ISSUE BRIEF
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How Well Does Insurance Coverage Protect Consumers from Health Care Costs?

Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016

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ABSTRACT

ISSUE: The United States has made historic progress on insurance coverage since the Affordable Care Act became law in 2010, with 20 million fewer people uninsured. However, we must also measure progress by assessing how well people who have insurance from all coverage sources are protected from high health care costs.

GOALS: To estimate the number and share of U.S. insured adults who are "underinsured" or have out-of-pocket costs and deductibles that are high relative to their incomes.

METHOD: Analysis of the Commonwealth Fund Biennial Health Insurance Surveys, 2003–2016.

FINDINGS: As of late 2016, 28 percent of U.S. adults ages 19 to 64 who were insured all year were underinsured — or an estimated 41 million people. This is more than double the rate in 2003 when the measure was first introduced in the survey, and is up significantly from 23 percent, or 31 million people, in 2014. Rates climbed across most coverage sources, and, among privately insured, were highest among people with individual market coverage, most of whom have plans through the marketplaces. Half (52%) of underinsured adults reported problems with medical bills or debt and more than two of five (45%) reported not getting needed care because of cost.

KEY TAKEAWAYS

- In 2016, 28 percent of U.S. adults who were insured all year were underinsured — an estimated 41 million people. This is more than double the rate in 2003, and up significantly from 2014 when it was 23 percent, or 31 million people.
- The share of adults who were underinsured has climbed in each coverage group since 2003: employer-based (both large and small employers), individual market, Medicaid, and Medicare.
- Deductibles have become an increasingly large factor in underinsurance — more people than ever before have plans with deductibles and more have deductibles that are high relative to income.

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BACKGROUND

The Affordable Care Act (ACA) has transformed the health insurance market, allowing Americans who lack job-based health benefits access to affordable health insurance options. The law's coverage expansions and protections have reduced the number of uninsured adults by more than 20 million.

Congress intended for the ACA to do more than expand access to insurance; it aimed for the new coverage to allow people to get needed health care at an affordable cost. Accordingly, for marketplace plans, the law includes requirements toward that end: an essential health benefit package, cost-sharing reductions for lower- income families, and out-of-pocket cost limits.[1] For those covered by the law's Medicaid expansion, there is little or no cost-sharing in most states.[2]

For people covered by employer-based insurance — which includes more than half of Americans under age 65, or more than 150 million people[3] — plans were historically far more comprehensive and cost-protective than individual market coverage.[4] However, over the past decade, premium cost pressures have led companies to share increasing amounts of health costs with workers, particularly in the form of higher deductibles.[5] At the same time, income growth has been sluggish, leaving families increasingly pinched by health care costs.

In this issue brief, we focus on how well health insurance protects people from medical costs, using a measure of "underinsurance" from the Commonwealth Fund's Biennial Health Insurance Survey to examine trends from 2003 to 2016. Adults in the survey are defined as underinsured if they had health insurance continuously for the preceding 12 months but still had out-of-pocket costs or deductibles that were high relative to their incomes (see Box). The survey was conducted between July 12 and November 20, 2016. We examined underinsured rates across all coverage sources, including private (employer and individual market) and public (Medicaid and Medicare). It is the first time in this survey series that we are able to estimate underinsurance in the ACA's marketplace plans.

WHO IS UNDERINSURED?

In this analysis, we use a measure of underinsurance that takes into account an insured adult's reported out-of-pocket costs over the course of a year, not including premiums, and his or her health plan deductible. The measure was first used in the Commonwealth Fund's 2003 Biennial Health Insurance Survey. These actual expenditures and the potential risk of expenditures, as represented by the deductible, are then compared with household income. Specifically, a person who is insured all year is underinsured if:

- out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; or
- out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level ($23,760 for an individual and $48,600 for a family of four); or
- deductible is 5 percent or more of household income.

The out-of-pocket cost component of the measure is only triggered if a person uses his or her plan. The deductible component provides an indicator of the financial protection the plan offers and the risk of incurring costs before a person gets health care. The definition does not include people who are at risk of incurring high costs because of other design elements, such as exclusion of certain covered benefits and copayments. It therefore provides a conservative measure of underinsurance in the United States.

SURVEY FINDINGS

Estimated 41 Million Adults Are Underinsured

As of July 2016 through November 2016, 28 percent of U.S. adults ages 19 to 64 who were insured all year, or an estimated 41 million people, were underinsured (Exhibit 1, Table 1). This is more than double the rate in 2003 when the measure was first introduced in the survey, and is up significantly from 23 percent, or 31 million people, in 2014.[6]

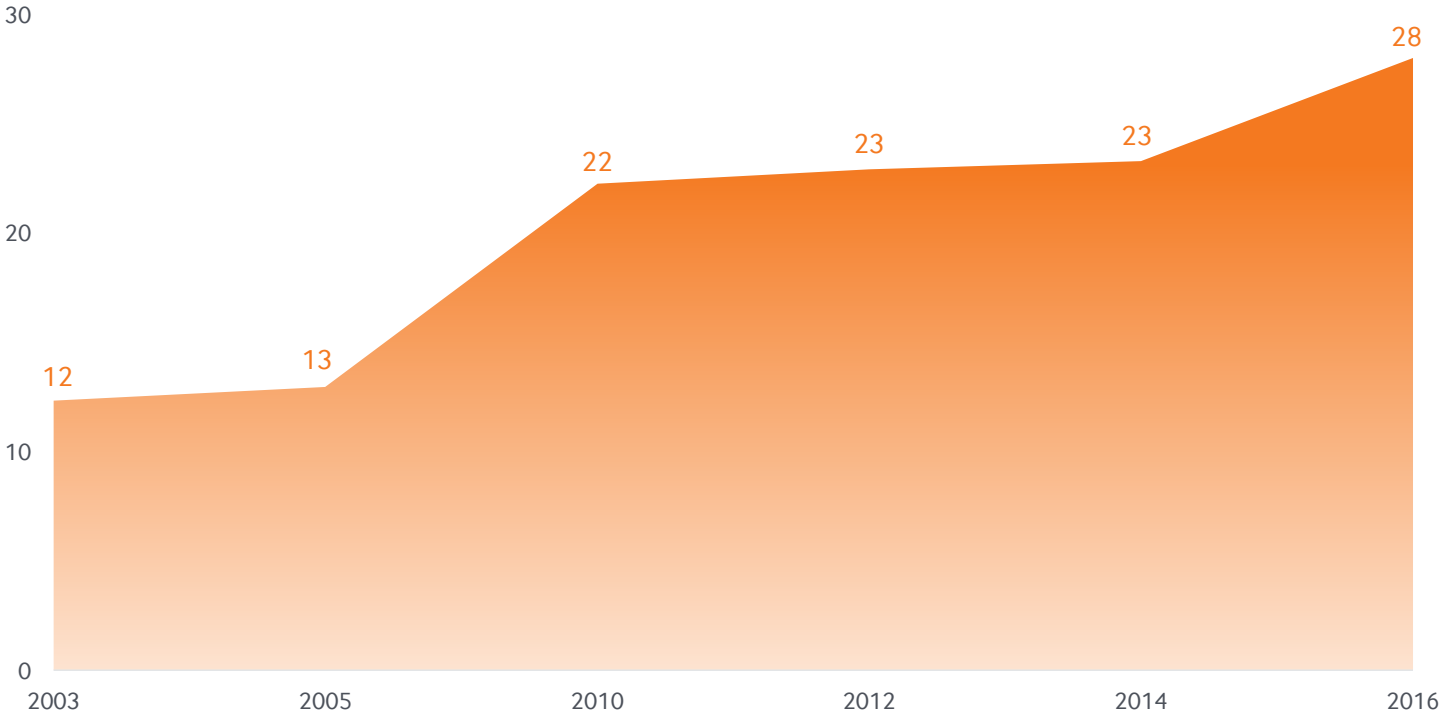
Underinsured rates by source of coverage. The underinsured population is predominantly composed of people in employer plans: 56 percent of underinsured adults had coverage through employers at the time of the survey (Table 2).[7] This reflects the fact that the majority of insured adults have employer coverage. However, people with coverage through the individual market, including the ACA marketplaces, and Medicare beneficiaries who are disabled adults under age 65, are disproportionately represented among the underinsured.

