

Health Care – A Prescription for Change

SUMMARY

Experience has taught us that making modest improvements to our nation's health-care system won't reverse the long-term trends of ever rising numbers of uninsured, soaring health-care costs, unnecessary treatments, and poor and unsafe care. It is time to enact far-reaching reforms that simultaneously address these interrelated problems. This brief presents Consumers Union's "prescription" for a new health-care system.

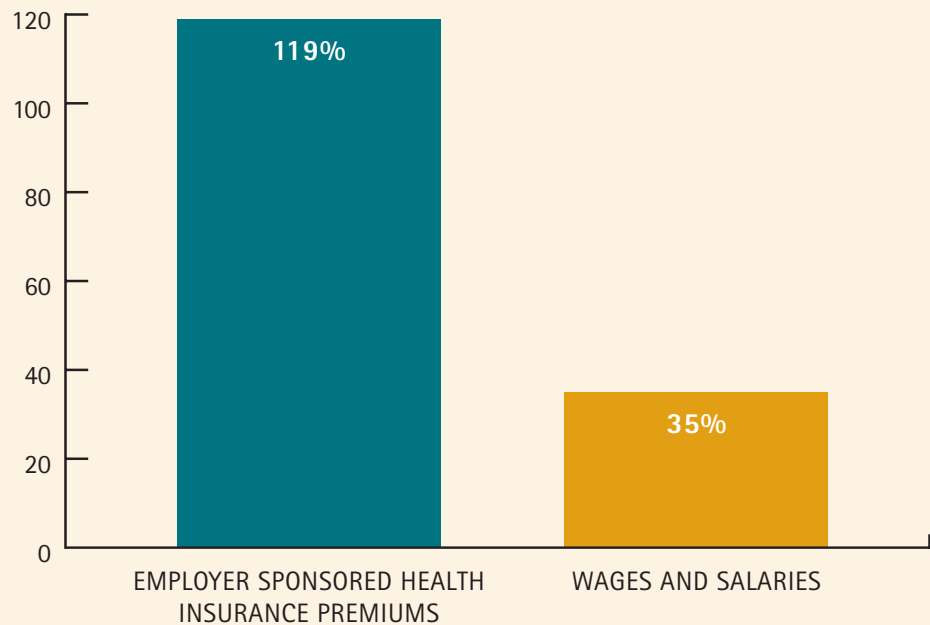
Do It Now!

Tackling the problems in our health-care system has been put off far too long. The limited efforts of the past 20 years have not succeeded in stemming the number of uninsured, clamping down on soaring health-care costs, or reducing unnecessary treatments and shoddy, unsafe care.

The current rate of health-care spending threatens our nation's economy. It limits our ability to compete in global markets.¹ It consumes an ever larger chunk of workers' overall compensation, leaving actual wage growth relatively flat (Exhibit 1). It paralyzes both state and federal governments as ever larger shares of their budgets go to pay for health care. Many believe these spending trends simply cannot be sustained. If comprehensive health-care reform is not enacted and things continue as they are, experts estimate that in the next 10 years:

- Health-care spending will rise from \$2.4 trillion today to \$4.4 trillion in 2018.²
- Family employer-sponsored health-care premiums could exceed \$30,000 a year, up from \$12,680 today.³
- The "trust fund" that pays Medicare hospital costs will run out of money.⁴
- We will spend as much as \$10 trillion on unnecessary care.⁵
- An estimated 62 million Americans will be uninsured as ever fewer people are able to afford coverage.⁶
- More than 220,000 of these uninsured will die because they sought care too late for their medical problem.⁷
- Over 1 million Americans will die due to preventable medical harm.⁸

EXHIBIT 1 – GROWTH IN THE COST OF HEALTH INSURANCE OUTPACES WAGE GROWTH, 1999-2008



Source: Kaiser Family Foundation & Health Research and Educational Trust, Employer Health Benefits 2008 Annual Survey and U.S. Bureau of Labor Statistics, Employer Cost of Compensation data (Wages and Salaries component).

Our overarching goals for health care reform are access to affordable, quality health care for every American, new mechanisms for managing costs, and a system of financing that is fair to all.

Our nation is at a historic juncture. We have unprecedented agreement that health-care reforms must be enacted – and quickly. Key stakeholders – large and small employers, hospitals, physicians and health plans – all agree that the status quo cannot continue. Indeed, these groups have identified some major areas of agreement about how to proceed.⁹ Furthermore, a great deal of policy analysis, political discussion and experience with state level reforms over the last two decades are informing the current debate.

It is imperative the most affected group, consumers, become informed and voice their support for changes to provide access to quality, affordable health care. Their lives, health, and financial well being are literally at stake.

For over 70 years, Consumers Union has advocated for fair, rational health-care policies and for regulations that protect consumers. Our overarching goals for health-care reform are access to affordable, quality health care for every American, new mechanisms for managing costs, and a system of financing that is fair to all. Below, we describe the types of changes we believe would accomplish these goals.

CONSUMERS UNION "PRESCRIPTION" FOR HEALTH CARE REFORM

- ✓ Health-care cost containment and quality improvement become national priorities.
- ✓ If you like your health insurance coverage, you can keep it.
- ✓ For everyone else, there are new comprehensive, affordable, understandable coverage options.
- ✓ New consumer protections make it easier to understand your health coverage options and reduce the risk of purchasing a bad policy.
- ✓ A new "store" called a health insurance exchange makes shopping for health coverage easier.
- ✓ Easy-to-use information on prices and the quality of services help consumers compare health plans, doctors, hospitals, and treatments.
- ✓ A public insurance plan option competes alongside private insurance options in the exchange.
- ✓ Premium subsidies to help lower and moderate income families afford coverage.
- ✓ Everyone has guaranteed access to health insurance at an affordable price, regardless of pre-existing medical conditions – and everyone must participate in the system.
- ✓ All but the smallest employers must offer or contribute to coverage.
- ✓ New measures increase the supply of primary care providers where they are needed.

