

HEALTH POLICY  
VIEWPOINT  
DECEMBER 2009

## Health Care – Our Prescription for Change

### SUMMARY

Congress is actively working to pass comprehensive health care reform this year. This legislative activity stems from widespread agreement that the limited reform efforts of the past 20 years have not succeeded in clamping down on soaring health care costs, stemming the number of uninsured or reducing shoddy, unsafe care. Out of necessity, the proposed reforms are sweeping. They seek to impose a “uniquely American solution” on a very complex health care system – a system like no other in the world.

For over 70 years, Consumers Union has advocated for fair, rational health care policies and for regulations that protect consumers. Our overarching goal for health care reform is a sustainable system that contributes to a healthy American population. This system features access to affordable, quality health care for every American, bold efforts to manage costs, and a system of financing that is fair to all.

In this “viewpoint,” we outline the set of legislative policies we’d recommend that would move us toward these goals, and we include the analyses that inform these recommendations. For the most part, the policy ideas are not new. They reflect two decades of policy analysis, evaluations of incremental reforms, and experience with state level approaches. What is new is the call for an integrated, comprehensive approach to health reform. The time for half-measures is past. Consumers’ lives, health, and financial well being are literally at stake.

## Current System Cannot Be Sustained

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.

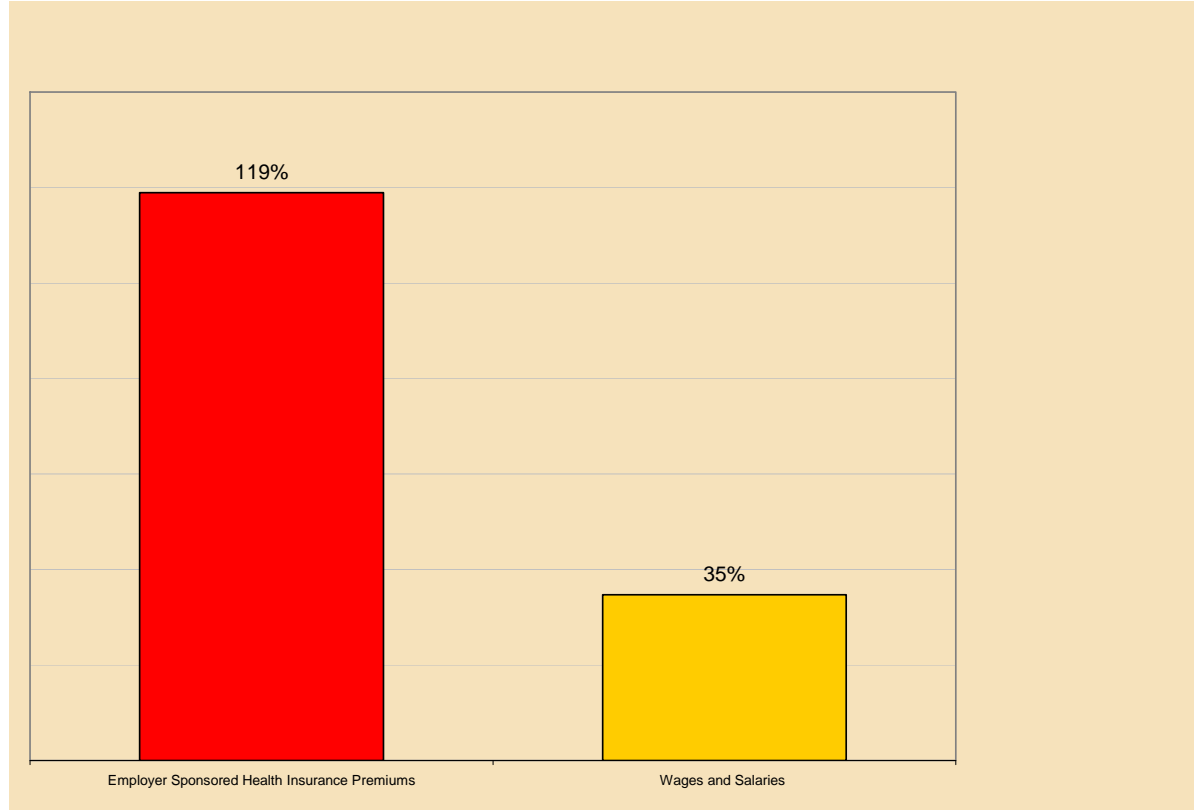
The current rate of health care spending threatens our nation's economy. It limits our ability to compete in global markets.<sup>1</sup> It consumes an ever larger chunk of workers' overall compensation, leaving actual wage growth relatively flat (Exhibit 1). It paralyzes both state and federal governments as ever larger shares of their budgets go to pay for health care. There is wide consensus that 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 \$4.7 trillion in 2019.<sup>2</sup>
- Family employer-sponsored health care premiums will exceed \$30,000 a year, up from \$12,680 today.<sup>3</sup>
- The "trust fund" that pays Medicare costs will run out of money.<sup>4</sup>
- We will spend as much as \$10 trillion on unnecessary care.<sup>5</sup>
- An estimated 62 million Americans will be uninsured as ever fewer people are able to afford coverage.<sup>6</sup>
- More than 220,000 of these uninsured will die because they sought care too late for their medical problem.<sup>7</sup>
- Over 1 million Americans will die due to preventable medical harm.<sup>8</sup>

