SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES

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ABSTRACT: As health care costs continue to rise, there has been steady erosion in the proportion of workers covered under employer-based plans, as well as in the adequacy of such coverage. Workers forced to turn to the individual insurance market often find coverage unaffordable or unavailable, while families with employer coverage face ever-rising deductibles and other cost-sharing burdens. This study uses the Commonwealth Fund Biennial Health Insurance Survey, 2005, to examine the experience of adults ages 19 to 64 in the individual insurance market compared with adults with employer-based coverage. Compared with adults with employer coverage, adults with individual market insurance give their health plans lower ratings, pay more out-of pocket for premiums, face higher deductibles, and spend a greater percentage of income on premiums and health care expenses. The report also analyzes the implications of rising out-of-pocket spending among all privately insured Americans, particularly focusing on the effect of high deductibles.

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EXECUTIVE SUMMARY

Employer-sponsored health insurance is the main source of coverage for working adults. Recently, there has been an erosion in both the proportion of workers covered under employer plans and the adequacy of such coverage, as rising health care costs have made it increasingly difficult for employers to continue offering comprehensive coverage.

Most workers who lose access to employer health insurance have few coverage options. Many turn to the individual insurance market, where coverage is often unaffordable—and sometimes unavailable—to older adults or people with health problems. For those families who continue to have employer coverage, ever-rising deductibles and other cost-sharing are consuming larger and larger shares of family income, particularly among families with low or moderate incomes.

The consequences are serious. According to this analysis of the Commonwealth Fund Biennial Health Insurance Survey, most adults who seek to purchase insurance coverage through the individual market never end up buying a plan, finding it either very difficult or impossible to find one that met their needs or is affordable (Figure ES-1). Compared with adults with employer coverage, adults with individual market insurance give their health plans much lower ratings, pay more out-of pocket for their premiums, face much higher deductibles, and spend a greater percentage of their income on health insurance premiums and health care expenses.[1] Eight percent of adults ages 19 to 64 who are privately insured all year, or 8.5 million people, are covered through the individual insurance market. Only a third (34%), however, rate their coverage as excellent or very good, compared with over half (54%) of those enrolled in employer plans.

Figure ES-1. Individual Market Is Not an Affordable Option for Many People

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

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Other key survey findings on the individual insurance market include:

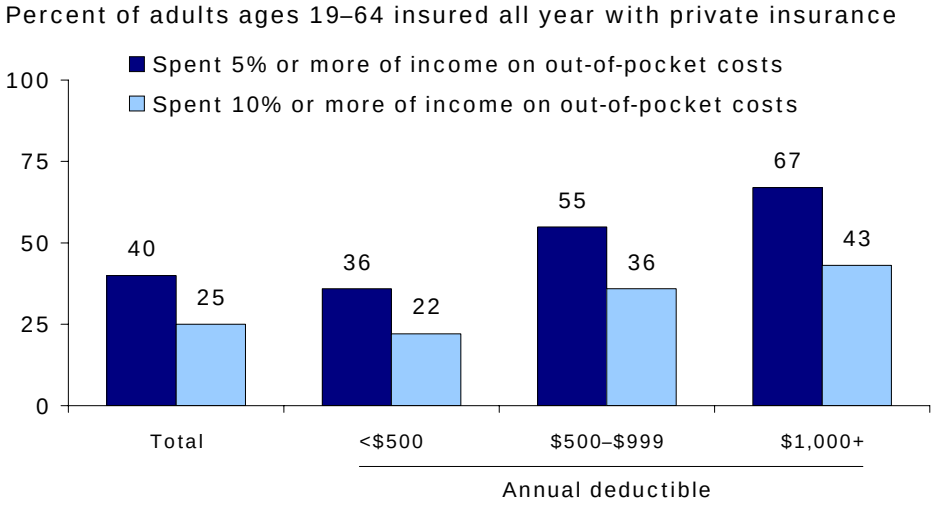
- Insurance in the individual market is often impossible to obtain or unaffordable. Nearly nine of 10 people who explored obtaining coverage through the individual market never bought a plan, citing difficulties finding affordable coverage or being turned down.
- More than half of adults with coverage through the individual market have annual premium costs of $3,000 or more, compared with one of five covered by employer plans.
- Two of five adults (43%) covered through the individual market spent more than 10 percent of their incomes on premiums and family out-of-pocket medical expenses, compared with one of four (24%) of those insured through employer plans.

Rising health care costs can negatively affect all privately insured Americans, not only those covered in the individual insurance market. Adults with high deductibles—including both those with individual and employer-based coverage—have higher out-of-pocket medical expenses than adults with lower deductibles, have greater problems obtaining needed care, are paying off medical debt over time, and are less satisfied overall with their health care. Families with high-deductible plans said they take on credit card debt and dip into their savings to pay bills.

Key survey findings on high-deductible health care plans include:

- Thirty-seven percent of those insured through the individual market have per-person deductibles of $1,000 or more, as do 8 percent of those insured through employer plans, for a total of 11 million people (8 million covered by employer plans and 3 million covered by individual plans).
- Individuals covered by high-deductible plans—either through the individual insurance market or an employer—have financial burdens. Of those adults with per-person deductibles of $1,000 or more, two of five (43%) spent 10 percent or more of their incomes on premiums and family out-of-pocket medical expenses, compared with one of five (22%) of those enrolled in plans with deductibles of $500 or less (Figure ES-2).

Figure ES-2. Adults with Higher Deductibles Are More Likely to Spend a Greater Share of Household Income on Family Out-of-Pocket Expenses and Premiums



Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

- Privately insured adults enrolled in high-deductible plans are less satisfied with coverage and care than those with lower deductibles. Forty-one percent of those with deductibles of $1,000 or more rated their coverage as fair or poor, compared with 15 percent of those enrolled in plans with deductibles of $500 or less. In addition, those with high deductibles were less satisfied with the quality of their health care. Only 29 percent of adults with deductibles of $1,000 or more said they were very satisfied with the quality of care they had received in the past 12 months, compared with more than half (54%) of adults with deductibles under $500.

- People with higher deductibles also are more likely to have problems getting needed care than those with lower deductibles. Forty-four percent of adults with deductibles of $1,000 or more reported one of four access problems: did not fill a prescription; did not see a specialist when needed; skipped a recommended test, treatment, or follow-up; or had a medical problem but did not see a doctor. Twenty-five percent of adults with deductibles under $500 cited similar access problems.

- Medical bill problems or accumulated medical debt were reported more frequently by those with higher deductibles compared with those with lower deductibles. Two of five (41%) of those with deductibles of $1,000 or more reported a medical bill problem or outstanding debt compared with one of four (23%) of those with deductibles of less than $500.

The erosion of comprehensive employer-based coverage disproportionately affects those who are most at risk: low- and middle-income families, and those with major illnesses or injuries. A substantial percentage of adults in families with incomes under $60,000 spend considerable shares of their annual income on medical expenses. For insurance to function as intended, risk must be pooled. Employer coverage is a natural pooling mechanism—those who obtain coverage do so because they become employed, not because they become sick. The individual insurance market, however, is often a last resort for those with no other alternative. Some states have required individual market insurance plans to accept all applicants. However, in most states, individuals with preexisting conditions are denied coverage, have conditions excluded, or face much higher and often unaffordable premiums. And while individual market regulations in some states have improved access for older and less healthy people, they also have made coverage more expensive for younger and healthier people.

Some states, such as Maine,[2] Massachusetts,[3] and Vermont,[4] have created new pooling mechanisms and have provided subsidies for lower-wage individuals to make coverage more affordable for those not insured under employer plans. Massachusetts and Vermont have taken the additional step of requiring some financial contribution from employers who do not provide coverage to their workers. By drawing upon the experience of these innovative states and others, policymakers at the national level may be able to devise effective ways to address this increasingly urgent problem.

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INTRODUCTION

Employers have voluntarily provided health insurance on a widespread basis to American workers and their families for over half a century.[5] The federal government has encouraged this role by making contributions to employee health benefits tax-deductible and exempt from the income taxes of workers. More than any other non-wage benefit, employers use health coverage to recruit and retain employees.[6]

But relentless annual growth in health care expenditures, combined with the steady rise in insurance premiums over the past five years, has made it increasingly difficult for employers—especially small employers—to continue providing comprehensive benefits. Employers have coped by sharing more of their expenses with employees or, in the case of many small companies, dropping coverage altogether.[7] The number of uninsured Americans climbed to 46.6 million in 2005, according to the most recent U.S. Census data, an increase of 7 million since 2000. Nearly all the growth in the number of uninsured Americans is attributable to a decline in employer-based coverage.

Workers who do not have access to health insurance through a job face a dearth of affordable health insurance options. While all 50 states have an individual, or non-group, insurance market, only a small percentage of Americans actually buys coverage in it. Through underwriting, individual insurers estimate individual or family risk and set premiums sufficiently high to cover risk, exclude certain high-cost conditions, or deny coverage altogether.[8] People who are older or who have health problems—if they qualify for a policy at all—may face exorbitant premiums for limited coverage. Some states, like Massachusetts, New Jersey, and New York, have strong individual market regulations that require community rating, under which everyone is charged the same premium regardless of age or health status, or impose "age rating bands" that limit the degree to which premiums charged to older people can exceed those charged to younger people.[9] Still, while these reforms have improved access for older and less healthy people, they also have made coverage less affordable for younger, healthier people.[10]

Some federal policymakers are seeking to encourage participation in the individual market by targeting tax credits and other tax benefits solely for the purchase of individual coverage, particularly favoring high-deductible plans that are eligible for tax-preferred

health savings accounts.[11] Other proposals include allowing individual insurance carriers to bypass state insurance regulations and making the tax treatment of health coverage purchased through the individual market more similar to that of employer-based benefits.[12]

This study uses the Commonwealth Fund Biennial Health Insurance Survey, 2005, to examine the experience of adults ages 19 to 64 in the individual insurance market compared with adults with employer-based coverage. It also analyzes the financial and health implications of rising out-of-pocket spending among all privately insured Americans, particularly focusing on the effect of high deductibles. The analysis finds that of working-age adults who sought to purchase insurance coverage on the individual market, 90 percent were unable to find a plan that met their needs or was affordable.