If You Like Your Current Health Coverage, You Can Keep It

Many Americans already have access to good coverage. One survey shows that a bit more than half of us are satisfied with our present coverage.¹⁰ One principle of reform should be to preserve current coverage options for people who are satisfied with them. Consumers Union supports leaving the current employer-sponsored insurance and Medicare options intact. Medicaid, our nation's program for the poor, would also continue, albeit with new rules for eligibility and better provider reimbursement.¹¹ Likewise people who have coverage through retiree policies, Tricare (health-care coverage for active and retired military families), or through the Veteran's Administration (VA) would be able to keep what they have.

What would be new for those with employer coverage is that you won't have to stay in a particular job just to keep good insurance. New coverage options (discussed below) would ensure that you have the freedom to choose your job based on considerations other than the need to maintain your health coverage. That's good for people and good for the economy. According to economists, up to 25 percent more workers would move on to other jobs, or strike out on their own, if they didn't fear losing their health coverage.¹² This so called "job-lock" stifles innovation and undermines the worker mobility needed for a vibrant economy.

Up to 25 percent of workers would move on to other jobs, or strike out on their own, if they didn't fear losing their health coverage.

New Coverage Options Are Available

Not all Americans are satisfied with their coverage. More than 25 million are insured but inadequately protected and another 46 million have no coverage at all.¹³ Many others are simply unhappy with the way they are treated by their insurance company or fear losing their job-based coverage because they have an “uninsurable” pre-existing condition. For these folks, we need new, improved coverage options that provide them with peace of mind. No more worrying about losing your current coverage, or facing a medical crisis with inadequate coverage – or worse, no coverage at all.

MINIMUM COVERAGE STANDARDS

Minimum coverage standards are needed to ensure the coverage you buy is “good” coverage – that is, coverage that provides adequate financial protection from large medical expenses and covers the services needed to maintain overall health. At a minimum, this coverage should be at least as generous as the coverage available to members of Congress. That means covering most medical and surgical procedures, including lab, x-ray, diagnostic tests, prescription drugs, mental health care, and preventive care. Consumers Union recommends that the scope of covered services also include non-cosmetic dental and vision, to foster an integrated approach to overall health.

It is critically important these minimum coverage standards provide adequate financial protection for the consumer. About 62% of personal bankruptcies in the U.S. are caused by unpaid medical bills – and 78% of these had health insurance.¹⁴ Families bankrupted by medical costs and who had private insurance reported average out-of-pocket medical bills of \$17,749 in 2007.¹⁵ One-in-ten non-elderly *insured* Americans report they had to change their way of life significantly due to medical debt.¹⁶ Clearly, the health insurance policies of these families are not serving their intended purpose – to protect the policyholder from financially catastrophic medical expenses.

To reduce consumers’ financial vulnerability, the new coverage standards should require that the plan limit on out-of-pocket medical expenses – the maximum a patient will owe for covered services – be a “firm” maximum. Out-of-pocket provisions must not contain exceptions that can drive the policyholder’s costs beyond the stated limit.¹⁷ In a similar vein, health insurance plans must not contain annual or lifetime benefit caps that limit what the health plan will pay.

CONSUMER PROTECTIONS

Compared to consumers making other expensive purchases, such as homes and cars, health insurance shoppers are very vulnerable. Insurance policies are complex documents, written in legalese, and they typically leave consumers completely befuddled as to what is and isn’t covered.¹⁸ Because this market works so poorly, consumers purchase policies they don’t understand and may not meet their needs.¹⁹ Some of the products they buy are outright scams.²⁰

The new coverage options must be guaranteed; they must offer adequate financial protection from large medical expenses and cover the services needed to maintain overall health.

Health coverage choices must be manageable, meaningful and clear-cut. None of these conditions exist in today's health insurance marketplace.

Research has conclusively demonstrated that for consumers to participate as effective, discriminating purchasers of health coverage, there should be a manageable number of meaningful and clear-cut coverage choices.²¹ None of these conditions exist in today's health insurance marketplace.

Consumers Union strongly supports new regulations that put consumers on a level playing field with insurance companies. These regulations should:

- Require insurers to offer products from among a set of standard benefit packages. These standard packages would cover the same comprehensive set of services and vary *only* by their cost-sharing provisions and the type of provider network.
- Require all insurance offerings to follow a structured, consumer-friendly format in their plan materials. Common insurance terms such as “deductible” should have a consistent, industry-wide definition. Insurers should also use a standard method to disclose potential out-of-pocket costs under several different medical scenarios.²² All insurers should use the same scenarios so that consumers can meaningfully compare their likely out-of-pocket costs under different health plans.
- Provide consumers with reliable, easy-to-use information on providers participating in the insurer's network. Provider contracts must be in place to ensure that this information does not change between the beginning of the plan's enrollment period and the end of the plan's contract year.

Policymakers should not underestimate the positive impact of standardizing health insurance products and making health plan materials easier to understand. One study found that changes like these could increase purchase rates as much as modest premium subsidies.²³ Furthermore, by limiting the amount of benefit variation health plans would be forced to compete more on price and quality, helping hold down our nation's health-care costs.

While these reforms can and should be enacted in all insurance “markets,” these improvements will work particularly well in the new “insurance store” actively being debated by Congress.

