

**PREMIUM**  
**David Blumenthal**  
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**David Blumenthal:** Good afternoon. I'm Dr. David Blumenthal, president of the Commonwealth Fund. Thank you for joining us to hear about findings from our new report out tomorrow looking at trends in employer health insurance costs in every state. I'll provide some brief background and then turn it to Sara Collins, vice president for the Commonwealth Fund's program on healthcare coverage and access and lead author of the study for an overview of the report's findings.

A reminder, the information discussed on this call is embargoed until 12:01 AM Eastern Time on Thursday, November 21st. This new report provides a state-by-state look at the cost of healthcare for the vast majority of people under age 65 in the United States, 164 million, who get their healthcare insurance through an employer. This report is unique in its state-by-state perspective measuring how much insurance is costing workers in premiums, deductibles, and as a share, their income from 2008 to 2018. The analysis shows wide variation across the 50 states in the burden that healthcare costs impose on working-age Americans with employer-sponsored insurance.

It shows that over the last decade, premiums and deductibles have taken up a larger share of families' income across the country. As the 2020 campaign season progresses, it's clear that healthcare is a top concern for American families and rightfully so. Healthcare and health insurance coverage are essential to people's well-being and financial security and yet employer healthcare coverage is leaving millions of families exposed to

high and potentially unaffordable costs. Ensuring that everyone can afford their healthcare will require policy fixes and system-wide efforts to get to the heart of the healthcare cost problem: the exorbitant prices we often pay for healthcare in the United States.

As Sara will detail shortly, there are several policy fixes that have the potential to reduce healthcare burdens for workers and families struggling to afford healthcare they need while also making our health system work better for everyone.

I'll turn it to Sara Collins now for the report findings.

**Sara Collins:**

Thank you, David. I want to recognize my coauthors, David Radley, who is on the call, and Jesse Baumgartner. The analysis and the report we are releasing tomorrow is based on the latest data from the insurance component of the Federal Medical Expenditure Panel Survey. The MEPS-IC is the most comprehensive national survey of US employer health plans. It surveyed more than 40,000 business establishments in 2018 with an overall response rate of 67%. The purpose of this study was to look at trends over the last decade in the amount that Americans pay for their employer health insurance and the size of their deductible in all 50 states and the District of Columbia. The study examines the amount of income these costs represent for middle-income families. To smooth year-to-year fluctuations, we examined two-year moving averages across the decade. Please go to Exhibit 1 where I provide an overview of the study findings.

The reason we wanted to look at people's insurance cost relative to income is that research indicates that these costs have consequences. People with low and moderate incomes may go without insurance if it competes with other expenses like housing or food and high deductibles may lead people to skip needed healthcare or not fill prescriptions. What

we found is that average annual growth and the combined cost of employees' contributions to premiums and deductibles outpace growth in US median income between 2008 and 2018 in every state. This means that premium contributions and deductibles in employer plans took up a growing share of people's incomes over that time period. Those costs together accounted for 11.5% of media household income by 2018, up from 7.8% a decade earlier.

Exhibit 2. I'm first going to discuss trends in these aggregate measures of premiums and deductibles. After that, I'll break them down into their component parts. Between 2008 and 2018, employee premium contributions across single and family plans in the light blue line on the chart grew faster than US median income, which is in the orange line. Deductibles are the amount of healthcare services people have to pay for out-of-pocket before their insurance coverage kicks in. Over the last decade, the size of deductibles, the dark blue line also grew faster than median income. While the gap between growth in median income and growth in premiums and deductibles has narrowed in the most recent two-year period, these costs continue to climb more rapidly than income.

Exhibit 3. To see how much income middle-income families might have to allocate on average to their health insurance premiums and deductibles, we looked at the ratio of employee premium contributions and deductibles to median income. The average employee cost across single and family plans, the light blue line, amounted to nearly 7% of median income in 2018, up from 5.1% in 2008. Deductibles, which are on orange line, also averaged across single and family plans, amounted to 4.7% of median income, up from 2.7% in 2008. Added together, the total cost of premiums and deductibles, which is the top line on the chart, was 11.5% of median income in 2018. This is up from 7.8% a decade earlier.