The share of adults who were underinsured has climbed over time in each coverage group. Among adults with employer-based coverage at the time of the survey, 24 percent were underinsured, which is more than double the rate in 2003, and is up significantly from 2014 (Exhibit 2). People working in small firms historically have had somewhat higher underinsured rates than employees of larger firms. But in 2016, the share of adults in firms with 100 or more workers who were underinsured climbed significantly to 22 percent — the same rate as among workers in small companies.

People with individual market coverage, including those in marketplace plans, are significantly more likely to be underinsured than people in employer plans. In 2016, 44 percent of adults with individual market policies, including marketplaces plans, were underinsured.

Exhibit 1. More Than One-Quarter of Insured Adults Were Underinsured in 2016

*Percent adults ages 19–64 insured all year who were underinsured**



* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

Exhibit 2. Underinsured Rates by Source of Coverage

*Percent adults ages 19–64 insured all year who were underinsured**	2003	2005	2010	2012	2014	2016
Total	**12%**	**13%**	**22%**	**23%**	**23%**	**28%**
Insurance source at time of survey**						
Employer-provided coverage	10%	12%	17%	20%	20%	24%
Individual coverage^	17%	19%	37%	45%	37%	44%
Marketplace^^	—	—	—	—	—	44%
Medicaid	22%	16%	32%	31%	22%	26%
Medicare (under age 65, disabled)	39%	24%	45%	32%	42%	47%
Firm size (*base: full- or part-time workers with coverage through their own employer*)^^^						
2–99 employees	—	14%	16%	26%	26%	22%
100 or more employees	—	11%	16%	16%	14%	22%

* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. ** Adults with coverage through another source are not shown here. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace. ^^ Adults enrolled in marketplace coverage are not shown for 2014 because no one in the sample would have had marketplace coverage for the full year. ^^^ Does not include adults who are self-employed. — Data not available.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

One-quarter (26%) of adults with Medicaid coverage — the poorest adults in the survey — were underinsured in 2016. Medicaid requires little cost-sharing, but because people eligible for the program have very low incomes, minor out-of-pocket costs can comprise a large share of income.

Adults under age 65 with Medicare who were continuously insured are by far the sickest group of covered adults in the survey — 77 percent have a chronic condition or are in fair or poor health — and the second-poorest after Medicaid enrollees (data not shown).[8] Many have very high health expenditures and low incomes. Almost half (47%) of adults in this group were underinsured in 2016.

Underinsured rates in the four largest states. The survey drew an additional sample of people in the nation's four most populous states.[9] Adults in Florida and Texas were underinsured at higher rates than those in California and New York. Among adults who were insured all year, 32 percent of Floridians and 33 percent of Texans were underinsured compared with 21 percent of Californians and New Yorkers (Exhibit 3, Table 3).

Differences in deductibles were a notable factor in the divide. Larger shares of adults in Florida and Texas had deductibles that were high relative to income compared to those in New York and California (Table 3). According to federal data, deductibles in employer plans are both more prevalent and higher on average in Florida and Texas than in California and New York.[10]

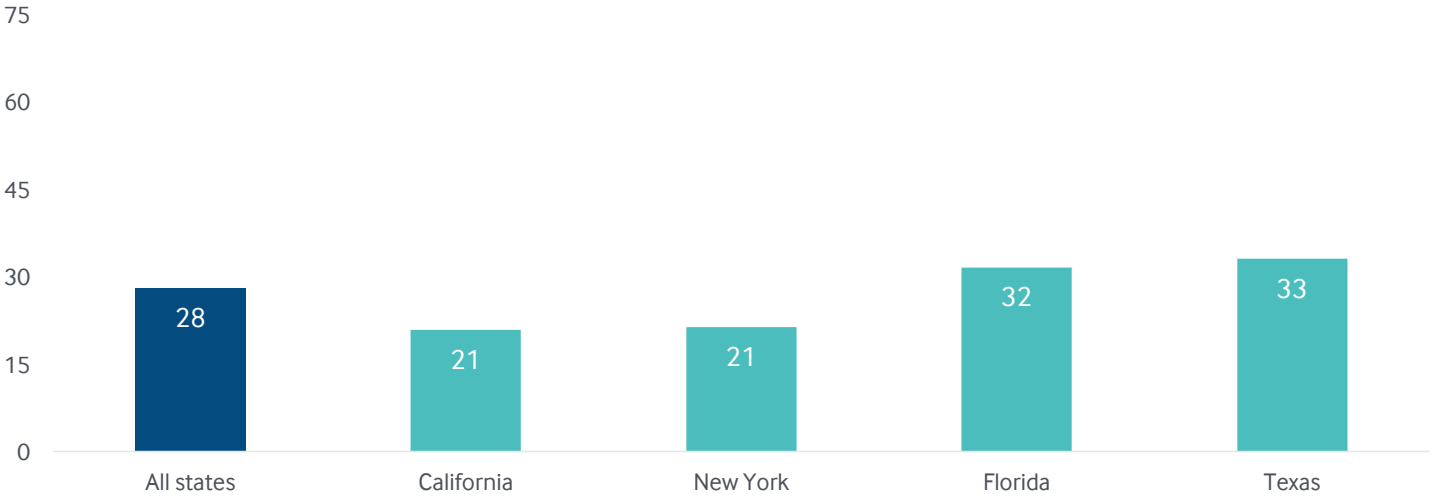
Higher Deductibles Are Increasingly a Factor in the Underinsured Rate

Between 2003 and 2016, deductibles were increasingly a factor in underinsurance: more people than ever before have plans with deductibles and more have deductibles that are high relative to income.

The share of privately insured adults who had health plans without deductibles has fallen by nearly half over the past 13 years, from 40 percent in 2003 to 22 percent in 2016 (Exhibit 4, Table 4). At the same time, deductibles have grown in size. By 2016, more than one of 10 (13%) adults enrolled in a private plan had a deductible of $3,000 or more, up from just 1 percent in 2003.[11]

Exhibit 3. In Florida and Texas, One-Third of Insured Adults Were Underinsured in 2016

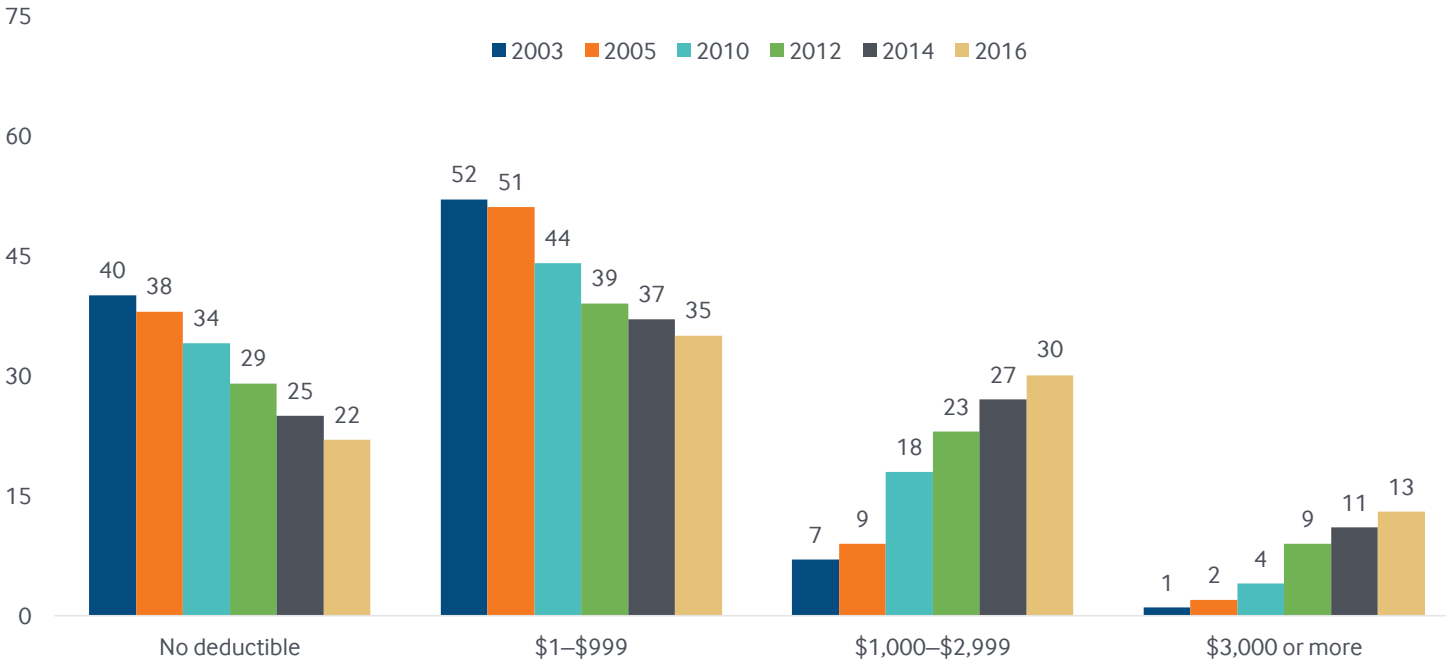
*Percent adults ages 19–64 insured all year who were underinsured**



* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Exhibit 4. Deductibles in Private Plans Have Grown over the Past Decade

*Percent adults ages 19–64 with private coverage**



* Base is those who specified deductible.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

Deductibles are outpacing growth in many families' incomes, and thus representing a greater share of income.[12] In 2016, 12 percent of adults with insurance coverage all year, or 18 million people, had a deductible that comprised 5 percent or more of their income, up from 3 percent, or 4 million people, in 2003 (Exhibit 5, Table 1).

High deductibles by coverage source. Deductibles that are high relative to income are more common in the individual market, but have grown increasingly prevalent in employer plans. Among those insured all year, about one-quarter of adults with individual market policies and marketplace plans had deductibles that equaled 5 percent or more of their income, up from 7 percent in 2003. Among people who had employer coverage, the share with a high deductible grew from 2 percent in 2003 to 13 percent in 2016 (Exhibit 5).

Large deductibles have been most common among small employers, but in 2016 the share of workers in large firms with high deductibles climbed significantly. Among adults with health benefits through their own employer who were working part-time or full-time in companies with 100 or more workers, the share with a high deductible relative to income climbed to 13 percent, the same rate as in small-employer plans.

When we examined the data more closely in the individual market, we found differences by income that likely reflect the effects of the Affordable Care Act's cost-sharing reductions. These reductions lower deductibles and other cost-sharing elements for lower-income enrollees in marketplace plans. In 2016, a smaller share of adults with incomes under 200 percent of poverty ($23,760 for an individual and $48,600 for a family of four) in the individual market had high deductibles relative to their income than did higher-income enrollees (data not shown). In contrast, in employer plans, lower-income enrollees have higher deductible burdens than do higher-income employees because the deductible amount does not vary with income. We have found a similar pattern in analyses of other survey data since the ACA's major coverage expansions in 2014.[13]

Exhibit 5. High Deductibles Relative to Income by Coverage Source

Percent adults ages 19–64 insured all year who had deductibles that were 5% or more of income	2003	2005	2010	2012	2014	2016
Total	**3%**	**3%**	**6%**	**8%**	**11%**	**12%**
Insurance source at time of survey*						
Employer-provided coverage	2%	2%	6%	8%	11%	13%
Individual coverage^	7%	12%	17%	30%	24%	23%
Marketplace^^	—	—	—	—	—	22%
Firm size (*base: full- or part-time workers with coverage through their own employer*)^^^						
2–99 employees	—	4%	6%	15%	20%	13%
100 or more employees	—	1%	5%	6%	8%	13%

* Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace. ^^ Adults enrolled in marketplace coverage are not shown for 2014 because no one in the sample would have had marketplace coverage for the full year. ^^^ Does not include adults who are self-employed.
— Data not available.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

Adults with Low Incomes or Health Problems Are at Greatest Risk of Underinsurance

People with low incomes in the United States are by far the most at risk of being underinsured. Among adults who had health insurance for the full year, 44 percent of those with incomes under 200 percent of the federal poverty level ($23,760 for an individual and $48,600 for a family of four) were underinsured in 2016, more than twice the rate of adults with incomes over 200 percent of poverty (20%) (Exhibit 6). Low-income adults comprised 61 percent of the 41 million underinsured adults in 2016 (Table 2).

People with health problems are also at greater risk of being underinsured because of their relatively higher health care costs. Among adults who were insured all year, more than one-third (34%) of those in fair or poor health or those with a chronic health problem were underinsured in 2016, compared to 23 percent of those in better health (Exhibit 6).

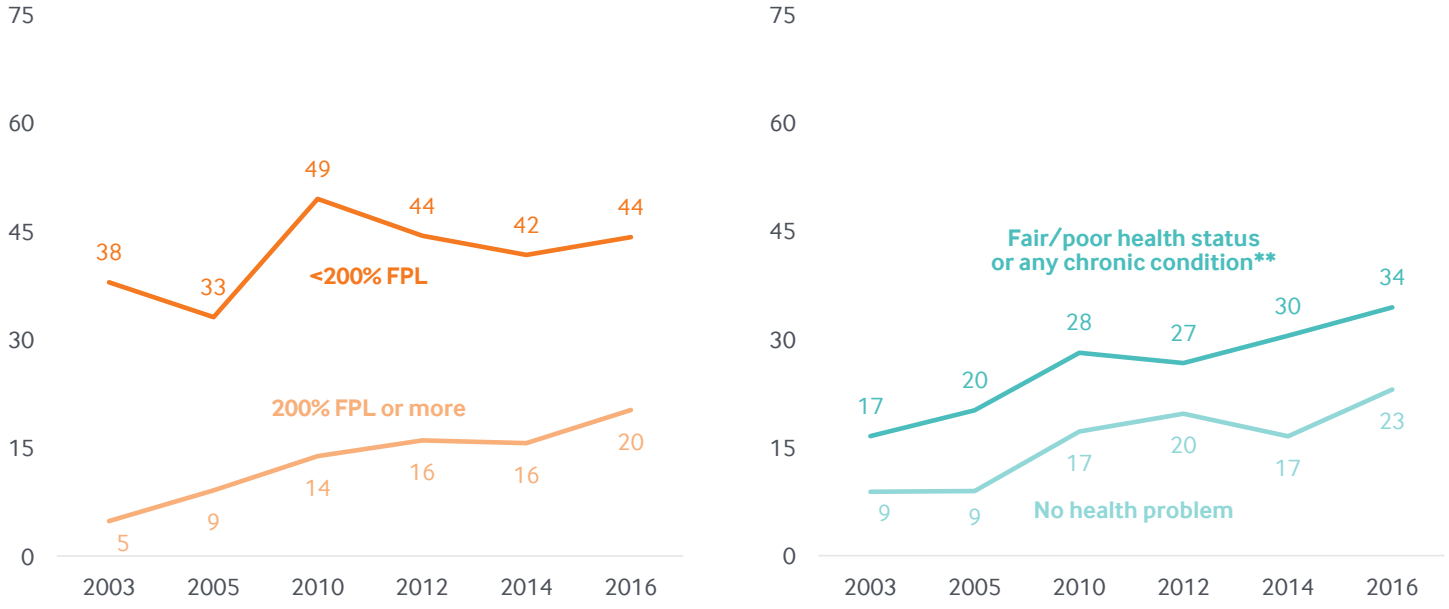
Underinsured Adults Have High Rates of Medical Bill Problems

Greater cost exposure is leaving Americans burdened with medical debt. Half (52%) of underinsured adults reported problems paying their medical bills or said they were paying off medical debt (Exhibit 7, Table 5). This is about the same rate as adults who lacked any coverage at all during the year and more than twice the rate reported by insured adults who were not underinsured (25%). The two states with the highest share of underinsured adults (Florida and Texas) also had the highest shares of insured adults who reported problems paying their medical bills (Table 3).