THE HEALTH INSURANCE EXCHANGE: A NEW INSURANCE “STORE”

The most important new structure being proposed by Congress is a health insurance exchange, also sometimes called a “connector” or “gateway.” In simple terms, the exchange (or exchanges if one is created in each state or region) is a new health insurance store. It would sell one product – health insurance.

You wouldn't be required to purchase your coverage thorough the exchange, but we think you'll likely want to if you don't have access to good employer coverage. Here's how it would work:²⁴

- The exchange lets you choose from among health insurance plans available in your area, including the option of a public plan (see Public Insurance Plan sidebar). All health plans would have to abide by the new rules specifying minimum coverage standards and limiting variation in benefit design.
- Selecting a health plan is easier because the exchange would offer “side-by-side” health plan comparisons so applicants could meaningfully compare their choices. The exchange would also offer one-on-one enrollment counseling to help consumers understand their options and enroll in the coverage that best meets their needs.
- Individuals may be eligible for help paying their health insurance premium depending on their income. These “premium subsidies” would not be available outside the exchange.

A PUBLIC INSURANCE PLAN COVERAGE OPTION

One of the most contentious issues in the health reform debate is whether or not the health insurance exchange should feature a “public insurance plan” coverage choice to compete with private coverage options.

In most ways, the public insurance plan would operate just like a private insurer. It would engage in the traditional insurance functions of negotiating contracts with providers, enrolling policyholders, collecting premiums, and paying claims. The key difference is that the public insurance plan would be run like a “public utility” with a clear mission of public *accountability*. Specifically, the public insurance plan option would be tasked with conducting its operations in an open and transparent fashion, maintaining the highest standard of patient and provider satisfaction, and working with providers to develop innovative measures that improve the quality of care, eliminate waste, and minimize the hassles of insurance reimbursement.

The goal is for the public insurance plan to serve as a “benchmark” plan consumers can use to evaluate their other insurance options. As such, the transparent operation of the public insurance plan option is intended to provide a catalyst for private plans to reexamine the way they operate, encouraging new ways of paying for care and driving new innovation.

Consumers Union supports a public plan and recommends the plan be required to operate using the same rules as private plans. Both public and private plans would be subject to the same regulations with respect to premium setting and financial reserves. Provider reimbursement would be negotiated with providers – not dictated by the government. Only by operating on a “level playing field” can the public and private plans compete and improve on each others’ innovations – thereby producing the system-wide improvement that our country needs.

Consumers Union explores the public insurance plan option more fully in our companion policy brief “The Public Insurance Plan Option – Making Health Insurance Affordable?” July 2009.

- The exchange would collect premium payments from participating enrollees and small employers, combine these payments with any subsidy amounts, and forward to participating health insurers.
- The exchange would be a “partner” for consumers, monitoring insurer compliance with new consumer protections and collecting and publishing quality data on participating health plans.
- The exchange itself would be non-profit, operate in the public interest, and be governed by a board that would include consumer and patient members.

It may be wise to have insurers competitively bid to participate in the exchange. The bidding system would take into account overall value – that is, both cost and quality of the coverage. This would provide a streamlined number of insurers to avoid the dizzying array of choices that could cloud rather than illuminate the purchase decision. What we don’t want is a situation like that confronting Medicare beneficiaries trying to purchase a prescription drug plan, also called Part D. Medicare seniors have found themselves overwhelmed with Part D plan options (see Part D sidebar). A detailed study found that very few enrollees opted for the plan that would have minimized their out-of-pocket costs.²⁵

Initially, the exchange would be open to consumers purchasing coverage on their own, the self-employed and very small employers. As many have noted, very small employers – with 10 workers or less, for example – report the same insurance purchasing hassles as individuals.²⁶ Their premiums increase when someone gets sick and shopping for coverage is a big headache. Many small companies would like to offer coverage to their employees but need an option that is administratively easy and provides some guarantee that premiums will still be affordable in a few years.²⁷

In the exchange these small employers would simply pay their premium contribution to the exchange and the exchange would handle all the other functions of enrollment, employee complaints, etc. – all while giving workers the choice of any of the offered plans. As experience is gained with the new health insurance exchanges, it may make sense to also let larger employers offer coverage through the exchange.

Exchange officials would work closely with state insurance commissioners, who would continue to serve as the primary enforcement mechanism for state and federal insurance regulations, as well as licensing health plans and monitoring their financial solvency.

AFFORDABLE COVERAGE

The cost of health insurance is the most common reason consumers today are uninsured or underinsured.²⁸ Under reform, millions of low- and moderate-income families would have help to buy their coverage.

PITFALLS TO AVOID – MEDICARE PART D EXPERIENCE

In 2006, Medicare seniors were given the opportunity to purchase a new prescription drug benefit, called Medicare Part D. While many consumers now have better access to prescription drugs, the experience also illustrates the potential pitfalls of setting up a new market.

Several studies indicate that there are more options than consumers can reasonably be expected to evaluate. On average, Medicare beneficiaries have a choice of 48 Part D plans – and some have a choice of around 70. One study found that most enrollees ended up spending \$360 to \$520 *more* per year than the optimal plan for them based on previous year's usage. Just 6 percent of enrollees picked the plan that would save them the most money. Furthermore, relatively few enrollees switch into other, more cost-effective plans. Out of 17 million Medicare Part D enrollees in 2008, only 1 million switched plans. In one survey, a majority of seniors agreed that "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing."

Source: Consumers Union policy brief "Simplifying Health Insurance Choices" June 2009.

