of the uninsured spends 54 percent less than the sickest 10 percent overall. These lower expenditures suggest that (unless the uninsured are healthier than average), the uninsured are denied access to health care.
- The sickest 10 percent of households with modest income spends 21 percent more than the sickest 10 percent overall. Medicare and Medicaid pay 65 percent of their costs.

Variation in Out-of-Pocket Costs: Burden is Highest for the Sick

Chart 3

Sickest People Face Highest Out-of-Pocket Costs, Annual Per Capita, Spending 2000

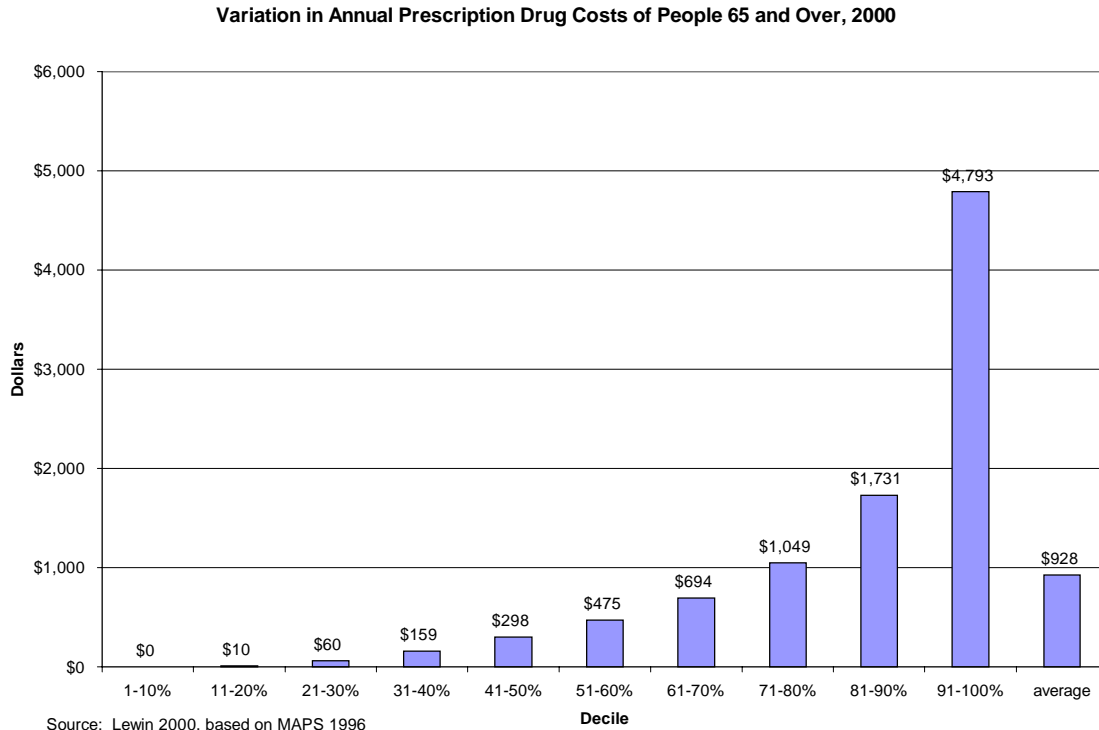


Source: Lewin 2000, Tables 7, 10, 14

- Regardless of income or insurance status, out-of-pocket costs are four to six times higher for the sickest 10 percent, compared with the average.
- Out-of-pocket costs of people with income below 150 percent of poverty (both average and sickest 10 percent) are lower than those of the average income person. These lower costs reflect, in part, the fact that Medicaid reaches only a portion of people at this income level.
- Out-of-pocket costs for the sickest 10 percent of the uninsured are 62 percent higher than those of the sickest 10 percent of people across all income levels.

Variation in Prescription Drug Costs of Elderly

Chart 4

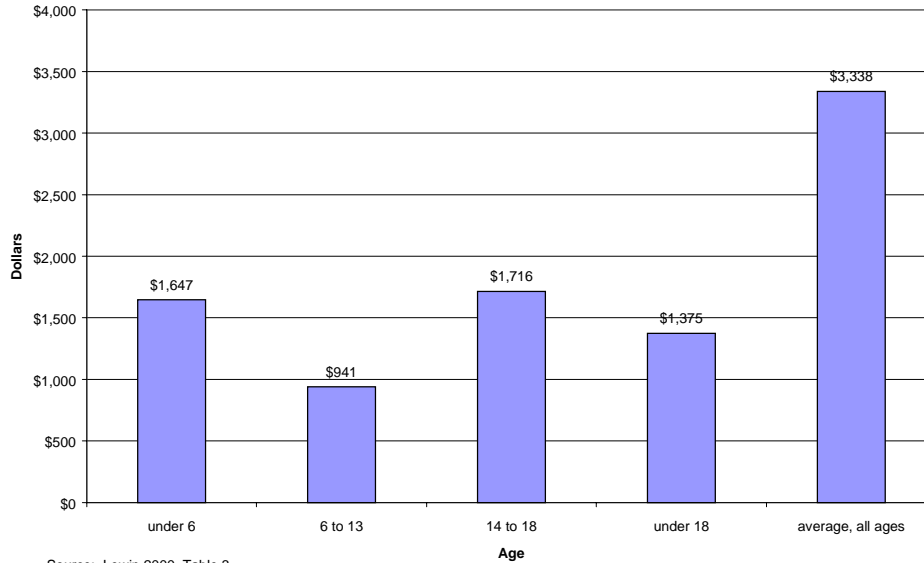


- The Lewin Group estimates for prescription drug spending by people 65 and over in the year 2000⁸ show considerable variation: while average costs were \$928, the sickest 10 percent had expenditures of \$4,793. The healthiest 10 percent will spend nothing.
- Most people over 65 will spend less than \$500 on medicines in 2000.
- The actual figures for 2000 may be higher than these in light of estimates of annual increases in prescription drug spending by the elderly of 9.8 percent to 13.7 percent between 1995 and 1999,⁹ and other estimates of 1999 drug expenditures increasing by 17.4 percent.¹⁰
- The variation in prescription drug expenditures has major implications for public policy: programs that provide choice (as in H.R. 4680, the Medicare Rx 2000 Act, which encourages private insurance companies to sell voluntary prescription drug coverage to Medicare beneficiaries¹¹) are likely to appeal to targeted groups of Medicare beneficiaries. Voluntary, private insurance options (again, as in H.R. 4680) are likely to appeal disproportionately to people most likely to use the benefit, splitting healthy from the sick.

