The Illusion of Coverage Teleconference Speaker Statements

Speaker #1: Carol Pryor, *Senior Policy Analyst*
The Access Project, Boston, MA

Good afternoon. My name is Carol Pryor. I am the Senior Policy Analyst at The Access Project and one of the authors of the report *The Illusion of Coverage*. In my comments, I will provide an overview of the findings of the report.

National data have clearly shown that medical bill problems and medical debt are a serious problem for people with health insurance as well as for the uninsured. However, these data cannot show the specific ways in which people with health insurance accrue medical debt. To study this, we worked with partner organizations in seven states to identify people who had accrued medical debt while privately insured, either through their employer or through individually purchased insurance. The Access Project then conducted in-depth telephone interviews with 45 of these individuals. Most of our interviewees were employed and about a third had incomes over the national median of $46,326.

I'd like to make three main points about the findings.

First, the interviews clearly show that affordability of insurance coverage cannot be measured solely in terms of the cost of the premiums. For middle-income people, a combination of premiums and high deductibles, co-payments or co-insurance often resulted in unaffordable medical expenses. For those with lower incomes, especially if they had chronic conditions, even relatively moderate cost-sharing resulted in unmanageable financial burdens –co-payments for multiple medications and frequent doctors' visits quickly added up to a significant portion of their incomes. And even for those with greater resources who had not experienced problems with their insurance in the past, annual or lifetime caps on coverage could leave them with enormous debts if they became very seriously ill. Most people did not willingly enroll in plans that left them with unaffordable out-of-pocket costs; for most, their choice was severely constrained by what they could afford.

Second, the interviews showed that one result of these complex cost-sharing arrangements is an insurance system so complicated that it is almost impossible to understand. The complexity of

insurance products made it difficult for people to compare and evaluate them with respect to covered services and financial exposure, which left them vulnerable to deceptive marketing practices. When people had coverage, it was hard for them to ascertain what their insurance covered or why claims had been denied. And when they tried to find out, they often received incomplete or inconsistent information from their insurance companies. As a result, people sometimes sought care that they thought their insurance would cover, only to find that the claims were denied because of fine-print policy provisions or procedural requirements. In other cases, insurers' refused to pay for services that should have been covered. Sorting out problems could take months and the investment of incredible amounts of energy, often at a time when people were also dealing with serious illness. Sometimes problems were never resolved and interviewees were left with the bill.

Third, our interviewees faced serious consequences because of unaffordable medical bills. Almost all had to delay or forgo needed care because of cost, which sometimes resulted in more serious health consequences later on. Most faced serious financial consequences, such as using up their savings, taking on expensive loans or debt, refinancing their homes, and in a few cases filing for bankruptcy. And almost all experienced serious stress and anxiety because of their medical debt, which sometimes made their ability to heal more difficult.

In sum, our interviewees found that their health insurance did not fulfill its primary function, which was to allow them to access needed care when they got sick without suffering overwhelming financial losses. Many began to question whether the premiums they paid were worth the coverage they received. The findings also suggest that the health insurance industry is not being held adequately accountable for the quality of its products and its processes.

Many policymakers have put forward proposals that would use the private insurance market as the vehicle for moving toward universal coverage. Massachusetts has already enacted a requirement that all uninsured residents purchase health insurance, and a number of states are considering a similar approach. However, our findings show that states must proceed with care. They must ensure that consumers have access to coverage that is truly affordable, taking into account *all* of the costs, not just the cost of the premiums. And they must require that insurance companies be held accountable for their products and practices. Without providing adequate support for consumers and holding insurers to higher standards, we risk trading the problems of lack of health insurance for the equally serious ones of inadequate insurance.

Speaker #2: Barbara Cook, *Consumer*

Mansfield, IL

My name is Barbara Cook and I live in Mansfield, Illinois, with my husband, EJ. I began having chest pains on March 12, 2006, so I called our son so he could take me to the Emergency Room. To make sure that I would be covered by insurance, I checked my Blue Cross Blue Shield policy before going to the hospital. Carle Foundation Hospital was listed as an in-network primary provider, so we chose to go there. While at Carle, I suffered a heart attack in the emergency room and a stent was put in me at once. I was in the hospital March 12th through the 15th.

Although the care I received was excellent, the billing procedures were terrible. A hospital billing person visited me in while I was still in the ICU. The machines I was hooked up to indicated that I was under acute stress, which was dangerous for my health, so the nurse kicked her out.

My husband, EJ, and I are self-employed small business owners. We own rental properties. Because EJ is over 65, he has Medicare insurance and a supplemental policy. Because I'm younger, we purchased an individual policy for me through Blue Cross Blue Shield. My premium is $350 every two months with a $2,500 deductible and 80/20 co-insurance.