Consumers Union favors a premium subsidy program that delivers the most help to low-income people while recognizing that many moderate-income families would also need assistance. However, taxpayer-financed premium subsidies should not be wasted on "junk" health insurance, inefficient health plans, or plans that feature poor quality providers. We advocate restricting premium subsidies to coverage purchased through the health insurance exchange and vetted for quality.

For coverage to be truly affordable, families must be able to purchase insurance that contains "cost sharing" (e.g., deductibles and co-pays) they can afford. In other words, a family that makes \$20,000 a year is simply too vulnerable if their health plan features an out-of-pocket maximum of, say, \$3,500. Similarly, we don't want such families to put off going to the doctor because the office visit co-pay will make a significant dent in their weekly food budget.

A system of carefully constructed premium subsidies can preserve choice yet create sound purchasing incentives for the consumer. To get these incentives right we recommend that the subsidy amounts be structured as follows:

- Allows families to purchase a health plan that contains cost-sharing they can afford.
- Links subsidy amounts to the cost of the most cost-effective, yet high-quality health plan (a benchmark plan).
- Avoids creating an incentive to purchase low quality health plans because they are cheaper.

Guaranteed Coverage, and a Requirement to Have Coverage

We need new nationwide insurance rules that require insurers to sell to all comers regardless of past medical conditions – a requirement known as "guaranteed issue."

Equally important, premiums should vary for only a few factors, like age and geography.

Health-care coverage must be guaranteed so that both young and old, both healthy and sick, can get the coverage they need. This is a major departure from the way individual insurance coverage is purchased today. Currently, insurers in all but a few states can refuse to cover those with a medical condition like diabetes, or they can issue a policy that doesn't cover pre-existing conditions. Such practices may make good business sense, but they don't get health coverage to those who need it most. Inadequate coverage can then lead to personal bankruptcy and uncompensated care, the cost of which is then borne by other payers.

Consumers Union supports new nationwide insurance rules that require insurers to sell to all who apply regardless of past medical conditions – a requirement known as "guaranteed issue." Insurers should also be required to cover pre-existing conditions and prohibited from imposing a waiting period before that coverage kicks in.

Equally important, premiums should vary for only a few factors, such as age and geography. That means insurers can't charge more just because someone has a chronic illness.

As insurance companies correctly point out, if insurers are required to accept all applicants and insure all medical conditions there is little incentive to purchase coverage until you need it. If people put off purchasing coverage until they get sick, only people who have significant medical expenses would be in the insurance "pool" and health care costs would be exorbitant. This would undermine the basic tenet of insurance – spreading the costs broadly across the healthy and the unhealthy.

Therefore, in order to obtain the critical consumer protections associated with guarantee issue and coverage of pre-existing conditions, two other policies must also be in place:

- A new industry-wide "risk adjustment" mechanism so that insurers don't try to avoid those who are poor health risks through their marketing practices or their service patterns.
- A requirement that everyone has to purchase health coverage, so that risks are spread broadly.

Recognizing the interrelated nature of these reforms, Consumers Union supports a requirement that all Americans enroll in coverage, also referred to as an "individual mandate." Our support for an individual mandate is contingent upon also having certain consumer protections in place, namely:

- Health insurers must accept all applicants without exclusion or limitations of any kind (guaranteed issue).
- Premium costs may vary only by age and geography.

- The insurance marketplace must feature new rules that standardize and simplify health-plan choices.
- Coverage must conform to a minimum coverage standard that covers necessary care and protects people from financial ruin.
- Sufficient subsidies must be available, making coverage affordable for individuals and families.
- A “hardship exemption” must be in place that waives the requirement to purchase insurance if consumers find themselves without an affordable, high quality coverage option in their area, despite the new rules.

We believe requiring people to buy insurance, under these conditions, is fair. If people can opt out it risks putting the burden of their medical costs on the rest of us. Younger people may be less likely to experience a major illness than older people – and their policies will cost somewhat less than those of older people. But an accident or major medical problem can hit anyone at anytime.

Furthermore, requiring the purchase of insurance is critical to realizing the goal of health coverage for all. Studies have shown a system of generous subsidies and administrative simplification *by itself* would leave as many as half the uninsured still without coverage.²⁹ People may be too busy to get around to buying coverage or may put it off because they feel they are healthy. Requiring people to buy insurance – and making it easy for them to do so – is the only way to get everyone in the system.³⁰

Employers Must Offer or Contribute to Coverage

Most people are used to getting health insurance from their employer. It’s a system that works reasonably well and has some distinct advantages. It is easy to enroll, employers typically make a significant contribution to coverage, and the employee’s share of the premium is conveniently handled using payroll deductions.

Under the proposed reforms, there would be greatly improved health coverage options in the individual or non-group market. Some workers who are dissatisfied with their employer’s coverage could purchase coverage through the exchange. In particular, the availability of premium subsidies for lower income workers would help offset the loss of the employer’s premium contribution – putting the cost of the two options on more equal footing. Indeed, employers may even actively encourage their employees to purchase in the exchange either to lower their compensation costs or because they believe their employees would be better off.

Reforms must not unravel our current system of employer financing for health care.

Providing meaningful coverage options besides those offered by your employer is a desirable goal of reform, but it has a downside. We don't want to unravel our current system of employer financing for health care. America is unique in the world with respect to the role of employers in the financing of health care. On average, employers contribute 72% to the cost of coverage for workers and their families, and enroll 163 million Americans in coverage.³¹ That's \$430 billion a year.³² To dismantle this system would have grave consequences for our health-care system.

Consumers Union recommends that all but the smallest employers be required to offer coverage or make a contribution for all their workers. Employers would have the option of *not* offering coverage to workers, but if their total payroll exceeds a certain threshold they would have to pay into a pool to help subsidize coverage for workers purchasing insurance through the exchange. This policy is usually called an "employer play-or-pay" requirement.