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.<sup>9</sup>

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

## 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).*

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## Consumers Union's Reform Recommendations

This “viewpoint” from Consumers Union outlines the changes we believe would accomplish these goals and that we’ll push to include in any reform package. While our list is comprehensive, we acknowledge there are many other changes that must also be addressed in our health care system—such as payment and delivery system reforms in the private sector. Consumers Union will continue to work for consumer-oriented improvements on all fronts, not restricting our efforts to just those discussed in this report.

## CONSUMERS UNION: OUR 10 RECOMMENDATIONS FOR HEALTH CARE REFORM

1. Ability to keep your health insurance coverage if you like it. For everyone else, there should be new comprehensive, affordable, understandable coverage options.
2. Development of new consumer protections to reduce the risk of purchasing a bad policy.
3. Creation of a new "store" called a health insurance exchange, which makes shopping for health coverage easier, and includes a new public insurance plan option, competing alongside private insurers.
4. Offering of premium subsidies to help lower and middle income families afford coverage.
5. Guaranteed access to health insurance at an affordable price, regardless of pre-existing medical conditions – and required participation in the system.
6. Required coverage or contribution to coverage by all but the smallest employers using standards that roughly mimic current levels of employer coverage.
7. Mandated efforts to improve health care quality. This should be done with payment reforms to encourage care coordination and to discourage over-treatment, and payment should be ended for care resulting from preventable medical errors.
8. Easy-to-use information on price and quality, which can help consumers compare health plans, doctors, hospitals, and treatments.
9. New measures to increase the supply of primary care providers where they are needed.
10. Concerted focus on health care cost containment to ensure the financial stability of Medicare and Medicaid, to drive economic growth, and to minimize the taxpayer burden of financing new reforms.

## If You Like Your Current Health Coverage, You Shouldn't Have to Change

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.<sup>10</sup> 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, although it would need to have new rules for eligibility and better provider reimbursement.<sup>11</sup> Likewise people who

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.

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.

However, you shouldn'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 of workers would move on to other jobs, or strike out on their own, if they didn't fear losing their health coverage.<sup>12</sup> This so called "job-lock" stifles innovation and undermines the worker mobility needed for a vibrant economy.

## New Coverage Options

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.<sup>13</sup> 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.

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.

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 bankrupt families had health insurance.<sup>14</sup> Families bankrupted by medical costs and who had private insurance reported average out-of-pocket medical bills of \$17,749 in 2007.<sup>15</sup> One-in-ten non-elderly insured Americans report they had to change their way of life significantly due to medical debt.<sup>16</sup> Clearly, the health insurance policies of these families are not serving their intended purpose—to protect the policyholder from financially catastrophic medical expenses.