Exhibit 4. Premiums and deductibles, as well as median income vary considerably across the country. The darker-shaded states in these three maps are states in which workers face the highest premiums and deductibles as a share of their income. By 2018, premiums and deductibles were 12% or more of median income in 17 states, the dark blue states on the map. These are states where median income is below the national average and most are in the south. In Louisiana and Mississippi, these combined costs were 16% or more of median income.

Exhibit 5. I'm going to shift now to a discussion of trends in these costs broken down into their component parts, premiums and then deductibles. First, with respect to premiums, the total premium in employer plans including contributions from both employers and employees rose at a faster pace between 2016 and 2018 than it did in the prior two-year period between 2014 and 2016. Premiums and single plans grew at an average annual rate of 4.9%. The family plan premiums grew at 5.1% annually.

Exhibit 6. For single-person plans, US workers are contributing about 21% of the cost of the total plan premium on average. This share has not changed overtime. In 2018, the premium amount that workers contributed for single-person plans ranged from a low of \$755.00 in Hawaii to a high of about \$1,900.00 in Massachusetts.

Exhibit 7. For family plans, workers contribute about 28% of the total premium cost on average. This also has not changed much overtime, but in five states, this share was as high as one-third of the total cost. Worker contributions to family plans ranged from a low of nearly \$3,900.00 in Washington to a high of nearly \$6,600.00 in Virginia.

Exhibit 8. This map shows worker premium contributions averaged across single and family plans as a share of median income in each state. In nine

states, the deep turquoise states on the map, premium contributions were 8% or more of median income, with a high of 10% in Louisiana.

Exhibit 9. In many states, even though premium costs take up a large share of people's incomes, many people are not getting insurance that offers them good cost protection. This is because for many, deductibles are also high. Over the decade, deductibles grew both in proliferation and size. About 87% of employer plans had deductibles in 2018. This is up from 71% in 2008. In 2018, deductibles ranged in size from a low of \$1,300.00 in the District of Columbia and Hawaii to a high of more than \$2,400.00 in Maine.

Exhibit 10. Research has indicated that high deductibles can act as a national barrier to care discouraging people with modest incomes from getting needed services and leaving them effectively underinsured.

In our studies of underinsurance, the Commonwealth Fund has defined people as underinsured if their plan deductible is equal to 5% or more of income. This map shows that per person deductibles averaged over single and family plan amounted to 5% or more of median income in 18 states, the deep turquoise states on the map indicating that many people in employer plans are effectively underinsured. Average deductibles ranged as high as 6.7% of income in Mississippi.

Exhibit 11. Just to recap the major findings of the report, over the last decade, US median income has not kept pace with families' premium cost in employer health plans. At the same time, deductibles in these plans have also grown faster than income leaving many families underinsured. People across the country are not experiencing employer health insurance costs equally. The most cost-burden families live in southern states. Democratic president candidates have proposed a range of options to

improve insurance affordability and lower healthcare costs, which are the key drivers of premiums.

Some proposals would build on the Affordable Care Act and provide people and employer plans with an option to enroll in a public plan like Medicare. Others proposed to replace the Affordable Care Act and all private insurance including employer coverage with a public plan like Medicare and eliminate all premiums and cost-sharing.

Republican reform ideas are less well-developed at this point, but tend to favor replacing the Affordable Care Act with market-oriented approaches and more state control over insurance markets and the Medicaid program. We are certain to hear more from candidates and likely voters on healthcare affordable issues in the coming years.

I'll stop there and hand this back over to David and look forward to your questions.

**David Blumenthal:** Thank you, Sara. We'll take questions now and Sara's coauthor is also here to answer your questions, David Radley, senior scientist in the Commonwealth Fund's tracking health system performance program.

**Operator** Thank you. At this time if you would like to ask a question on the phone, please press the \* then 1 keys on your touchtone telephone. You may withdraw your question at any time by pressing the # key. Again, \* 1 to ask a question today.

We'll take our first question of the day from Sussanah Luthi with Politico. Please go ahead. Your line is open.

**Sussanah Luthi:** Hi. Thanks so much for doing a study and this call. Just wondering if you saw much difference in your findings between the small and the large-group employer insurance, if there is a significant premium difference?

**Sara Collins:** We actually did not look at differences in the small – we just limited to the whole group. We didn't break out differences.