In our view, the goal of this policy is to maintain current levels of employer spending *on average*, not to generate large new sources of revenue. To be sure, some employers would find they must increase their spending on health care if their contribution as a percent of payroll was well below average, but most would continue offering coverage "as usual" while hopefully benefiting from the new cost containment initiatives, quality improvements, and insurer transparency requirements.

With the "pay or play" requirement and other proposed reforms in place, Consumers Union does not believe the new coverage options created by health reform will undermine the current system of employer provided health care. Roughly half of all workers would not qualify for any subsidy in the exchange (Exhibit 2), and for many others the subsidy would be modest enough that their employer's coverage would still be cheaper. Many people will simply prefer to stick with "what they know." A similar "pay-or-play" policy has been operating in San Francisco for a little over a year and employers in that city have largely opted to leave their existing benefit programs intact (see sidebar).

EXHIBIT 2 – ILLUSTRATION OF HEALTH INSURANCE OPTIONS AFTER REFORM

Income Group (Income as a percent of Federal Poverty Level – FPL)	Sample Annual Family Income (for family of three in 2009)	Distribution of Workers by Income Group	INSURANCE OPTIONS AFTER REFORM			
			Medicaid	Employer Coverage (if offered)	Individual (non-group) in the Exchange (premium subsidy available depending on income)	Individual (non-group) Outside the Exchange (no premium subsidies)
<100% FPL	<\$18,301	7%	✓	✓	✓	✓
100% to 199% FPL	\$18,301 to \$36,600	15%	✓ (depending on income)	✓	✓	✓
200% to 400% FPL	\$36,601 to \$73,200	33%		✓	✓	✓
> 400% FPL	> \$73,200	45%		✓	✓	✓

Source: *Distribution of workers by income group from: Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* (Urban Institute 2001). Larger and smaller families would have different income thresholds than the sample family displayed in this table.

HEALTHY SAN FRANCISCO – EMPLOYER MINIMUM SPENDING REQUIREMENT

Launched in July 2007, *Healthy San Francisco* is a program that provides comprehensive health services to uninsured San Francisco residents regardless of income. The program operates on the principle of shared responsibility, with funding coming from government, individuals and employers.

One component of these reforms is a **minimum health spending requirement** for firms with 20 or more workers. The minimum health spending requirement was designed to level the playing field for firms that already provide coverage, discourage firms from dropping coverage, and reduce the taxpayer cost of caring for the firm's uninsured workers. In 2009 the minimum spending requirement is:

- Firms 100+ employees – \$1.85 per employee per hour
- Firms 20-99 employees – \$1.23 per employee per hour
- Firms 1-19 employees – no spending requirement

The requirement can be met with contributions toward health benefits, health savings accounts, direct reimbursement of health care costs or payment into the city program. The requirement imposed on larger firms is set to be equivalent to 75 percent of the average amount that the 10 largest counties in California (other than San Francisco) spend on individual health coverage for their employees.

Experience to date, while limited, shows that employers have largely opted to leave their existing benefit programs intact. For those workers who don't have coverage, employers meet the requirement by paying into the city's program. A number of restaurants have adapted to this new expense by adding surcharges to the cost of dining, ranging from one dollar an entrée to 5 percent of the bill.

Source: Ken Jacobs. *San Francisco Health Security Ordinance, February 2009.*

Constrain Costs and Improve the Quality of Care

The United States spends more than any other nation on health care – around \$8,160 per person per year at last count.³³ At the same time, studies consistently show that about 30 percent of the health care we consume is of no benefit to patients.³⁴ That means we are wasting something on the order of \$400 to \$600 billion a year.

Staggering differences also exist in what consumers, their employers, and government pay for health care around the country, with no rational basis for the difference and with *no link to quality of care*. In some areas where care costs less, patients fare better in terms of treatment outcomes, according to years of data from the Dartmouth Atlas Project.³⁵ The same avenues of research also indicate that “more is not always better” when it comes to health care. For example, the research indicates expensive and somewhat risky surgery to open up blocked heart arteries in some situations doesn’t yield any better medical outcomes than safer and much less expensive treatment with medications.³⁶

Without a successful effort to eliminate unnecessary treatments and bring down the rate of health care inflation, our nation is unlikely to be able to sustain the costs of guaranteed coverage for all Americans.

What’s worse is that an unacceptable portion of this unnecessary care is actually harmful. Ten years ago the Institute of Medicine (IOM) published its groundbreaking report *To Err Is Human*, which detailed the epidemic of medical errors in the United States. The report estimated that 98,000 Americans die every year from preventable medical errors. More than 2 million Americans experience medical harm in a given year.³⁷ And in the decade since the IOM report, there is no evidence of overall improvement in patient safety. Furthermore, the IOM’s major recommended reforms have not been adopted.³⁸

Without a successful effort to eliminate unnecessary and potentially harmful treatments and bring down the rate of health-care inflation, our nation is unlikely to be able to sustain the costs of guaranteed coverage for all Americans. The problem is of sufficient magnitude and seriousness that Consumers Union believes reforms to slow cost growth and improve the quality of care must become national priorities. Efforts to solve this problem should be undertaken with the same level of ambition, boldness and focus as our earlier efforts to send astronauts to the moon.

For all its complexity, however, there are only so many ways to control health costs. At the end of the day, we need to improve underlying population health, cut waste and unnecessary care, and improve the quality of care through better coordination, better treatments, and better “on demand” information.