Among adults with private coverage who had been insured all year, those with high deductibles were more likely to report problems with medical bills than those with low or no deductibles. Two of five (40%) adults with a deductible of $3,000 or more said they had difficulty paying their medical bills or had accumulated medical debt compared with 21 percent of those who did not have a deductible (Exhibit 8, Table 5).

Exhibit 6. Underinsured Rates Highest Among Low-Income Adults and Those with Health Problems

*Percent adults ages 19–64 insured all year who were underinsured**



Notes: FPL refers to federal poverty level. Income levels are for a family of four in 2016.

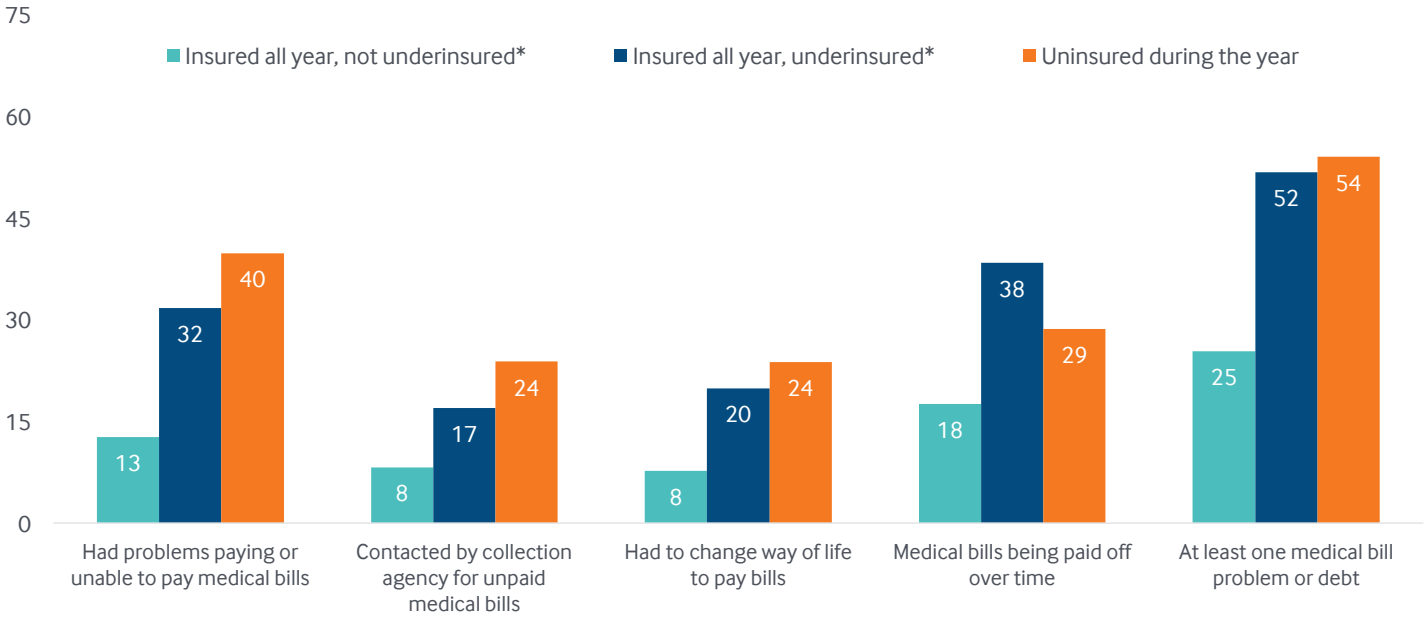
* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

** Respondent has at least one of the following health conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

Exhibit 7. More Than Half of Underinsured Adults Reported Medical Bill Problems, Close to Rate of Uninsured

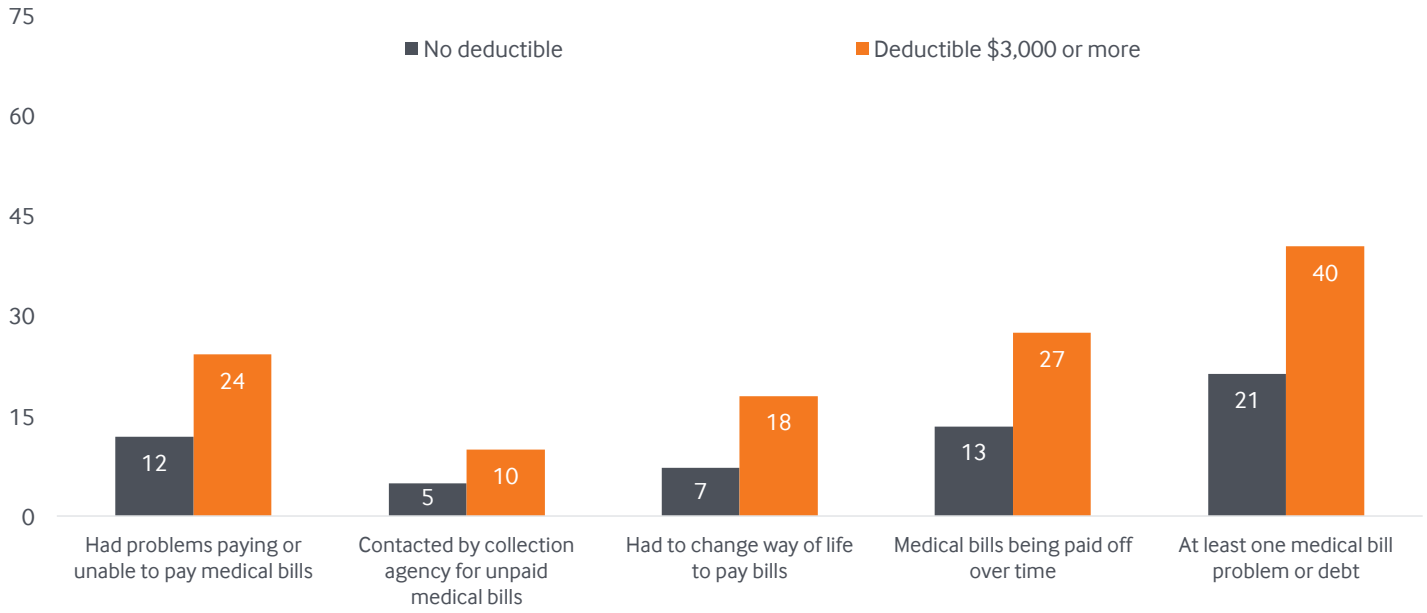
Percent adults ages 19–64



* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Exhibit 8. Adults with High Deductibles Reported Problems Paying Medical Bills at Twice the Rate of Adults Without Deductibles

Percent adults ages 19–64 with private coverage who were insured all year



Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Among adults who were paying off medical bills over time, those who had high deductibles were carrying the largest debt loads. Nearly two of five (39%) privately insured adults with deductibles of $1,000 or higher were paying off accumulated medical bills of $4,000 or more (Table 5).