Adults who do have individual market insurance give their health plans much lower marks than do adults with employer coverage. Compared with adults with employer coverage, people with individual market insurance pay more out-of-pocket for their premiums, face much higher deductibles, and spend larger shares of their income on health insurance and health care expenses. Adults with high deductibles—including both those with individual and employer-based coverage—allocate substantial shares of their income to health expenses, avoid getting necessary health care because of costs, are paying off medical debt over time, and are less satisfied overall with their health care.

Asking people to spend more of their income on out-of-pocket costs and premiums is harder on low-income individuals—a substantial percentage of adults in families with incomes under $60,000 spend considerable shares of their annual income on medical expenses. New, affordable health insurance options are needed for people who lose access to employer-based benefits. It is imperative that those options pool risk on both equity and efficiency grounds.

SURVEY FINDINGS

Low Participation in the Individual Insurance Market

Of the 108 million Americans ages 19 to 64 who have private insurance for the full year, only 8 percent have insurance they purchased through the individual market (Table 1). The remaining 100 million adults have coverage through employer-sponsored health plans. On average, adults with individual market insurance have slightly lower incomes than those with employer coverage: about one-third (34%) of people with individual insurance have incomes below $40,000, compared with one-quarter (24%) of those with coverage through a job. The individual market has disproportionate numbers of both

younger and older adults. About 19 percent of working-age adults with individual coverage are ages 19 to 29, compared with 14 percent of those with employer-based coverage. Forty-six percent of adults with individual coverage are ages 50 to 64, compared with 35 percent of those with employer insurance. Adults in the individual market are also in somewhat better health than those with employer coverage. About 19 percent of people with individual insurance have at least one chronic condition (e.g., hypertension, heart disease, diabetes, asthma, emphysema, or lung disease) compared with 29 percent of those with employer coverage.

Due to their employment status, adults with individual market insurance are less likely to have access to employer-based coverage. Thirty-three percent of people with individual insurance are unemployed, more than double the proportion of those with employer coverage (Table 1). Adults with individual insurance are also somewhat less likely to live in a household where at least one family member works full-time.

Individual Insurance Market Not an Affordable Option for Many

The individual insurance market exists in all 50 states, yet about 48 million working age adults were uninsured for all or part of the year in 2005.[13] Low participation in the individual market likely reflects the difficulty people have finding affordable and suitable coverage. The survey asked adults whether they had sought coverage in the individual market in the past three years. About 58 million adults ages 19 to 64 reported either that they had coverage purchased through the individual market or had considered buying, or tried to buy, a plan (Table 2). Of these, nearly 90 percent never bought a plan.

The survey asked respondents about particular challenges they encountered in attempts to purchase a health plan in the individual market. These included ease of finding a plan with suitable or affordable coverage or being turned down for a preexisting condition. One-third (34%) of those in the individual market said they found it very difficult or impossible to find a plan with the coverage they needed (Figure 1). This problem was particularly pronounced among people with health problems: 48 percent of those with health problems (fair or poor health status, any one of four chronic conditions, or a disability) found it very difficult or impossible to find a plan with the coverage they needed.

Figure 1. Individual Market Is Not an Affordable Option for Many People

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

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Even greater numbers of people had difficulty finding an affordable plan. Nearly three of five (58%) adults who had ever shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford. This problem was especially evident among those with health problems and low incomes. More than 70 percent of people with health problems or incomes under 200 percent of the federal poverty level found it very difficult or impossible to find an affordable plan (Figure 1).

Even people who were able to find plans that met their needs were not always able to obtain coverage. About one-fifth (21%) of adults who had ever sought coverage in the individual market were turned down by an insurance carrier, charged a higher price, or had a specific health problem excluded from their coverage. People with health problems were the most likely to report such an experience: one-third had been turned down, charged a higher price, or had a health problem excluded from their coverage.

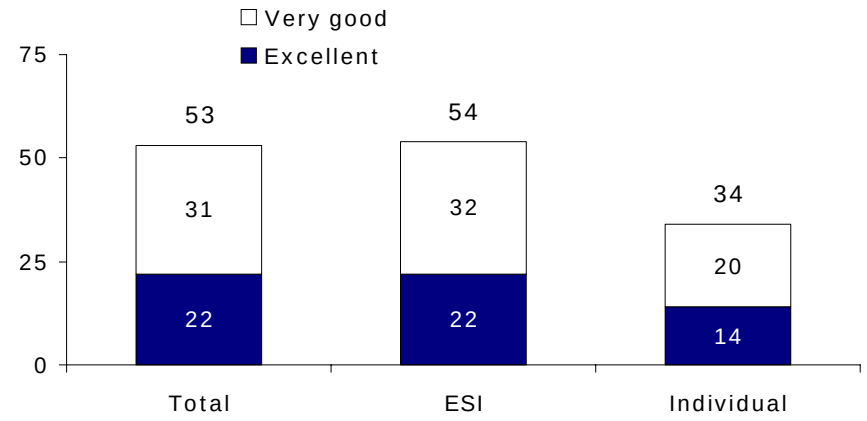
Most Adults with Employer-Based Insurance View Their Coverage Favorably

Approximately 100 million adults ages 19 to 64 have employer-sponsored insurance coverage (Table 3). The majority of these adults (71%) have coverage through their own employer and about 30 percent have coverage through a spouse or parent.

People with employer-based benefits give their health insurance higher marks than do those with individual market insurance. More than half of adults with employer coverage rate their health insurance as excellent or very good, while only one-third of those with individual insurance do so (Figure 2).

Figure 2. Adults Insured in the Individual Market Are Less Likely to Give Their Health Plans High Ratings

Percent of adults ages 19–64 insured all year with private insurance

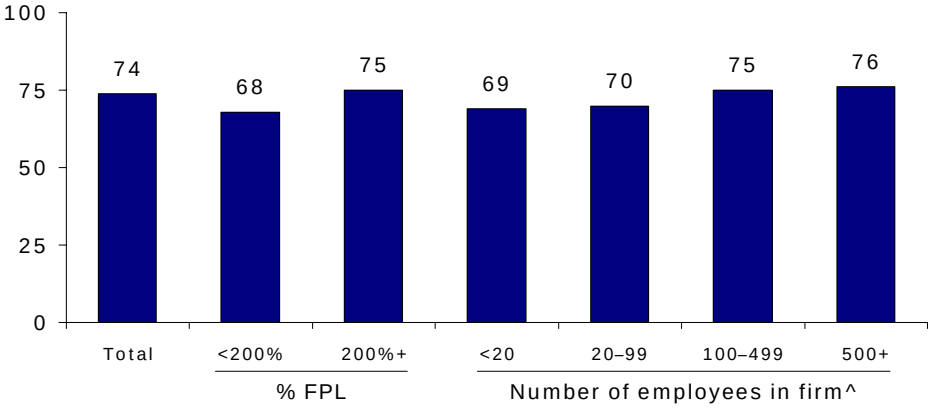


Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

A majority of adults with employer coverage give their employers high marks in their ability to select health plans. Almost three-quarters (74%) of people with employer health benefits said employers do a good job selecting quality health insurance plans to offer their workers (Figure 3). This view was uniformly held, regardless of age or income. There was also little variation in this view across firm size.

Figure 3. Percent of People Who Say That Employers Do a Good Job Selecting Quality Insurance Plans to Offer Their Workers

Percent of adults ages 19–64 insured all year with ESI



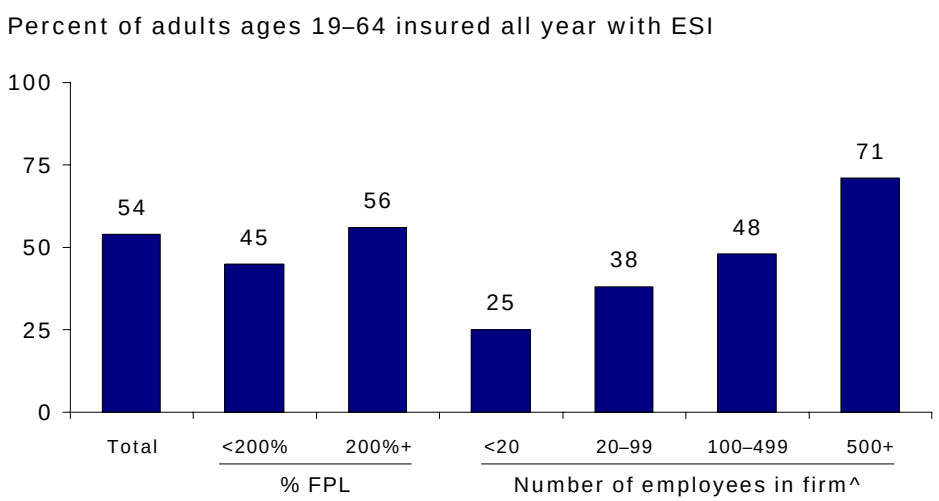
ESI = employer-sponsored insurance.

^ Based on respondents who are covered by their own employer's insurance.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

A little over half of adults with employer health benefits have more than one health plan from which to choose (Figure 4). Workers with coverage through their own employers in small firms are far less likely to have a choice of plans than are those in large firms. One-quarter (25%) of workers in firms with fewer than 20 employees were offered two or more plans, compared with 71 percent of those in firms of 500 or more employees.