One approach to cutting waste and improving care is to reform the way the government and the private sector pay doctors, hospitals and other providers – to peg payments to the overall outcome of an episode of illness, not reward the quantity of lab tests, procedures, and exams given. A second way is that price competition – with the appropriate reforms in place – could also lower costs, although the track record to date is poor. And a third approach, which we do not endorse, would be to put an overall cap on expenditures and simply not permit spending more than that amount.

Of these three, the last is least attractive and all but “off the table” in the discussion now underway in Congress. But the others are being actively considered and dozens of targeted efforts are being proposed in each. There is no magic bullet and many new ideas will have to be tried and monitored as to their effectiveness. Here are some promising approaches that focus on health-care providers:

- Institute payment reforms that pay a flat fee for managing an episode of illness. This “bundle of care” would include all services associated with the episode, including post-operative follow-up.
- Give incentives to doctors and hospitals to create “integrated” systems of care that follows patients along the path of an illness and coordinates care for people with chronic diseases.
- Prohibit payment for care that arises from medical errors or preventable hospital-acquired infections.³⁹
- Continue federal support for independent research that compares treatments, drugs and medical devices head-to-head so consumers and doctors can make better informed decisions – sometimes called comparative effectiveness research or patient-centered outcomes research.⁴⁰
- Enact strong conflict-of-interest rules for all providers requiring disclosure of the receipt of anything of value (gifts, travel, etc.) from drug, device, and other suppliers, as well as ownership interest in facilities to which that patient is referred. We also recommend strong conflict-of-interest rules for any new boards or agencies established as part of health-care reform, and greater transparency for conflicts of interest in research and medical education settings.⁴¹
- Develop alternative sites of care open late and on weekends to deal with non-emergency medical conditions. Emergency rooms are the most expensive setting to receive non-traumatic care and are often used because no other options are available.
- Strengthen the inducements for doctors to adopt electronic health records, featuring strong privacy provisions, so that each patient’s medical history is readily available.⁴²

Consumers also have a role to play in controlling costs. Even though consumers defer most treatment decisions to their doctor, they deserve to know more about these cost/quality conundrums. In some experiments by Dartmouth researchers and others, when patients are fully informed of their treatment options, the majority of the time they choose fewer interventions, more conservative and usually less expensive care. Providing better information in ways that consumers are likely to use it is fair and may help to bring about better, safer care that costs less. Consumers Union recommends:

- Collecting information on the quality, safety and cost of care by doctors and hospitals and make all of it easily available to the public. Make sure the measurements are accurate and meaningful to consumers.⁴³
- Providing incentives for people to get electronic “personal health records” (PHRs) – software and programs that provide you with a complete record and ongoing history of your care by all doctors, including test and lab results, medication history, and doctors’ diagnoses and treatment recommendations.
- Provide incentives for prevention and wellness in health insurance benefit packages and enact public health measures designed to foster healthy lifestyles.

Increase The Supply Of Primary Care Providers

We support expansion of current federal programs to increase the supply of primary care providers and ensure that they are located where they are needed.

Under a newly reformed system, providing care to those who now go without and improving care coordination will greatly increase our nation’s need for primary care providers – both physicians and physician “extenders” such as physician assistants and nurse practitioners. Several studies suggest that the supply of primary care providers – particularly those serving adults – may be insufficient to meet this demand, with rural areas facing the worst shortages.⁴⁴ For example, a detailed survey of practicing primary care physicians in California found that even though the state *on average* had sufficient primary care providers, when examined at the county level only 16 of 58 counties had a sufficient number primary care physicians.⁴⁵ In eight California counties the supply was less than half of what is needed.

To go beyond access to health *coverage* and ensure access to health *care*, our nation’s supply of primary care providers must be sufficient to meet the new demand. Hence, Consumers Union supports expansion of current federal programs such as the National Health Services Corps to increase the supply of primary care providers and ensure that they are located where they are needed.⁴⁶ Furthermore, primary care providers must be compensated fairly under the new coverage initiatives. Not only should primary care physicians be reimbursed for new tasks such as coordinating patient care, but disparities in compensation between primary care physicians and specialists must be addressed. Primary care doctors earn much less for interacting with patients than specialists for procedures that take the same amount of time.⁴⁷ “Compensation” may also be increased in another way – the proposed reforms should greatly reduce the insurance reimbursement “hassles” providers face, making it more attractive to practice in this field.

Tilting the balance of physicians towards more primary care physicians and away from our nation’s over-reliance on specialty care services may also help save money. Although specialists provide higher-quality care for some conditions, at least one study showed that primary care physicians, using fewer resources, deliver care similar in quality to that of specialists for such conditions as diabetes and hypertension.⁴⁸

Paying for Health Reform

Any serious discussion of health reform must recognize that new revenue sources will be needed to “jump start” the new monitoring systems, support research that helps deliver health care in new ways, and – the big expense – fund premium subsidies for lower-income families.

Some financing should come from new employer payments to the exchange for workers who decline employer coverage; the premiums paid by the newly enrolled; and from money that is now spent to cover the cost of care for the uninsured. However, most analysts believe that a truly comprehensive set of health-care reforms would require financing over and above these amounts.

Consumers Union recognizes and supports the need to identify new sources of financing to ensure that all elements of comprehensive health reform are enacted. As noted earlier, the time for half-measures is past.

The burden of new financing must be distributed fairly across the U.S. population – everyone must contribute based on ability to pay. That means that families and employers must contribute to the cost of coverage, doctors and hospitals must root out wasteful care and become more efficient, and state and federal government must find new sources of tax revenue that are progressive and consistent with the goals of health reform. Furthermore, we feel that a strong, comprehensive system of new cost containment initiatives *must* accompany the implementation of any new taxes. In other words, taxpayers should *not* be asked to pay into a system that looks much like today’s inflated, inefficient, and often poor-quality health-care system.