Medical Bill and Debt Problems Have Long-Term Financial Consequences

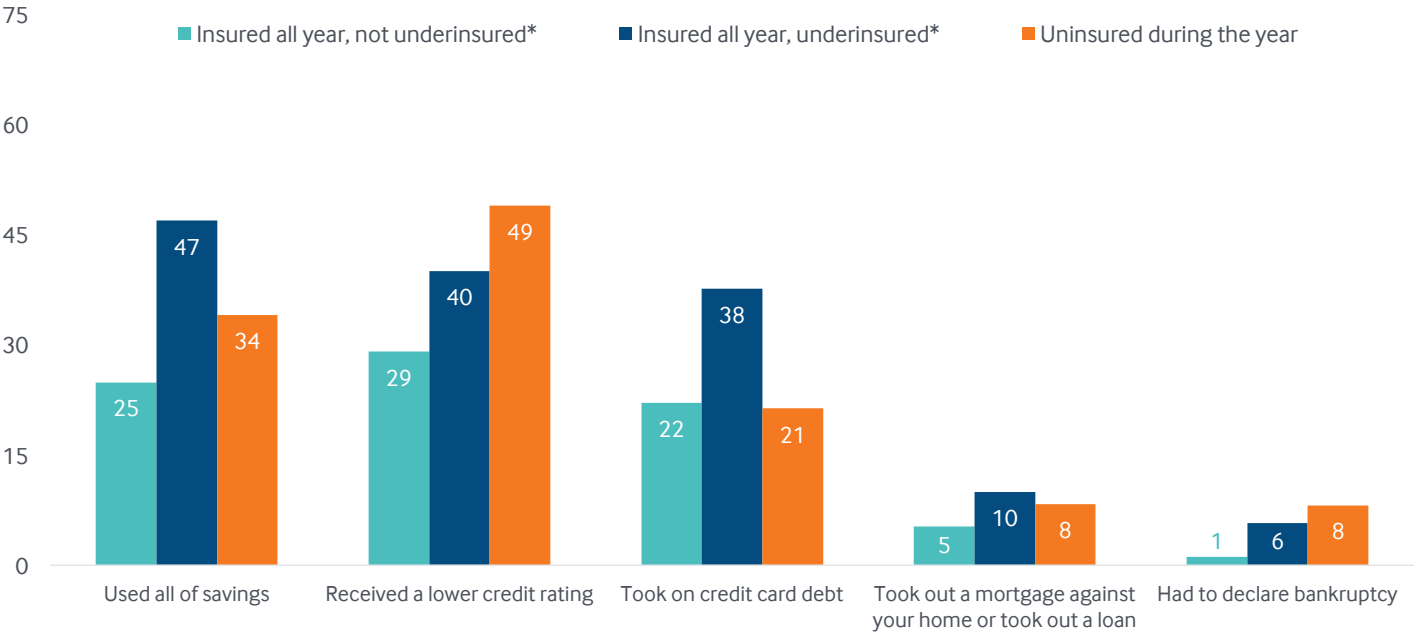
Many adults who have struggled to pay their medical bills report lingering financial problems. People who are either underinsured or uninsured have the highest rates of such problems: both groups had higher debt loads and lower incomes than adequately insured adults (data not shown). Half (47%) of underinsured adults who had problems paying medical bills or had medical debt said they had used up all their savings to pay their bills; 40 percent said they had received a lower credit rating because of their bills (Exhibit 9, Table 5). Over one-third (38%) of underinsured adults with medical bill problems said they had taken on credit card debt to pay bills. About 6 percent of underinsured adults reported they had to declare bankruptcy.

Underinsured Adults Report Not Getting Needed Care Because of Cost

Underinsured adults are more likely to skip needed health care because of cost than are adults with more cost-protective insurance. More than two of five (45%) underinsured adults reported not getting needed care because of cost in the past year, including not going to the doctor when sick, not filling a prescription, skipping a test or treatment recommended by a doctor, or not seeing a specialist (Exhibit 10, Table 6). This is twice the rate of continuously insured adults who were not underinsured (22%). It is also close to the rate reported by adults who were uninsured (52%). The two states with the highest share of underinsured adults (Florida and Texas) also had the highest shares of insured adults who reported cost-related problems getting needed health care (Table 3).

Exhibit 9. Adults with Medical Bill Problems Had Lingering Financial Problems

*Percent adults ages 19–64 who reported the following happened in the past two years because of medical bill problems^*

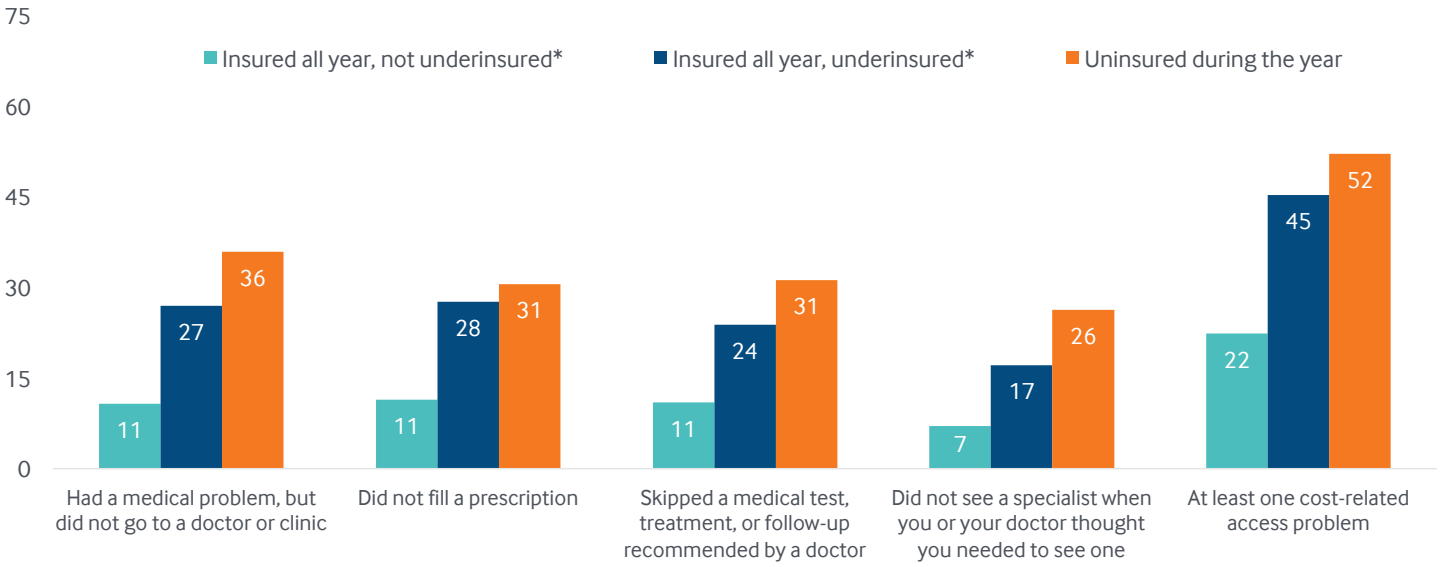


^ Base: Respondents who reported at least one of the following medical bill problems in the past 12 months: had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt. * Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Exhibit 10. More Than Two of Five Underinsured Adults Reported Problems Getting Needed Care Because of Cost

Percent adults ages 19–64



* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Privately insured adults who had health plans with high deductibles were more likely than those with no deductibles to report cost-related problems getting health care. More than two of five (47%) privately insured adults who were insured all year with a deductible of $3,000 or more reported not getting needed care because of cost compared with 22 percent of adults who did not have a deductible (Exhibit 11, Table 6).

Many underinsured adults with health problems reported difficulty getting appropriate care. Among underinsured adults with at least one chronic health condition, nearly a quarter (24%) said they had not filled a prescription for their condition or had skipped a dose of their medication because of cost, compared with 10 percent of those with adequate coverage. (Exhibit 12, Table 6).[14] Similarly, underinsured adults with chronic health conditions were more likely to say they had gone to the emergency room or stayed overnight in the hospital for their condition than were adequately insured adults with health problems.