Figure 4. Percent of Employees Who Are Offered Two or More Health Plan Choices

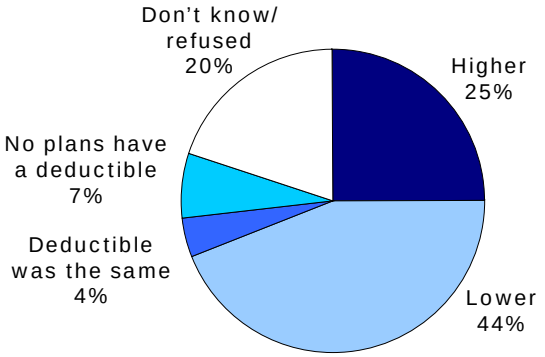


ESI = employer-sponsored insurance.
^ Based on respondents who are covered by their own employer's insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

People offered choices tend to favor plans that provide greater protection from out-of-pocket costs. The survey asked people with a choice of employer health plans whether they selected the plan with the higher or lower deductible. Forty-four percent said they chose a plan with a lower deductible, and a quarter (25%) chose a plan with a higher deductible (Figure 5). A sizeable percentage (20%) did not know if their plan had a relatively lower or higher deductible.

Figure 5. Did You Choose the Plan with the Higher or Lower Deductible?

Percent of adults ages 19–64 insured all year with ESI



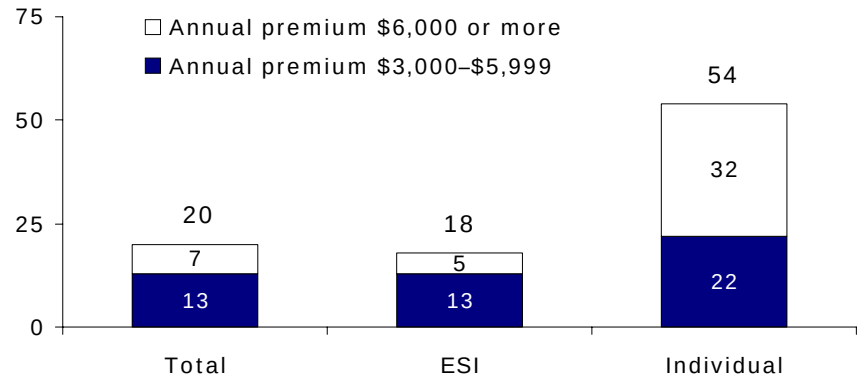
ESI = employer-sponsored insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Adults with Individual Market Insurance Have Fewer Benefits and Higher Costs

Adults with individual market coverage are more likely to have high out-of-pocket premium costs compared with people covered through employers, who generally share the costs with workers.[14] More than half of adults with individual market coverage have premium costs of $3,000 a year or more, versus 18 percent of those with insurance through a job (Figure 6). Nearly one-third (32%) of those with individual market coverage spend $6,000 or more, compared with 5 percent of those with employer coverage. The median annual premium cost was $3,750 for adults with individual plans; for adults with coverage through an employer, it was $2,250 (Table 4).

Figure 6. More than Half of Adults with Individual Market Coverage Have Annual Premium Costs of $3,000 or More

Percent of adults ages 19–64 insured all year with private insurance

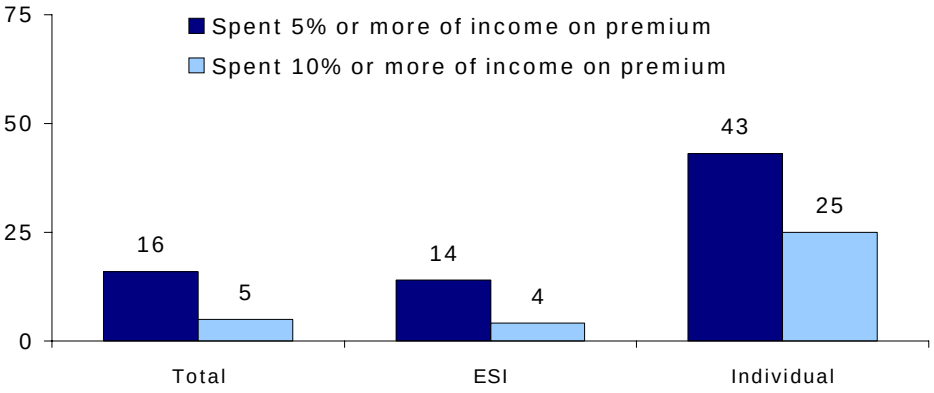


ESI = employer-sponsored insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

High premium costs can translate into a substantial share of income. More than two of five (43%) adults with coverage purchased on the individual market spent 5 percent or more of their household income on premiums in 2005, and one-quarter (25%) spent 10 percent or more (Figure 7). In contrast, only 4 percent of those with employer-based coverage spent 10 percent or more of their incomes on premium costs.

Figure 7. Two of Five Adults with Individual Coverage Spent 5 Percent or More of Income on Premium Costs

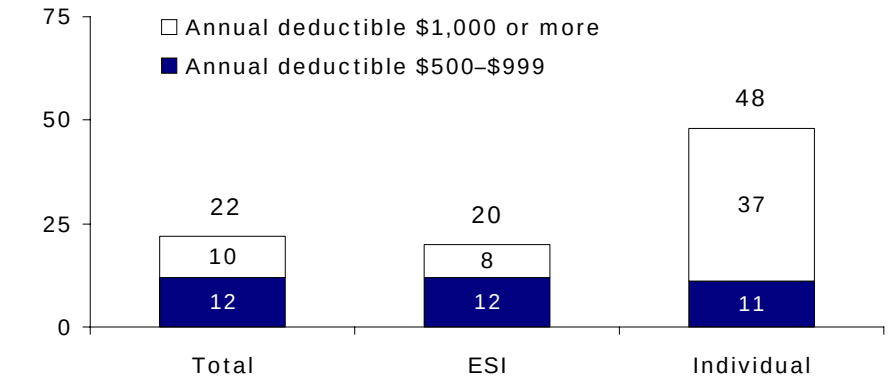
Percent of adults ages 19–64 insured all year with private insurance



ESI = employer-sponsored insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Adults with individual market coverage are also more likely to face high deductibles, on average, than are adults with coverage through a job. Thirty-seven percent of people with individual market coverage have deductibles of $1,000 or more, compared with 8 percent of those with employer-based insurance (Figure 8). Fifteen percent of adults with individual market coverage must meet per-person deductibles of $3,000 or more per year (Table 4).

Figure 8. More than One-Third of Adults with Individual Coverage Have Annual Deductibles of $1,000 or More



ESI = employer-sponsored insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Individual insurance benefits are generally less comprehensive than employer plan benefits, as well. For example, adults with individual market insurance are less likely to be covered for prescription drugs or dental care: about 22 percent of adults with individual insurance lack prescription drug coverage, while only 4 percent with employer coverage do (Table 6). More than 70 percent of adults with coverage through the individual market go without dental insurance, about four times the rate of adults with employer coverage.

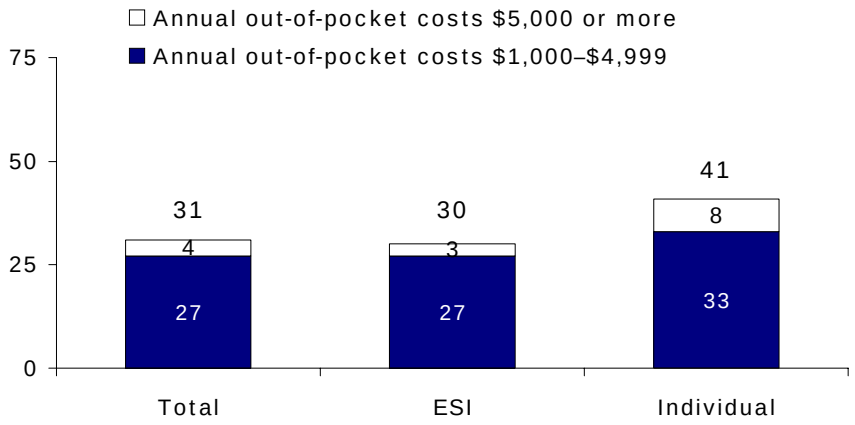
Out-of-Pocket Health Care Costs Greatest for Adults with Higher Deductibles

The out-of-pocket costs people pay over the course of a year are associated with several factors: deductible amounts, services covered by their plans, limits on what plans will pay for, health problems, and age, among others. The survey finds that 31 percent of privately insured adults spent $1,000 or more out-of-pocket, excluding premiums, for their own personal medical care, prescription drugs, and dental and vision care over a 12-month

period (Figure 9). Adults with coverage through the individual insurance market, despite the fact that they are in better health, on average, than those with employer-based coverage, are more likely to have high personal out-of-pocket costs than those with employer coverage. More than two of five (41%) adults insured through the individual market spent $1,000 or more out-of-pocket on their personal health care over 12 months compared with 30 percent of adults with employer coverage. Median annual out-of-pocket costs for adults in the individual market were $960 compared with $575 for those in employer-based plans (Table 5). The median family out-of-pocket expenditures—including all family members—on medical care, prescription drugs, and dental and vision care was $1,100 for respondents with individual market coverage and $900 for those with employer-based insurance.[15]

Figure 9. Adults with Individual Coverage Are More Likely to Spend $5,000 or More Annually on Personal Out-of-Pocket Expenses

