



**RISING HEALTH CARE COSTS: IMPLICATIONS FOR THE
HEALTH AND FINANCIAL SECURITY OF U.S. FAMILIES**

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Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on high health care costs and the implications for U.S. families. The soaring costs of health care and stagnant household incomes are leaving many working families without insurance or with medical expenses that consume a large share of their budgets. An analysis of the Commonwealth Fund Biennial Health Insurance Survey found that nearly two-thirds of working-age adults—an estimated 116 million people—either were uninsured for a time during 2007, had such high out-of-pocket costs relative to their incomes that they were “underinsured,” reported a problem paying medical bills, or did not get needed care because of costs. Over the past seven years, these problems have spread inexorably up the income scale. The nation now faces a potentially severe economic downturn that could have potent financial implications for lower-income and middle-income families—those most at risk of being uninsured or underinsured. There is now an urgent need for a national solution that will provide families with affordable coverage options to ensure access to timely health care and provide protection against catastrophic financial losses.

Rising Health Care Costs Are Leading Employers to Drop Coverage or Increase Cost-Sharing

- In 2006, national health expenditures increased at a rate of nearly 7 percent per year, more than two times the rate of growth in the economy. Similar annual rates of growth are projected through 2017.
- Americans spend two times as much on out-of-pocket medical expenses than do residents of other industrialized countries.
- Premiums are growing at rates more than twice that of other indicators, such as wages and consumer price inflation. The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped

\$12,680 in 2008—more than the average yearly earnings of a full-time worker earning the minimum wage.

- Employer coverage remains the predominant form of health insurance coverage for U.S. families; 99 percent of companies with 200 or more employees offer health benefits. But rising premiums have weakened the ability of small firms to offer comprehensive coverage. About 49 percent of employers with three to nine employees offered health insurance to their employees in 2008, down from 57 percent in 2000.
- Employers have tried to hold their premiums by increasing employee cost-sharing. In-network deductibles for single coverage in PPO plans have tripled since 2000. Among employers with fewer than 200 employees, deductibles have risen by greater than a factor of four.

Increasing Numbers of People Are Uninsured or Underinsured

- Rising health care costs over the past decade have occurred as incomes for working families have barely budged. Real incomes among working-age families have yet to regain levels prior to the 2001 recession: median income among households headed by someone under age 65 was \$56,545 in 2007 compared with \$58,721 in 2000.
- This dynamic is captured in the increasing numbers of Americans who are spending large shares of their income on health care. Between 2001 and 2007, the share of adults under age 65 who spent 10 percent or more of their incomes on health care costs, including premiums, climbed from 21 percent to 33 percent. Adults in all income groups spent more of their incomes on health care.
- As employer coverage has declined, the number of people without health insurance has surged, rising from 38 million in 2000 to 46 million in 2007.
- An increasing number of adults who are insured have such high out-of-pocket costs relative to their income that they are effectively “underinsured.” In 2007, an estimated 25 million adults were underinsured, up from 16 million in 2003.

Increasing Numbers of Adults in All Income Groups Are Not Getting Needed Health Care Because of Cost

- The share of adults under age 65 who reported problems getting needed health care because of costs increased dramatically between 2001 and 2007, rising to 45 percent

from 29 percent. Cost-related problems getting needed care rose across all income groups, with adults in low- and moderate-income families reporting the highest rates.

- Among adults with chronic health problems, more than 60 percent of those who were uninsured and nearly half of those who were underinsured reported skimping on medications because of cost. Both groups were more likely than those with adequate insurance to go to an emergency room or stay overnight in a hospital for their condition.
- McWilliams and colleagues found that previously uninsured adults with chronic health problems who acquire Medicare coverage at age 65 report significantly greater increases in the number of doctor visits and hospitalizations and in total medical expenditures than do previously insured adults, with the difference persisting through age 72.

Increasing Numbers of Adults Are Struggling to Pay Medical Bills

- Forty-one percent of working-age adults, or 72 million people, reported problems paying their medical bills or were paying off accrued medical debt during the past year, up from 34 percent or 58 million people in 2005. An additional 7 million adults 65 and older also reported bill or debt problems.
- This increase occurred across all income groups but families with low and moderate incomes were particularly hard hit: more than half of adults with incomes under \$40,000 reported medical bills problems in 2007. Adults with gaps in health insurance coverage or those underinsured were most at risk of having problems with medical bills.
- One-quarter of adults with medical debt were carrying \$4,000 or more in debt and 12 percent had \$8,000 or more.
- Among adults who reported any problems with medical bills or accumulated debt, 29 percent said they had been unable to pay for basic necessities like food, heat, or rent because of medical bills; 39 percent had used all their savings; 30 percent had taken on credit card debt; and 10 percent had taken out a mortgage against their home
- Three-quarters of adults under age 65 who reported a problem with medical bills said they had not pursued needed health care because of cost, compared with one-quarter of those who had not reported such problems.

Policy Implications

- The public's desire for relief from rising health care costs is evident in recent polling data. Eight of 10 adults said in a May 2008 Commonwealth Fund survey that the health care system is in need of a major overhaul or fundamental reform. A strong majority of adults across political parties said that it will be important for the next president to improve the quality of health care, ensure that insurance and health care are affordable, and reduce the number of people who are uninsured.
- The Commonwealth Fund Commission on a High Performance Health System has identified the following five key strategies for moving the health care system to a higher level of performance:
 - extending affordable health insurance to all;
 - aligning incentives to reward high-quality, efficient care;
 - organizing the health system to achieve accountable, coordinated care;
 - investing in public reporting, evidence-based medicine, information technology, and infrastructure needed to deliver the best care; and
 - exploring the creation of a national entity to set goals for improving health system performance and recommend best practices and policies.
- Universal coverage is a necessary, though not sufficient, condition for improving the overall performance of the health system. Moreover, the way in which policymakers design health insurance reform will affect whether everyone can be covered and sustained improvements in the quality and efficiency of care can be achieved. The Commission has identified the following principles of health insurance reform:
 - equitable and comprehensive insurance for all;
 - benefits should cover essential services with financial protection;
 - premiums, deductibles, and out of pocket costs should be affordable relative to family income;
 - broad health risk pools; competition based on performance, not risk or cost shifting;
 - simple to administer: coverage should be automatic, stable, seamless;
 - choice of health plans or care systems;
 - dislocation at the outset should be kept to a minimum—people could stay in the coverage they have, if desired; and

- financing that is adequate, fair, and shared across stakeholders.
- Universal coverage must be pursued along with strategies geared to improving quality and efficiency and reducing the growth in health care costs.
- A report by the Commission, *Bending the Curve*, examined the impact on health care costs of several strategies to improve quality and efficiency, including increasing the use of health information technology and comparative effectiveness evidence in insurance benefit design, promoting better health and disease prevention, aligning incentives to improve quality and efficiency, and correcting price signals in health care markets.
- Potential health system savings from these strategies ranged from \$9 billion to \$368 billion over 10 years.
- Including savings to state governments, businesses, and households, the nation could actually save \$1.6 trillion over 10 years if universal coverage were coupled with efforts to reform the way the U.S. pays for health care, invest in better information systems, and adopt initiatives to improve public health.

The continuing loss of adequate health insurance—as well as the ability to afford it—is not only dangerous to the health and wealth of families, it also imperils the efficient functioning of the overall health system and the economic productivity of the nation. The U.S. is unique among industrialized nations in its failure to protect the population against the uncertainties of health. This failure has now turned into crisis for many working families facing economic pressures in nearly every aspect of their lives. The time has never been more urgent for policymakers to forge consensus around strategies for reform that have the greatest potential for success and move forward with pragmatic solutions to the worsening performance of our health system.

Thank you.

RISING HEALTH CARE COSTS: IMPLICATIONS FOR THE HEALTH AND FINANCIAL SECURITY OF U.S. FAMILIES

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The Commonwealth Fund

Thank you, Mr. Chairman, for this invitation to testify on high health care costs and the implications for U.S. families. The soaring costs of health care, along with a faltering economy and stagnant wages, are leaving many working families without insurance or with medical expenses that consume a large share of their incomes. An analysis of the Commonwealth Fund Biennial Health Insurance Survey found that nearly two-thirds of working-age adults—an estimated 116 million people—either were uninsured for a time during 2007, had such high out-of-pocket costs relative to their incomes that they were “underinsured,” reported a problem paying medical bills, or did not get needed care because of costs (Figure 1). Over the past seven years, these problems have spread inexorably up the income scale. The nation now faces a potentially severe economic downturn that could have potent financial implications for lower-income and middle-income families—those most at risk of being uninsured or underinsured. There is now an urgent need for a national solution that will provide families with affordable coverage options to ensure access to timely health care and provide protection against catastrophic financial losses.

Rising Health Care Costs Are Leading Employers to Drop Coverage or Increase Cost Sharing

Spending on health care in the U.S. continues to climb apace. In 2006, national health expenditures rose at a rate of nearly 7 percent per year, more than two times the rate of growth in the economy.¹ Similar annual rates of growth are projected through 2017.² U.S. spending on health care comprised about 16 percent of gross domestic product in 2005 (and 2006), compared with 9.1 percent in the median Organization for Economic

¹ A. Catlin, C. Cowan, M. Hartman, et al., “National Health Spending in 2006: A Year of Change for Prescription Drugs,” *Health Affairs*, Jan./Feb. 2008 27(1):14-29; Council of Economic Advisors, *Economic Report of the President* (Washington D.C.: U.S. G.P.O., February 2008), Table B-4.