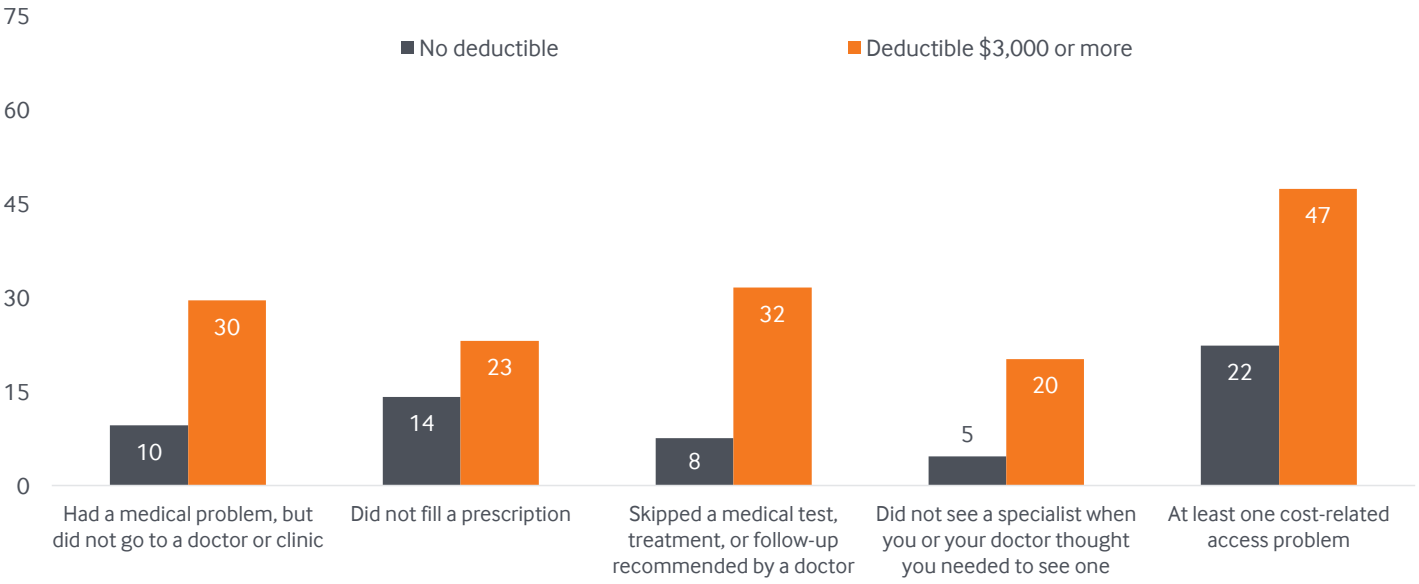
CONCLUSION AND POLICY IMPLICATIONS

Since the passage of the Affordable Care Act in 2010, the nation has experienced gains in coverage, as well as improvements on key indicators of access and medical bill problems.[15] These improvements reflect coverage gains — fewer people are exposed to the full cost of health care — as well as more comprehensive health plans with greater cost protection. This is especially true for low-income people covered by Medicaid and marketplace plans. But, as this analysis shows, the United States has not eliminated cost-related barriers to timely health care or protected people from medical debt. While these problems continue to be most apparent in the individual insurance market, they are increasing in the employer group market. Even public insurance programs like Medicare, which covers seniors and disabled people under age 65, leave many struggling to pay for health care.[16]

The latest Republican-led effort to repeal and replace the Affordable Care Act would have significantly increased

Exhibit 11. Adults with High Deductibles Reported Problems Getting Needed Care Because of Cost

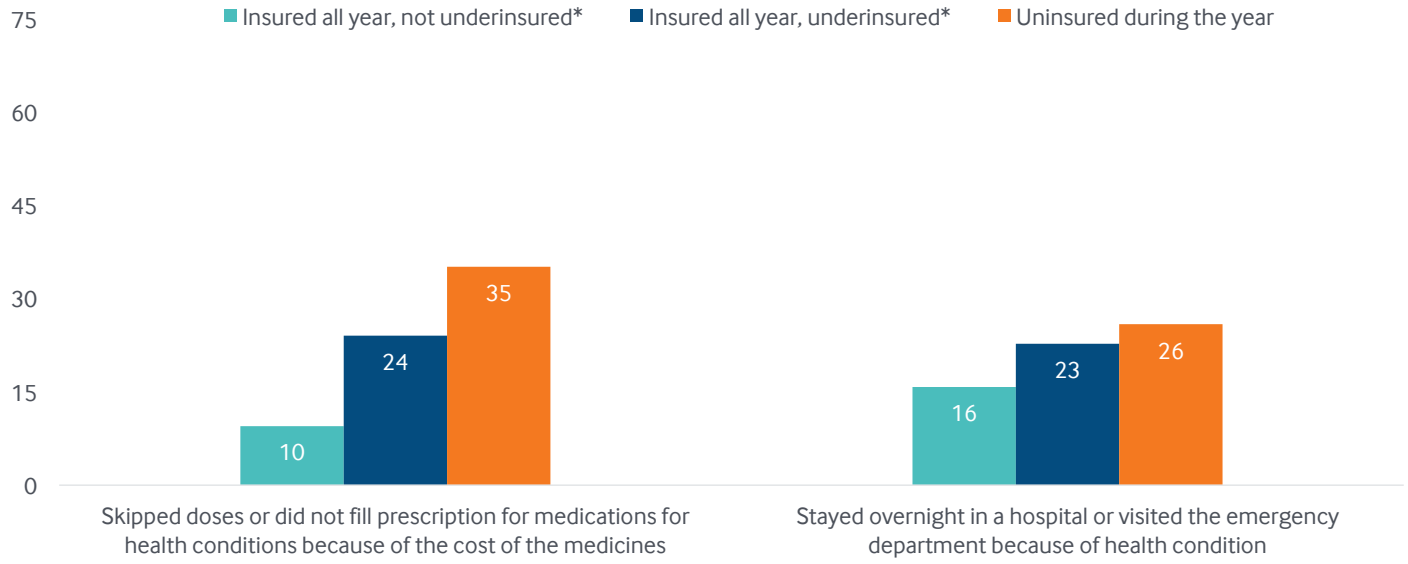
Percent adults ages 19–64 with private coverage who were insured all year



Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Exhibit 12. Nearly a Quarter of Underinsured Adults with Health Problems Skimped on Medications or Got Care in a Hospital or Emergency Department

*Percent adults ages 19–64 who have at least one health problem^*



^ Respondent has at least one of the following health conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; high cholesterol; depression or anxiety; chronic kidney disease or kidney failure; cancer, not including skin cancer; or a stroke. * Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

the cost of health care for many Americans. After that effort failed in September, the Trump administration took two major actions in October, which could also have the effect of increasing costs. The first was an executive order to federal agencies to write new regulations that would allow the sale of insurance products that skirt the ACA's consumer protections and cost-sharing standards.[17] In the second action, the administration ended the federal payments for the ACA's cost-sharing reductions.[18] At the other end of the political spectrum, Senator Bernie Sanders has introduced legislation that would phase out the ACA and eliminate most cost-sharing in a Medicare-for-All framework. Seeking middle ground, Senators Lamar Alexander and Patty Murray held hearings on stabilizing the marketplaces in September, which included an appropriation for the cost-sharing reductions. To reduce the number of underinsured people in our health system, we also suggest the following policy options:

For people in individual market and marketplace plans

- ***Increase the cost coverage of health plans.*** The law's cost-sharing reductions (CSRs) increase the actuarial value (the percentage of medical costs covered on average by a health plan) of the marketplace's silver level plans from 70 percent to as high as 94 percent for people with incomes under 250 percent of poverty ($30,150 for an individual and $61,500 for a family of four). The Commonwealth Fund has found that these reductions have been effective in lowering deductibles for those eligible to levels in employer plans.[19] To counteract the administration's executive order, Congress can immediately reinstate the cost-sharing reduction payments by making an appropriation. Since the Congressional Budget Office (CBO) has already assumed the cost of the CSRs in the federal budget baseline, the appropriation is a formality: it would not increase the federal deficit. To make health care more affordable for middle-class families, Congress could then consider extending the CSRs higher up the income distribution.

- ***Increase the number of services excluded from the deductible.*** Most plans sold in the individual market nationwide exclude certain services from the deductible, such as primary care visits and certain prescriptions.[20] In 2016, the U.S. Department of Health and Human Services (HHS) provided a standardized plan option for insurers that excluded eight services from the deductible at the silver and gold level. These include primary and specialty care visits, urgent care visits, mental health and substance-use disorder outpatient visits, and all prescription drugs. HHS or Congress could make these exceptions mandatory for all plans. Covered California, the California marketplace, requires all health plans sold in the marketplace to exclude all physician visits and outpatient services from the deductible.