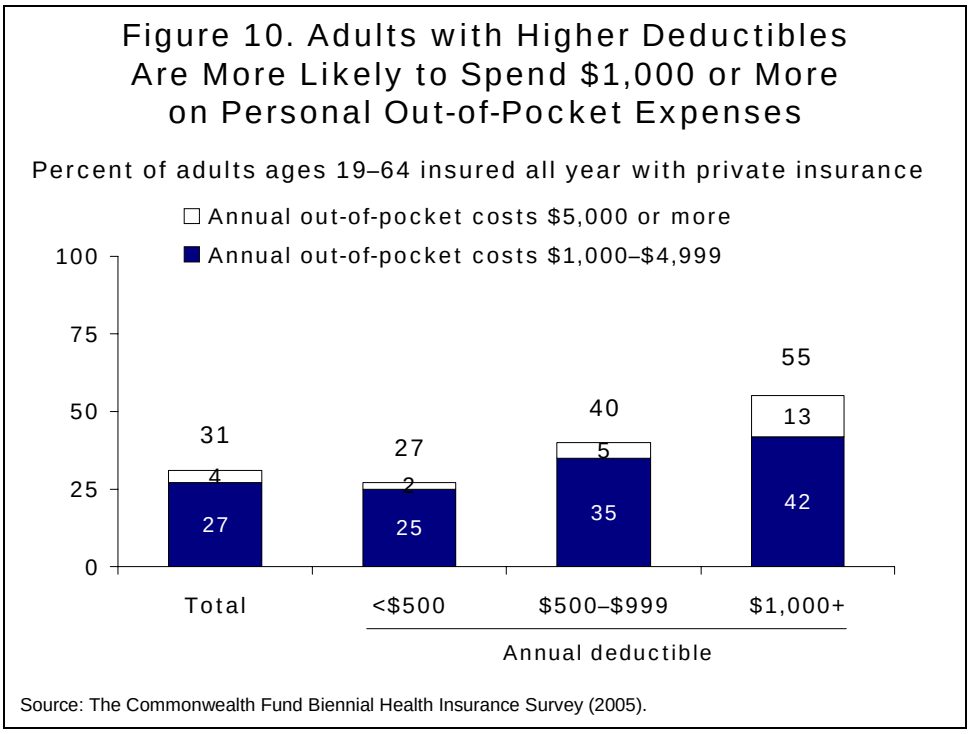
Percent of adults ages 19–64 insured all year with private insurance



ESI = employer-sponsored insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Adults with high-deductible health plans—both those with individual market or employer-based coverage—have higher out-of-pocket costs than do those with lower-deductible plans. More than half (55%) of adults with deductibles of $1,000 or more per year spent $1,000 or more out-of-pocket, excluding premiums, for their own personal medical care, prescription drugs, and dental and vision care over 12 months (Figure 10). In contrast, slightly more than one-quarter (27%) of adults with deductibles of under $500 spent that much. The median personal annual out-of-pocket expenditure for individuals with a $1,000 deductible or higher was $1,300 compared with $525 for those with a deductible of less than $500 (Table 5). The median family out-of-pocket expenditures on

medical care, prescription drugs, and dental and vision care was $2,000 for respondents reporting a per-person deductible of $1,000 or more compared with $835 for those with a $500 or lower per-person deductible.

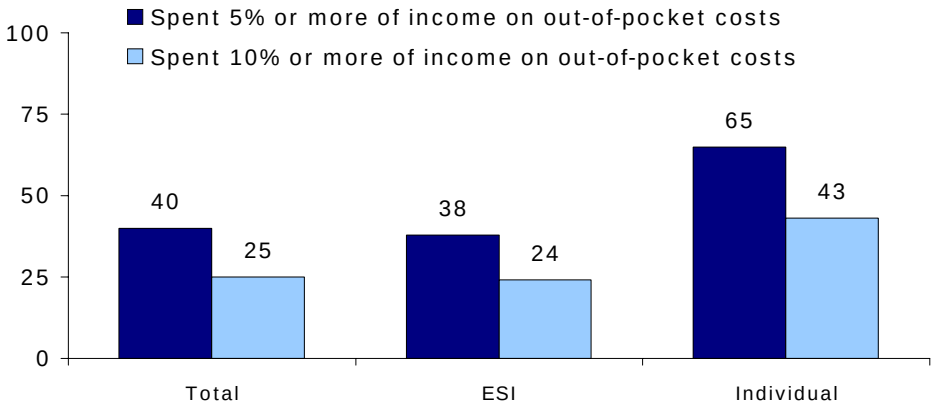


Costs High for Adults with High Deductibles or Individual Market Insurance

Working-age families allocate considerable amounts of their income to health insurance and health care costs. Two of five (40%) adults were in households that spent 5 percent or more of their annual income on premiums and family members' out-of-pocket spending for medical care, prescription drugs, and dental and vision care (Figure 11). One-quarter were in households where at least 10 percent of family income went toward premium payments and health care costs. Those with individual insurance or high-deductible plans reported cost burdens at higher rates. Nearly two-thirds (65%) of adults with individual market insurance spent 5 percent or more of their household income on premiums and out-of-pocket costs and more than two of five (43%) spent 10 percent or more. In contrast, one-quarter (24%) of adults with employer-based coverage spent 10 percent or more of their family income on premiums and out-of-pocket expenses.

Figure 11. One-Quarter of Adults Spent 10 Percent or More of Their Household Income Annually on Family Out-of-Pocket Expenses and Premiums

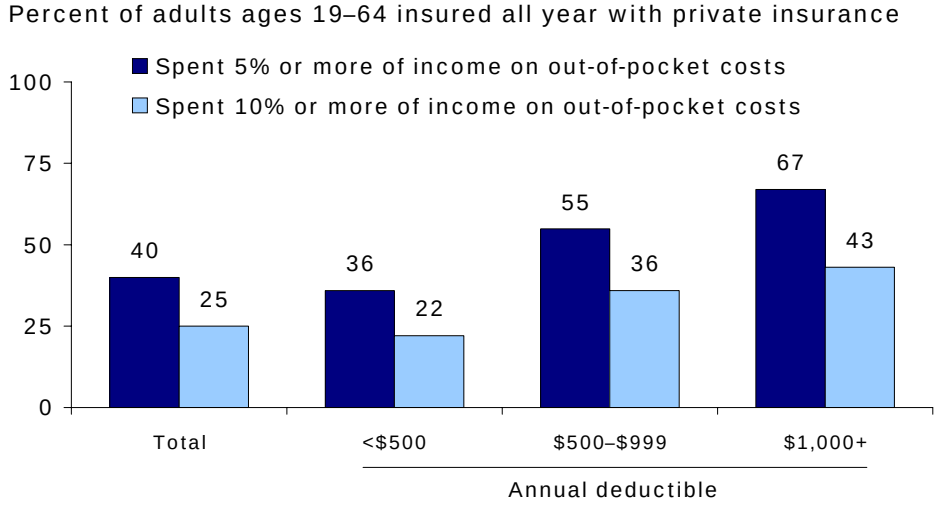
Percent of adults ages 19–64 insured all year with private insurance



ESI = employer-sponsored insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Privately insured adults with high deductibles are more likely to spend a large share of their household income on health care costs and premiums than are those with lower deductibles. More than two-thirds (67%) of adults with deductibles of $1,000 or more spent 5 percent or more of their family income on premiums and family members' out-of-pocket expenses and more than two of five (43%) spent 10 percent or more (Figure 12). Smaller shares of adults in households with per-person deductibles of less than $500 spent as much: 36 percent spent 5 percent or more of household income on premiums and out-of-pocket costs and 22 percent spent 10 percent or more.

Figure 12. Adults with Higher Deductibles Are More Likely to Spend a Greater Share of Household Income on Family Out-of-Pocket Expenses and Premiums



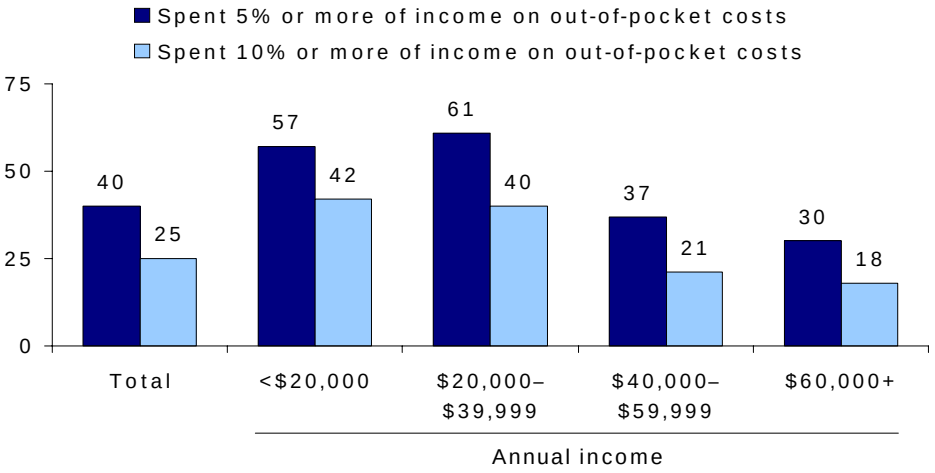
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

High Costs for Privately Insured Adults with Low to Moderate Incomes

The costs of health care and health insurance impose the greatest burden on families with low or moderate incomes. Over half (57%) of privately insured adults with annual household incomes of less than $20,000 spent 5 percent or more of their income on premiums and family members' out-of-pocket costs and 42 percent spent 10 percent or more (Figure 13). Middle- and moderate-income families are also greatly burdened by health care costs. Three of five (61%) adults with annual household incomes of $20,000 to $39,999 spent 5 percent or more of income on family out-of-pocket health care costs and premiums and 40 percent spent 10 percent or more. Of those with incomes between $40,000 and $59,999, over one-third (37%) spent 5 percent or more on health care and insurance premiums and 21 percent spent 10 percent or more. Even many families with higher incomes spend a considerable share of income on health care costs—30 percent of those with incomes of $60,000 or more spent 5 percent or more of their income on family out-of-pocket health care costs and premiums.

