



**Testimony Before**  
**U.S. House of Representatives**  
**Committee on Energy and Commerce**  
**Subcommittee on Health**

**Hearing on**  
**“Living without Health Insurance:**  
**Why Every American Needs Coverage”**

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**Summary**  
**“Living Without Health Insurance: Why Every American Needs Coverage”**  
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We have an opportunity and an obligation to seek solutions to the health system problems that have put insurance out of reach for millions of Americans. However, we must also recognize the limitations of policies that are narrowly focused on increasing the number of newly-covered individuals without also addressing broader system issues. Those issues have an impact on everyone who uses health care in this country, whether or not they have insurance.

The uninsured are not easily characterized. They come from every sector of society and their reasons for not having health insurance vary, but cost is the dominant concern. Some individuals simply cannot afford insurance even though they need it. Others may be able to purchase coverage but do not think the value outweighs the cost.

The mismatch between cost and value is at the heart of our health system crisis. We spend over \$2 trillion annually for health care, but there is a growing sense that we are not getting our money's worth. This crisis is driven principally by perverse economic incentives, massive information failures, uncompetitive markets, and a health system that does not adequately meet the needs of high-cost patients.

Work is proceeding on many fronts to correct these problems and to promote a more efficient and effective health system. Many states, most notably Massachusetts, have developed innovative solutions through the use of Medicaid waivers. Employers, insurers, and providers are developing new approaches that could reduce unnecessary health spending and enhance the quality and effectiveness of care.

The Congress has indicated its intention to expand the State Children's Health Insurance Program (SCHIP) by \$50 billion over the next five years. Such an expansion could draw substantial numbers of children out of the private coverage that they already have and into the public program. Better targeting of the funds and enhanced state flexibility to manage their programs would minimize this crowd-out effect and direct our subsidies to those who are most in need. That is particularly important when budget resources are scarce, as they are this year.

Although a great deal of attention will be paid to the SCHIP reauthorization, Congress should take the opportunity to address broader health system problems. The high cost of health care is driving efforts in both the public and private sectors to improve the performance of the health system. Congress has an opportunity to build upon those efforts with policies that promote better value for our health care dollars. We can and must find ways to slow the growth of health spending, improve the effectiveness of care, and make health insurance more accessible for the uninsured and more affordable for everyone.

Mr. Chairman and members of the Committee, it is a pleasure to appear before you today to discuss the challenges facing the uninsured. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute for Public Policy Research (AEI). AEI is a private, nonpartisan, not-for-profit institution dedicated to research and education on issues of government, politics, economics, and social welfare.

We have an opportunity and an obligation to seek solutions to the health system problems that have put insurance out of reach for millions of Americans. However, we must also recognize the limitations of policies that are narrowly focused on increasing the number of newly-covered individuals without also addressing broader system issues. Those issues have an impact on everyone who uses health care in this country, whether or not they have insurance.

Three points must be emphasized. First, access to health insurance does not guarantee that the care will be either appropriate or affordable. Being able to finance treatment is only the first hurdle for patients. Financial incentives encourage the provision of services that may offer little benefit to patients. The lack of solid clinical evidence on the effectiveness of alternative therapies and on provider performance confounds decision-making by patients and their physicians.

Second, access to health care does not guarantee good health. There are limits to what the best clinical intervention can do if individuals do not accept personal

responsibility for their life styles, health habits, and adherence to treatment regimens. That responsibility also includes making appropriate provision for financing care through the purchase of insurance.

Third, there is no magic policy bullet that will solve the problems facing the uninsured. Expanding subsidies for health insurance, through the purchase of private coverage or broader eligibility for public programs, will prove to be unsustainable unless we also undertake more fundamental reforms. The policy agenda must include efforts to improve the efficiency of the health system, expand the knowledge base available to providers and patients, increase transparency of prices and quality of care, improve the functioning of the health insurance market, encourage individual choice and responsibility, and promote effective competition.

### **Barriers to Affordable and Appropriate Care**

The nearly 45 million people without health insurance cannot be easily characterized. They span across the spectrum of ages, genders, family makeup, ethnicity, labor force participation, health status, and tastes. Their reasons for being uninsured also vary, but cost is a dominant concern.<sup>1</sup> Some individuals simply cannot afford insurance even though they need it. Others may be able to purchase coverage but do not think the value outweighs the cost.

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<sup>1</sup> This point is made by Mark Pauly and Bradley Herring, "Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes," *Health Affairs*, January/February 2001: 9-26.

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Work is proceeding on many fronts to correct these problems and to promote a more efficient and effective health system. Many states, most notably Massachusetts, have developed innovative solutions through the use of Medicaid waivers. Employers, insurers, and providers are developing new approaches that could reduce unnecessary health spending and enhance the quality and effectiveness of care.