In the past decade, several states have tried to enact comprehensive health reform measures, yet failed over the political difficulty of finding new sources of revenue. This must not be the fate of our national health reform efforts. All stakeholders must keep in mind the tremendous economic value that would be derived from enhanced population health, less wasteful systems, a reduction in job-lock, and higher value for our health-care spending. Benefits will outweigh the costs, according to one detailed study.⁴⁹ What we *cannot afford* is failure to pass comprehensive health reform.

In Conclusion

It is hard to think of another market that is failing consumers as badly as the health-care market. While many Americans at any given time are insulated from the direct effects of this inefficient system, they pay indirectly through higher premiums, burdensome increases in out-of-pocket costs, reduced benefits, and anxiety over a future loss of coverage. For the millions without health coverage or with inadequate health coverage, their health and financial future are on the line.

The burden of new financing must be distributed fairly across the U.S. population – everyone must contribute based on ability to pay.

Overhauling this complex system with its myriad imbedded interests is a difficult proposition. It will require leadership of historic proportions. But this country has shown itself capable of rising to such challenges. Americans, both insured and uninsured, deserve nothing less than an all out, truly bi-partisan effort to fix our health-care system.

This policy brief was written by Lynn Quincy.

ENDNOTES

- 1 Arnold Milstein, MD, M.P.H. and Carrie Hoverman Colla, M.A. *Tracking the Contribution of U.S. Health Care to the Global Competitiveness of American Employers and Workers: 2009 Business Roundtable Health Care Value Comparability Study*, Mercer Health & Benefits, February 28, 2009.
- 2 Office of the Actuary, Centers for Medicare & Medicaid Services (CMS); *National Health Expenditure Projections 2008–2018*, February 2009. Using the prior year’s growth rates, CU estimated that spending would increase another \$310 billion between 2018 and 2019.
- 3 2008 premium from Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits 2008 Annual Survey*. According to this source, family premiums for employer coverage increased 119% between 1999 and 2008. Our 10 year projection merely continues this trend.
- 4 Boards Of Trustees Of The Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds, *2009 Annual Report*, May 12, 2009.
- 5 This estimate assumes that 30 percent of projected spending for the years 2010–2019 (see endnote 1) is spent on unnecessary care. The “30 percent” estimate comes from Elliott Fisher, “More Care Is Not Better Care,” *Expert Voices*, Issue 7 (National Institute for Health Care Management, January 2005).
- 6 John Holahan, Bowen Garrett, Irene Headen, and Aaron Lucas. *Health Reform: The Cost of Failure*, The Urban Institute, May 21, 2009.
- 7 Extrapolates from Dorn’s estimate that 22,000 died in 2006 due to lack of health insurance. Stan Dorn, *Uninsured and Dying Because of It*, The Urban Institute, January 2008.
- 8 The U.S. Centers for Disease Control and Prevention estimate that health care-associated infections in hospitals (just one type of medical harm) kill 99,000 Americans a year. R. Monina Klevens and others. “Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002,” *Public Health Reports*, March–April 2007, Vol. 122.
- 9 Noam N. Levey. “Consensus Emerging On Universal Healthcare,” *Los Angeles Times*, December 1, 2008.
- 10 Lydia Saad. “Americans Rate National and Personal Healthcare Differently,” Gallup, December 4, 2008.
- 11 Consumers Union advocates eliminating the current “categorical” eligibility requirements in Medicaid and instituting simple income-based eligibility requirements. The main impact of this reform would be to extend Medicaid eligibility to very low-income adults without dependent children at home.
- 12 Jonathan Gruber. “A Shot In The Arm. How Today’s Health Care Reform Can Create Tomorrow’s Entrepreneurs,” *Washington Monthly*, May/June 2009.
- 13 DeNavas-Walt, C.B. Proctor, and J. Smith. Income, Poverty, and Health Insurance Coverage in the United States: 2007. U.S. Census Bureau. August 2008 and Cathy Schoen, Sara Collins, Jennifer Kriss and Michelle Doty. “How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007,” *Health Affairs Web Exclusive*, June 10, 2008.
- 14 David Himmelstein, Steffie Woolhandler, Elizabeth Warren and Deborah Thorne. Medical Bankruptcy in the United States, 2007, *the American Journal of Medicine*, August 2009.
- 15 Bankruptcy filers who were uninsured had bills averaging \$26,971 in 2007.
- 16 M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss., *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families*, The Commonwealth Fund, August 2008.