Figure 13. Low-Income Households at Most Risk for Spending Greater Shares of Income on Family Out-of-Pocket Expenses and Premiums

Percent of adults ages 19–64 insured all year with private insurance



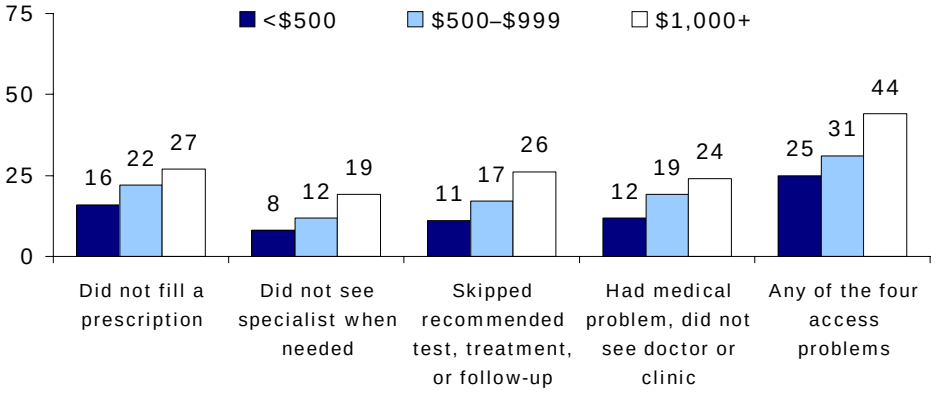
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

More Cost-Related Access Problems for Adults with High Deductibles

The potential for incurring high out-of-pocket costs appears to interfere with the ability to get needed health care. The survey asked adults whether, in the past 12 months, they had not sought medical care because of cost. Specifically, respondents were asked if, because of cost, they did not go to a doctor or clinic when sick; had not filled a prescription; skipped a medical test treatment or follow-up visit recommended by a doctor; or did not see a specialist when a doctor or the respondent thought it was needed. More than one-quarter (28%) of adults with private insurance all year reported at least one of these access problems (Table 7). Adults with insurance through the individual market were only somewhat more likely to say they had not accessed needed care, with slightly more than one-third (35%) reporting at least one access problem, compared with 27 percent covered through employer health insurance plans. Adults with high deductibles reported high rates of problems getting necessary care: 44 percent of privately insured adults with per-person annual deductibles of $1,000 or higher reported at least one cost-related access problem. Twenty-five percent of privately insured adults with deductibles of less than $500 reported similar access problems (Figure 14).

Figure 14. Adults with High Deductibles Are More Likely to Avoid Needed Health Care Because of Cost

Percent of adults ages 19–64 insured all year with private insurance



Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

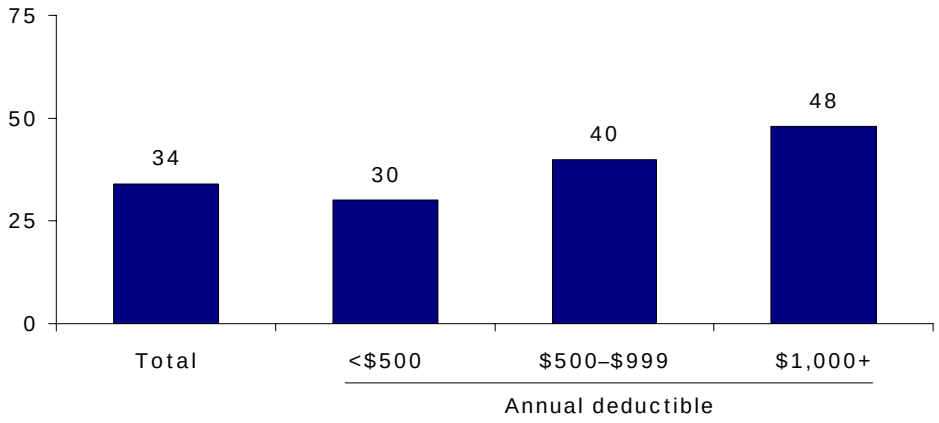
People with higher deductibles are also less likely to receive cancer screening tests. These tests—including colonoscopies and mammograms—can amount to hundreds of dollars in a private physician's office or radiology center. The survey asked respondents whether in the past 12 months they had delayed or not gotten preventive screening tests, such as colon cancer screens or mammograms. One of five (20%) adults with deductibles of $1,000 or more said that they had delayed or not received preventive screening tests, compared with 5 percent of adults with deductibles of less than $500 (Table 7). Those with high deductibles, however, were just as likely as adults with lower deductibles to say they had their blood pressure and cholesterol checked within the recommended time periods and had a dental exam in the past year.

Adults with High Deductibles More Likely to Have Problems Paying for Care

People with employer or individual market insurance coverage and high deductibles are more likely to face limits on what their health plans will pay for care and to have encountered reimbursement problems than those with lower-deductible plans. Nearly half (48%) of adults with annual deductibles of $1,000 or more said that their health plans imposed a total dollar limit on the amount they would pay for medical care (Figure 15). In contrast, 30 percent of adults with annual deductibles of less than $500 reported their plans maintained such limits.

Figure 15. Adults with Higher Deductibles Are More Likely to Have Health Plans That Limit Total Dollar Amount Plans Will Pay for Medical Care Each Year

Percent of adults ages 19–64 insured all year with private insurance who report plan limits

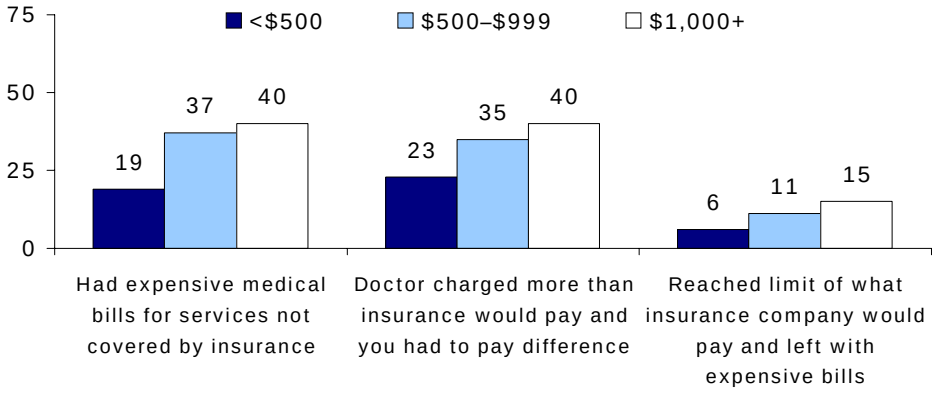


Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

The survey asked respondents a series of questions about payment-related problems they experienced with their health plans. These included whether they ever had expensive medical bills for services not covered by insurance, if a doctor had ever charged a lot more than their plans would pay, if they ever had to contact their insurance company over an unpaid bill, and if they had ever reached the limit of what their health plans would pay. People with deductibles of $1,000 or more were more likely than those with deductibles less than $500 to report any one of these problems. Two of five (40%) adults with high deductibles said they had received expensive medical bills for services not covered by their insurance, two times the rate reported by adults with deductibles of less than $500 (Figure 16, Table 6). Forty percent said their doctor had charged a lot more than their plan would pay, leaving the respondent to pay the difference, compared with 23 percent of people with lower-deductible plans. About 15 percent of adults in high-deductible plans said they reached the limit of what their insurance plans would pay and had been left with expensive bills, about twice the rate reported by people in lower-deductible plans. Two of five (40%) adults with high-deductible plans said they had to contact their insurance company because it did not pay a bill promptly or denied payment, compared with about one-third of adults in lower-deductible plans (Table 6).

Figure 16. Problems with Health Insurance Plan, by Deductible

Percent of adults ages 19–64 insured all year with private insurance



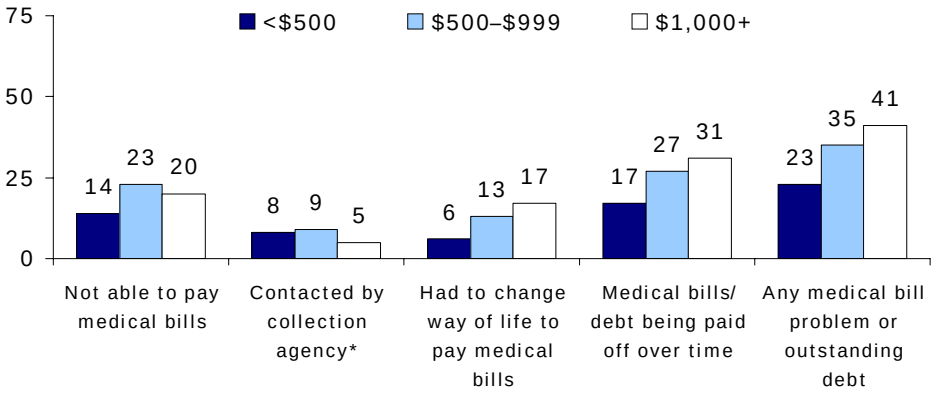
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Adults with High Deductibles Have More Problems Paying Medical Bills

When people with less financial protection become ill and seek diagnosis and treatment, they may find themselves with medical bills they are unable to pay right away. The survey asked respondents about their ability to pay their medical bills in the past 12 months, including whether there were times when they had difficulty or were unable to pay their bills, whether they had been contacted by a collection agency about outstanding medical bills, or whether they had to change their lives significantly in order to meet their obligations. Respondents were also asked if they were currently paying off medical debt they had incurred this year or in previous years. Overall, one-quarter (26%) of all privately insured adults either had a problem with medical bills in the past 12 months or were paying off accrued medical debt (Table 8). Those who said they were contacted by a collection agency because of a billing mistake—and not because they were unable to pay a bill—were excluded from the total. People with annual deductibles of $1,000 or higher were particularly affected by bills and debt: more than two of five (41%) reported bill problems or accrued debt (Figure 17). In contrast, 23 percent of adults with deductibles of less than $500 reported similar problems.