² S. Keehan, A. Sisko, C. Truffer, et al., “Health Spending Projections Through 2017: The Baby-Boom Generation is Coming to Medicare,” *Health Affairs* Web Exclusive (Feb. 26, 2008):w145-w155.

Cooperation and Development (OECD) country in 2005 (Figure 2). Per capita spending on health care in the U.S. totaled \$6,649 in 2005 (\$7,026 in 2006), twice that of the median for all 30 OECD countries at \$2,922 in 2005.³ In addition, Americans spend two times as much on out-of-pocket expenses than do residents of other industrialized countries (Figure 3).

Steady increases in health care costs have placed upward pressure on the cost of health insurance: premiums are growing at rates more than twice that of other indicators, such as wages and consumer price inflation (Figure 4). The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped \$12,680 in 2008—more than the average yearly earnings of a full-time worker earning the minimum wage.⁴

Employer coverage remains the predominant form of health insurance coverage for U.S. families; 99 percent of companies with 200 or more employees offer health benefits. But rising premiums have weakened the ability of small firms to offer comprehensive coverage. About 49 percent of employers with three to nine employees offered health insurance to their employees in 2008, down from 57 percent in 2000 (Figure 5).⁵ People with low and moderate incomes are most at risk of lacking coverage through an employer and are most at risk of being uninsured. Only 22 percent of adults under age 65 in families with incomes of \$20,000 or less had coverage through an employer in 2006, down from 29 percent in 2000 (Figure 6). Employer-based coverage in the next income category—under \$37,800 annually—declined from 62 percent in 2000 to 53 percent in 2006.

Employers have tried to hold their premiums by increasing employee cost-sharing. In-network deductibles for single coverage in PPO plans have tripled since 2000, rising from \$187 to \$560 in 2008 (Figure 7). Among employers with fewer than 200

³ J. Cylus and G. F. Anderson, *Multinational Comparisons of Health Systems Data, 2006* (New York: The Commonwealth Fund, May 2007).

⁴ G. Claxton, J. Gabel, B. DiJulio et al., “Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises In Small Firms,” *Health Affairs* Web Exclusive (September 24, 2008):w492-502.

⁵ G. Claxton, J. Gabel, B. DiJulio et al., “Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises In Small Firms,” *Health Affairs* Web Exclusive (September 24, 2008):w492-502.

employees, deductibles have risen by greater than a factor of four, climbing to an average \$917 in 2008.⁶

Increasing Numbers of People Are Uninsured or Underinsured

Rising health care costs over the past decade have occurred as incomes for working families have barely budged. Despite the fact that the economy expanded between 2001 and 2007, real median incomes rose from \$49,455 in 2001 to \$50,233 in 2007, an increase of 1.6 percent.⁷ According to an analysis by the Center on Budget and Policy Priorities, real incomes among working-age families have yet to regain pre-recession levels: median income among households headed by someone under age 65 was \$56,545 in 2007, compared with \$58,721 in 2000.⁸

This dynamic is captured in the increasing numbers of Americans who are spending large shares of their income on health care. According to an analysis of Commonwealth Fund Biennial Health Insurance Surveys, 2001, 2003, 2005, and 2007, between 2001 and 2007, the share of adults under age 65 who spent 10 percent or more of their incomes on health care costs including premiums and out-of-pocket costs climbed from 21 percent to 33 percent (Figure 8).⁹ Adults in all income groups spent more of their earnings on health care. More than half of adults in families with incomes under \$20,000 and more than one-third of adults earning between \$20,000 and \$60,000 spent 10 percent or more of their income on health care. Among those earning between \$40,000 and \$60,000, the rate doubled from 18 percent in 2001 to 36 percent in 2007.

The relentless annual growth in health care costs has left many working families with few options for health insurance. As employer coverage has declined, the number of people without health insurance has surged, rising from 38 million in 2000 to 46 million

⁶ G. Claxton, J. Gabel, B. DiJulio et al., "Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises In Small Firms," *Health Affairs* Web Exclusive (September 24, 2008):w492-502.

⁷ C. DeNavas-Walt, B.D. Proctor, J.C. Smith, *Income, Poverty and Health Insurance Coverage in the United States: 2007*, U.S. Census Bureau, August 2008.

⁸ A. Sherman, R. Greenstein, S. Parrot, *Poverty and Share of Americans Without Health Insurance Were Higher in 2007 – and Median Income for Working Age Households was Lower – Than at Bottom of Last Recession*, Center on Budget and Policy Priorities, August 26, 2008, <http://www.cbpp.org/8-26-08pov.pdf>.

⁹ S.R. Collins, J.L. Kriss, M.M. Doty, S.D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001-2007* (New York: The Commonwealth Fund) August 2008.

in 2007 (Figure 9).¹⁰ There was a slight decline in the number of uninsured people in 2007 compared with the prior year. This is attributable to higher enrollment in public insurance programs, while the decline in employment-based coverage continued.

The individual insurance market—in which only about 6 percent of the under-65 population buys coverage—has proven largely inadequate to stem the rising tide of the uninsured.¹¹ While the number of people who have lost coverage through their employers has risen steadily over the past few years, the share of the population that buys coverage in the individual insurance market has stayed relatively constant. In most states individual market policies are underwritten so that older people or those with health problems are charged higher premiums than healthier and younger applicants. In addition, applicants may have a pre-existing condition excluded from their policy or may be declined a policy altogether.

The high costs of insurance administration and the lack of economies of scale also increase premiums in the individual market relative to employer-based plans. Coverage equivalent to an employer plan in the individual market is estimated to cost at least an additional \$2,000.¹² Nor do people with individual market coverage receive a tax-exempt premium contribution as they do from employers. The Commonwealth Fund Biennial Health Insurance Survey of 2005 found that 34 percent of adults who had individual coverage—or those who had thought about or tried to buy a plan in the individual market in the past three years—found it very difficult or impossible to find coverage they needed: 58 percent found it very difficult or impossible to find a plan they could afford; and 21 percent said they were turned down or charged a higher price because of a pre-existing condition (Figure 10).¹³ Nearly 90 percent said they never bought a plan.

For families with health insurance, the combination of rising exposure to health costs and stagnant incomes has led to an increasing number of adults with such high out-of-pocket costs relative to their income that they are effectively “underinsured.” As

¹⁰ C. DeNavas-Walt, B.D. Proctor, J.C. Smith, *Income, Poverty and Health Insurance Coverage in the United States: 2007*, U.S. Census Bureau, August 2008.

¹¹ Analysis of Current Population Survey 2007 by Bisundev Mahato, Columbia University, Mailman School of Public Health.

¹² T. Buchmueller, S.A. Glied, A. Royalty, K. Swartz, “Cost and Coverage Implications of the McCain Plan to Restructure Health Insurance,” *Health Affairs*, Web Exclusive (September 16, 2008)472-481.

¹³ S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

reported in a recent *Health Affairs* article by Cathy Schoen and colleagues, between 2003 and 2007, the number of underinsured adults climbed from 16 million to 25 million (Figure 11).¹⁴ Underinsured adults in the 2003 and 2007 Commonwealth Fund Biennial Health Insurance Surveys were defined as those who reported: spending 10 percent or more of their income on out-of-pocket health costs, excluding premiums; spending 5 percent or more of their income, if their incomes were under 200 percent of poverty; or deductibles that amounted to 5 percent or more of their income. Almost one-quarter of adults with incomes under 200 percent of poverty were underinsured, up from 19 percent in 2003. The problem of cost exposure moved dramatically up the income scale. The share of adults with incomes of 200 percent of poverty or more who were underinsured nearly tripled over the four-year period, climbing from 4 percent in 2003 to 11 percent in 2007. Underinsured adults were more likely to have health plans with limits on physician visits and on the total amount plans would pay. They were also more likely to have plans with higher deductibles: more than one-quarter of underinsured adults reported a deductible of \$1,000 or more compared with 8 percent of insured adults who were not underinsured (Figure 11).

Increasing Numbers of Adults in All Income Groups Are Not Getting Needed Health Care Because of Cost

The purpose of health insurance is to provide timely and affordable access to care and to protect against the costs of catastrophic illnesses and injuries. However, the rising costs of health insurance and inadequate health insurance are straining limited family budgets and leaving people less protected. The Commonwealth Fund Biennial Health Insurance Surveys, 2001, 2003, 2005, and 2007, asked respondents whether they had not pursued needed medical care in the past 12 months because of cost. Specifically, respondents were asked if, because of cost, they did not go to a doctor or clinic when sick; had not filled a prescription; skipped a medical test, treatment, or follow-up visit recommended by a doctor; or did not see a specialist when a doctor or the respondent thought it was needed.

¹⁴ C. Schoen, S.R. Collins, J.L. Kriss, M.M. Doty, “How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007,” *Health Affairs* Web Exclusive (June 10, 2008): w298–w309.