- 17 A detailed comparative study of health plans in Massachusetts and California found that plans with seemingly similar provisions would have left policyholders with out-of-pocket obligations that differed by thousands of dollars. Karen Pollitz, Eliza Bangit, Jennifer Libster, Stephanie Lewis, and Nicole Johnston. *Coverage When It Counts, How Much Protection Does Health Insurance Offer And How Can Consumers Know?*, Center for American Progress Action Fund, May 8, 2009.
- 18 Anna Wilde Mathews, “The Importance of Deciphering Your Insurance,” *The Wall Street Journal*, June 2, 2009.
- 19 See our companion policy brief *Simplifying Health Insurance Choices*.
- 20 Kathryn Allen and Robert Cramer. *Unauthorized or Bogus Entities Have Exploited Employers and Individuals Seeking Affordable Coverage*, GAO Testimony, March 3, 2004. See also “Hazardous Health Plans,” *Consumer Reports*, May 2009.
- 21 See our companion policy brief *Simplifying Health Insurance Choices*.
- 22 For an example, see our companion policy brief *Simplifying Health Insurance Choices* and Pollitz, op cit.
- 23 MS Marquis, MB Buntin, JJ Escarce, K Kapur TA Louis, JM Yegian. “Consumer Decision Making in the Individual Health Insurance Market,” *Health Affairs*, May 2006.
- 24 *Explaining Health Care Reform: What Are Health Insurance Exchanges?*, Kaiser Family Foundation, May 2009.
- 25 Jonathan Gruber. *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?*, Henry J. Kaiser Foundation, March 2009.
- 26 “Health Care Challenges for Small and Micro Businesses,” *Center for Rural Affairs Newsletter*, December 2005.
- 27 Ed Neuschler and Rick Curtis. *Premium Assistance: What Works? What Doesn't?*, Institute for Health Policy Solutions, April 2003.
- 28 John Graves and Sharon K. Long. *Why Do People Lack Health Insurance?*, The Urban Institute, May 22, 2006.
- 29 Linda J. Blumberg and John Holahan. *Do Individual Mandates Matter?*, The Urban Institute, January 28, 2008.
- 30 Experts recognize that even these policies may not get everyone enrolled. Similar reforms have been enacted in Massachusetts and officials there estimate that they are unlikely to get every last resident enrolled. However, three years after its health care law passed, 97 percent of state residents are insured, the highest coverage rate in the country.
- 31 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey – Insurance Component, Table IV.A.1 and Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey,” *EBRI Issue Brief*, No. 321, September 2008.
- 32 Holahan et al., op cit.
- 33 CMS Office of the Actuary, op cit.
- 34 Fisher, op cit.
- 35 Maggie Mahar. “The State of the Nation’s Health,” *Dartmouth Medicine*, 5/1/2007. See also “Too Much Treatment,” *Consumer Reports*, July 2008.
- 36 Thomas A Trikalinos, Alawi A Alsheikh-Ali, Athina Tatsioni, Brahmajee K Nallamothu, David M Kent. Percutaneous coronary interventions for non-acute coronary artery disease: a quantitative 20-year synopsis and a network meta-analysis, *Lancet* 2009; 373: 911–18.
- 37 Medical harm includes preventable medical errors and healthcare-associated (hospital acquired) infections. The latter were estimated to affect 1.7 million people per year (Klevens RM, and others, “Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002,” *Public Health Reports*, March–April 2007; Vol. 122). Other types of preventable medical errors were estimated to number more than 700,000 per year (Zahn C, and Miller MR, “Excess length of stay, charges and mortality attributable to medical injuries during hospitalization,” *JAMA*, 2003;290:1917–19).
- 38 See CU commissioned report *To Err is Human—To Delay is Deadly*, May 2009.
- 39 See CU commissioned report *To Err is Human—To Delay is Deadly*, May 2009.
- 40 See CU paper *Comparative effectiveness: Common-sense research that saves money, lives*.
- 41 See CU’s 2008 Statement before the Institute of Medicine Committee on Conflict of Interest in Medical Research, Education, and Practice. <http://www.iom.edu/Object.File/Master/52/425/Consumer.pdf>

- 42 See CU 2006 testimony before the Committee on Energy and Commerce, Subcommittee on Health, U.S. House of Representatives.
- 43 See CU paper *Public Transparency: Encourages Health-Care Safety And Prevention That Saves Lives*.
- 44 Colwill JM, Cultice JM, Kruse RL. "Will Generalist Physician Supply Meet Demands of an Increasing and Aging Population?" *Health Affairs*, April 29, 2008. See also: Fordyce MA, Chen FM, Doescher MP, Hart LG. *2005 Physician Supply And Distribution In Rural Areas Of The United States*. Final Report #116. WWAMI Rural Health Research Center, 2007, and *Recent Studies and Reports on Physician Shortages in the U.S.*, AAMC, April 2009.
- 45 Kevin Grumbach, M.D., Arpita Chattopadhyay, Ph.D. and Andrew Bindman, MD. *Fewer and More Specialized: A New Assessment of Physician Supply in California*, California HealthCare Foundation, June 2009.
- 46 This federal government website has detailed information about the National Health Services Corps:
- 47 T. Bodenheimer, R. A. Berenson, P. Rudolf. "The Primary Care-Specialty Income Gap: Why It Matters," *Annals of Internal Medicine*, 2007;146:301-6.
- 48 T. Bodenheimer and A. Fernandez. "High and Rising Health Care Costs. Part 4: Can Costs Be Controlled While Preserving Quality?" *Annals of Internal Medicine*, 5 July 2005, Volume 143 Issue 1, pages 26-31.
- 49 Institute of Medicine. *Hidden Costs, Value Lost*. Washington, DC: National Academy Press, 2004.

ConsumersUnion®

NONPROFIT PUBLISHER OF CONSUMER REPORTS

Consumers Union has a long history of advocating for improvements in the consumer marketplace. Since our creation in 1936, we have worked for safer, more affordable, and better quality products and services at both the state and federal levels. We are a non-profit, non-partisan organization with an overarching mission to test, inform and protect.

WWW.CONSUMERSUNION.ORG

HEADQUARTERS

101 Truman Avenue, Yonkers, NY 10703
Phone: (914) 378-2000 Fax: (914) 378-2928

WASHINGTON DC OFFICE

1101 17th Street NW, Suite 500, Washington, DC 20036
Phone: (202) 462-6262 Fax: (202) 265-9548

SOUTHWEST OFFICE

506 West 14th St., Suite A, Austin, Texas 78701
Phone: (512) 477-4431 Fax: (512) 477-8934

WEST COAST OFFICE

1535 Mission Street, San Francisco, CA 94103
Phone: (415) 431-6747 Fax: (415) 431-0906