**Sussanah Luthi:** Okay. Do you do much talking to employers for the study of whether they're seeing much pushback from employees as the deductibles rise?

**Sara Collins:** Actually, we used a federal database. So, it's a federal survey of employers. We actually did not do the interviewing.

**Sussanah Luthi:** Okay.

**David Blumenthal:** This is David Blumenthal. I would say, and it's not direct information, that the current concern with the affordability of healthcare has a lot to do with employer deductibles – employer-sponsored insurance and premiums and deductibles. So I think if you look to the origins of healthcare's salience as an issue with the current time, trends that this report cites are likely to be an important factor.

**Sussanah Luthi:** Thank you.

**Operator:** Thank you. We'll move next to Ben Conarck with the Miami Herald. Please go ahead. Your line is open.

**Ben Conarck:** Thank you. Thanks for holding this call. I actually have a couple questions, but I want to start with do we have any reason to think that these cost increases are leading to a rise in the number of uninsured people? In other words, are people faced with high premiums and deductibles opting to go uninsured as opposed to using their employer-provided health insurance?

**Sara Collins:**

That's a really good question and we haven't seen much change in employer enrollment overtime, so it has remained pretty stable. One factor that might change that of course is withdrawal of the individual mandate in the Affordable Care Act which means that not everybody – you no longer face the tax penalties if you don't have coverage, but I think there is some real concern. When you look at some of these numbers particularly in states where the premiums start to rise as a share of median income and you think about the income distribution of people kind of in the midrange, about \$64,000.00 a year are paying quite a bit of their income in some states across the country.

So if you think about people who are just below that level whose premiums are even a larger share of their income, and the question is if people are facing premium costs that high, at which point do they decide not to continue having insurance or electing insurance in plans? What point does it become a matter of public policy to think about addressing that affordability issue? The Affordable Care Act obviously caps what people spend of the share of their income that extends to employer plans, but many people get caught in this family coverage glitch and they're in unaffordable plans because their family premiums are high. So I think it is a concern looking forward. The Congressional Budget Office does estimate that some people in employer-based plans, because of the loss of the mandate penalty, will actually drop coverage. When you add the rising premium contributions, the flat growth in income that we're seeing, it does become a concern overtime.

**Ben Conarck:**

Thank you. Just one second. So the other question I had is just – actually, you set it up pretty well. It does have to do with the Affordable Care Act and also the timeline here in these trends that we're seeing. Could you talk a little bit more about what you think might be driving these increases and



how does that timeline match up with the rollout of the Affordable Care Act?

**Sara Collins:** For a few years right after the Affordable Care Act, there was a flattening in growth in employer premiums. So if you look at the exhibit – I'll point to Exhibit 5 in the chart [pack], you could see kind of a drop off in growth in employer premiums after 2010 and it's upticked recently between 2016 and 2018. The premium growth actually slowed a bit after the implementation of the Affordable Care Act in employer plans.

**Ben Conarck:** Thank you. Those are all my questions.

**Operator:** Thank you. Well move next to Sarah Gantz with the Philadelphia Inquirer. Please go ahead.

**Sarah Gantz:** Hi. Thank you, guys, for doing this call. I was hoping you could speak a little bit more to what you see as the potential ways that the cost of insurance will influence how people use their plans, the type of care they get.

**Sara Collins:** That's a really good question. The research that Commonwealth Fund has done on high deductibles and people with high out-of-pocket costs has shown that as your deductibles increase, you're less likely to get needed healthcare, you're less likely to fill prescriptions that you need, you're less likely to go to the doctor when you're sick. So these do act as a financial barrier to care. People tend on average to not use very much healthcare, but the fact of the deductible, the fact that many people, particularly in the midrange of the income distribution don't have that much savings does act as a disincentive to get needed healthcare.

**David Blumenthal:** So I wanted just to inject a personal story which I think is okay to share because the person involved has told it publicly, a physician by the name

of Ashish Jha, who is a very well-known health services researcher and professor at Harvard and also an active physician decided to enroll in a high-deductible health plan through his Harvard insurance to get an idea of what it was like to have that kind of a policy and he tells the story of waking up in the middle of the night with heart palpitations. He actually had an abnormal rhythm called atrial fibrillation and he said that as a physician, he knew he should go to the hospital, but because he had such a high deductible, he decided not to and I think that that's an interesting indicator of how at the point of decision, even well-informed people may change their behavior because of the cost of the care they're facing.