The share of adults who reported problems getting needed health care because of cost increased dramatically between 2001 and 2007. In 2007, 45 percent of adults under age 65 reported any one of these cost-related access problems, up from 29 percent in 2001 (Figure 13). Cost-related problems in getting needed care rose across all income groups, with adults in low- and moderate-income families reporting the highest rates. Notably, reported problems getting needed care rose up the income scale. Among adults earning between \$40,000 and \$60,000, more than two of five reported they had not received care because of cost, up from 24 percent in 2001. In fact, the rate of adults reporting not getting needed care in this income group in 2007 is at the same level that low- and moderate-income adults reported in 2001. Even adults in households earning more than \$60,000 a year reported not getting needed care at double the rates they did in 2001.

Across all four years of the Biennial Survey, adults who were uninsured or underinsured experienced the highest rates of cost-related problems accessing health care (Figure 14). In 2007, more than 70 percent of adults who were uninsured at the time of the survey or spent some time uninsured in the past year cited cost-related problems accessing needed health care, up from just over half in 2001 (data not shown). Underinsured adults reported not getting needed care at rates that were nearly as high as those who were uninsured: three of five underinsured adults reported at least one cost-related problem getting care in 2007.

There is considerable evidence that exposure to costs can have a negative effect on the ability of adults with chronic conditions to effectively manage their diseases. The Commonwealth Fund Biennial Health Insurance Survey asked respondents whether a doctor had told them they had any one of four chronic conditions: high blood pressure; heart disease; diabetes; or asthma, emphysema, or other lung disease.¹⁵ In 2007, among adults with chronic health problems who regularly took prescription drugs, more than three of five who had gaps in coverage (62%) or lacked insurance at the time of the survey (64%) reported skipping doses of medications or not filling prescriptions for their chronic conditions because of cost (Figure 15). Underinsured adults also reported poor rates of medication adherence: 46 percent of underinsured adults with chronic conditions

¹⁵ About 34 percent, or an estimated 59.7 million adults in the Commonwealth Fund Biennial Health Insurance Survey, 2007, reported at least one chronic health problem.

reporting skipping doses or not filling their prescriptions. In contrast, only 15 percent of adults with chronic conditions who were insured all year with adequate health insurance reported skimping on their medications. The survey also found that adults with chronic health problems and inadequate coverage reported seeking care in an emergency room, staying overnight in the hospital, or both, for their condition at higher rates than did those with adequate coverage.

Hadley found that uninsured patients who experienced an injury or were newly diagnosed with a chronic health condition received less medical care, were more likely to report not being fully recovered but no longer receiving care, and were more likely to report lower health status seven months after the event than were insured patients who experienced a similar medical event.¹⁶ The Commonwealth Fund Commission on High Performance Health System's *National Scorecard on Health System Performance* found that 63 percent of uninsured adults with diabetes had their illness under control compared with 81 percent of insured adults with diabetes. In addition, uninsured adults reported their high blood pressure was under control at half the rates that insured adults did (Figure 16). A study by Hsu and colleagues of Medicare beneficiaries found that people with capped drug benefits had lower drug utilization than those without capped benefits. Consequences included poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels.¹⁷ Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use.¹⁸

The health care incentives of inadequately insured families—to delay or avoid care when conditions are relatively inexpensive to treat, before they become serious and costly—run counter to long-held notions of the need for chronic care management and preventive care to promote healthy and productive lives, as well as to control long-term costs. McWilliams and colleagues found that among adults with chronic conditions, previously uninsured adults who acquired Medicare coverage at age 65 reported significantly greater increases in the number of doctor visits and hospitalizations and in

¹⁶ J. Hadley, "Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury of the Onset of a Chronic Condition," *Journal of the American Medical Association*, Mar. 14, 2007 297(10):1073–84.

¹⁷ J. Hsu, M. Price, J. Huang et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine*, June 1, 2006 354(22):2349–59.

¹⁸ See also, S.R. Collins, et al, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund) October 2008.

total medical expenditures than did previously insured adults, with the difference persisting through age 72 (Figure 17).¹⁹ The findings suggest that the costs of providing health insurance for uninsured near-elderly adults may be partially offset by subsequent reductions in health care use and spending once they enter Medicare.

Increasing Numbers of Adults Are Struggling to Pay Medical Bills

More adults are struggling to pay their medical bills and are accumulating medical debt over time. The Commonwealth Fund Biennial Health Insurance Surveys of 2005 and 2007 asked respondents whether they had experienced problems with medical bills over the past year, including whether they were able to pay their medical bills, if there were times when they had difficulty or were unable to pay bills, whether they had been contacted by a collection agency concerning outstanding medical bills, or whether they had to change their lives significantly to meet their obligations. In addition, the survey asked respondents whether they were paying off medical debt over time. In 2007, more than two of five (41%) adults under age 65, or 72 million people, reported any one of those problems, up from 34 percent, or 58 million people, in 2005 (Figure 18).²⁰ An additional 7 million adults ages 65 and older also reported bill or debt problems.²¹ This increase occurred across all income groups but families with low and moderate incomes were particularly hard hit: more than half of adults with incomes under \$40,000 reported problems with medical bills in 2007 (Figure 19). Adults with gaps in health insurance coverage or those underinsured were most at risk of having problems with medical bills: in 2007 three of five reported any one medical bill problem or accrued medical debt, more than double the rate of those who had adequate insurance all year (26%) (Figure 20).

Of the estimated 50 million adults who were paying off medical debt in 2007, many were carrying substantial debt loads that had accrued over time. One-quarter of adults with medical debt were carrying \$4,000 or more in debt and 12 percent had \$8,000

¹⁹ J. M. McWilliams, et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *NEJM* 357;2, Jul 12 2007.

²⁰ S.R. Collins, J.L.Kriss, M.M. Doty, S.D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001-2007* (New York: The Commonwealth Fund) August 2008.

²¹ M.M. Doty, S.R. Collins, S.D. Rustgi, J.L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by Families* (New York: The Commonwealth Fund) August 2008.

or more (Figure 21). Adults who were uninsured at any time during the year had the highest debt loads: more than one-third (34%) of those who were uninsured at the time of the survey reported debt of \$4,000 or more, as did one-quarter (24%) of those who were uninsured for a period in the past year. And 18 percent and 12 percent of these two groups, respectively, had more than \$10,000 in debt. In addition, many people are carrying debt incurred over multiple years. More than one-third (37%) of adults with medical debt were carrying overdue bills from care received more than one year ago.

In the face of mounting medical bills and debt, many adults are making stark trade-offs in their spending and saving priorities. Among adults who reported any problems with medical bills or accumulated debt in 2007, nearly one of three (29%) said they had been unable to pay for basic necessities like food, heat, or rent because of medical bills; nearly two of five (39%) had used all their savings; one of three (30%) had taken on credit card debt; and one-tenth (10%) had taken out a mortgage against their home (Figure 22). Rates of reported trade-offs were especially high among people who had spent any time uninsured or those underinsured. Nearly half of adults who had spent any time uninsured and reported medical bill problems had used all their savings to pay for their medical bills and two of five were unable to pay for food, heat, or rent. Underinsured adults made similar trade-offs: 46 percent said they had used all their savings, 33 percent took on credit card debt, and 29 percent were unable to pay for basic life necessities.

Adults burdened with medical debt are significantly more likely to report cost-related problems getting needed health care. In the 2007 Commonwealth Fund Biennial Health Insurance Survey, three-quarters of adults under age 65 who reported a problem with medical bills said that they had not pursued needed health care because of cost compared with one-quarter of those who had not reported a problem with medical bills (Figure 23). Fifty-six percent said they had not filled a prescription when it was needed and 57 percent said they had not gone to the doctor when they were sick.

Policy Implications

The public's desire for relief from the mounting pressure of health care costs is evident from recent polls.²² In a May survey by The Commonwealth Fund, eight of 10 adults said the health care system is in need of a major overhaul or fundamental reform.²³ A strong majority of adults across political parties said it will be important for the next president to improve the quality of health care, ensure that insurance and health care are affordable, and reduce the number of people who are uninsured.

State and federal policymakers are responding to the public's call for reform. Massachusetts and Vermont have moved ahead of the federal government to expand insurance coverage in those states.²⁴ The 2008 presidential candidates have developed proposals to reform the health care system, and members of Congress have introduced bills to expand health insurance coverage.^{25,26} In addition, other policy experts have outlined frameworks and ideas for reform.²⁷

The Commonwealth Fund Commission on a High Performance Health System has identified the following five key strategies for moving the health care system to a higher level of performance:²⁸

²² S.R. Collins and J.L. Kriss, *The Public's Views of Health Care Reform in the 2008 Presidential Election*, (New York: The Commonwealth Fund, Jan. 2008); K. K. Shea, S. R. Collins, K. Davis, *Health Care Opinion Leaders' Views on The Presidential Candidates' Health Reform Plans* (New York: The Commonwealth Fund, Jan. 2008); S.K.H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, (New York: The Commonwealth Fund, August 2008).

²³ S.K.H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, (New York: The Commonwealth Fund, August 2008).

²⁴ S. K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs* Web Exclusive (June 3, 2008) w:270–w284; J. E. McDonough et al., "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," *Health Affairs* Web Exclusive (3 June 2008)w285–w297.

²⁵ S.R. Collins, J.L. Kriss, S.D.Rustgi, K. Davis, *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America* (New York: The Commonwealth Fund, Oct. 2008); S. R. Collins and J. L. Kriss, *Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals* (New York: The Commonwealth Fund, Jan. 2008).

²⁶ S. R. Collins, K. Davis, and J. L. Kriss, [An Analysis of Leading Congressional Health Care Bills, 2005–2007: Part 1, Insurance Coverage](#) (New York: The Commonwealth Fund, Mar. 2007).