Relatively Low Cost of Insuring Children

Chart 5

Annual Per Capita Health Spending for Children, 2000



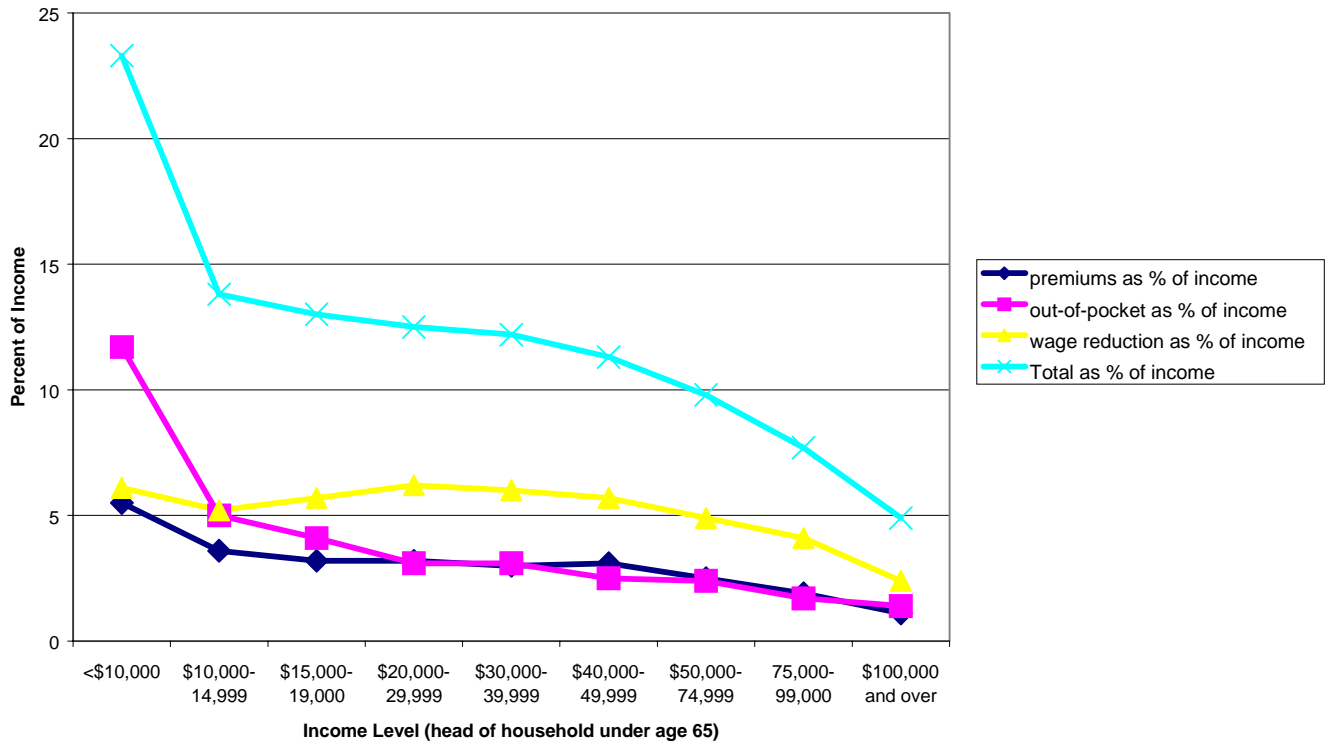
Source: Lewin 2000, Table 3

- The average per capita spending for all children under 18 is \$1,375, 59 percent lower than the cost of the average spending across all ages.
- Children between 6 years and 13 years have the lowest average costs, with average per capita spending estimated to be \$941 in 2000.
- Major recent initiatives, such as the State Children's Health Insurance Program (SCHIP) have extended eligibility for coverage to most of the lowest income children. However, for a variety of reasons, millions of children remain uninsured. In California alone, an estimated 2 million children are uninsured; 1.5 million of them are eligible for either Medi-Cal (i.e., Medicaid) or Healthy Families (California's CHIP program).¹²
- Many middle income families (who are not even eligible for existing programs) have difficulty finding affordable health coverage for their children.

Heavy Burden on People with Low Income

Chart 6

Annual Health Care Spending as Percent of Income, 2000



Source: Lewin 2000, Table 5

- The burden of health care spending is highest on those with low income.
- When *total* burden is measured (including premiums, out-of-pocket costs, and wage-reduction from employer-paid premiums), people earning under \$10,000 pay 23 percent of income for health care, while those with income of \$100,000 and over pay 5 percent of their income for health care.
- The health care burden has increased between 1996 and 2000. Average out-of-pocket payments plus premiums increased (for people under 65) from \$1,783 (1996) to \$2,226 (2000), increasing as a percent of income from 4.0 to 4.4 percent.
- When wage reduction (due to employer's premium payments) is included, the percent of income devoted, on average, to health care increased from 7.9 percent to 8.6 percent.¹³

XXX The Burden on the Underinsured

Even consumers who have health insurance are at risk of financial ruin if they incur catastrophic health care expenditures. Health care researchers Pamela Short and Jessica Banthin define the “underinsured” (in an article in the *Journal of the American Medical Association* in 1995¹⁴) to be individuals who have private health insurance, yet run the risk of incurring out-of-pocket expenses (not including premiums) that exceed 10 percent of income in the event they faced catastrophic illness. Short and Banthin estimated that the percent of underinsured adults increased from 12.6 percent in 1977 to 18.5 percent in 1994. In 1998, we estimated that 31 million adults were underinsured, under this definition, extrapolating to 1996.¹⁵