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

To reduce consumers' financial vulnerability, the new coverage standards should require firm limits (a "hard cap") on patient out-of-pocket medical expenses. These out-of-pocket provisions must not contain exceptions that can drive the policyholder's costs beyond the stated limit.<sup>17</sup> In a similar vein, health insurance plans must not contain annual or lifetime benefit caps that limit what the health plan will pay.

## NEW 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.<sup>18</sup> Because this market works so poorly, consumers purchase policies they don't understand and may not meet their needs.<sup>19</sup> Some of the products they buy are outright scams.<sup>20</sup>

Consumers Union strongly supports new regulations that put consumers on a level playing field with insurance companies. 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.<sup>21</sup> We recommend:

- 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 common, consumer-friendly format in their plan materials. Common insurance terms such as "deductible" must 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.<sup>22</sup> 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 should 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 improve purchase rates as much as modest premium subsidies.<sup>23</sup> 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”

One of the most important new structures being proposed by Congress – and which we support – 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. Here’s how it would work:<sup>24</sup>

- 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 discounts would not be available outside the exchange.
- 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 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. Having a streamlined number of “good” choices will enable consumers to meaningfully compare their options. On the other hand, a dizzying array of choices can cloud the purchase decision. What must be avoided 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.<sup>25</sup>

## PITFALLS TO AVOID – THE 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 with too many choices.

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 just 6 percent of enrollees picked the plan that would save them the most money, based on amount and type drugs they took. In fact, most enrollees ended up in plans that cost them \$360 to \$520 *more* for drugs, per year, than the optimal plan for them. Furthermore, when it was time to re-enroll, 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 does not recommend permitting the purchase of individual insurance outside the exchange. This approach would divide the market. Consumers would need to compare their choices inside and outside the exchange, undermining the benefits of structured choice inside the exchange.

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.<sup>26</sup> 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.<sup>27</sup>

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.

## 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 that competes alongside private coverage options.

In many areas of the country, the health insurance market is dominated by one or two large insurers and, with few competitors, insurers have little incentive to practice cost control or to compete aggressively on customer service. The proposed solution is to introduce a new type of competitor. Specifically, this new competitor would be tasked with conducting its operations in an open and transparent fashion, maintaining the highest standard of satisfaction for patients and providers (doctors and hospitals), 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 provide introduce meaningful price competition (helping to lower costs), drive innovation and provide an incentive for private plans to focus on customer service.

In many respects, 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 option would be run like a “public utility” with a clear mission of public accountability. The plan would be non-profit and operated by federal government, although certain administrative functions (like claims payment) could be contracted out to private companies. The public plan would pay for operations out of premiums; it would not be funded by taxpayers (although start-up costs would be provided in the form of a “loan” to be repaid).

Consumers Union supports using a public insurance plan to play this role of the new competitor. Our support for this approach rests strongly on the need for a large plan if the new option is to be a viable competitor. New insurance competitors are exceedingly rare. It is very difficult to enter health insurance markets and remain viable. Any new competitor must be well financed, large enough to negotiate effectively with providers, and feature leadership that understands their large, sophisticated competition.

We recommend the public plan be required to operate using the same rules as private plans. That is, both public and private plans would be subject to same the regulations with respect to premium setting and financial reserves. Provider payment levels 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.

*For more: see our policy brief “The Public Plan: A New Type of Competitor,” September 2009.*

## Premium Subsidies

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

Consumers Union supports a premium subsidy program to help people afford their coverage. The program should deliver the most help to low-income people while recognizing that many moderate-income families also need assistance.

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.

Taxpayer-financed premium discounts (or 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. To preserve consumer choice, yet also provide sound purchasing incentives for the consumer, we recommend the subsidy amounts be structured so that:

- Families can purchase a health plan that contains cost-sharing they can afford.
- Subsidy amounts are linked to the cost of the most cost-effective, yet high-quality health plan (a benchmark plan).
- Incentives to purchase low quality health plans because they are cheaper are avoided.