²⁷ C. Schoen, K. Davis, and S. R. Collins, "[Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance.](#)" *Health Affairs*, May/June 2008 27(3):646–57; L. Ku and M. Broaddus, "Public and Private Health Insurance: Stacking Up the Costs," *Health Affairs* Web Exclusive (June 24, 2008)w318–w327.

²⁸ For more detail, see The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, November 2007).

- extending affordable health insurance to all;
- aligning incentives to reward high-quality, efficient care;
- organizing the health system to achieve accountable, coordinated care;
- investing in public reporting, evidence-based medicine, information technology, and infrastructure needed to deliver the best care; and
- exploring the creation of a national entity that would set goals for improving health system performance and recommend best practices and policies.

Universal coverage is a necessary, though not sufficient, condition for improving the overall performance of the health system. Moreover, the way in which policymakers design health insurance reform will affect whether everyone can be covered and sustained improvements in the quality and efficiency of care can be achieved. The Commission has identified the following principles of health insurance reform as essential in moving the health system toward high performance.²⁹

Access to Care

- Provide equitable and comprehensive insurance for all.
- Insure the population in a way that leads to full and equitable participation.
- Provide a standard benefit package for essential coverage and financial protection.
- Make premiums, deductibles, and out-of-pocket costs affordable relative to family income.
- Ensure coverage is automatic and stable, with seamless transitions between plans to maintain enrollment.
- Provide a choice of health plans or care systems.

Quality, Efficiency, and Cost Control

- Foster efficiency by reducing complexity for patients and providers, and by reducing transaction and administrative costs as a share of premiums.

²⁹ For more detail, see S.R. Collins, C. Schoen, K. Davis, A.K. Gauthier, S.C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).

- Work to improve health care quality and efficiency through administrative reforms, provider profiling and network design, utilization management, pay-for-performance payment models, and structures that encourage adherence to clinical guidelines.
- Minimize dislocation, so that people can maintain current coverage if desired.
- Be simple to administer.
- Pool health risks across broad groups and over life spans, and eliminate insurance practices designed to avoid individuals with high health risks.
- Have the potential to lower overall health care cost growth.

Financing

- Financial commitment is necessary to achieve these principles.
- Financing should be adequate and fair, based on the ability to pay, and should be the shared responsibility of federal and state governments, employers, individual households, and other stakeholders.

Achieving universal coverage will require a serious financial investment by federal and state governments, employers, households, and other stakeholders. But universal coverage must also be pursued along with strategies geared to improving quality and efficiency and reducing the growth in health care costs. A Commission report, *Bending the Curve*, examined the impact on health care costs of several strategies to improve quality and efficiency (Figure 24).³⁰ These include: increasing the use of health information technology and comparative effectiveness evidence in insurance benefit design; promoting better health and disease prevention, for example through efforts to reduce tobacco use and obesity; aligning incentives to improve quality and efficiency, such as paying hospitals for improved outcomes; and correcting price signals in health care markets, for example, by allowing Medicare to negotiate drug prices with pharmaceutical companies.

The Lewin Group estimated the impact these strategies would have on national health expenditures and spending by major stakeholders over a 10-year period. Many of the options include initial investments, such as expanding the use of health information

³⁰ C. Schoen, S. Guterman, T. Shih et al., *Bending the Curve :Options for Achieving Savings and Improving Value in the U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

technology, that would result in returns in later years. Potential health system savings from these strategies ranged from \$9 billion to \$368 billion over 10 years.³¹ For example, by promoting the diffusion of health information technology through a 1 percent assessment on insurance premiums and Medicare outlays, net health system savings could reach \$88 billion over 10 years. Establishing a center on medical effectiveness, along with the creation of payment and cost-sharing incentives for providers and consumers to draw on the results of medical effectiveness research, could yield savings of up to \$368 billion over 10 years, shared across all payers. Implementing a medical home model within the Medicare program in which primary care providers are paid for improved care coordination, care management, and improving access to appropriate care could result in savings of up to \$194 billion over 10 years. The potential savings associated with resetting the benchmark payment rates for Medicare Advantage plans closer to the per capita costs of people enrolled in the traditional Medicare program would be an estimated \$50 billion over 10 years. Allowing the federal government to directly negotiate prescription drug prices available through the Medicare program with pharmaceutical companies could result in savings of \$43 billion over 10 years (although without provisions to prevent cost-shifting, payers other than the federal government could experience a net increase in spending).

These cost-saving strategies could potentially offset some of the costs of expanding health coverage. For example, Schoen and colleagues outlined a framework for universal coverage referred to as *Building Blocks* which is similar in structure to the reform implemented in Massachusetts and proposed by presidential candidate Senator Barack Obama (although *Building Blocks* includes an individual requirement to have insurance). The estimated federal cost of the *Building Blocks* approach in 2008 is just over \$82 billion.³² The Lewin Group modeled how some of the savings options outlined in *Bending the Curve* would affect the costs of the *Building Blocks* coverage proposal. Specifically, it modeled the effects on costs of: increasing the use of health information technology; creating a center on medical effectiveness; reforming provider payment; increasing the tobacco tax; lowering Medicare Advantage plan payments to the level of traditional Medicare coverage, and allowing Medicare to negotiate prescription drug

³¹ Schoen, Guterman, Shih et al., *Bending the Curve*, 2007.

³² C. Schoen, K. Davis, S.R. Collins, "Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance," *Health Affairs* (May/June 2006):646-657.

prices with pharmaceutical companies.³³ With these cost-saving strategies in place, The Lewin Group found that net federal spending on the *Building Blocks* proposal would fall to \$31 billion in the first year (Figure 25). Savings from the initiatives increase over time, so that spending offsets are estimated to be even larger in future years. By 2017, the federal costs of expanding coverage according to the *Building Blocks* proposal—without the savings strategies in place—would climb to \$205 billion. The savings strategies would reduce that cost to just \$10 billion. Including savings to state governments, businesses, and households, the nation could actually *save* \$1.6 trillion over 10 years if health insurance expansions were coupled with efforts to reform how the United States pays for health care, invest in better information systems, and adopt initiatives to improve public health.

Conclusion

The continuing loss of adequate health insurance—as well as the ability to afford it—is not only dangerous to the health and wealth of families, it also imperils the efficient functioning of the overall health system and the economic productivity of the nation. The deterioration of insurance coverage points to a need for a national solution that will give families affordable options to ensure access to timely health care and provide protection against catastrophic financial losses. The U.S. is unique among industrialized nations in its failure to protect the population against the uncertainties of health. This failure has now turned into crisis for many working families facing economic pressures in nearly every aspect of their lives. The time has never been more urgent for policymakers to forge consensus around strategies for reform that have the greatest potential for success and move forward with pragmatic solutions to the worsening performance of our health system.

Thank you.

³³ K. Davis, C. Schoen, S.R. Collins, *The Building Blocks of Universal Coverage and Health System Savings* (New York: The Commonwealth Fund, May 2008)

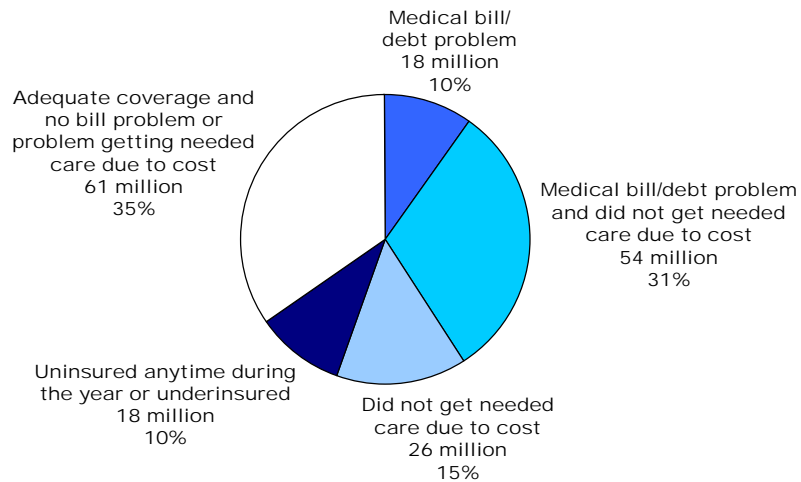


Rising Health Care Costs: Implications for the Health and Financial Security of U.S. Families

Sara R. Collins, Ph.D.
Assistant Vice President
The Commonwealth Fund

Invited Testimony
U.S. Senate Finance Committee
Hearing on "High Health Care Costs: A State Perspective?"
October 21, 2008