Data available for this report (MEPS 1996, Lewin 2000 estimates, and premiums imputed by Lewin) do not allow easy estimation of the number of underinsured (among those with private health insurance) based on the JAMA article’s use of the risk of out-of-pocket expenditures resulting from catastrophic illness. Instead, the data allow an estimate of families’ *actual* experience with health care spending. As in *Hidden from View: The Growing Burden of Health Care Costs*, three definitions of health care costs are used to provide measures of the health care burden based on *actual* health care expenditures. The three measures of health care costs are (1) out-of-pocket costs; (2) out-of-pocket costs plus consumer-paid premiums; and (3) out-of-pocket costs, plus consumer-paid premiums, plus premiums paid indirectly by employees through lower wages.¹⁶

It is important to keep in mind that while researchers have used 10 percent as a benchmark figure (for out-of-pocket expenditures alone), there has not been extensive consideration by health policy experts about what the appropriate percent of income that should be devoted to health care is. When it comes to the low-income population, 10 percent of income could pose a greater financial burden than it does on higher-income families, since these families are struggling to meet all of their basic needs.

The tables below estimate *real* burden of health care spending, regardless of insurance status. They are for all people (in the relevant age bracket) including people with private insurance, people with public insurance, and people who are uninsured. It is important to keep in mind that they substantially understate the number of the underinsured since many more people are *at risk* of burdensome health expenditures if serious illness strikes.

Underinsured: Under 65

Chart 7

Percent of Families With Health Care Costs Over 10 Percent of Income Head of household under 65

Included Costs	Number of Families	Percent of Families
Out-of-pocket	6,632,000	7% (1 in 15)
Out-of-pocket & Direct premiums	16,365,000	16% (1 in 6)
Out-of-pocket & Direct premiums & Indirect premiums (wage loss)	38,965,000	39% (2 in 5)

Source: Lewin 2000, Table 5

- These figures show the number (and percent) of families (with head of household under 65) who (regardless of insurance status) spend 10 percent or more of their income on health care.
- Using the most limited measure of burden, out-of-pocket costs alone, 7 percent of households (1 in 15) spend 10 percent or more.
- Using the measure of out-of-pocket costs plus directly paid premiums, one in six households spend 10 percent or more on health care.
- Using the most comprehensive definition of burden: out-of-pocket costs plus directly paid premiums plus wage loss associated with employer-paid premiums, 39 percent of households spend 10 percent or more on health care.
- While the numbers in this table are for *all* households (with head under 65), regardless of insurance status, similar percentages result from using the numbers in Lewin 2000, Table 5A, which includes only families in which all members have health insurance.

Underinsured: People 55 to 64 Years Old

Chart 8

Percent of Families With Health Costs Over 10 Percent of Income Head of Households 55 to 64

Included Costs	Number of Families	Percent of Families
Out-of-pocket	1,554,000	11% (1 in 9)
Out-of-pocket & Direct premiums	3,438,000	24% (1 in 4)
Out-of-pocket, Direct premiums, & Indirect premiums (wage loss)	6,014,000	42% (3 in 7)

Source: Lewin 2000, Table 5C

- Health care costs are burdensome on people who are a few years short of qualifying for Medicare.
- One quarter of people 55 to 64 years old have health care expenditures (counting out-of-pocket expenditures plus directly paid premiums) totaling 10 percent or more of their income.
- Three out of seven households in this age group spent 10 percent or more on health care when the most comprehensive definition of health care spending is considered: out-of-pocket spending, direct premiums plus indirectly paid premiums (from wage loss).

Underinsured: 65 and Over

Chart 9

Percent of Families With Health Care Costs Over 10 Percent of Income Head of Household 65 or Over

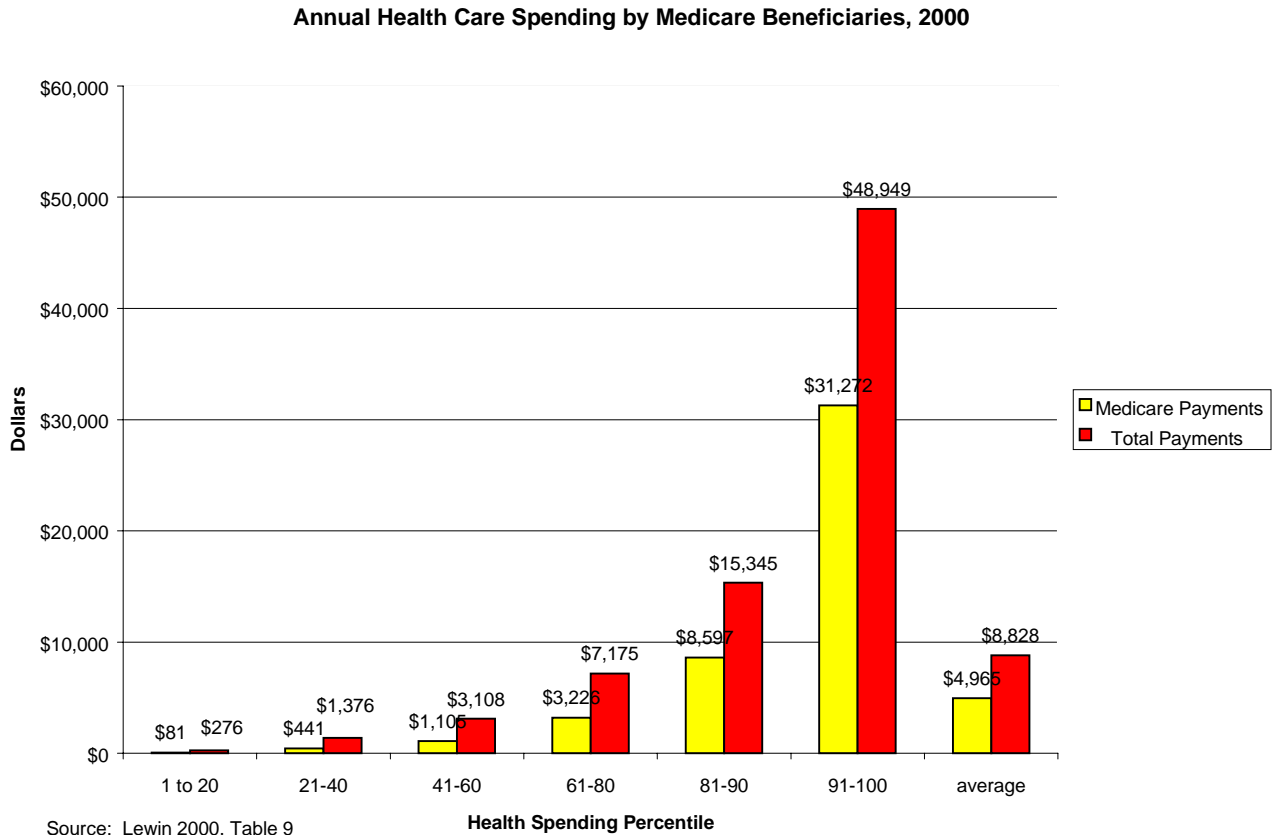
Included Costs	Number of Families	Percent of Families
Out-of-pocket	4,867,000	20% (1 in 5)
Out-of-pocket & Direct premiums	12,309,000	51% (1 in 2)