**Sarah Gantz:** Thank you very much.

**Operator:** Thank you. We'll go next to Jack O'Brien with HealthLeaders Magazine. Please go ahead.

**Jack O'Brien:** Hi there. Thank you for taking my question. I'm really curious about what's the most pressing takeaway for hospital executives. They comprise most of our readership and I'm curious what these trends mean for the bottom line of their organization.

**David Blumenthal:** That's a complicated question and I think on the whole, it will probably be unfortunate for hospital finances because it will discourage utilization and it will add to bad debt because when people with high deductibles use their healthcare, they go home with unpaid bills and those bills have to be collected and often they can't be afforded by the individuals who incur them. Though the Affordable Care Act reduced uncompensated care for hospitals generally, this trend threatens to at least in part reverse the relief that the Affordable Care Act provided.

**Sara Collins:** I'll add, just a survey data point in a survey that come up and ran about a year or two ago, we asked people if they were to get a surprise bill, if they were to maybe go into an emergency room or have an expected bill of \$1,000.00, would they have the money to pay it off in one month and about a third of the people in employer-based plans said no to that question and about half people - as you go down the income scale, half of the people with lower income said no. People may avoid care, but at some point, it becomes the inevitable emergency room visit, and people just tend not to have the assets to cover an unexpected cost like that.

**David Blumenthal:** Just to add another perspective on this, we've seen over the last half decade or a decade fall in utilization for inpatient services, and that is a problem for hospitals, especially hospitals that have excess capacity. The response seems to have been, looking at national trends, to raise prices, and in raising prices, hospitals create at least the public relations vulnerability for themselves that they are now struggling with. So, I think deductibles have an indirect effect on hospital finances that can create a backlash from – and I think as you see the pressure for price transparency, that has its origin at least in part in the perception that prices are very high.

**Sara Collins:** I just want to make a quick point, another on people on that, there's a loop there. Just to close the loop. We know that the primary driver of healthcare cost right now are provider prices in commercial-based plans, so the extent that hospital prices are rising, that drives premium cost, it drives deductible cost, so people are facing higher deductibles that reduces their incentive to get care from the very providers that are on average the source of the growth in their insurance cost.

**Jack O'Brien:** Excellent. Thank you for your answers.

**Operator:** Thank you. We'll go next to [Randy Crable] with [Puzzle] World. Please go ahead.

**Randy Crable:** Well, I'm wondering if you have any explanations for the state-to-state variations in the cost?

**Sara Collins:** That's a great question, and I guess it's good to keep in mind all the different components of what we're measuring. There is the overall premium that employers and employees pay for. There is the part that employees pay for, the share that they are required to pay. There is the deductible that they base, and critically there is their median income. In states that just generally have lower median income, even if their premium contributions might be a little lower than average, they may have a much larger burden than people on a state with higher median incomes and even higher premium cost.

**Randy Crable:** The actual dollar costs, on some of the charts they vary quite a bit, but were you able to see any correlations between states that have expanded Medicaid and those that have not?

**Sara Collins:** That's a good question. We didn't actually just break it down, presenting us a straightforward set of data to look at, but it's an important question because for people in expansion states who are in employer-based plans where their costs are high, everyone below 138% of poverty is actually eligible for Medicaid, so people can enroll in it. That helps people in that lower end of the income distribution. For states that have an expanded Medicaid, obviously, people don't have that ability to shift into Medicaid, but they also might be eligible for a marketplace subsidy if their costs are unaffordable.