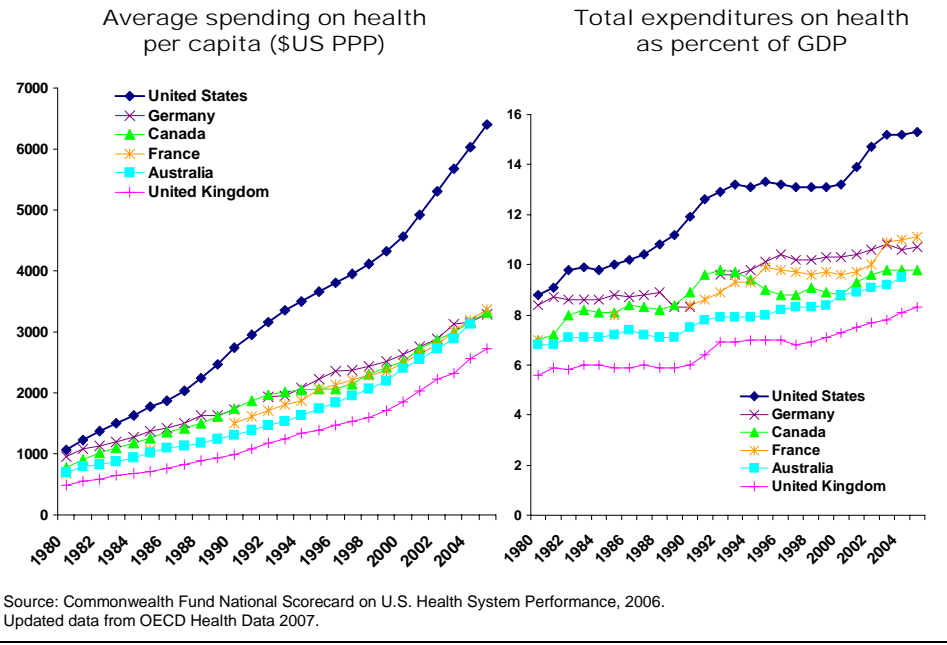
Figure 1. 116 Million Working-Age Adults Were Uninsured, Underinsured, Reported a Medical Bill Problem and/or Did Not Access Needed Health Care Because of Cost, 2007



177 Million Adults, Ages 19–64

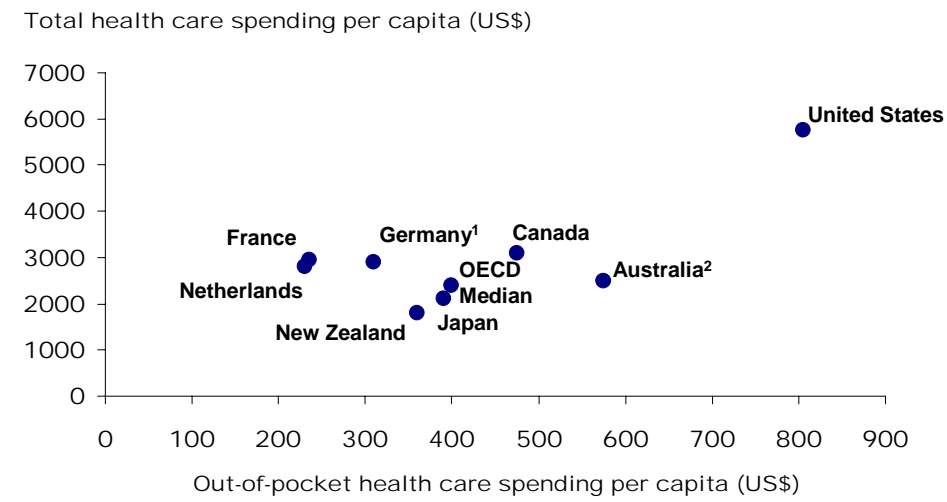
Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 2. International Comparison of Spending on Health, 1980-2005



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006. Updated data from OECD Health Data 2007.

Figure 3. Americans Spend More Out-of-Pocket on Health Care Expenses Than Citizens in Other Industrialized Countries

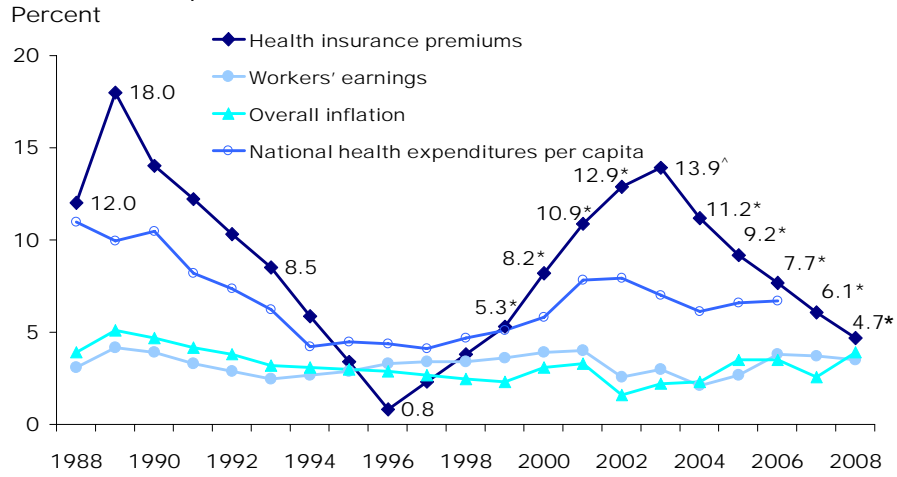


¹ 2003

² 2003 Total Health Care spending, 2002 OOP Spending

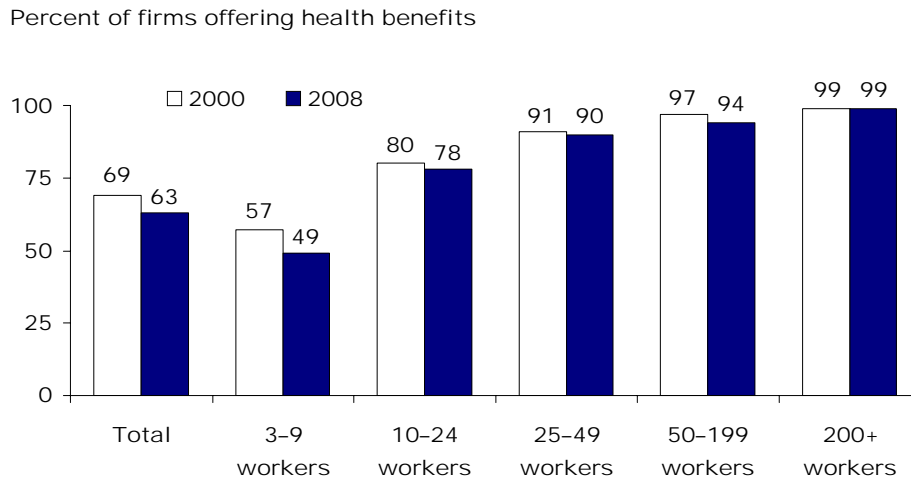
Source: J. Cylus and G. F. Anderson, *Multinational Comparisons of Health Systems Data*, 2006, The Commonwealth Fund, May 2007.

Figure 4. Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2007



* Estimate is statistically different from the previous year shown at p<0.05.
 ^ Estimate is statistically different from the previous year shown at p<0.1.
 Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).
 Source: G. Claxton, J. Gabel et al., "Health Benefits In 2008: Premiums Moderately Higher, While Enrollment In Consumer-Directed Plans Rises In Small Firms," *Health Affairs*, Sept./Oct. 2008 27(6): w492-502. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008. S. Keehan, A. Sisko et al., "Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare," *Health Affairs*, March/April 2008 27(2):w145-w155.

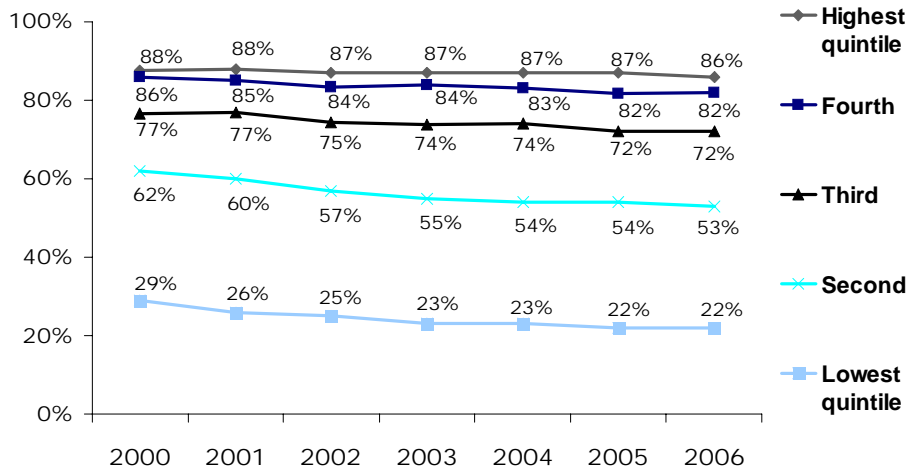
Figure 5. Employer Coverage Continues to Be Major Source of Coverage for Employees of Larger Firms But Has Declined Among Small Firms



Source: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits, 2000 and 2008 Annual Surveys*.

Figure 6. Employer-Provided Health Insurance, by Income Quintile, 2000–2006

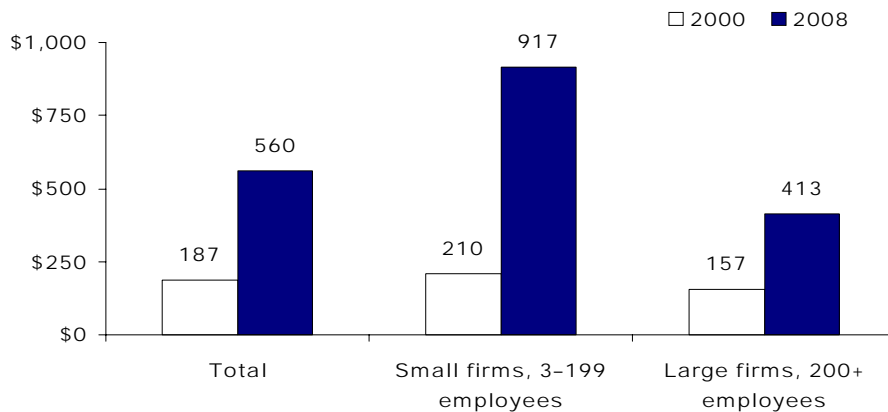
Percent of population under age 65 with health benefits from employer



Source: Analysis of the March Current Population Survey, 2001–07, by Elise Gould, Economic Policy Institute.