Source: Lewin 2000, Table 6

- Despite Medicare, people 65 and over still shoulder a considerable burden from health care costs.
- When the most limited definition of health care costs is considered (out-of-pocket spending alone), one in five households headed by a person 65 or over have payments 10 percent or more of income.
- When out-of-pocket payments plus directly paid premiums are considered, one in two households in this age bracket spend more than 10 percent of income on health care.

Variation in Medicare Beneficiaries' Spending

Chart 10



- While average Medicare payments are \$4,965 in 2000, the healthiest 20 percent have payments of only \$81 while the sickest 10 percent have payments of over \$31,000.
- On average, Medicare pays 56 percent of health care costs, leaving a significant portion for beneficiaries to insure privately or pay out-of-pocket.
- These figures (from Lewin 2000, Table 9) include acute care spending only. They do not include skilled nursing facility (SNF) or home care, which represent about 20 percent of Medicare costs.

Part III

Adverse Selection – Fragmenting the Risk Pool Implications of MEPS Data for Medical Savings Accounts

Introduction

The charts in Part II explain the variation in health care spending across various categories of consumers. This section explores in greater detail the implications of the variation of health care spending for medical savings accounts (MSAs), which combine tax-favored savings accounts with high deductible insurance coverage. MSAs were included on a demonstration basis as part of the Health Insurance Portability and Accountability Act of 1996, and were also extended to the Medicare program in the Balanced Budget Act of 1997. Both the House- and the Senate-passed managed care reform bills in the 106th Congress include provisions that would expand MSAs substantially, raising the possibility that they will eventually be used by a substantial portion of the population. This section explores the implications of variation of health care spending in a world that includes expanded MSAs.

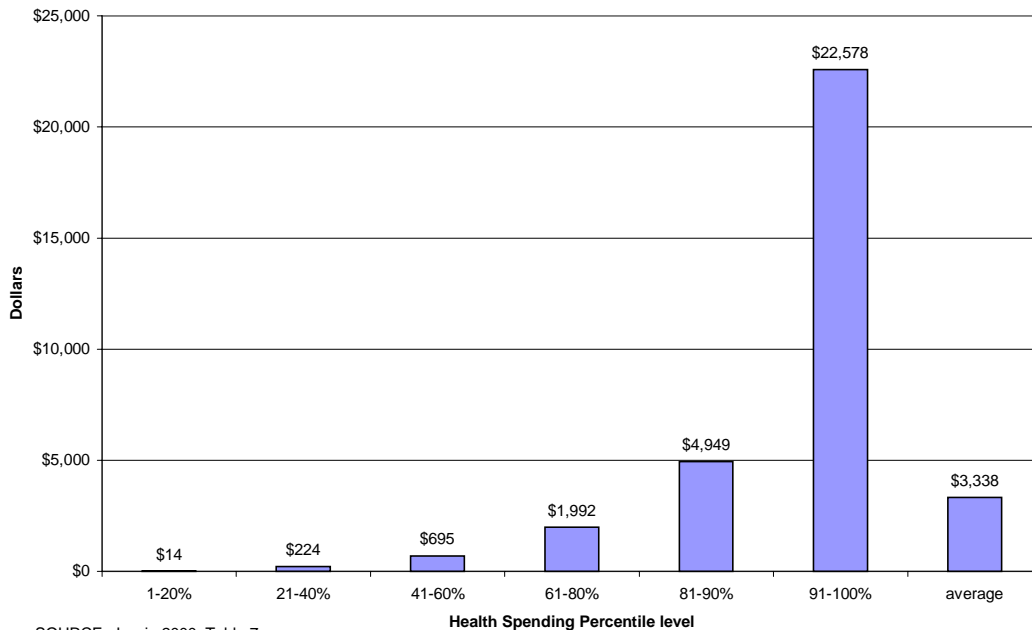
New Data on Variation in Health Care Risks

Newly released government data (MEPS, 1996) show once again that health care risks vary across the population. The Lewin Group has used its Health Benefits Simulation Model (HBSM) to project the new 1996 survey data through the year 2000 (Lewin 2000, Table 7). Chart 11 (page 19) shows the total health care payments across the entire population (for all income groups and ages), by percentile of health care spending.

While the average per capita total health care payments are estimated to be \$3,338 in 2000, the healthiest 20 percent have per capita total health care payments of just \$14, while the sickest 10 percent have per capita payments of \$22,578. The sickest percentile have per capita health care payments over \$86,000. Ten percent of the population accounts for 68 percent of health care spending. This sickest ten percent of the population spends nearly seven times as much as the average person.