In April, I received bills from Carle Foundation Hospital and Carle Clinic Association, the doctors group. The hospital bill was not a surprise because we understood that we owed the $2,500 deductible and another $1,000 for co-insurance. The problem was the doctors' bill. They said we owed almost $13,000. I found out that the doctors group was not covered by BCBS insurance because it was technically "out-of-network." This was not explained anywhere in the BCBS information that I received.

EJ and I tried to deal with the insurance company and the doctors group on our own, but got nowhere. We turned to several advocacy groups, particularly Champaign County Health Care Consumers. CCHCC was a great help navigating the complex insurance and hospital systems. We also contacted the Illinois Attorney General's office for assistance.

We tried every approach recommended to deal with the expensive bills. These efforts consumed a great deal of time and energy. Each was a stress-filled event. With the help of the advocacy organizations, we filed three different appeals to the insurance company. With each appeal, BCBS

paid a little more on the bill, but never the full amount. Frustration grew. At the end of December, nine months after my heart attack, my husband came to an out of pocket settlement with the Carle doctors group. Although the insurance never paid all that it could have, at least we were finally able to resolve the problem.

The medical bills had a financial effect on our business. The bills didn't allow us to maintain our properties in the way we see fit. We couldn't afford new roofs, appliances, furnaces, etc. It also affected how much help we could hire, which was especially hard because I couldn't work as much while recovering. Like all endeavors, funds taken for medical bills affect the loss or success of our small business. In 2006, my husband calculated that we spent 22% of our income on health care expenses, including insurance premium costs and out-of-pocket expenses. The entire experience put our family under great physical, mental, and emotional stress.

Speaker #3: Kathleen Stoll, *Director of Health Policy*
Families USA, Washington, DC

I am pleased to join my colleagues at the Access Project to talk about their excellent report. I'd like to make two points about the report and why I think it is extremely important and timely.

First, it is so easy to forget the real people behind the statistics. The 45 stories from seven states featured in the report – including those of Nancy and Barbara who you will hear from today – remind us that failed policy – especially failed health policy that leaves so many without adequate health insurance coverage– has very real and harsh consequences.

Yet the stories presented in this report are not a rare few – but reflect the reality of millions of hard-working Americans. A scan of the literature reinforces the depth and breadth of the crisis of medical debt among the "underinsured" in our nation.

- Research by the Lewin Group for my own organization, Families USA, found that **10.7 million** *insured* Americans spend more than a **quarter of their paycheck** on health care.
- According to a national survey (of workers) by the Commonwealth Fund, more than **one third** of *insured* adults have experienced substantial problems with medical bills or are paying off accrued debt.

- ❖ Research by the Kaiser Family Foundation documents that **half** of adults enrolled in health insurance plans that have a yearly deductible of $500 or more struggle with high medical bill burdens and debt.
- ❖ **Three out of ten** adults *with private coverage* and who report having medical debt skipped a recommended test or treatment because of cost. For **more than half** of these adults, the delay resulted in temporary disability that included significant pain and suffering. And **more than one in six** said the delay caused a long-term disability.

Second, the report's recommendations drive home that states can take action right now to help the kind of "product failure" in health insurance coverage described in the report. States can strengthen the regulation of health insurance in a number of ways – for example strengthening premium rate review to make comprehensive coverage more affordable and increasing oversight of insurance company profitability (through medical loss ratios), holding insurance companies accountable for their behavior through market conduct examinations, enforcing consumer rights to appeal denials of coverage, and reforming laws addressing billing practices. There is no excuse for a governor or state legislature to not take action - even states that continue to face tight fiscal budgets can afford to reform laws that ensure that "fair rules of the game" are created to balance the playing field between consumers and insurers.

Speaker #4: Joseph P. Ditré, Esq., *Executive Director*
Consumers for Affordable Health Care, Augusta, ME

Good day. My name is Joe Ditré and I serve as the executive director of a non-profit organization in Maine called Consumers for Affordable Health Care Foundation. I've been working as a lawyer and advocate in Maine for 20 years.

The Access Project's Report, *The Illusion of Coverage*, documents the real life problems that consumers are facing in the 7 states covered by this report. But these are not isolated cases. Our nonprofit organization operates a Toll-Free Consumer Assistance HelpLine and our workers hear stories like the Cook's and the Warrington's everyday.

The Access Project's Report documents <u>market failures</u> that call out for government action to protect consumers.