*Incentives.* Perhaps the most significant factor contributing to the cost-value mismatch is the complex array of perverse economic incentives facing every actor in the health system—patients, providers, insurers, and employers. Traditional first-dollar coverage<sup>2</sup> largely insulates patients from the direct cost of care, and guarantees higher payment to providers who deliver a larger volume or more complex services. As a result, the third-party payment system promotes the use of services that, at the margin, are not worth their cost.

The overuse of services adds to the cost of insurance and drives up premiums. In other markets, rising prices would be met with consumer resistance. However, health insurance is typically purchased through employers, and workers are not fully cognizant

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<sup>2</sup> That is, insurance with low deductible and cost-sharing requirements.

of the full cost of their coverage. There is a kind of “premium illusion” that confounds public understanding of insurance costs. Few people realize that the employer’s premium contribution is ultimately paid by the worker himself, who would otherwise receive higher wages or other forms of compensation.

In addition, federal tax policy promotes the purchase of excessive and inefficient insurance coverage. Premiums paid for employer-sponsored health insurance are excluded from taxable income.<sup>3</sup> For the average earner, the tax break can reduce the cost of coverage by nearly a third.<sup>4</sup> However, this provision provides greater advantages to those with higher incomes and those who have more generous health insurance coverage. It disadvantages lower-income workers and those who do not have access to employer coverage.

Recent federal initiatives have begun to improve financial incentives in health insurance. The introduction of Health Savings Accounts (HSAs) is a major milestone. Consumer-directed health plans, which combine high-deductible insurance with health savings accounts, promote greater awareness of the cost of care on the part of both consumers and providers. The HSA provision extends a tax break for contributions to the accounts that partly levels the field between insured health expenses and expenses that are paid out of pocket.

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<sup>3</sup> The self-employed receive a partial tax break. They may exclude their premium payments from income subject to the personal income tax, but not from the payroll tax. Others who purchase coverage on the non-group market do not receive any tax benefits.

<sup>4</sup> The average earner pays a 15 percent marginal federal income tax, a 15.3 percent payroll tax rate, and some additional state and local income tax.

According to a recent survey, 4.5 million people were covered by HSA-compatible health plans as of January 2007.<sup>5</sup> The growth of such plans demonstrates the interest of employers and insurers in the potential such insurance products have to lower costs. Importantly, the introduction of HSA-compatible insurance has focused attention on the fact that consumers cannot become smarter purchasers without information about their treatment alternatives, the quality of care offered by different providers, and the price of care. Such data are needed by all patients, not only those with consumer-directed health plans.

President Bush's proposal to replace the open-ended tax exclusion of employer-sponsored health insurance premiums with a tax deduction represents an even greater departure from convention. The proposal would offer a standard amount that would be deducted from taxable income for anyone purchasing health insurance, either from an employer or from the individual insurance market. Individuals buying a lower cost policy would benefit from the full deduction; those buying a more expensive policy would not receive additional tax benefits above the standard amount.

The proposal is not perfect. The most common criticism is that the deduction should be augmented with a refundable tax credit for low-income individuals. Nonetheless, the proposal is bold. It would rein in a massive middle-class entitlement that promotes inefficient forms of insurance. By advancing the proposal, the President

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<sup>5</sup> America's Health Insurance Plans (AHIP), *January 2007 Census Shows 4.5 Million People Covered By HSA/High Deductible Health Plans*, April 2007, [http://www.ahipresearch.org/PDFs/FINAL%20AHIP\\_HSAReport.pdf](http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf).

has opened the door to a serious debate on the economic incentives driving our health system.

*Information.* The health system is a knowledge-based industry that does not have the information it needs to function well, and that does not use the information it does have to best advantage. The evidence basis for determining proper medical treatment is limited, and we have few studies comparing the effectiveness of alternative clinical interventions.

Complicating this issue is the fact that treatment decisions usually involve some degree of uncertainty. The average patient may not fit the profile of those who participated in clinical trials or other studies, or may have comorbidities that must be taken into account in treatment. Providers often do not have ready access to laboratory tests or other patient information relevant to the course of treatment because of the lack of electronic medical records or other systems that can communicate that information from one provider to another.

Patients as consumers also have limited access to vital information. Information on the clinical effectiveness of treatment alternatives is limited and difficult to interpret without professional guidance. Price information is becoming more available, although that information is also limited. Even if the provider's charge for a specific service can be learned, the patient is unlikely to know what the entire episode of care will cost. Indicators of the quality of care offered by providers are also available in some markets,

but such indicators may not provide information about the skill and experience of a provider in delivering the specific service that a patient is about to receive.