Chart 11 (repeat of Chart 1)

Annual Per Capita Total Health Care Payments, 2000



This high level of risk variation demonstrates why it is so important to keep the healthy and the sick together in combined risk pools. Separating the healthy from the sick will deplete the risk pool of needed premium dollars, and will inevitably lead to higher, unaffordable premiums for those with higher risks.

Potential for Adverse Selection with Medical Savings Accounts

The key to keeping health insurance affordable (even to people with pre-existing health conditions such as high blood pressure, heart disease, and cancer) is to spread the costs as broadly as possible. MSAs do the opposite. MSAs consist of a tax advantaged savings account (meant to be used to cover health care expenses) and a high deductible (e.g., \$1,500 to \$2,250 for an individual). People with chronic health conditions are unlikely to enroll voluntarily in such high deductible plans. MSAs appeal disproportionately to people who are healthy and expect to be able to build up large unspent balances in their MSA. Proposals before Congress to expand MSAs do not assure that they will be available to people with existing health conditions since applicants can be denied and since premiums can vary according to risk. There is no mechanism for “risk adjustment,” which would eliminate any premium break that results simply from the fact that healthier people, on average, select high deductible coverage linked with MSAs. (Premiums would be lower for the high deductible coverage simply

because coverage is less.) In the absence of risk adjustment, those electing to stay in traditional coverage will very likely face higher premiums since healthy people will more likely be drawn to the high-deductible coverage, draining their premium dollars that formerly held premiums down for those with higher risks. If MSA proponents built in workable risk adjustment (and other market reforms), something that they have not been willing to do, then the analysis of the risks posed by MSAs would change substantially.

Numerous studies describe how risk selection can impact health insurance markets, many with a focus specifically on medical savings accounts. Below are short excerpts from some of these studies:

[R]isk selection is a concern because it encourages socially unproductive competition based on risk selection rather than on cost-effective management of care for the ill and injured...Any strategy of health care reform that is based on competition and choices about health coverage should address these problems....

--Institute of Medicine¹⁷

In a well-functioning market (e.g., for cars), producers compete by price and quality. In the health insurance market, carriers can compete, not by price, but by attracting the healthy (and hence cheapest) enrollees...[T]he greater the ease of disproportionately attracting healthy enrollees, the more the incentive for carriers to worry about selection bias.

-- in *Inquiry* (Blue Cross and Blue Shield Association)¹⁸

The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures.

--American Academy of Actuaries¹⁹

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."

--The Urban Institute²⁰

If MSA/CHP's are offered alongside comprehensive plans, biased MSA/CHP enrollment can lead to premium spirals that drive out

comprehensive coverage. Our estimates also raise concerns about equity, insofar as those who stand to lose the most tend to be poorer and in families with infant children.

--Agency for Health Care Policy and Research (AHCPR) study²¹

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. Insurers confirmed this conclusion in the survey.

--U.S. General Accounting Office²²

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.

--Center for Budget and Policy Priorities²³

Whether or not MSAs become law, if the market offers plans that are more attractive to healthy people, there will be a need for risk adjustment to ensure that premium differences reflect differences in plan generosity and efficiency and not just the average health of members.

--RAND²⁴

Examples of Adverse Selection in Health Insurance Markets

An estimated 45,000 MSAs were sold in 1999, a low number in comparison with the statutory limit of 750,000.²⁵ The limited number of MSAs sold during the current demonstration program has precluded analysis of the *actual* impact of MSA enrollment on premiums of those who choose traditional coverage. However, the phenomenon of *adverse selection* – the disproportionate appeal of a particular health insurance policy to the sick or to the healthy – is a regular and expected occurrence in health insurance markets. ***It is important to understand that once the process of adverse selection begins, even if it starts out slowly, the process works its effects over time and typically***

has an irreversible, devastating impact on the marketplace. Below are some examples of how adverse selection has affected real health insurance markets.

- Medicare HMOs have appealed disproportionately to healthy Medicare beneficiaries. While payments to HMOs were initially set at 95 percent of average costs, this level of payment overpaid HMOs since the average enrollee was substantially healthier than average. The federal government continues to struggle to adjust payments to HMO's in order to avoid overpaying them.²⁶
- In 1990, Congress enacted a law to simplify the Medicare supplement market, calling for ten standard benefit packages. Included in the ten standard packages required by the National Association of Insurance Commissioners were three packages with a limited prescription drug benefit. Because these packages were structured to represent first-dollar coverage (no deductible, no catastrophic benefits, with a maximum benefit of \$1,250 or \$3,000, depending on plan), they appeal disproportionately to people who are most likely to use these benefits. Because of this adverse selection, consumers are now charged premiums for medigap coverage (including prescription drugs) where the extra cost of the drug coverage is about the same or even exceeds the maximum amount of prescription drug benefits they can collect. For example, an 80-year-old in South Carolina would typically pay \$1,683 for Medigap policy F (with no drug coverage), and \$2,904 for policy I (with similar coverage, plus a maximum drug benefit of \$1,250). In other words, this person would pay \$1,221 for a maximum benefit of \$1,250.²⁷
- In the mid-1990's, Harvard University changed its health insurance program to a system that contributed the same amount to each plan. This led to adverse selection, with the health plans that offered the most generous benefits attracting the highest risks and suffering large losses. The two most generous plans, the Blue Cross/Blue Shield PPO and the Baystate policy, were driven from the market. These companies stopped offering these plans because of adverse selection and overall losses.²⁸
- Xerox recently proposed, and then quickly abandoned, its plan to replace its health insurance coverage with a payment of \$5,000 to \$6,000 per employee to purchase a health plan of his/her choice. Critics of the plan expressed concern that younger and healthier employees could opt for barebones coverage, while those with higher risks would face the high cost of comprehensive coverage.²⁹ With the average total per capita health care costs of the healthiest 20 percent just \$14, and the costs for the sickest 10 percent over \$22,000, it is easy to see that a \$6,000 payment would mean extra cash for the healthy, and a huge burden on the sick who are likely to face premiums well over \$10,000. Many of the sickest may not even be able to find any health insurance policy that is both affordable and available to them.