The Access Project's Report also shows that the only thing worse than being uninsured – is paying to be uninsured. And that is what consumers who are buying high deductibles plans are doing – they are paying to be uninsured. They are buying asset protection, not health coverage. High deductible plans are causing people to skip, delay or go without care. While some are buying these plans because they have the resources to cover the deductible, most consumers are buying high deductible plans because they are the only plans they can afford.

Some of the market failures being reported around the country include:
High deductible plans that leave people uninsured for care they need
Cancellation of policies once the insured files a claim
Retroactive denials of coverage for covered services
Risk avoidance by "benefit design" that serve to segregate risks
Pricing strategies that dump higher risks and costs onto public programs or other payers, and
Benefit caps and limitations that are put in place by the companies without regulatory approval
For example, Maine's largest health insurer controls 98% of the individual market. After buying our non-profit Blue Cross plan, it closed to new sale all low deductible plans and began offering only $5K – $10K – $15K high deductible plans. Ninety six percent of its individual policyholders are in one of these high deductible plans.

In 2003, the Maine Legislature enacted the Dirigo Health Program, the nation's first universal access to health coverage program. The Dirigo Health Program was developed in part to respond to market failures that are leaving more and more people in medical debt.

People need guaranteed, comprehensive coverage on a sliding scale basis; consumers need to be able to compare coverage on an apples-to-apples basis; and good prevention coverage.

Maine's Dirigo Health Program offers coverage that:

- has sliding scale premiums, deductibles and coinsurance;
- no pre-existing condition exclusions or waiting periods;
- 100% prevention coverage without cost sharing;
- full medical and drug coverage; no deductible on drugs; and
- mental health parity down to the individual level – not just for groups of 20 or more

Each of these elements is intended to reverse market trends that leave consumers with medical debt and insecurity. But states who are not ready to adopt a universal plan like Maine, need to begin acting now to at a minimum adopt fair rules that address the market failures documented in the Access Project's report. These market failures will only worsen as underlying health care costs increase. Hopefully, this report will enlighten state policymakers to take action now. The most costly thing that states can do is nothing. Thank you.

Speaker #5: Nancy Warrington, *Consumer*
San Diego, CA

My name is Nancy Warrington. I am from San Diego, CA, and have a wonderful 4 year old son named Joshua. My husband, Todd, is an electrician and until recently he worked for a small family owned company that could not afford to provide health insurance. Prior to the birth of our son we had health insurance through my employer, which we lost when we decided that I would stay home to raise Joshua in 2003.

We wanted to do the right thing, so we chose to purchase insurance on the individual market. The only affordable option that we could find had a $2,500 deductible and a monthly premium of $333.00. Although we could afford the monthly premium, it turned out that the insurance plan wasn't affordable for our family when we needed to get care—the out of pocket expenses drove us into debt.

A number of routine sick visits, MRIs for both my husband and me, and three minor surgical procedures by a dermatologist resulted in over $3,000 in out-of-pocket medical bills. Around that time, I also became pregnant and unfortunately the baby's heartbeat could not be found. I had to have a d&c which cost over $2,000. My attempts to arrange a payment plan that would work for my family were denied by the hospital and they advised me that I could do one of two things: either sign a waiver so they could deduct $82.00 per month directly from our checking account, or let the bill go to collections. In an attempt to save our credit, we begrudgingly let them take the money out of our account and began to heal from the grief our loss.

In 2006 the policy's monthly premium increased so it was unaffordable for us. We chose to increase the deductible to $5,000 to maintain a premium that we could afford on a single income. Shortly after that, I developed a horrific pain in my stomach which grew in intensity and I became

violently ill. After much urging from my husband we went to the emergency care facility. I refused to go to the hospital because I was so afraid of what it would cost, but the doctor told my husband to take me to the hospital emergency room right away. I had an emergency appendectomy. Suddenly, we owed another $5,000.

A year ago, my husband was diagnosed with a hernia that needed an operation, but we put it off because we couldn't afford the procedure. Todd and I decided that we could not afford to go another month living in fear of going to the doctor—we needed health insurance that would protect us. Todd left his job to work for a different company that offers benefits through union membership. Thanks to our new health coverage, he will be getting the hernia operation this year.

My husband would never tell me outright because he is a good man, but I know deep down he has some resentment that was not there 5 years ago. Resentment that our medical bills will not allow us to go on a family vacation—whenever we have a little extra money, it always seems like another medical bill comes to haunt us. This has hurt our credit, caused us to delay care and put hardship on the very core of our relationship. It is heartbreaking for me to see my husband working so very hard for his family, paying for our insurance because it is the right thing to do - only to be buried by debt. It makes even honest, hardworking people like us wonder if it would have been better to not have had insurance in the first place.

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