Figure 7. Deductibles Rise Sharply, Especially in Small Firms, 2000–2008

Mean deductible for single coverage (PPO, in-network)

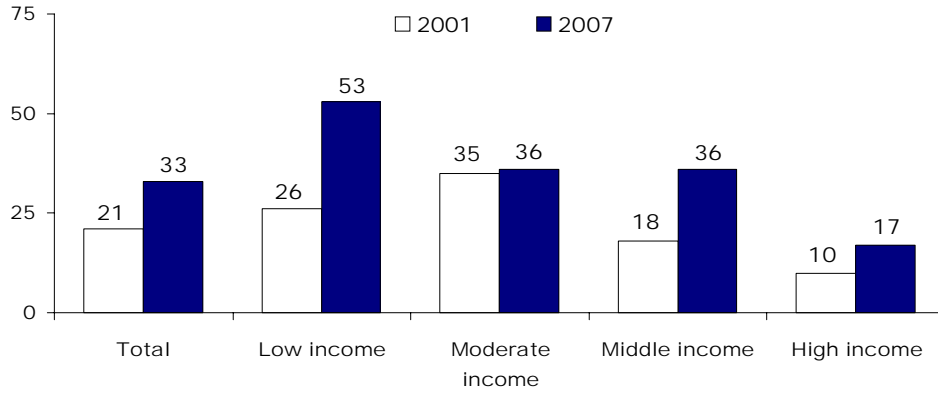


PPO = preferred provider organization. PPOs covered 57 percent of workers enrolled in an employer-sponsored health insurance plan in 2007.

Source: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2007 Annual Surveys.

**Figure 8. High Out-of-Pocket Spending Climbs
Across Income Groups, 2001–2007**

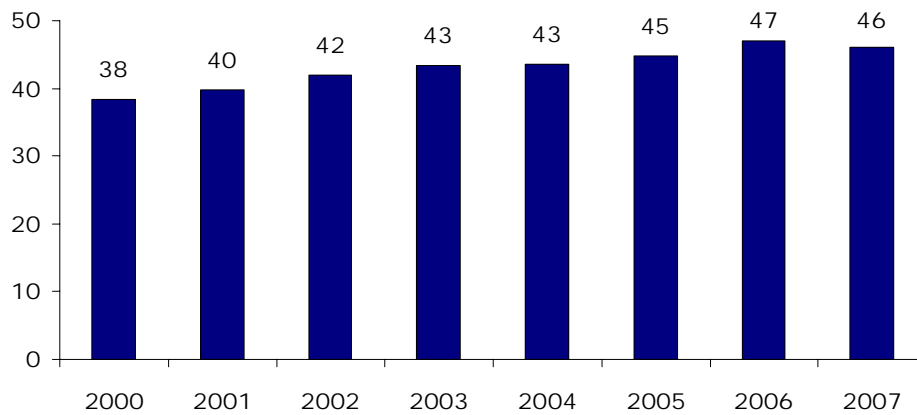
Percent of adults ages 19–64 who spent 10% or more of income annually on out-of-pocket costs and premiums



Note: Income refers to annual income. In 2001 low income is <\$20,000, moderate income is \$20,000–\$34,999, middle income is \$35,000–\$59,999, and high income is \$60,000 or more. In 2007, low income is <\$20,000, moderate income is \$20,000–\$39,999, middle income is \$40,000–\$59,999, and high income is \$60,000 or more.
Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

**Figure 9. Forty-Six Million Uninsured in 2007;
Increase of 7.2 Million Since 2000**

Number of uninsured, in millions



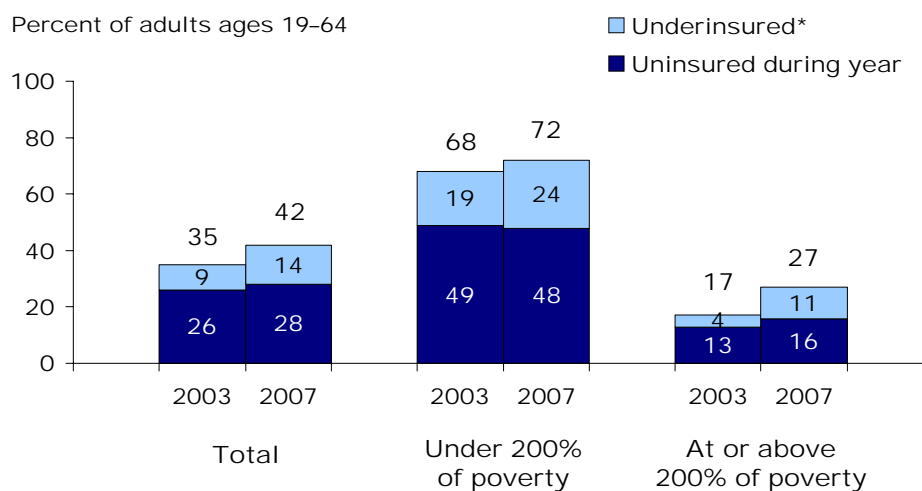
Source: U.S. Census Bureau, March Current Population Survey, 2001–2008.

Figure 10. Individual Market Is Not an Affordable Option for Many People

Adults ages 19-64 with individual coverage or who thought about or tried to buy it in past three years who:	Total	Health problem	No health problem	<200% poverty	200%+ poverty
Found it very difficult or impossible to find coverage they needed	34%	48%	24%	43%	29%
Found it very difficult or impossible to find affordable coverage	58	71	48	72	50
Were turned down or charged a higher price because of a pre-existing condition	21	33	12	26	18
Never bought a plan	89	92	86	93	86

Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well Being of American Families*, The Commonwealth Fund, September 2006.

Figure 11. The Number of Underinsured Adults Under Age 65 Rose to 25 Million in 2007, Up from 16 Million in 2003



*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).

Figure 12. Health Plan Characteristics of Privately Insured Adults, 2007

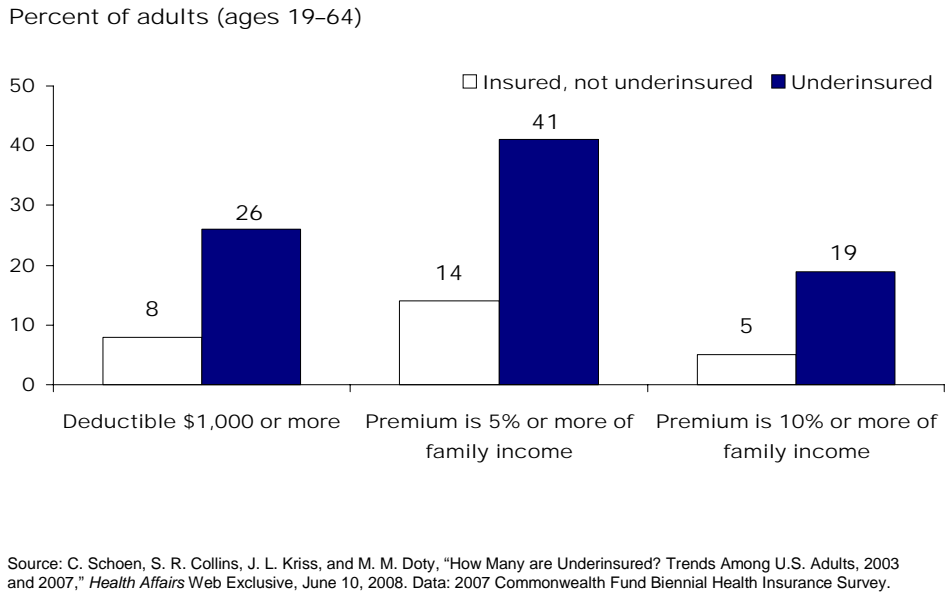


Figure 13. Cost-Related Problems Getting Needed Care Have Increased Across All Income Groups, 2001-2007