Figure 17. Adults with High Deductibles Have Problems Paying Medical Bills or Are Paying Off Medical Debt

Percent of adults ages 19–64 insured all year with private insurance



* Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

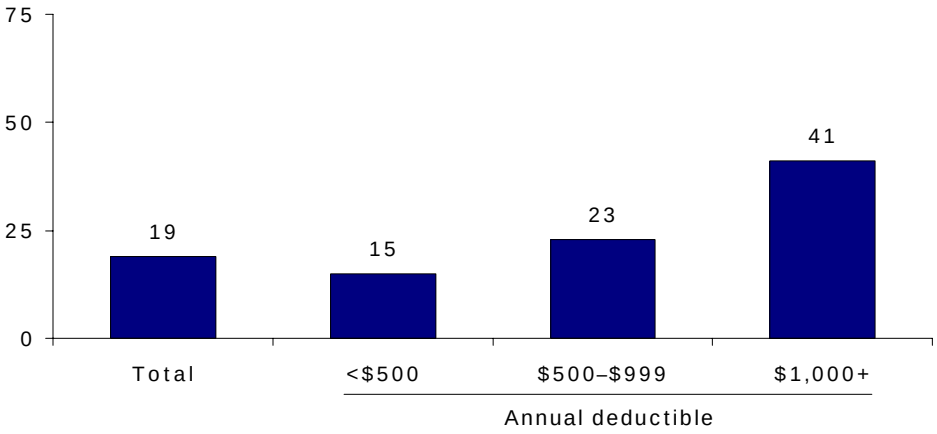
Confronted with medical bills and debt, many people are forced to make tradeoffs between spending and saving priorities. Among privately insured adults, 6 percent said that, due to medical bills, they were unable to pay for basic necessities like food, heat or rent; 10 percent used all their savings to pay bills; 4 percent took out a mortgage against their home or other loan; and 10 percent took on credit card debt (Table 8). Adults with coverage through the individual market or those who had deductibles of $1,000 or more were much more likely to say they had accumulated debt on credit cards because of medical bills. Nearly one-quarter (22%) of adults with deductibles of $1,000 or more and 15 percent of those with coverage purchased in the individual market reported that they had taken on credit card debt to pay their bills.

Adults with High-Deductible Plans Less Satisfied with Health Care Quality

Adults with less financial protection give their health plans low ratings and are less satisfied overall with their health care. More than two of five (41%) adults with deductibles of $1,000 or more per year said their health insurance was fair or poor compared with 15 percent of adults with deductibles under $500 (Figure 18).

Figure 18. Adults with Higher Deductibles Are More Likely to Rate Their Current Health Insurance Coverage "Fair" or "Poor"

Percent of adults ages 19–64 insured all year with private insurance who rate plan "fair" or "poor"

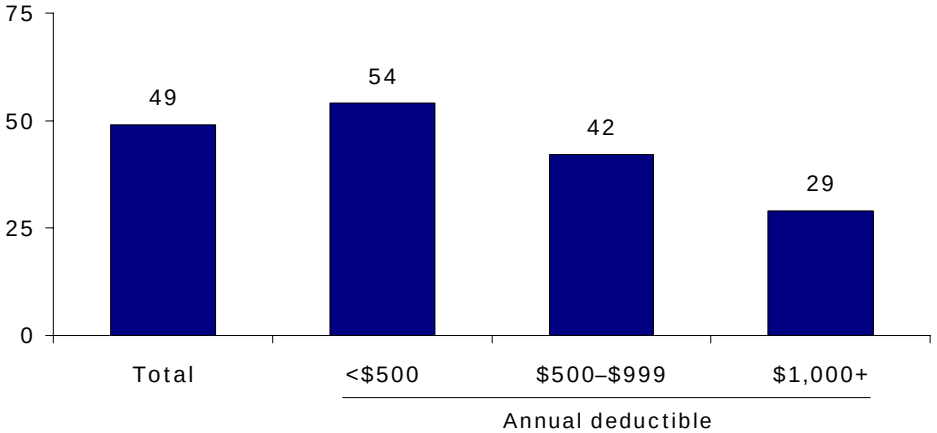


Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

People with high deductibles were also less satisfied with the quality of their health care. Only 29 percent of adults with deductibles of $1,000 or more said they were very satisfied with the quality of care they had received in the past 12 months compared with more than half (54%) of adults with deductibles of under $500 (Figure 19).

Figure 19. Adults with Higher Deductibles Are Less Satisfied with the Quality of Health Care They Have Received in the Past Year

Percent of adults ages 19–64 insured all year with private insurance who are "very" satisfied



Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

CONCLUSION AND POLICY IMPLICATIONS

The United States leads the industrialized world in health care spending. In 2002, health care expenditures totaled $6,000 per person, twice the amount of the median for industrialized countries.[16] Many U.S. policymakers and industry leaders have argued that having families pay more out-of-pocket—through high deductible health plans and health savings accounts—will make them more prudent consumers of health care. As patients shop around for the cheapest and best providers, thereby driving down growth in health care costs, the market for health care services will ultimately look more like the market for other goods and services.

Yet Americans already pay more out-of-pocket for their health care than citizens in all other industrialized countries. In 2002, out-of-pocket medical spending per capita in the U.S. was $800, two times the average in the median Organization for Economic Cooperation and Development (OECD) country in that year. Moreover, few adults have access to information either on the costs or quality of their providers, limiting their ability to choose the most efficient or highest quality providers.[17]

Indeed, evidence from this study and others suggests that increasing deductibles and other cost-sharing leads people—particularly those with chronic health problems like heart disease and diabetes—to avoid needed health care. Higher cost-sharing, consequently, has the potential to fuel growth in health care costs over time if people delay care that might prevent more serious illnesses.[18] People who must pay for the first $1,000 of their health care frequently decide not to go to the doctor when they are sick, do not always fill prescriptions when they should, delay recommended follow up visits and medical tests, or fail to schedule appointments with specialists after getting a referral from their doctor.

The RAND Health Insurance Experiment, conducted in the 1970s, found that greater cost-sharing reduced the use of both essential and less-essential health care.[19] A study by Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs, and it increased the risk of adverse health events.[20] A review by Rice and Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people 65 and older found that increases in cost-sharing nearly always reduced health care use or health status.[21]

In addition, increasing the amount people pay for their health insurance and health care imposes a much greater burden on families with low and moderate incomes than on wealthier families, leaving little money left over for savings, and exacerbating the ever-

widening gap between wealthy and poor Americans. In 2005, the average premium for family coverage in an employer-based health plan climbed to $10,800, equivalent to the annual salary of a full-time worker earning minimum wage.[22] The Employee Benefit Research Institute Health Confidence Survey of 2005 found that rising health care costs are associated with a decrease in contributions to all forms of savings, including retirement accounts like 401(k) plans.[23]

Incentives designed to encourage people to buy coverage on the individual market are also unlikely to reduce health care costs, or decrease the number of uninsured. The administrative costs of individual market coverage comprise an estimated 25 percent to 40 percent of each premium dollar compared with 10 percent of employer group coverage.[24] This means each premium dollar buys fewer benefits in the individual market than it would in the employer group market. Few plans in the individual market, for example, provide maternity benefits without a special rider.[25]

In addition, since those voluntarily seeking coverage are more likely to anticipate greater needs for health care, insurers in the non-group market necessarily estimate risk and set premiums sufficiently high to cover risk. This means that people who are older, in poorer health, or have a chronic health problem like diabetes or heart disease, will either be charged a higher premium than younger and healthier people, have their condition excluded from their coverage, or be turned down altogether.

In this study, 21 percent of working-age adults who had ever sought coverage on the individual market were turned down, charged a higher price because of a pre-existing condition, or had a health condition excluded from their coverage. One-third of adults with health problems were similarly declined. Some states, like Massachusetts, New Jersey, and New York, have strong individual market regulations that require community rating or impose age rating bands. But others, like Iowa, Kansas, Kentucky, and Washington, require no community rating and carriers can reject applicants based on medical underwriting criteria.[26] In these four states, Turnbull and Kane found that as many as 30 percent to 40 percent of applicants are rejected for coverage.[27] Turnbull and Kane also found a 14- to 17-fold difference in premiums—based on health and age characteristics—for the same insurance product based in Kentucky.

For example, a 25-year-old Kentucky man could buy a $2,500 deductible plan for $624 a year, while a 63-year-old man would be charged $2,736 for the same product. If the 63-year-old had health problems and was eligible for coverage in Kentucky's high risk pool, the lowest premium for a $1,800 deductible plan was $10,800 annually.

Still, while individual market regulations have improved access for older and less healthy people, they also have made coverage more expensive for younger and healthier people. In addition, most states that have regulated their individual insurance markets have also experienced a reduction in the number of insurance carriers, leaving healthier consumers with fewer choices and distributing risk across fewer insurers.[28]

Pooling risk is the purpose of insurance and is necessary to make coverage affordable for those who are sicker or older.[29] New forms of pooling are needed to ensure affordable and meaningful coverage for people who lose—or have never had access to—employer-based coverage. Given the inherent weaknesses and poor performance of the individual insurance market, strategies that expand options for group coverage under employer-based coverage must be examined, as well as those that encourage development of publicly organized purchasing pools for small businesses and individuals. Policymakers should also consider expanding public programs. These options include eliminating the two-year waiting period for coverage of the disabled under Medicare, letting older adults "buy in" to Medicare, and building on Medicaid and the State Children's Health Insurance Program to cover low-income parents, young adults, and single adults.[30]

Further deterioration of employment-based coverage runs the risk that larger and larger numbers of lower and middle-income families will be unable to afford health insurance. Ultimately, policy officials will need to decide whether responsibility for financing coverage should be shared among employers, individuals, and government. New legislation in some states—such as Maine, Massachusetts, and Vermont—will provide models that may prove useful in shaping national policy to address this increasingly urgent problem.