**Randy Crable:** One other thing, copays, are they included in the deductibles?

**Sara Collins:** We don't analyze copay separately, so this is just deductible size in premium contribution.

**Randy Crable:** Okay. Thank you.

**David Blumenthal:** Just to add, another generalization to thinking about this cost burden issue. The most difficult state or location for an employee and their family would be a state where wages are low and employers don't feel pressure or are not inclined to be generous in their sharing of healthcare cost. The way the market - the nature of the workers is a very important factor in this equation, that and of course healthcare cost, but I'd say that you don't want to be in a low-wage environment where there's an abundance of workers. [Pause]

**Randy Crable:** All right. Thank you.

**Operator:** Thank you. We'll move next to Sarah Hanserd with Bloomberg Law. Please go ahead.

**Sarah Hanserd:** Hi, thank you. Sara did mention that the primary driver of cost in employer plans is provider fees. As I'm sure you're aware, employers have been complaining for some time now that their costs have been going up well beyond inflation. I was wondering if you have any thoughts on that as well as the issue of high deductibles in ACA plans. The point that the administration makes a lot is that there's been a big increase. In fact, I think the biggest part of the increase in the uninsured is from people who

are over 300% of the poverty limit, which seems to indicate that if you don't get subsidies or if you don't get much [Unintelligible] subsidies and you're in the individual market, that that's a factor, but just on the employer side, any thoughts on the ACA deductible issue as well as employer cost?

**David Blumenthal:** On the topic of employer cost, employers are indeed in a real [bond] for capita cost that have been incurred by Medicare and Medicaid have been pretty stable since the enactment of the Affordable Care Act but for capita cost for employees have been going up. Utilization has been stable. The cost of the increased cost has been increasing prices. Employers have not found a way working with insurers to negotiate lower prices from the hospitals and doctors who supply services. There are a lot of reasons for that, and I don't know if you want to go into them all, but that's the core issue on the employer side with respect to increasing cost. They have, as a solution, transferred more cost unto their employees. There is a pretty widespread opinion right now that that approach to managing the cost of the healthcare benefits they provide has run its course and that continuing to shift those costs unto employees is no longer feasible, that they're getting [Audio Gap] where employees can't bear more of the cost. That's going to vary from place to place as our data suggest but speaking generally across the nation. So, they have a real dilemma right now, and they are going to have to come up with some innovative solutions. That's why you see the example of the alliance between Amazon, the Warren Buffett organization Berkshire Hathaway, and JP Morgan. It's in search of innovative ways to manage those prices. That's the issue with cost and price. Sara can...

**Sara Collins:** Just on the deductible issue, you raised a very good point. The Affordable Care Act subsidies have been effective in lowering deductibles for people under 250% of poverty, which is about \$30,000.00 for an individual, \$60,000.00-ish for a family of four, but when you go above that, there are no [cost during subsidies], so people are facing pretty high deductibles often in those plans. That is an increasingly shared issue among people on employer-based plans as these data point out. So, I think that just in terms of a policy solution and what we're seeing really among Democratic proposals at this point in the campaign is extending those subsidies, so both on the premium side and the cost-sharing side higher up the income scale, but I think critically also removing the employer-based insurance so-called firewall, so allowing people through this public option that's been discussed in employer plans, the ability to take advantage of those subsidies, the ability to buy in the individual market, so I think that that does collectively address some of the affordability issues we're seeing in the individual market and then also in employer-based plans for a lot of people that have middle incomes and are facing pretty high deductibles and premium cost.

**Sarah Hanserd:** Okay. Could I add one more question? The other question would be, that might take care of those people but it doesn't take care of the underlying healthcare cost issue, like I think David was talking about the hospitals when they have more beds that they just raise their cost, they don't seem to figure out a way to get cost down. That raises the amount of money that taxpayers have to spend on subsidies, but what about getting healthcare cost down?

**Sara Collins:** I think it's probably a paired challenge. I think policymakers do need to address the affordability issues people are facing particularly since it does

seem to be affecting people's ability to get their healthcare, but I think the cost issue is critically important. It is the major driver of these trends that we're seeing really in both markets.

**Sarah Hanserd:** Okay. Thanks a lot.

**David Blumenthal:** If I could just add some perspective on this issue. The reason for the recent rules on price transparency is to get at precisely this question. There are two theoretical approaches to dealing with prices. One is to enhance competition, and the other is to regulate prices. Maryland I think is the only state that still regulates healthcare prices. The administration is promoting a strategy of competition. I'm betting that if you make prices visible and knowable that people will shop for lower prices. That remains to be seen because the employers have never been effective at exerting market power to negotiate down prices. Right now, providers are very consolidated and have a lot of market power. Employers are fragmented and have very little market power. So, knowing prices will not be sufficient, in my view, in and of itself to give them the power to negotiate prices down.