- The Federal Employee Health Benefits Plan (FEHBP) experienced adverse selection in the 1980's. In the late 1980s, one of the most popular plans (Aetna) stopped participating because it attracted too many costly high-risk enrollees.³⁰ In 1987, Blue Cross offered federal employees a high-option plan and a low-option plan, with equal actuarial values. In other words, if enrollment in the high or low option plan were random, the expected costs would be the same (even if the benefits varied). However, sicker people were attracted by the benefit design of the high-option plan. Because of this selection bias, costs for the high option were 79 percent greater than costs for the low option.³¹ Other studies have shown significant variation in actuarial value of various FEHBP Plans.³²

Possible Scenarios for Fragmenting the Risk Pool With Medical Savings Accounts

It is not possible to project the precise impact that removing the restrictions on MSAs (as proposed in both the Senate and House-passed managed care bills), because the MSA demonstration program has not been fully evaluated and might not be indicative of the likely response in the broader marketplace.³³ We can, however, predict what the average total health care costs would be for various risk pools, *if* a given percent of the “healthy” and the “sick” choose to enroll in MSAs. Table A below shows what the average costs would be, for those both selecting MSAs and those selecting traditional coverage, with varying definitions of the “healthiest” and varying percentages of the healthy enrolling in MSAs. Table A shows that even relatively modest enrollment in MSAs can have a very real impact on the risk pool: if 20 percent of the healthiest 80 percent of risks enroll in MSAs, the average per capita health care costs of those who stay in traditional policies would increase from \$3,338 to \$3,835, a 15 percent increase. This 15 percent increase in premiums is likely to encourage a new round of the healthiest of this new group to enroll in an MSA, and a selection spiral – with continued risk selection *into* MSAs, could ultimately lead to dramatically higher increases in costs and ultimately forcing people out of traditional coverage.

While Table A shows per capita dollar cost figures (for given enrollment in MSAs), Table B estimates the percentage change in premiums. This conversion to “premiums” assumes that premiums are proportional to costs. In other words, we assume that insurers are experience-rating their premiums, and making them proportional to underlying risks. Table C shows how the figures were calculated.

People can not predict with certainty their future health care costs. Included in Tables A and B are “mixed” scenarios, in which a portion of the healthy and a portion of the sick would enroll in MSAs. If 25 percent of the healthiest 80 percent and 10 percent of the sickest 20 percent enroll in MSAs, the average costs for traditional coverage would increase by 12 percent.

The numbers in Tables A and B are static. A more complex dynamic model would show small adjustments in each cycle – with relatively small migration to MSAs resulting in relatively small increases in premiums for traditional coverage. Year after year, the increases in premiums for traditional coverage would encourage a new group of relatively healthy consumers (and employers) to switch to an MSA. H.R. 2990 would relax various limitations on MSAs (e.g., deductibles would be lower, tax-free contributions larger, and flexibility of use of MSA funds could be increased), and it is possible that sellers of MSAs will develop ambitious marketing plans that will greatly expand the role MSAs play in the marketplace. Based on our current knowledge, we can not predict just how large the percent of people in MSAs would be, and how quickly the proportion of people enrolled in MSAs vs. traditional coverage would be, but the numbers below suggest that even relatively modest sales of MSAs would be harmful.

The nature of the distribution of costs [Chart 11 (page 19)], combined with the premium projections in Table B, show why MSAs pose a considerable threat to the health insurance market:

- Chart 11 (page 19) shows that a very large portion of the population is relatively healthy: While costs are very low (average costs of \$14) in the lowest fifth of the population, even in the 4th quintile (61 to 80th percentile), the average per capita health care costs are under \$2,000, far less than the overall average cost of \$3,338.
- Table B shows that the healthy who enroll in MSAs on average get *large* premium savings (with premiums 78 percent lower than with traditional coverage, for the assumptions in the table) and therefore have a strong incentive to enroll in MSA coverage. Of course, the larger the percent of the healthy enrolling in MSAs, the larger the premium increase for those enrolling in traditional coverage, and the quicker the impact on the marketplace will be.
- Table B shows that even relatively moderate enrollment in MSAs can lead to a 15 percent increase in premiums for those seeking traditional coverage. The estimate of premiums increasing by a factor of over 300 percent (premiums actually being over three times higher than they are before MSAs are introduced) if 100 percent of the healthy enroll in MSAs is consistent with estimates that the Urban Institute made in 1996, based on NMES data for 1994.³⁴
- Even if MSAs do not totally force out traditional low-deductible coverage, they could lead to a “bifurcated” system, in which relatively high-deductible MSAs are offered to some people, while very expensive (considerably more expensive than today) traditional coverage is available to those willing and able to pay much higher premiums.

Table A:

***Effect on Average Health Care Costs
If a Portion of the “Healthiest” Chooses MSA’s (2000)***

% of Healthiest 80% choosing MSA	Avg. costs MSA Group	Avg. costs Traditional Coverage Group
20%	\$731	\$3,835
50%	\$731	\$5,076
80%	\$731	\$7,973
100%	\$731	\$13,764

Assumptions:

- In each of the four scenarios (20%, 50%, 80%, 100%), a percent of the healthiest 80 percent enroll in MSAs, while 100 percent of the sickest 20 percent remain in traditional coverage.
- Average costs for MSA enrollees and for enrollees in traditional coverage are those of the respective health care spending quintile (or decile).
- Table C shows the underlying figures, which are based on data from Lewin 2000, Table 7.

***Effect on Average Health Care Costs If a Portion of the “Healthiest”
and a Portion of the “Sickest” Choose MSA’s***

	Avg. costs MSA Group	Avg. costs Traditional Coverage Group
25% of healthiest 80% AND 10% of sickest 20%	\$1,916	\$3,739
50% of healthiest 80% and 20% of sickest 20%	\$1,916	\$4,456

Assumptions:

- In each of the two scenarios, a percent (as specified) of the healthiest 80 percent enroll in MSAs, and a percent of the sickest 20 percent enroll in MSAs.
- For each scenario, the average costs (e.g., for the healthiest 20 percent or the sickest 10 percent) are used for those enrolled in MSAs or traditional coverage.
- Table C shows the underlying figures.