## Guaranteed Coverage and a Requirement to Have Coverage

Health care coverage must be guaranteed so that young and old, 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 medical 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.

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."

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 coverage 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 guaranteed issue and coverage of pre-existing conditions, we believe two other policies must also be put 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 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 having certain consumer protections in place, namely we recommend that:

- 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.
- Premium discounts, or 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.<sup>29</sup> Studies have shown a system of generous subsidies and administrative simplification *by itself* would leave as many as half the uninsured still without coverage.<sup>30</sup> People may be too busy to get around to buying coverage or may put it off because they feel they are healthy.

## 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 worker's share of the premium is conveniently handled using payroll deductions.

We support keeping 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.<sup>31</sup> That's \$430 billion a year.<sup>32</sup> To dismantle this system would have grave consequences for the financing of our health care system.

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

Consumers Union supports proposals that call for all but the smallest employers 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 fund that helps subsidize coverage for workers without an offer of employer coverage. 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.

Under our recommendations for reform, there would be greatly improved health coverage options in the individual or non-group market. All workers—whether they have an employer offer of coverage or not—could purchase in the exchange.

However, premium subsidies would *not* be available to workers with a qualified offer of employer coverage—unless the worker’s cost for employer coverage were very high. This policy will help ensure that public subsidies don’t “crowd out” today’s employer contribution to health care.

With the “pay or play” requirement and other proposed reforms in place, Consumers Union believes the new coverage options created under our proposal for health reform will leave the current system of employer provided health care largely intact. Employers with an “average” mix of workers will find that roughly half of all workers would not qualify for any subsidy in the exchange (Exhibit 2). For many others workers the exchange subsidy would be modest enough that they would be much worse off if their employer stopped offering coverage. Hence, employers have a compelling incentive to continue to offer employer subsidized coverage in order to attract workers. Providing support for this outcome, a similar “pay-or-play” policy operates in San Francisco and employers have opted to leave their existing benefit programs intact (see sidebar).

**EXHIBIT 2 – ILLUSTRATION OF HEALTH INSURANCE OPTIONS AFTER OUR PROPOSAL FOR 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
<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%		√	√

\* Premium subsidy available if no access to other “qualified” coverage (like employer coverage, Medicare, or Medicaid).  
 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 businesses with 20 or more workers. The minimum health spending requirement was designed to level the playing field for firms that already provide coverage, discourage them from dropping coverage, and reduce the taxpayer cost of caring for the business' uninsured workers. In 2009 the minimum business spending requirement is:

- 100+ employees – \$1.85 per employee per hour
- 20-99 employees – \$1.23 per employee per hour
- 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 calculated 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, most 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.*

## Improved Access to High Quality Health Care

To go beyond access to health *coverage* and ensure access to high quality health *care*, several things must happen.

For one, we must better monitor and continuously improve the quality of care that Americans receive. An unacceptable portion of health care received today 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. Another 2 million Americans experience preventable medical harm in a given year.<sup>33</sup> Research clearly shows that the majority of adverse medical events are preventable and that the key to reducing medical errors is to focus on improving the systems of delivering care. However the IOM's major reform recommendations have not been adopted. In the decade since the IOM report, there is no evidence of overall improvement in patient safety.<sup>34</sup>

Second, we must reduce wasteful care. The U.S. spends more than any other nation on health care – around \$8,160 per person per year at last count.<sup>35</sup> Incredibly, studies consistently show that about 30 percent of the health care we consume is of no benefit to patients.<sup>36</sup> That means we are wasting something on the order of \$400 to \$600 billion a year. This excess consumption of health care may not be good for us. For example, research indicates expensive and somewhat risky surgery to open up blocked heart arteries doesn't always yield better medical outcomes than safer and much less expensive treatment with medications.<sup>37</sup> In some areas of the country where less care is consumed, patients fare better in terms of treatment outcomes, according to years of data from the Dartmouth Atlas Project.<sup>38</sup>