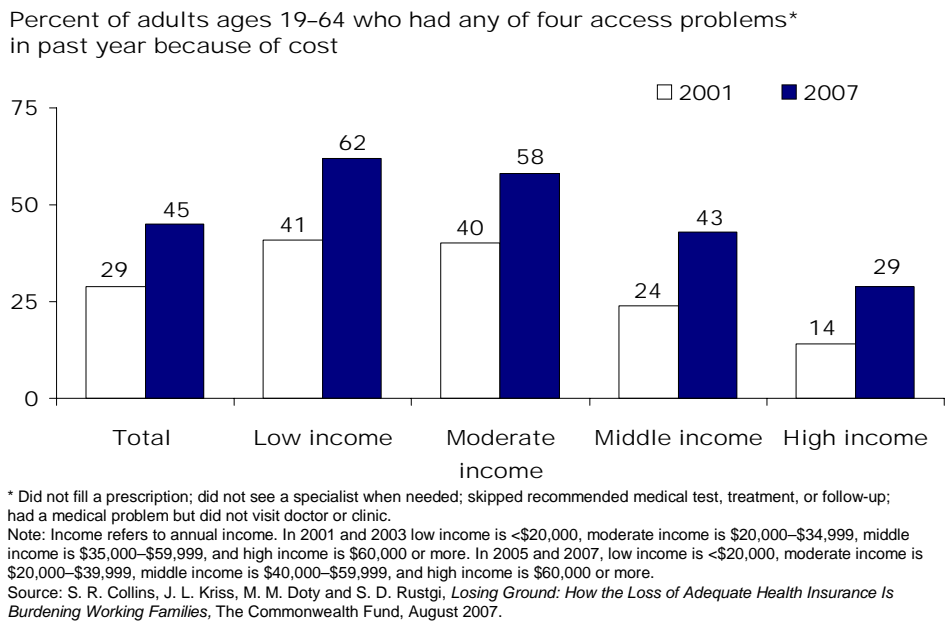
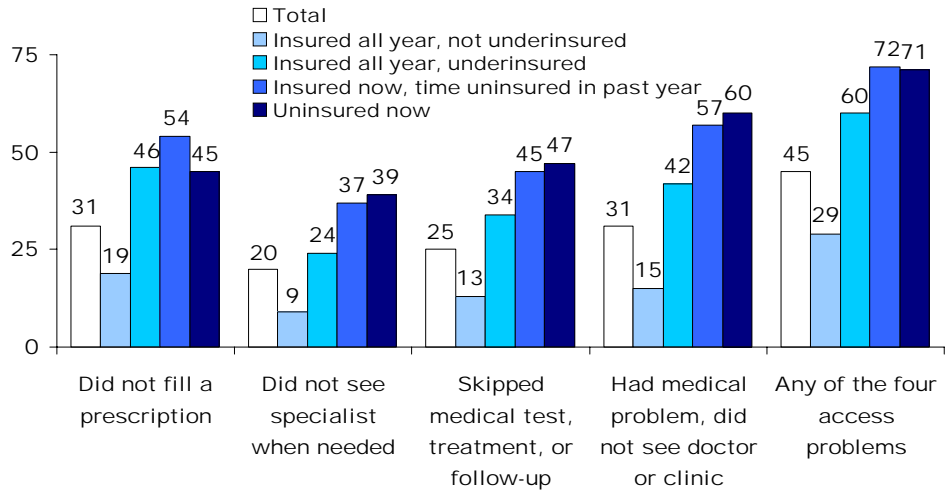


Figure 14. Uninsured and Underinsured Adults Report High Rates of Cost-Related Problems Getting Needed Care

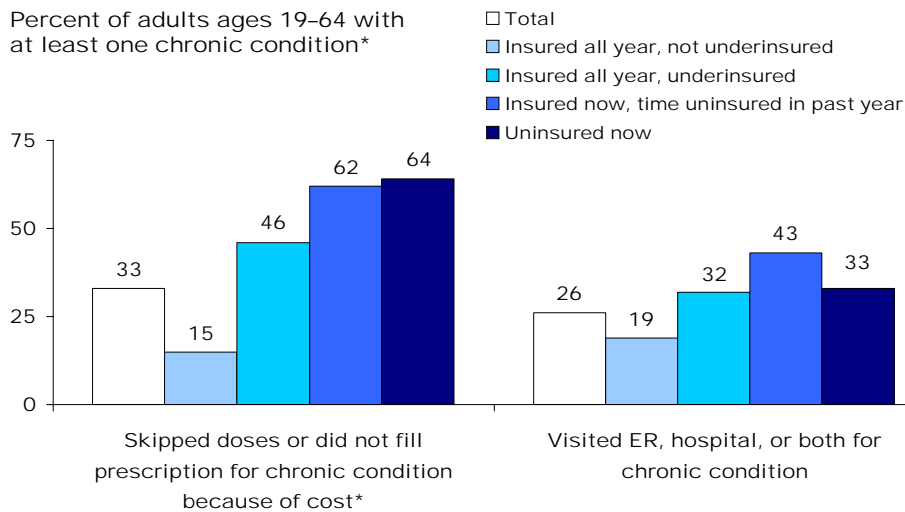
Percent of adults ages 19–64 who had cost-related access problems in the past 12 months



Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

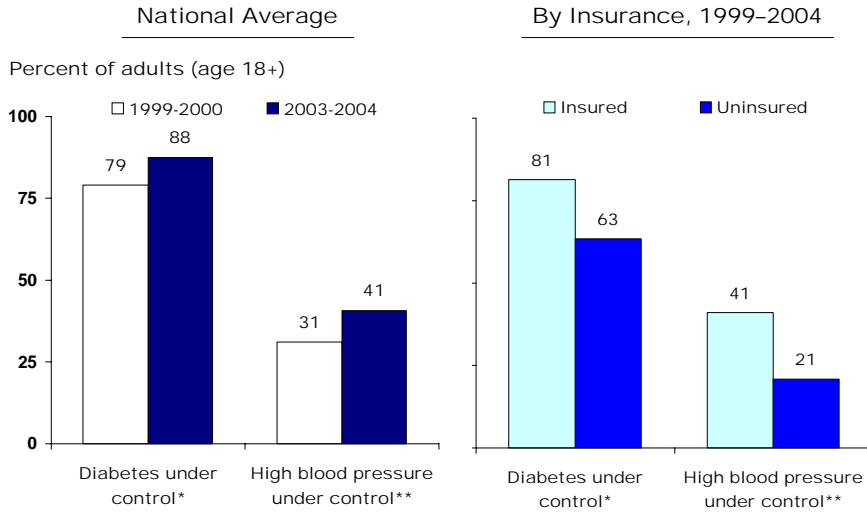
Figure 15. Uninsured and Underinsured Adults with Chronic Conditions Are More Likely to Visit the ER for Their Conditions

Percent of adults ages 19–64 with at least one chronic condition*



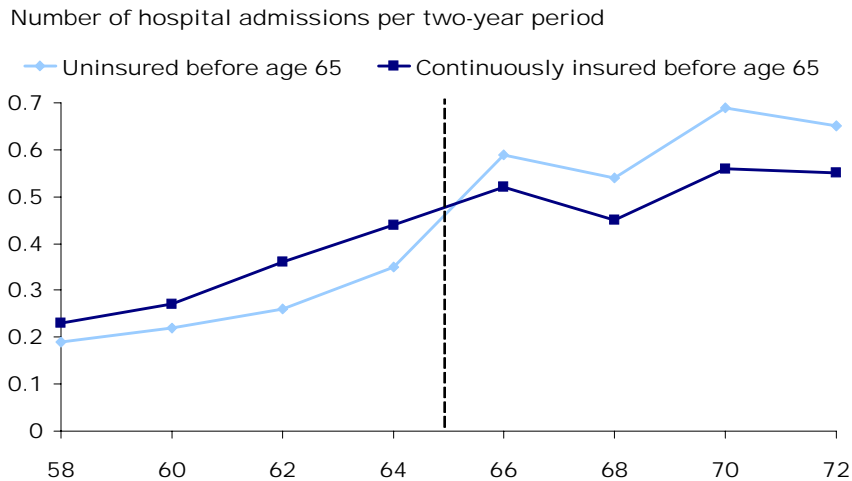
*Adults with at least one chronic condition who take prescription medications on a regular basis.
Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 16. Chronic Disease Under Control:
Diabetes and Hypertension



*Refers to diabetic adults whose HbA1c is <9.0
 **Refers to hypertensive adults whose blood pressure is <140/90 mmHg.
 Data: J. M. McWilliams, Harvard Medical School analysis of National Health and Nutrition Examination Survey.
 Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Figure 17. Previously Uninsured Medicare Beneficiaries
with History of Cardiovascular Disease or Diabetes
Have Much Higher Self-Reported Hospital Admissions
After Entering Medicare Than Previously Insured



Source: J. M. McWilliams, E. Meara, A. M. Zaslavsky et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine*, July 12, 2007 357(2):143-53.