Table B:

***Effect on Premiums
If a Portion of the “Healthiest” Chooses MSA’s***

% of Healthiest 80% choosing MSA	Avg. costs MSA Group	Avg. costs Traditional Coverage Group
20%	78% lower	15 % higher
50%	78% lower	52% higher
80%	78% lower	139% higher
100%	78% lower	312% higher

***Effect on Premiums
If a Portion of the “Healthiest” and a Portion of the “Sickest”
Chooses MSA’s***

	Avg. costs MSA Group	Avg. costs Traditional Coverage Group
25% of healthiest 80% AND 10% of sickest 20%	43% lower	12% higher
50% of healthiest 80% and 20% of sickest 20%	43% lower	33% higher

Table C

**Health Expenditures, 2000
20% of Healthiest 80% Choose MSA's**

Decile/ Quintile	Total Number of People ('000's)	Average Cost	# Choosing MSA ('000's)	Average Cost \$	Total Cost \$(millions)	# NOT in MSA ('000's)	Average \$ Cost	Total Costs \$(millions)
1-20%	56,515	14	11,303	14	158	45,212	14	632
21-40	56,520	224	11,304	224	2,532	45,216	224	10,128
41-60	56,542	695	11,308	695	7,859	45,234	695	31,438
61-80	56,523	1,992	11,305	1,992	22,520	45,212	1,992	90,062
81-90	28,267	4,949	-	4,949	-	28,267	4,949	139,893
91-100	28,271	22,578	-	22,578	-	28,271	22,578	638,303
Total	282,638		45,220		33,069	237,412		910,457
Average:					\$ 731			\$3,835

**Health Expenditures 2000
50% of Healthiest 80% Choose MSA's**

Decile/ Quintile	Total Number of People ('000's)	Average Cost	# Choosing MSA ('000's)	Average Cost \$	Total Cost \$(millions)	# NOT in MSA ('000's)	Average \$ Cost	Total Costs \$(millions)
1-20%	56,515	14	28,258	14	396	28,259	14	396
21-40	56,520	224	28,260	224	6,330	28,260	224	6,330
41-60	56,542	695	28,271	695	19,648	28,271	695	19,648
61-80	56,523	1,992	28,262	1,992	56,298	28,262	1,992	56,298
81-90	28,267	4,949	-	-	-	28,267	4,949	139,893
91-100	28,271	22,578	-	-	-	28,271	22,578	638,303
Total	282,638		113,051		82,672	169,590		860,868
Average:					\$731			\$5,076

**Health Expenditures,2000
80% of Healthiest 80% Choose MSA's**

Decile/ Quintile	Total Number of People ('000's)	Average Cost \$	# Choosing MSA ('000's)	Average Cost \$	Total Cost \$(millions)	# NOT in MSA ('000's)	Average Cost \$	Total Costs \$(millions)
1-20%	56,515	14	45,212	14	633	11,303	14	158
21-40	56,520	224	45,216	224	10,128	11,304	224	2,532
41-60	56,542	695	45,234	695	31,437	11,308	695	7,859
61-80	56,523	1,992	45,218	1,992	90,074	11,304	1,992	22,518
81-90	28,267	4,949	-	-	-	28,267	4,949	139,893
91-100	28,271	22,578	-	-	-	28,271	22,578	638,302
Total	282,638		180,880		132,272	101,757		811,262
Average:					\$ 731			\$ 7,973

**Health Expenditures 2000
100% of Healthiest 80% Choose MSA's**

Decile/ Quintile	Total Number of People ('000's)	Average Cost \$	All Persons of People ('000)	#	Average Cost \$	Total Cost \$(millions)	# NOT in MSA ('000)	Average Cost \$	Total Costs \$(millions)
1-20%	56,515	14	56,515	14	791	-	14	-	
21-40	56,520	224	56,520	224	12,660	-	224	-	
41-60	56,542	695	56,542	695	39,297	-	695	-	
61-80	56,523	1,992	56,523	1,992	112,594	-	1,992	-	
81-90	28,267	4,949	-	-	-	28,267	4,949	139,893	
91-100	28,271	22,578	-	-	-	28,271	22,578	638,302	
Total	282,638		226,100		165,342	56,538		778,195	
Average:					\$731			\$13,764	

Health Expenditures, 2000
25% of Healthiest 80% and 10% of the Sickest 20% Choose MSA's

Decile/ Quintile	Total Number of People ('000's)	Average Cost \$	# Choosing MSA ('000's)	Average Cost \$	Total Cost \$(millions)	# NOT in MSA ('000's)	Average Cost \$	Total Costs \$(millions)
1-20%	56,515	14	14,129	14	198	42,386	14	593
21-40	56,520	224	14,130	224	3,165	42,390	224	9,495
41-60	56,542	695	14,136	695	9,825	42,406	695	29,472
61-80	56,523	1,992	14,131	1,992	28,149	42,392	1,992	84,445
81-90	28,267	4,949	2,827	4,949	13,991	25,440	4,949	125,903
91-100	28,271	22,578	2,827	22,578	63,828	25,440	22,578	573,475
Total	282,638		62,180		119,156		220,458	824,383
Average:					\$1,916			\$3,739

Health Expenditures 2000
50% of Healthiest 80% and 20% of Sickest 20% Choose MSA's

Decile/ Quintile	Total Number of People ('000's)	Average Cost \$	All Persons of People ('000)	#	Average Cost \$	Total Cost \$(millions)	# NOT in MSA ('000)	Average Cost \$	Total Costs \$(millions)
1-20%	56,515	14	28,258		14	396	28,258	14	396
21-40	56,520	224	28,260		224	6,330	28,260	224	6,330
41-60	56,542	695	28,271		695	19,648	28,271	695	19,648
61-80	56,523	1,992	28,262		1,992	56,298	28,262	1,992	56,298
81-90	28,267	4,949	5,653		4,949	27,977	22,614	4,949	111,917
91-100	28,271	22,578	5,654		22,578	127,656	22,617	22,578	510,647
Total	282,638		124,358			238,305	158,282		705,236
Average:						\$1,916			\$4,456

SOURCE: Distribution figures: Lewin 2000, Table 7. Calculations by Consumers Union

Endnotes

¹ World Health Organization, page 14.