**Sarah Hanserd:** Okay. Thank you.

**Sara Collins:** I think we're also seeing in states like Washington who are attempting to add a public option into the marketplaces in an effort to go to a more regulated approach or a reference pricing approach, so setting prices in those networks closer to Medicare rates or some percentage of Medicare rates.

**Sarah Hanserd:** Yes. That starts on 2021. All right. Thank you very much.



**Operator:** Thank you. We'll go next to [Jan Wang] what North Carolina Health News. Please go ahead.

**Jan Wang:** Hi, thank you. I know you've already addressed the Medicaid expansion question, but why are things just seem worse in the South? For instance, this high level of 11% seen nationally, North Carolina, we were at that in 2008 and now we're just getting worse, so what's special about the South that's causing these trends?

**Sara Collins:** So just looking at North Carolina as an example, North Carolina has a median income that's below the national average which is one of the drivers of the larger burden in that state. Premiums overall in North Carolina are actually below the national average, so both single and family coverage. But contributions, what people are paying for those premiums who are employees are spending on those premiums are somewhat above the national average and then when you – and the same is true for deductibles. The deductibles in North Carolina are higher than the national average. When you combine that with the relatively lower median income, you end up with a much bigger cost burden relative to states like Massachusetts that have higher incomes and actually somewhat lower premium contributions. So median income is a big part of the story, but as David mentioned earlier, it's also what employers are asking their employees to contribute in these states.

And obviously, this is a state average too. It's not the same in every region of North Carolina and every county, but on average, this seems to be the flavor that we're seeing.

**Yen Duong:** So it's like another state that has below national average median income but still has a pretty decent percentage that people are paying for their healthcare costs?

**Sara Collins:** Mississippi, I believe, is one that we highlighted at the end of the report. It's another state with a similar set of higher premium contributions, somewhat higher deductibles, but also one of the lowest median incomes in the country.

I guess too if you look at – I mean, you'll look at it more carefully when you're doing your analysis, but what people are spending, what people are required to contribute is as a – and particularly in family plans, in five states, it was more than a third of the overall cost and most of those states are actually in the South. Again, it's a combination of what people already have to contribute to their plans and the lower than national average median income.

**Yen Duong:** Thank you very much.

**David Blumenthal:** I'm from Massachusetts and as I look at where Massachusetts stands on this, Massachusetts has some of the highest costs in the country, maybe the highest costs for healthcare in the country but it also has very high incomes because of the quality of the jobs there. The fact that there's a big biotech, a big high-tech component to the employment, so it's a very competitive labor market and the result is a, even though the – So employers have to offer generous benefits in order to attract workers and the result is the high cost do not translate into a high share of work or burden. They may absolutely pay more but the burden as a percent of income is less.

**Yen Duong:** Thank you.

**Operator:** Thank you. We'll move next to Laura Garcia with San Antonio Express-News. Please go ahead.

**Laura Garcia:** Hi. I'm interested in the median. So for somewhere like Texas, you're going to be using the state median which I believe is around \$60,000.00. Like you said, it's going to be different in different regions, but in San Antonio for example, our median family income is \$49,000.00. What does that cost burden look like?

**Sara Collins:** That's a great question. I think it's important for now too, I appreciate your question because Texas is a really big state, so this is the average across the state, average across rural areas, average across lower income parts of urban areas. So there are clearly going to be people like in San Antonio who have lower incomes for which these costs are actually going to be if they're in employer-based plans are going to be a much larger share of their income.

**Laura Garcia:** [Pause] Okay. Thank you.

**Operator:** Thank you -

**Sara Collins:** But I'd also point out too, I mean, just the flipside of that too is that the premium cost, the deductible costs are also a statewide average. So it also may be the case in San Antonio that the premiums will be different from your statewide average; they could be lower, they could be higher, and the same is true with deductibles. [Pause]

**Operator:** Thank you. We'll move next to David Ress with Daily Press. Please go ahead.

**David Ress:** Hi, I guess this is me. My question was answered earlier, I thought I registered the # key on that. Thank you, though.