APPENDIX. SURVEY METHODOLOGY

The Commonwealth Fund Biennial Health Insurance Survey was conducted by Princeton Survey Research Associates International from August 18, 2005, through January 5, 2006. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 4,350 adults age 19 and older living in the continental United States. This report restricts the analysis to the 1,878 respondents ages 19 to 64 who were insured all year with private insurance.

Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental United States. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the approximately 108 million adults ages 19 to 64 who were insured all year with private insurance.

The survey has an overall margin of sampling error of +/– 2 percentage points at the 95 percent confidence level. The 47 percent response rate was calculated consistent with standards of the American Association for Public Opinion Research.

Table 1. Demographic Characteristics of Adults with Private Insurance

(base: adults 19–64, insured all year with private insurance)

	Total	Employer	Individual
Total (millions)	108.2	99.6	8.5
Percent distribution	100%	92%	8%
Age			
19–29	15%	14%	19%
30–49	50	51	35
50–64	36	35	46
Race/Ethnicity			
White	77	77	80
Black	9	9	5
Hispanic	7	7	8
Income			
Less than $20,000	8	7	13
$20,000–$39,999	18	17	21
$40,000–$59,999	22	22	14
$60,000 or more	43	44	35
Poverty Status			
Below 100% poverty	4	4	3
100%–199%	9	9	13
200%–299%	15	15	18
300%–399%	23	24	15
400% poverty or more	39	40	33
Below 200% poverty	13	12	16
200% poverty or more	77	78	66
Health Status			
Excellent/very good	63	62	68
Good	27	27	26
Fair or poor	11	11	6
Chronic Condition			
Hypertension, high blood pressure, or stroke	18	19	11
Heart attack or heart disease	5	5	4
Diabetes	6	7	1
Asthma, emphysema, or lung disease	9	9	9
Any chronic condition†	28	29	19
None	72	71	81
Fair/Poor Health Status, or Any Chronic Condition or Disability	34	35	26
Adult Work Status			
Full-time	73	74	54
Part-time	11	10	13
Not currently employed	17	16	33
Family Work Status			
At least one full-time worker	88	89	78
Only part-time worker(s)	4	4	5
No worker in family	8	7	16

† Chronic condition includes hypertension, high blood pressure, or stroke; heart attack or any other heart disease; diabetes; and asthma, emphysema, or lung disease.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 2. Individual Market Experiences by Age, Health, and Poverty Status

(base: adults 19–64 who sought to purchase insurance in individual market†)

		Age			Health Status		Poverty Status	
	Total	19–29	30–49	50–64	Health problem††	No health problem	<200% FPL	200%+ FPL
Total (millions)	58.4	13.5	28.1	16.8	24.8	33.6	21.5	32.2
Percent distribution	100%	23%	48%	29%	42%	58%	37%	55%
How difficult was it to find a plan with the coverage you needed?								
Very difficult or impossible	34	28	36	38	48	24	43	29
Somewhat difficult	23	32	22	16	19	27	21	24
Not too/not at all difficult	36	38	35	37	28	43	30	41
How difficult was it to find a plan you could afford?								
Very difficult or impossible	58	52	65	52	71	48	72	50
Somewhat difficult	17	29	11	16	11	21	10	21
Not too/not at all difficult	20	18	19	25	12	27	15	23
Did any company turn you down, charge a higher price because of your health, or exclude a specific health problem when you tried to buy coverage on your own?								
Yes	21	21	22	20	33	12	26	18
No	75	75	74	76	61	86	70	78
Did you end up buying a plan?								
Yes	11	10	12	10	8	14	7	13
No	89	90	88	89	92	86	93	86

† Currently has individual insurance, bought individual insurance in past three years, or thought about or tried to buy individual insurance in past three years.

†† Fair or poor health status or any chronic condition or disability.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 3. Views of Employer Coverage by Age, Poverty Status, and Employer Size

(base: adults 19–64, insured all year with employer coverage)

		Age Group			Poverty		Employer Size†			
	Total	19–29	30–49	50–64	<200% FPL	200%+ FPL	<20	20–99	100–499	500+
Total (millions)	99.6	14.4	50.6	34.6	12.3	78.2	15.5	12.9	14.0	40.5
Percent distribution	100%	14%	51%	35%	12%	78%	18%	15%	17%	48%
Source of Employer-Sponsored Coverage										
Own	71	64	70	73	63	73	51	64	85	87
Other	29	36	30	27	37	27	49	36	15	13
Do employers do a good job or a bad job selecting quality health insurance plans to offer their workers?										
Good job	74	78	74	72	68	75	69	70	75	76
Bad job	14	14	15	14	21	14	14	17	19	12
Some good, some bad/mixed	7	2	9	8	5	7	9	7	5	8
Does employer offer a choice of health plans or only one plan?										
Only one plan	42	41	41	45	46	42	70	58	52	28
Two or more plans	54	51	57	52	45	56	25	38	48	71
Did you pick the plan with the higher or lower deductible? (base: employer offers a choice of plans)										
Higher	25	29	27	21	18	28	24	27	19	28
Lower	44	45	48	37	48	44	54	48	52	46
Deductible was the same	4	4	3	5	1	4	0	2	2	4
No plans have a deductible	7	5	5	11	5	7	12	0	9	6
Don't know/refused	20	18	16	26	28	17	11	22	19	15
If you had to choose a health plan on your own with no help from your employer, how confident are you that you could choose the best plan for you?										
Very confident	40	30	42	41	34	41	48	47	39	37
Somewhat confident	34	41	33	31	35	34	21	31	34	35
Not too/not at all confident	24	27	24	24	31	24	28	20	27	26
How long was the waiting period to receive insurance from employer?										
No waiting period	43	48	40	44	30	44	49	36	30	42
Waiting period, but less than 1 month	4	7	3	4	4	4	8	6	4	4
1 to 2 months	14	13	16	12	12	14	5	16	19	15
2 to 3 months	24	19	26	22	34	23	22	30	33	25
4 months or more	8	7	9	8	13	8	8	7	9	9

† Note: Analysis based on respondents covered by their own employer's insurance plan.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 4. Annual Insurance Premiums and Deductibles by Insurance Source

(base: adults 19–64, insured all year with private insurance)

		Insurance Source	
	Total	**Employer**	**Individual**
Total (millions)	108.2	99.6	8.5
Percent distribution	100%	92%	8%
Type of Plan			
Single/individual plan	37	36★	47
Family plan	60	61★	53
Annual Premium Costs (All Plans)			
None	20	21★	3
$1–$499	6	6	4
$500–$1,499	21	21	9
$1,500–$2,999	17	17	10
$3,000–$4,499	9	9	16
$4,500–$5,999	4	4	6
$6,000–$7,999	4	3	17
$8,000 or more	3	2	15
Median annual premium among those who pay a premium	$2,250	$2,250	$3,750
Median annual premium including those who do not pay a premium	$1,000	$1,000	$3,750
Annual Deductible per Person			
No deductible	33	33★	26
Less than $100	6	6	4
$100–$499	26	28	10
$500–$999	12	12	11
$1,000–$2,999	8	7	22
$3,000–$4,999	1	0	10
$5,000 or more	1	1	5
Less than $500	65	67★	39
$500–$999	12	12	11
$1,000 or more	10	8	37
Spent 5% or more of income on deductibles	3	2★	12
Deductible applies to preventive care tests such as mammogram or colon cancer screening (base: those with annual per person deductible $1,000 or more)	39	39	‡
Separate deductible for prescription drugs	27	27	23

★ Difference between source of insurance and difference between deductible of $1,000 or more and other deductibles is significant at $p \leq 0.05$ or better, for full distribution.

‡ Not shown due to insufficient sample size (n<100).

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 5. Out-of-Pocket Health Care Expenses by Insurance Source and Deductibles

(base: adults 19–64, insured all year with private insurance)

		Insurance Source		Deductibles		
	Total	**Employer**	**Individual**	**<$500**	**$500–$999**	**$1,000+**
Total (millions)	108.2	99.6	8.5	70.1	13.1	10.9
Percent distribution	100%	92%	8%	65%	12%	10%
Annual Individual Out-of-Pocket Medical Expenses, Including Prescription Drugs						
None	9	9★	9	9★	6★	7
$1–$499	39	40	29	41	33	24
$500–$999	20	21	16	21	20	11
$1,000–$1,999	16	16	19	15	21	23
$2,000–$2,999	6	6	6	6	8	9
$3,000–$4,999	5	5	8	4	6	10
$5,000 or more	4	3	8	2	5	13
Spent annually 5% or more of income	11	11	13	10★	13★	21
Spent annually 10% or more of income	5	5	8	4★	6★	14
Median individual out-of-pocket costs	$600	$575	$960	$525	$800	$1,300
Annual Household Out-of-Pocket Medical Expenses, Including Prescription Drugs						
None	7	7	9	7★	3★	6
$1–$499	29	29	23	31	21	14
$500–$999	18	18	19	18	15	11
$1,000–$1,999	19	19	19	20	24	19
$2,000–$2,999	8	8	7	8	10	9
$3,000–$4,999	9	9	8	8	10	14
$5,000 or more	9	9	12	6	16	23
Median household out-of-pocket costs	$900	$900	$1,100	$835	$1,300	$2,000
Total Household Out-of-Pocket Medical Expenses, Including Prescription Drugs and Premiums						
None	4	5★	2	4★	1★	3
$1–$499	15	16	7	17	5	4
$500–$999	8	8	6	8	6	2
$1,000–$1,999	18	19	6	20	17	10
$2,000–$2,999	13	13	12	14	18	10
$3,000–$4,999	15	16	14	16	19	17
$5,000 or more	25	23	49	20	34	52
Spent annually 5% or more of income	40	38★	65	36★	55★	67
Spent annually 10% or more of income	25	24★	43	22★	36	43
Median household out-of-pocket costs and premiums	$2,450	$2,300	$5,250	$2,250	$3,450	$5,320