The acute need for better information is widely acknowledged, and a variety of initiatives have been undertaken in both the public and private sectors to fill the gap. The Veterans Health Administration has been a leader in developing interoperable computer-based medical records systems. Considerable effort by federal officials and private firms has gone into developing standards for such systems.

Employers, including those participating in the Leapfrog Group, have taken steps to promote high-value health care and information that can inform the purchase and use of health care. Insurers are experimenting with ways to more efficiently provide information on treatment alternatives, cost, and quality of care to their enrollees. The federal government also is promoting greater information transparency for consumers.

There is widespread interest in creating a data base of information from billing records and other patient-specific information collected by Medicare and private insurers. Such a resource could provide valuable insights into the effectiveness of health services, the performance of providers, and the management of patients with multiple conditions. These and other activities will ultimately contribute to improvements in health care delivery that could improve the effectiveness of treatment and reduce unnecessary spending.

*Competition.* The power of competitive markets to bring about needed improvements in the health system is frequently questioned. Health care, it is sometimes said, is different from other consumer goods and should be carefully controlled by the government. However, the health system is an amalgam of competitive and regulatory elements that cannot be pried apart. The policy challenge is finding a balance that ensures consumer protection without stifling either consumer choice or medical innovation.

Much needs to be done before we will see widespread and effective competition in the health sector with informed consumer and provider decision-making. Essential reform steps are already under development, including policies to improve financial incentives, promote price transparency, and improve evidence on clinical effectiveness and quality of care. Indeed, most observers acknowledge that such actions are necessary even under a more regulatory approach to health system management.

The new Medicare drug benefit demonstrates the advantages of effective competition. As a result of competition, Part D premiums paid by seniors fell from \$37 a month, as originally expected, to about \$22 a month for 2006.<sup>6</sup> Most enrollees in Part D have opted for an alternative to the standard plan defined by Congress, and 80 percent of enrollees have indicated that they are happy with the new benefit.

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<sup>6</sup> Joseph R. Antos and others, "Medicare Part D and Prescription Drug Prices: Policy Fact Sheet," January 9, 2007, [http://www.aei.org/publications/pubID.25420.filter.economic/pub\\_detail.asp](http://www.aei.org/publications/pubID.25420.filter.economic/pub_detail.asp).

*High-Cost Patients.* One of our most vexing problems is providing affordable health insurance to chronically-ill patients whose high medical costs persist year after year.<sup>7</sup> Private insurers can offer affordable protection for unforeseen expenses since they can spread those costs over a pool of healthier enrollees. If they are to remain in business, insurers would be forced to charge people with predictably high and persistent costs enough to at least cover those costs—in some cases, hundreds of thousands of dollars a year. As a result, high-cost patients are often medically uninsurable.

State high risk pools are designed to provide coverage to those who are medically uninsurable. Such pools, which have been implemented in 34 states, offer discounted insurance coverage to persons who have been denied coverage by private insurers.<sup>8</sup> Although the states provide substantial subsidies, individuals in those pools must also pay sizeable premiums (albeit lower than the full market price). Enrollment in the pools has been low, due in part to high premiums, limited benefits, and limited outreach by states concerned about keeping program costs down. Additional state and federal funding would help to promote this health insurance safety net.

Obtaining insurance is only one of the health system challenges facing high-cost patients. These patients typically rely on a number of physicians, health professionals, and health facilities for their treatment. Patients could benefit from a more coordinated approach to their care, which would at least simplify their dealings with providers and

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<sup>7</sup> John F. Cogan and others, *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System*, AEI Press, 2005.

<sup>8</sup> Lori Achman and Deborah Chollet, “Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools,” Commonwealth Fund, August 2001.

might also reduce costs and improve quality. That requires the development of improved treatment protocols, more efficient sharing of patient information among multiple providers, and financial incentives to manage complex cases.

### **Elements of a Policy Agenda**

The Congress has indicated its intention to expand the State Children's Health Insurance Program (SCHIP) by \$50 billion over the next five years. Such an expansion could draw substantial numbers of children out of the private coverage that they already have and into the public program. Better targeting of the funds would minimize this crowd-out effect and direct our subsidies to those who are most in need. That is particularly important when budget resources are scarce, as they are this year.

Congress could also grant the governors additional flexibility to expand access to employer-sponsored insurance using SCHIP funds. Enabling low-income workers to purchase family coverage through their employer can make limited federal and state funds go further.

Although a great deal of attention will be paid to the SCHIP reauthorization, Congress should take the opportunity to address broader health system problems. The high cost of health care is driving efforts in both the public and private sectors to improve the performance of the health system. Congress has an opportunity to build upon those efforts with policies that promote better value for our health care dollars. We can and

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