**Operator:** Thank you. We'll move next to Jonathan LaMantia with Crain's New York Business. Please go ahead.

**Jonathan LaMantia:** Hi, there. Thanks for taking my question. I just had sort of technical question about the data because it reported on the Commonwealth Fund's brief back in May using the current population survey and kind of gave like a directionally different impression of. So just looking at New York which is where I cover, it was below the national overage in cost and it was combined premium and deductible exposure was something like \$2,300.00; whereas in this report, it's up near \$6,300.00/\$6,400.00. So I was wondering if there are certain differences between the medical expenditure panel survey and the one that you based the May report on that might account for that kind of discrepancy.

**Sara Collins:** That's a really good question and I'll let Dave Radley jump in on that, but the current population survey so that I know that report that you're referring to, is a population-based survey. So those are people's reports of what they're paying both in premiums and deductibles; whereas, these data are reported by employers. These are premiums reported by employers and deductibles. It's a different survey, and you're right, it doesn't always match up. People's reports of what they pay may be different from what their employers are reporting. Again, these are

averages, so these are state averages and the same is true for the current population survey at the state level.

**David Radley:** Hi, this is David Radley and I'll just add that we also looked at something slightly different in the May report which was actual out-of-pocket spending that individuals faced, like the actual dollars that they paid. In this report, we're focusing more on what the deductible is, so, effectively their potential out-of-pocket (if you were to use the entire deductible, this is how much you would have spent).

So it could be that in New York State, if people have high deductibles and they are feeling like they can't afford to get care, they're actually forgoing care, then they would potentially actually spend less out-of-pocket, right, and that could account.

But if you wanted to, I'll just offer, if you wanted to follow-up offline, I'd probably want to take a look back at our May report just to refresh myself and we can talk a bit more about some of the details about that if you'd like.

**Jonathan LaMantia:** Sure, thank you.

**Sara Collins:** Dave highlights a really good point which is that on average, most people have very low out-of-pocket expenditures every year. It's really concentrated among higher spenders, the amount, out-of-pocket cost. So the deductible sits out there, but it doesn't mean that everyone's going to meet that deductible in a given year, but it does act, as we've seen in our survey data, as a disincentive for people to get healthcare.

**Jonathan LaMantia:** Thank you.

**Operator:** Thank you. We'll go next to Amy Lotven with Inside Health Policy. Please go ahead.

**Amy Lotven:** Hi! Thanks for taking the question. I actually have a couple and my first has to do with Exhibit 2, which I'm sort of obsessed with, but I paused the call for a little while and I may have missed what you said about it. But I was really wondering if you could explain a little bit about what was going on from 2016 to 2018 that had the drop in the increase in deductible. My second question has to do with more recent policies. I'm curious what you guys think about the recent policy that allows HSA-linked high-deductible plans to cover more services through deductible. Additionally, in the transparency rule, there were some changes to MLR for I think employer and fully insured plans that do value-based insurance design, so I'm curious how those will impact the future of employers [though through] coverage if you sort of think about that? Thank you.

**Sara Collins:** Right. So just on Exhibit 2, those are average annual rates of growth across a two-year period. The deductibles themselves aren't falling, it's the rate of growth, they're year-to-year growth. So what's really happening, you can see it in the next chart, deductibles have really not changed that much, and we've seen that in some of the Kaiser survey data too, they kind of have held kind of steady at a relatively high level. So they haven't come down, they just haven't grown as much in the last couple of years, but as a share of people's income, they're still relatively high. That's a change in the rate of growth across the two-year period.

**Amy Lotven:** Okay. But it does indicate, as you said, that this is the ending, the pressure has gotten so high, that they can't really increase anymore.

**Sara Collins:** Right. I think so and I think that some anecdotal evidence from employers, employer surveys are indicating that or they're just at a point where they've gone as high as they can on deductibles.

I think the other thing that they're seeing, the Employee Benefit Research Institute had a great piece out last week that actually their costs are concentrated on their high spenders and most people don't really spend that much, so the deductible, like I said, acts as a disincentive for people to get care but it's really not where the cost issue is. The cost issue is coming from high spenders and those pressures are coming really from overall cost trends.