² These are described in Appendix C of the Lewin report.

³ *Analysis of Health Spending Across the US Population in 2000*, The Lewin Group, explains that the 1996 MEPS used different definitions of households, and such differences in definition explain many of the data differences.

⁴ *The World Health Report 2000 -- Health Systems: Improving Performance*, World Health Organization, Geneva, 2000, Annex Table 1.

⁵ John Holahan and Johnny Kim, *TRENDS: Why Does the Number of Uninsured Americans Continue to Grow?* *Health Affairs*, July/August 2000, pages 178-187.

⁶ Lewin 2000, Table 17.

⁷ MEPS was developed by the Agency for Healthcare Research and Quality and the National Center for Health Statistics.

⁸ MEPS 1996 data adjusted using HCFA indices.

⁹ *Rx Health Value*, reported in *Medicine & Health*, (vol. 54, no. 20), May 15, 2000. The Department of Health and Human Services estimates that spending on prescription drugs increases at an annual rate of 12 percent. Department of Health and Human Services, *Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices, April 2000*.

¹⁰ p. 2, *1999 Drug Trend Report*, Express Scripts, June 2000.

¹¹ The Medicare Rx 2000 Act, which was passed by the House of Representatives on June 28, 2000.

¹² E. Richard Brown, UCLA School of Public Health, *California's Growing Uninsured Population and Options to Expand Coverage*, May 2000.

¹³ Lewin 1996 and 2000, Table 5.

¹⁴ Pamela Farley Short and Jessica S. Banthin, *New Estimates of the Underinsured Younger than 65*, *JAMA*, 274: 1302-1306.

¹⁵ *Hidden from View: The Growing Burden of Health Care Costs*, Consumers Union, 1998, p. 11.

¹⁶ *Ibid.* pages 19-22.

¹⁷ p. 169, *Employment and Health Benefits—A Connection at Risk*, Institute of Medicine, National Academy Press, 1993. The potential for risk selection is explored in depth by the Institute of Medicine, which identified benefit design (e.g. patient cost-sharing) as a “crucial” factor in determining risk selection, p. 173.

¹⁸ W. Pete Welch, *Restructuring the Federal Employees Health Benefits Program: The Private Sector Option, Inquiry*, 26 (321-334), Fall 1989.

¹⁹ American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995.

²⁰ 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.

²¹ 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.

²² *Medical Savings Accounts: Results From Surveys of Insurers*, U.S. General Accounting Office, December 31, 1998, GAO/HEHS-99-34, Appendix, p. 14.

²³ Iris J. Lav, Center on 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.

²⁴ Emmett B. Keeler, PhD, et.al, Health Sciences Program and RAND Graduate School, RAND, Santa Monica, California, *Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?* *JAMA*, June 5, 1996, vol. 275, No. 21.

²⁵ The exact estimate for MSA sales (that count against the statutory limit) is 44,784 in 1999. The IRS reported that 36,638 tax returns reporting an excludable or deductible contribution to an MSA for 1998 were filed by April 15, 1999. The IRS estimated that 32,371 returns count toward the applicable statutory limitation of 750,000 accounts. IRS Announcement 99-95 (Doc 1999-31533).

²⁶ See GAO/HEHS-97-16, *Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments*, Letter Report, April 25, 1997, General Accounting Office and GAO/HEHS-94-119, *Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs*, Chapter Report, September 2, 1994, General Accounting Office.

²⁷ Letter from Laura A. Dummit, Associate Director, Health Financing and Public Health Issues, United States General Accounting Office, to The Honorable John D. Dingell, March 1, 2000. See also Gail Shearer, Consumers Union, *Prescription Drugs for Medicare Beneficiaries: 10 Important Facts*, April 14, 2000.

²⁸ David M. Cutler and Sarah Reber, National Bureau of Economic Research, *Paying for Health Insurance: The Tradeoff Between Competition and Adverse Selection*, October 1996.

²⁹ *American Healthline*, December 6, 1999, citing Rubin, Los Angeles Times/Washington Post News Service/Richmond Times-Dispatch, December 5, 1999.

³⁰ p. 176, *Employment and Health Benefits: A Connection at Risk*, Institute of Medicine, National Academy Press, 1993. See also, p. 52, Julie Rovner, *Health Care Policy and Politics*, Congressional Quarterly, 2000.

³¹ p. 324, W. Pete Welch, *Restructuring the Federal Employees Health Benefits Program: The Private Sector Option*, *Inquiry*, 26 (321-334), Fall 1989.

³² A study by the Congressional Research Service found that there was a 56 percent maximum difference in actuarial value among family plans. P. 15, Mark Merlis, Institute for Health Policy Solutions, *Medicare Restructuring: The FEHPB Model*, Prepared for the Henry J. Kaiser Family Foundation, 1998, citing: U.S. Library of Congress, Congressional Research Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, Report prepared for the House Committee on Post Office and Civil Service, Washington, 1989 (Committee Print 101-5).

³³ A new study shows that in only six years (coinciding with the abandonment of community rating and guaranteed issue requirements), MSAs have captured over half of the private health insurance market in South Africa. MSA enrollees were disproportionately younger than non-MSA enrollees. Also disturbing is that health care spending is substantially lower for MSA enrollees than non-MSA enrollees, suggesting that MSA enrollees were healthier, on average, than enrollees in non-MSA coverage. The study, in contrast, concluded that “joining an MSA plan induces people to cut their discretionary spending by more than half.” Shaun Matisonn, *Medical Savings Accounts in South Africa*, National Center for Policy Analysis, Policy Report No. 234, June 2000.

³⁴ Len M. Nichols, Marilyn Moon and Susan Wall, *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996.