Figure 18. Medical Bill Problems and
Accrued Medical Debt, 2005–2007

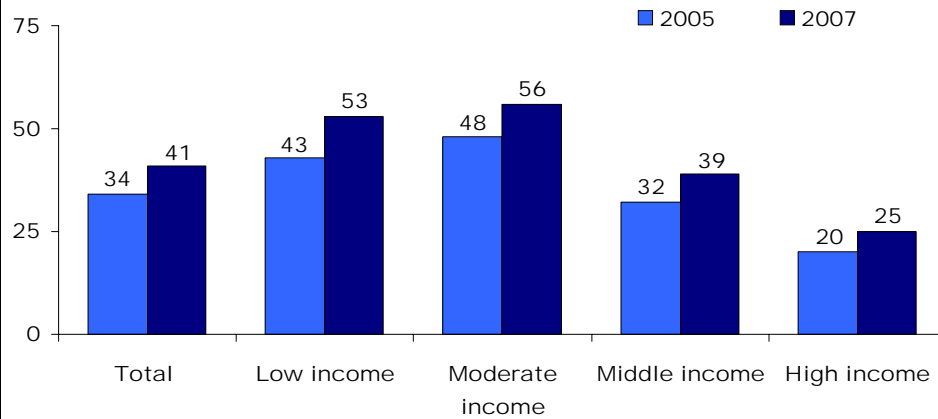
Percent of adults ages 19–64

	2005	2007
In the past 12 months:		
Had problems paying or unable to pay medical bills	23% 39 million	27% 48 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 28 million
Had to change way of life to pay bills	14% 24 million	18% 32 million
<i>Any of the above bill problems</i>	28% 48 million	33% 59 million
Medical bills being paid off over time	21% 37 million	28% 49 million
<i>Any bill problems or medical debt</i>	34% 58 million	41% 72 million

Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 19. Problems with Medical Bills or
Accrued Medical Debt Increased, 2005–2007

Percent of adults ages 19–64 with medical bill problems
or accrued medical debt

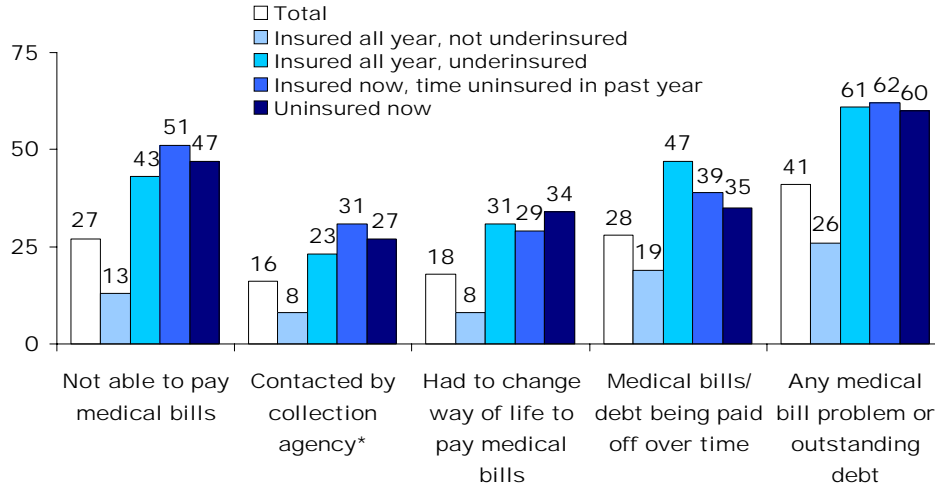


Note: Income refers to annual income. In 2005 and 2007, low income is <\$20,000, moderate income is \$20,000–\$39,999, middle income is \$40,000–\$59,999, and high income is \$60,000 or more.

Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 20. Sixty Percent of Underinsured or Uninsured Adults Reported Medical Bill Problems or Debt

Percent of adults ages 19–64 with medical bill problems or accrued medical debt



* Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.
 Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 21. Uninsured Adults Are More Likely to Be Paying Off Large Amounts of Medical Debt Over Time

Percent of adults ages 19–64 who are paying off medical bills over time

	Total	Insured all year	Uninsured Anytime in Past Year	
			Insured now, time uninsured in past year	Uninsured now
How much are the medical bills that are being paid off over time?				
Less than \$2,000	51%	57%	46%	38%
\$2,000–\$3,999	21	20	25	22
\$4,000–\$7,999	12	11	11	14
\$8,000 or more	12	9	13	20
Was this for care received in past year or earlier?				
Past year	54	57	53	43
Earlier year	37	38	37	44
Both	8	7	9	12

Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 22. More Than One-Quarter of Adults Under Age 65 with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

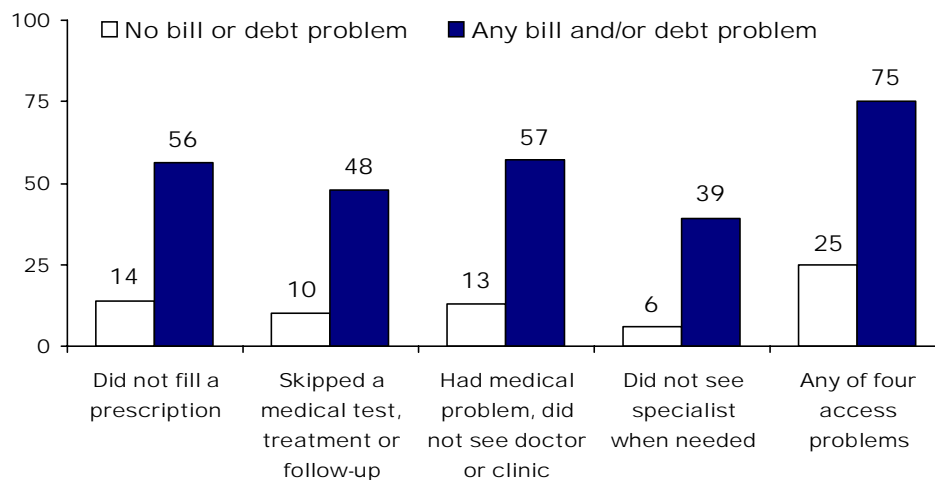
Percent of adults ages 19-64 with medical bill problems or accrued medical debt

Percent of adults reporting:	Total	Insured All Year		Uninsured Anytime During Year	
		No underinsured indicators	Underinsured	Insured now, time uninsured in past year	Uninsured now
Unable to pay for basic necessities (food, heat, or rent) because of medical bills	29%	16%	29%	42%	40%
Used up all of savings	39	26	46	46	47
Took out a mortgage against your home or took out a loan	10	9	12	11	11
Took on credit card debt	30	28	33	34	26
Insured at time care was provided	61	80	82	46	24

Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 23. Adults with Medical Bill Problems Report High Rates of Cost-Related Problems Getting Needed Care

Percent of adults ages 19-64 who had the following problems in the past year



Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.

Figure 24. Policy Options and Distribution of 10-Year Impact on Spending Across Payer Groups (in billions)

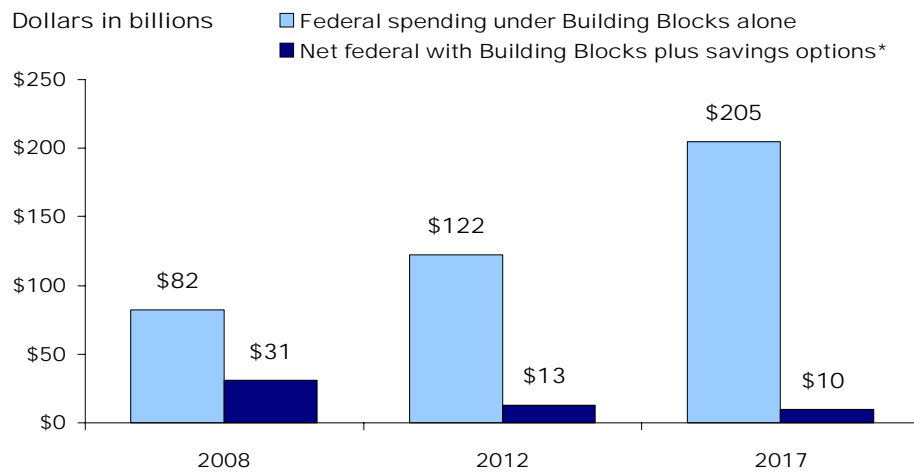
	Total NHE*	Federal Government	State/Local Government	Private Payer	Households
Producing and Using Better Information					
1. Promoting Health Information Technology	-\$88	-\$41	-\$19	\$0	-\$27
2. Center for Medical Effectiveness and Health Care Decision-Making	-\$368	-\$114	-\$49	-\$98	-\$107
3. Patient Shared Decision-Making	-\$9	-\$8	\$0	\$0	-\$1
Promoting Health and Disease Prevention					
4. Public Health: Reducing Tobacco Use	-\$191	-\$68	-\$35	-\$39	-\$49
5. Public Health: Reducing Obesity	-\$283	-\$101	-\$52	-\$57	-\$73
6. Positive Incentives for Health	-\$19	\$2	-\$12	-\$4	-\$5
Aligning Incentives with Quality and Efficiency					
7. Hospital Pay-for-Performance	-\$34	-\$27	-\$1	-\$2	-\$4
8. Episode-of-Care Payment	-\$229	-\$377	\$18	\$90	\$40
9. Strengthening Primary Care and Care Coordination	-\$194	-\$157	-\$4	-\$9	-\$23
10. Limit Federal Tax Exemptions for Premium Contributions	-\$131	-\$186	-\$19	-\$55	\$130
Correcting Price Signals in the Health Market					
11. Reset Benchmark Rates for Medicare Advantage Plans	-\$50	-\$124	\$0	\$0	\$74
12. Competitive Bidding	-\$104	-\$283	\$0	\$0	\$178
13. Negotiated Prescription Drug Prices	-\$43	-\$72	\$4	\$17	\$8
14. All-Payer Provider Payment Methods and Rates	-\$122	\$0	\$0	-\$105	-\$18
15. Limit Payment Updates in High-Cost Areas	-\$158	-\$260	\$13	\$62	\$27

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

* In some cases, because of rounding, the sum of the payer group impact does not add up to the national health expenditures total.

Source: C. Schoen, S. Guterman, A. Shih et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, December 2007).

Figure 25. Savings Can Offset Federal Costs of Insurance for All: Federal Spending Under Two Scenarios



* Selected options include improved information, payment reform, and public health.

Data: Lewin Group estimates of combination options compared with projected federal spending under current policy.

Source: Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, December 2007).