**Amy Lotven:** Okay. Excellent. So kind of segue from that to the new policy about the HAS-linked high-deductible plan and [Crosstalk]

**Sara Collins:** Right, I think – That's great, and most employers and also in the individual markets too don't require or exclude certain services pre-deductible. California has actually standardized that in its marketplace plans, but most employers do exclude sets of services from deductibles, like certain kinds of prescription drugs. Obviously, the Affordable Care Act excluded preventive services; there's no cost sharing for those even if you haven't met your deductible. This change would enable people who have HSAs to have services excluded.

I guess the question is, why you wouldn't extend that to everybody who have high-deductible plans? Why limit it to just people who actually have

a savings account attached to that plan? But it certainly does help people in those plans who are facing high deductibles.

**Amy Lotven:** Okay, great. Thank you.

**Operator:** Thank you. We'll move next to Andy Davis with the Arkansas Democrat-Gazette. Please go ahead.

**Andy Davis:** Hey. I was wondering if you could talk about, I think you mentioned that the reason for the increase in cost recently is due to prices and not utilization. So what are some of the reasons for the increase in prices and what relationship, if any, does the cost have to the increase in coverage under the Affordable Care Act?

**David Blumenthal:** So the biggest source of increased cost in our healthcare system right now seems to be that increasing prices that are charged by providers of care to commercial insurers and that are passed on to employers. Prices and utilization in the Medicare program have been stable, relatively speaking, and that's also true in the Medicaid program. Together, those account for most of the people in the United States who have coverage.

So why are prices going up? Well, there are undoubtedly multiple explanations. The first is probably because they can. Let's say if you're running a business – let's not call it a healthcare business, let's call it some other kind of business – and your volumes of sales are declining, you can lower prices and try to increase volume, or you can increase prices and stay if you can't influence the volume.



It's very hard to increase prices when your volumes are falling in most businesses, but in healthcare, it's possible and that is a true peculiarity of the healthcare market. It's a conundrum and it reflects, as I said before, the disorganization of the purchasers, the what economists would call the inelasticity of demand, the fact that demand for healthcare is not price-sensitive for many services. There you have to keep in mind that 50% of spending is attributed to 5% of the population and that 5% of the population that has multiple chronic conditions, often complicated by behavioral health issues. So that 50% is not really elastic in its use of healthcare services. They are sick and they need care. Those are again peculiarities in the healthcare market.

The fact also is that even the biggest employers that you can imagine – think Walmart, think Amazon, the really big U.S. employers have very few markets where they have more than a very small fraction of the population. Amazon may dominate Seattle, but it doesn't dominate anywhere else and the same would be true with Walmart. They may dominate in certain parts of Arkansas, but they don't dominate anywhere else. So when they go to the local hospital and say, "Give us a better price," the local hospital says, "No, thanks," because they can live without that segment of the population. And if that's true for Walmart, it's true for everybody.

So that's the nature of healthcare markets. There's very little restraint on pricing. Add that to the fact that our studies show that 70% of hospital markets in the United States are highly concentrated, meaning that there's no competition, so people like the Walmarts of the world can't say to the hospital that refuse to lower prices, "Well, that's okay, we'll go to the

hospital down the street.” There is no hospital down the street. That is the nature of our healthcare market right now.

**Andy Davis:** I guess I still don’t understand why the costs had been slowing down and then increased all of a sudden.

**David Blumenthal:** It’s not costs that are increasing, it’s prices.

**Andy Davis:** All right, but so why does that happen with prices, like why do they all of a sudden start increasing more?

**David Blumenthal:** I think it has something to do with the fact that volumes have been falling so that you have to maintain your revenue. You have to make more per unit of service than you did before in order to maintain your bottom line.

**Sara Collins:** I guess too, I mean, and this is not new. I think there’s been a lot research that has shown that prices and when you just compare to other countries, the prices are a lot higher in the United States than they are in other countries. So it’s always been a feature of our healthcare system and it’s particularly visible, it has become increasingly visible. As David said, utilization has gone down yet costs are continuing to climb but it’s really driven by prices.

**Operator:** Thank you. We have no further questions in queue at this time.

**David Blumenthal:** Thank you very much for your attention and for the questions and thanks for listening. If you need additional information, we will be available this afternoon and, just to remind you, the embargo for this report lifts at 12:01 AM tomorrow.

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**END**