Third, we must make health care patient-centered and, for complex cases, improve how that care is coordinated across various providers. Care should be delivered using a team approach that centers around a “medical home.” This “medical home” (for example, one's primary care physician) is accountable for the overall coordination of the patient's care. Surprisingly, in most health care today, there is no doctor playing this overall role of “coordinator.” Pilot programs around the country suggest that this care model improves patient outcomes and saves money by ensuring that the correct diagnosis is made quickly, avoiding duplicative tests and reducing patient hassle. Another promising approach is to reform the way we pay doctors, hospitals and other providers by pegging their payments to the overall outcome of an episode of illness, not rewarding the quantity of lab tests, procedures and exams given.

Fourth, our nation's supply of primary care providers must be expanded to meet the new demand. Under a reformed system, providing care to those who now go without and improving care coordination would 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.<sup>39</sup>

Consumers Union supports a reform package designed to ensure access to health care providers and to improve the quality of the care we receive. We recommend that both public and private insurers move swiftly to implement the following steps:

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.

- Prohibit payment for care that arises from preventable medical errors and health care-acquired infections.<sup>40</sup>
- Collect information on the quality, safety and cost of care by treatment, and when appropriate, by doctor or hospital and make all of it easily available to the public. Make sure the measurements are accurate and meaningful to consumers.<sup>41</sup>
- 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.<sup>42</sup>
- Expand 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.<sup>43</sup>
- 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.
- Compensate primary care providers fairly. Not only should they be reimbursed for new tasks such as coordinating patient care, but disparities in compensation between physicians and specialists should be addressed.

## Paying for Reform: Constrain Costs

Any serious discussion of health reform recognizes that new revenues will be needed to “jump start” the new monitoring systems, support research that helps deliver health care in new ways, and fund—the big expense—premium subsidies for lower-income families. Most analysts believe that a truly comprehensive set of national health care reforms would require financing over and above what would be collected from new employer payments, the premiums paid by the newly enrolled; and from money that is now spent to cover care for the uninsured.

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 first source for “financing” must be to extract savings from today’s health care system. 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.

Bold reforms to slow cost growth must be our national priority. 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. The skyrocketing cost of health care places a heavy burden on every American. It is stifling economic growth, hurting our businesses both large and small and saddling taxpayers with huge costs.

Short of draconian wage and price controls, how do we reduce health care cost growth? At the end of the day, we need to improve underlying population health, cut unnecessary care, reduce medical harm, and improve the quality of care through better coordination, better treatments, and better “on demand” information. Yet these “outcomes” can’t be directly legislated. Instead, reforms must proceed in three ways. One, finance the underlying research, pilot tests, and evaluations to clarify the path that leads to lower costs while improving quality. Two, create financial incentives that encourage doctors, hospitals and other providers work in a coordinated fashion to root out wasteful care and become more efficient. Finally, establish monitoring systems and clear savings targets to measure our national progress towards a lower, sustainable health care cost curve.

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 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.<sup>44</sup> Providing better information is fair and may help to bring about better, safer care that costs less.

There is no magic bullet and many new ideas will have to be tried and monitored as to their effectiveness. We recommend starting with these steps:

- Establish specific savings targets for all stakeholders, and a monitoring system to measure progress. Consider establishing a well-advertised penalty, triggered if we fail to accomplish these savings.
- 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.<sup>45</sup>
- 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 patient privacy provisions, so that each patient’s medical history is readily available.<sup>46</sup>
- Provide incentives for prevention and wellness in health insurance benefit packages and enact public health measures designed to foster healthy lifestyles.

Pulling together an overall financing approach is critical to the task of accomplishing health care reform. 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. Done correctly, benefits should outweigh the costs.<sup>47</sup> 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. When insured, Americans are somewhat insulated from the direct effects of this inefficient system, but 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 is on the line.

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.

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