★ Difference between source of insurance and difference between deductible of $1,000 or more and other deductibles is significant at $p \leq 0.05$ or better, for full distribution.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 6. Insurance Benefits, Cost-Sharing, and Health Plan Limitations and Problems by Insurance Source and Deductibles

(base: adults 19–64, insured all year with private insurance)

		Insurance Source		Deductibles		
	Total	Employer	Individual	<$500	$500–$999	$1,000+
Total (millions)	108.2	99.6	8.5	70.1	13.1	10.9
Percent distribution	100%	92%	8%	65%	12%	10%
Insurance Benefits						
Prescription medications	94	96★	78	96★	97★	86
Prescription drug coverage limits the total amount it will pay or the number of different prescriptions that can be filled	28	28	29	27	33	31
Dental care	78	83★	27	82★	73★	54
Mammogram (females age 50+)	93	95	‡	96	‡	‡
Colon cancer screening (age 50+)	81	84	‡	84	‡	‡
Health Plan Limitations						
Number of doctor visits per year	8	8★	13	7★	10	14
Number of mental health visits per year	22	23	18	23★	26	29
Total dollar amount it will pay for medical care	34	33	36	30★	40★	48
Length of Time on Health Plan						
Less than 1 year	8	8	11	8★	10	12
1 year to less than 2 years	10	9★	17	8★	12	14
2 years to less than 3 years	11	10	14	11	7	9
3 years or more	71	72★	58	73★	71★	63
Problems with Health Insurance Plan						
Had expensive medical bills for services not covered by insurance	23	22★	33	19★	37	40
Doctor charged more than insurance would pay and you had to pay difference	27	26	30	23★	35	40
Doctor's office did not accept insurance plan	19	19	14	17★	25	22
Had to contact insurance company because they did not pay a bill promptly or denied payment	35	36★	24	32★	46	40
Reached the limit of what the insurance company would pay, left with expensive bills	8	8	10	6	11	15
Ever negotiated with a physician, hospital, or other provider to get a lower price for health care services received?						
Yes	10	10★	17	10★	12★	16
No	90	90	83	90	88	84
How would you rate current health insurance coverage?						
Excellent	22	22★	14	25★	15★	7
Very good	31	32★	20	34★	31★	20
Good	26	26	29	26	30	27
Fair/poor	19	18★	34	15★	23★	41

★ Difference between source of insurance and difference between deductible of $1,000 or more and other deductibles is significant at $p \leq 0.05$ or better.

‡ Not shown due to insufficient sample size (n<100).

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 7. Access to Care, Satisfaction and Confidence with Care by Insurance Source and Deductibles

(base: adults 19–64, insured all year with private insurance)

		Insurance Source		Deductibles		
	Total	**Employer**	**Individual**	**<$500**	**$500–$999**	**$1,000+**
Total (millions)	108.2	99.6	8.5	70.1	13.1	10.9
Percent distribution	100%	92%	8%	65%	12%	10%
Went without needed care in past year due to costs:						
Did not fill prescription	18	18	17	16★	22	27
Skipped recommended test, treatment or follow-up	13	12	16	11★	17★	26
Had a medical problem, did not visit doctor or clinic	14	14★	20	12★	19	24
Did not get needed specialist care	10	10	8	8★	12★	19
At least one of four access problems due to cost	28	27★	35	25★	31★	44
Delayed or did not get preventive care screening	7	7★	11	5★	9★	20
Delayed or did not get physical therapy or other rehabilitative care when needed	8	8	7	8★	11	14
Preventive Care						
Blood pressure checked (past year)	92	93	89	94	90	92
Dental exam (past year)	73	73	67	74	72	71
Cholesterol checked within past 5 years	78	78	75	79	77	80
Satisfaction and Confidence with Care						
Overall satisfaction with care received in last 12 months						
Very satisfied	49	50★	40	54★	42★	29
Somewhat satisfied	35	36★	32	32★	44★	43
Somewhat dissatisfied	6	6	8	5	7	9
Very dissatisfied	4	4	7	4	3	11
Have not received health care in past 12 months	4	4	10	4	3	6
Confidence in ability to get high quality health care when needed						
Very confident	37	38	33	41★	31★	23
Somewhat confident	39	39	38	37★	44★	40
Not too confident	14	14	15	14	13	22
Not at all confident	7	7	9	6	10	13
Amount of choice in where to go for medical care						
A great deal of choice	37	37	38	40★	30	32
A fair amount	44	44	42	43★	47	44
Not too much	12	12	11	11	16	17
No choice	5	5	6	5	8	6

★ Difference between source of insurance and difference between deductible of $1,000 or more and other deductibles is significant at $p \leq 0.05$ or better.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 8. Medical Bill Problems and Debt by Insurance Source and Deductibles

(base: adults 19–64, insured all year with private insurance)

		Insurance Source		Deductibles		
	Total	**Employer**	**Individual**	**<$500**	**$500–$999**	**$1,000+**
Total (millions)	108.2	99.6	8.5	70.1	13.1	10.9
Percent distribution	100%	92%	8%	65%	12%	10%
Medical Bill Problems in Past Year						
Had problems paying or unable to pay medical bills	15	15	15	14★	23	20
Contacted by a collection agency for medical bills	16	16	14	15	24★	13
Bill was sent to collection agency for unpaid bills only	7	7	4	8	9	5
Had to change way of life to pay bills	8	8	11	6★	13	17
Any bill problem†	19	19	22	17★	26	28
Medical bills/debt being paid off over time	19	19	16	17★	27	31
Any bill problem or medical debt	26	26	28	23★	35	41
Percent reporting that the following happened in the past 2 years because of medical bills:						
Unable to pay for basic necessities (food, heat, or rent)	6	6	5	5	7	6
Used up all of savings	10	10	10	9★	16	18
Took out a mortgage against your home or took out a loan	4	4	3	3	6	5
Took on credit card debt	10	9★	15	8★	11★	22

★ Difference between source of insurance and difference between deductible of $1,000 or more and other deductibles is significant at $p \leq 0.05$ or better.

† Problems paying or unable to pay medical bills, contacted by collection agency for inability to pay medical bills, or had to change way of life significantly in order to pay medical bills.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

NOTES

[1] All reported differences are statistically significant at $p \leq 0.05$ or better, unless otherwise noted.

[2] S. Silow-Carroll and T. Alteras, *States in Action: A Quarterly Look at Innovations in Health Policy*, vol. 1 (New York: The Commonwealth Fund, May 2005).

[3] S. Silow-Carroll and F. Pervez, *States in Action: A Quarterly Look at Innovations in Health Policy*, vol. 5 (New York: The Commonwealth Fund, July 2006).

[4] Ibid.

[5] P. Fronstin, *The Tax Treatment of Health Insurance and Employment-Based Health Benefits,* Issue Brief no. 294 (Washington, D.C.: Employee Benefit Research Institute, June 2006).

[6] P. Fronstin and R. Helman, *Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey,* Issue Brief no. 275 (Washington, D.C.: Employee Benefit Research Institute, Nov. 2004).

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[8] S. R. Collins, C. Schoen, M. M. Doty et al., *Paying More for Less: Older Adults in the Individual Insurance Market* (New York: The Commonwealth Fund, June 2005); E. Simantov, C. Schoen, and S. Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs,* July/Aug. 2001 20(4):139–49; N. C. Turnbull and N. M. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market—Findings from a Study of Seven States* (New York: The Commonwealth Fund, Feb. 2005).

[9] Turnbull, *Insuring the Healthy?* 2005.

[10] Ibid.

[11] Office of Management and Budget, *Budget of the United States Government—Fiscal Year 2007,* Feb. 6, 2006; H.R. 5262, "Tax Free Health Savings Act of 2006."

[12] S.1015, "Health Care Choice Act of 2005"; H.R. 4625, "Health Care Freedom of Choice Act."

[13] S. R. Collins, K. Davis, M. M. Doty et al., *Gaps in Health Insurance: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Apr. 2006).

[14] Economic theory suggests that employees covered by employer-based health insurance effectively pay for their premiums through lower wages. This means that the difference in premium costs between those with individual coverage and those with employer coverage might be less than these data suggest. However, there is mixed empirical evidence to support this theory suggesting that employer premium costs are likely only partially offset by lower wages, or at least reduced wage growth. See S. R. Collins, K. Davis, and A. Ho, "A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to Employees," *Inquiry,* Spring 2005 42(1):6–15.

[15] Only the insurance coverage of the sample respondent is known; other family members could have different sources of insurance coverage including public insurance or could be uninsured.

[16] B. K. Frogner and G. F. Anderson, *Multinational Comparisons of Health Systems Data, 2005* (New York: The Commonwealth Fund, Apr. 2006).

[17] S. R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come,* Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," Mar. 15, 2006.

[18] P. Fronstin and S. R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey* (EBRI/Commonwealth Fund, Dec. 2005); K. Davis, M. M. Doty, and A. Ho, *How High Is Too High? Implications of High Deductible Health Plans* (New York: The Commonwealth Fund, Apr. 2005).

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[26] Turnbull, *Insuring the Healthy?* 2005.

[27] Ibid.

[28] Ibid.; A. M. Kirk, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *Journal of Health Politics, Policy & Law*, Feb. 2000 25(1):133–73; M. A. Hall, "An Evaluation of New York's Reform Law," *Journal of Health Politics, Policy & Law*, Feb. 2000 25(1):71–99.

[29] Collins, *Paying More for Less,* 2005.

[30] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (Apr. 23, 2003):W3-199–W3-211.

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