- ***Simplify the metal tiers and increase premium tax credits.*** As an alternative to extending cost-sharing reductions to people above 250 percent of poverty, Congress could lower the number of metal tiers in the individual market from four to two at higher actuarial values. For example, insurers could be required to sell just gold and platinum plans, which have actuarial values of 87 percent and 94 percent and much lower deductibles and copayments than silver and bronze plans. Tax credits would adjust to reflect the plans' higher premium costs. This avoids the circuitous route of covering insurers' costs through the cost-sharing reductions. Premium tax credits could be increased and extended to people earning more than 400 percent of poverty.[21]

For people in employer plans

- ***Set a standard actuarial value for employer plans.*** Currently under the ACA, people in employer plans may become eligible for marketplace tax credits if the actuarial value of their plan is less than 60 percent. Congress could increase this level to 70 percent (the level of silver plans) or higher.

- ***Set standards for deductible exclusions in employer plans.*** Most employer plans exclude at least some services from their deductibles.[22] Congress could set a minimum set of exclusions that could resemble the current standard plan option for the marketplaces.

Addressing the Key Driver of Insurance Costs: Health Care Cost Growth

Health care costs are the single largest factor in the growth of private insurance premiums in the United States. Insurers and employers have tried to manage premium growth by making consumers increasingly responsible through higher deductibles and other cost-sharing vehicles. Advocates of this approach argue that with more skin in the game, consumers will help to slow cost growth by choosing more-efficient providers and being more selective in the services they use. But years of experience with high-deductible health plans in the U.S. has yielded scant evidence that such a strategy is effective. Instead, as the survey findings indicate, many consumers have responded to higher deductibles by avoiding needed health care and skipping their medications.

Innovations under way in the delivery system, some of which stem from the ACA, have helped slow the rate of growth in health care costs in the past few years. But moving the nation closer to the performance of other countries on both cost and health outcomes will require considerably more work.[23] While targeted consumer cost-sharing may help to reduce use of low-value health services, this approach is unlikely to be successful unless consumers are better informed on prices and the value of alternative approaches to their health care problems. Such information is largely unavailable. Evidence suggests that consumers cannot do the heavy lifting required to reduce the rate of growth in medical costs in the United States.

HOW THIS STUDY WAS CONDUCTED

The Commonwealth Fund Biennial Health Insurance Survey, 2016, was conducted by Princeton Survey Research Associates International from July 12 to November 20, 2016. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 6,005 adults age 19 and older living in the continental United States. A combination of landline and cellular phone random-digit dial (RDD) samples was used to reach people. In all, 2,402 interviews were conducted with respondents on landline telephones and 3,603 interviews were conducted on cellular phones, including 2,262 with respondents who live in households with no landline telephone access. Oversampling of the four largest states was conducted to reach a minimum of 1,000 interviews each in California, Florida, New York, and Texas.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. This report limits the analysis to respondents ages 19 to 64 (n=4,186), and much of the report focuses on adults who have been insured all year (n=3,268). Statistical results are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau's 2016 Annual Social and Economic Supplement.

The resulting weighted sample is representative of the approximately 187.4 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 14 percent response rate and the cellular phone component achieved a 10 percent response rate.

We also report estimates from the 2003, 2005, 2010, 2012, and 2014 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy that was used in 2016, except the 2003 and 2005 surveys did not include a cellular phone random-digit dial sample. In 2003, the survey was conducted from September 3, 2003, through January 4, 2004, among 3,293 adults ages 19 to 64; in 2005, the survey was conducted from August 18, 2005, to January 5, 2006, among 3,352 adults ages 19 to 64; in 2010, the survey was conducted from July 14 to November 30, 2010, among 3,033 adults ages 19 to 64; in 2012, the survey was conducted from April 26 to August 19, 2012, among 3,393 adults ages 19 to 64; and in 2014, the survey was conducted from July 22 to December 14, 2014, among 4,251 adults ages 19 to 64.

Table 1. Underinsured Indicators Among Adults Ages 19–64 Insured All Year, 2003, 2005, 2010, 2012, 2014, 2016

	Adults ages 19–64 insured all year											
	Percent						Estimated millions					
	2003	2005	2010	2012	2014	2016	2003	2005	2010	2012	2014	2016
Total (millions)	127	125	132	129	131	147	127	125	132	129	131	147
Percent distribution	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Unweighted n	2,341	2,326	2,206	2,417	3,032	3,268	2,341	2,326	2,206	2,417	3,032	3,268
Out-of-pocket medical expenses equal 10% or more of family annual income	7%	8%	15%	15%	13%	17%	9	10	20	19	17	24
Out-of-pocket medical expenses equal 5% or more of income if low-income*	8%	6%	12%	10%	12%	13%	10	7	16	14	15	19
Cumulative percent/millions, using two indicators above	*11%*	*11%*	*19%*	*18%*	*18%*	*21%*	*14*	*14*	*25*	*23*	*24*	*31*
Deductible equals 5% or more of income	3%	3%	6%	8%	11%	12%	4	4	8	11	14	18
*Cumulative percent/millions, using all three indicators***	*12%*	*13%*	*22%*	*23%*	*23%*	*28%*	*16*	*16*	*29*	*30*	*31*	*41*

* Less than 200% of the federal poverty level. ** Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductible equaled 5% or more of income.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

Table 2. Demographics of Adults Ages 19–64 Insured All Year, 2016

		Percent by demographic characteristics		Percent distribution by demographic characteristics	
	Total adults ages 19–64 insured all year	Insured all year, not underinsured*	Insured all year, underinsured*	Insured all year, not underinsured*	Insured all year, underinsured*
Total (millions)	147	106	41	106	41
Percent distribution	100%	72%	28%	100%	100%
Unweighted n	3,268	2,402	866	2,402	866
Age					
19–34	31	70	30	30	33
35–49	30	73	27	31	29
50–64	39	73	27	40	38
Poverty status					
Below 133% poverty	25	52	48	18	43
133%–249% poverty	17	64	37	15	22
250%–399% poverty	20	74	26	20	19
400% poverty or more	31	85	15	37	16
Below 200% poverty	38	56	44	30	61
200% poverty or more	55	80	20	60	39
Race/Ethnicity					
Non-Hispanic White	64	71	29	63	65
Black	12	73	27	13	12
Latino	13	74	26	14	12
Asian/Pacific Islander	4	79	21	5	3
Other/Mixed	5	58	42	4	7
Insurance source at time of survey					
Employer coverage	65	76	24	68	56
Individual**	10	56	44	8	16
Marketplace	6	56	44	5	10
Medicaid	11	74	26	12	11
Medicare	8	53	47	6	13
Health status					
Fair/Poor health status, or any chronic condition***	44	66	34	40	54
No health problem	56	77	23	60	46
Adult work status					
Full-time	56	77	23	60	47
Part-time	11	62	38	10	16
Not currently employed	32	68	32	30	37
Employer size^					
Self-employed	4	63	37	4	6
2–99 employees	22	78	22	22	22
100 or more employees	76	78	22	76	76

Notes: Categories may not sum to 100 percent because of "Don't know/Refused" responses. For insurance source at time of survey, we do not show adults who reported being insured through an "Other" category. * Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. ** Includes those who get their individual coverage through the marketplace and outside of the marketplace. *** At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol. ^ Base: Full- and part-time employed adults ages 19–64 with coverage through their own employer, except for those who were self-employed.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Table 3. Underinsured Indicators Among Adults Ages 19–64 Insured All Year in the Four Largest States, 2016

	Adults ages 19–64 insured all year				
	U.S. total	California	New York	Florida	Texas
Total (millions)	147	20	10	8	11
Percent distribution	100%	100%	100%	100%	100%
Unweighted n	3,268	585	627	479	476
Out-of-pocket medical expenses equal 10% or more of family annual income	17	11	11	17	20
Out-of-pocket medical expenses equal 5% or more of income if low-income*	13	10	11	14	16
Cumulative percent, using two indicators above	*21*	*15*	*17*	*22*	*25*
Deductible equals 5% or more of income	12	8	8	16	15
*Cumulative percent, using all three indicators***	*28*	*21*	*21*	*32*	*33*
Cost-related access problems and medical bill problems or debt					
At least one medical bill problem or debt^	33	25	26	36	41
At least one-cost related access problem^^	29	24	27	35	40

* Less than 200% of the federal poverty level.

** Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

^ Respondent reported experiencing at lease one of the following problems in the past 12 months: had problems paying or unable to pay medical bills; contacted by a collection agency for unpaid bills; had to change way of life in order to pay medical bills; or had outstanding medical debt.

^^ Respondent reported experiencing at least one of the following problems in the past 12 months because of cost: 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 visit doctor or clinic.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Table 4. Deductibles and Benefits Covered by Insurance Adequacy and Income, Adults Ages 19–64, 2016

				Insured all year			
	Total adults ages 19–64 currently insured	Total adults ages 19–64 privately insured	Total adults ages 19–64 insured all year	Not underinsured*	Underinsured*	Below 200% poverty	200% poverty or more
Total (millions)	165	120	147	106	41	56	80
Percent distribution	100%	100%	100%	72%	28%	38%	55%
Unweighted n	3,666	2,573	3,268	2,402	866	1,298	1,745
Annual deductible per person**							
No deductible	37	22	35	38	26	57	20
$1–$99	6	5	6	7	5	7	5
$100–$499	13	14	13	15	9	11	14
$500–$999	12	16	12	14	9	10	15
$1,000–$2,999	22	30	24	21	30	11	33
$3,000–$4,999	5	7	5	4	9	2	7
$5,000 or more	5	6	5	2	13	2	6
Insurance covers all or part of the following health care needs:							
Dental care	74	78	76	80	67	69	82
Child's dental care^	73	74	74	79	61	69	77

* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

** Limited to adults who are aware of their deductible amount.

^ Base: Respondent has children age 25 or younger.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Table 5. Medical Bill Problems by Insurance Continuity, Insurance Adequacy, and Deductible Level, Adults Ages 19–64, 2016

		Insurance continuity				Deductible levels among adults with private coverage who were insured all year						
	Total ages 19–64	Insured all year	Insured all year, not underinsured*	Insured all year, underinsured*	Uninsured during the year	Total adults with private coverage who were insured all year**	No deductible	$1–$999	$1,000–$2,999	$3,000 or more	<$1,000	$1,000 or more
Total (millions)	187	147	106	41	40	102	21	36	32	14	57	45
Percent distribution	100%	78%	56%	22%	22%	100%	21%	35%	31%	13%	56%	44%
Unweighted n	4,186	3,268	2,402	866	918	2,193	502	823	580	288	1,325	868
Medical bill problems in past year												
Had problems paying or unable to pay medical bills	23	18	13	32	40	17	12	16	18	24	14	20
Contacted by collection agency for unpaid medical bills	14	11	8	17	24	9	5	11	9	10	9	10
Had to change way of life to pay bills	14	11	8	20	24	11	7	9	13	18	9	15
Any of above three bill problems	*29*	*23*	*18*	*38*	*47*	*22*	*14*	*21*	*25*	*30*	*19*	*26*
Medical bills/debt being paid off over time	24	23	18	38	29	26	13	27	31	27	22	30
Any bill problem or medical debt	*37*	*33*	*25*	*52*	*54*	*33*	*21*	*33*	*38*	*40*	*29*	*38*
Base: Any medical debt												
Unweighted n	*1,020*	*756*	*415*	*341*	*264*	*551*	*54*	*223*	*178*	*96*	*277*	*274*
How much are the medical bills that are being paid off over time?												
Less than $2,000	41	42	48	36	37	42	–	52	35	–	51	34
$2,000 to less than $4,000	24	23	20	27	24	23	–	21	25	–	23	23
$4,000 to less than $8,000	15	15	14	15	16	16	–	8	22	–	7	24
$8,000 to less than $10,000	5	5	3	7	8	4	–	2	2	–	3	5
$10,000 or more	12	12	11	13	13	12	–	16	10	–	14	11
Was this for care received in past year or earlier?												
Past year	50	50	51	50	48	53	–	53	46	–	55	52
Earlier year	43	42	41	43	46	39	–	44	38	–	43	35
Both	7	7	7	8	6	8	–	2	16	–	2	13
Base: Any bill problem or medical debt												
Unweighted n	*1,573*	*1,065*	*609*	*456*	*508*	*723*	*86*	*280*	*221*	*136*	*366*	*357*
Percent reporting that the following happened in the past two years because of medical bills:												
Received a lower credit rating	39	34	29	40	49	30	–	34	25	29	33	26
Used up all of savings	34	35	25	47	34	35	–	29	34	47	31	38
Took on credit card debt	27	29	22	38	21	33	–	30	37	39	28	38
Unable to pay for basic necessities (food, heat, or rent)	23	19	15	24	31	16	–	21	11	16	19	13
Delayed education or career plans	20	18	13	25	25	18	–	17	19	21	16	20
Took out a mortgage against your home or took out a loan	8	7	5	10	8	8	–	7	10	9	6	10
Had to declare bankruptcy	5	3	1	6	8	3	–	3	2	4	3	2
Insurance status of person/s at time care was provided												
Insured at time care was provided	66	81	80	83	33	88	–	88	84	94	89	87
Uninsured at time care was provided	28	14	14	13	61	8	–	10	7	5	10	7
Other insurance combination^	1	1	<1	1	1	1	–	<1	2	<1	<1	1

* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

** Limited to adults who are aware of their deductible amount.

^ More than one person with medical bill problems and one person uninsured and the other insured.

– Sample size too small to show results.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Table 6. Access Problems by Insurance Continuity, Insurance Adequacy, and Deductible Level, Adults Ages 19–64, 2016

		Insurance continuity				Deductible levels among adults with private coverage who were insured all year						
	Total ages 19–64	Insured all year	Insured all year, not underinsured*	Insured all year, underinsured*	Uninsured during the year	Total adults with private coverage who were insured all year**	No deductible	$1–$999	$1,000–$2,999	$3,000 or more	<$1,000	$1,000 or more
Total (millions)	187	147	106	41	40	102	21	36	32	14	57	45
Percent distribution	100%	78%	56%	22%	22%	100%	21%	35%	31%	13%	56%	44%
Unweighted n	4,186	3,268	2,402	866	918	2,193	502	823	580	288	1,325	868
Access problems in past year												
Went without needed care in past year because of costs:												
Did not fill prescription	19	16	11	28	31	15	14	15	14	23	15	16
Skipped recommended test, treatment, or follow-up	18	15	11	24	31	15	8	14	14	32	12	20
Had a medical problem, did not visit doctor or clinic	20	15	11	27	36	16	10	14	17	30	13	21
Did not get needed specialist care	13	10	7	17	26	10	5	11	8	20	9	12
At least one of four access problems because of cost	*34*	*29*	*22*	*45*	*52*	*29*	*22*	*27*	*26*	*47*	*25*	*33*
Preventive care												
Regular source of care	88	93	93	93	72	93	91	92	94	92	92	94
Blood pressure checked in past two years ¥	90	94	94	93	75	95	93	94	97	95	93	96
Received mammogram in past two years (females age 40+)	68	72	74	66	47	73	76	78	64	80	77	70
Received Pap test in past three years (females ages 21–64)	73	74	75	72	68	79	75	81	82	75	78	80
Received colon cancer screening in past five years (age 50+)	58	62	62	62	37	64	61	64	61	71	63	65
Cholesterol checked in past five years ¥¥	74	80	80	78	51	83	76	82	87	86	80	87
Seasonal flu shot in past 12 months	43	47	48	47	28	46	46	46	46	48	46	46
Access problems for people with health conditions												
Unweighted n	*2,199*	*1,753*	*1,205*	*548*	*446*	*1,054*	*216*	*411*	*289*	*138*	*627*	*427*
Skipped doses or not filled a prescription for medications for the health condition(s)^ . . . because of the cost of the medicines?	19	14	10	24	35	12	9	13	10	20	12	13
Stayed overnight in a hospital or visited the emergency room because of [this/any of these] problem[s]^	20	18	16	23	26	14	23	12	12	14	16	13

* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

** Limited to adults who are aware of their deductible amount.

¥ In past year if respondent has hypertension or high blood pressure.

¥¥ In past year if respondent has hypertension or high blood pressure, heart disease, or high cholesterol.

^ Base: Respondents with at least one of the following health problems: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; high cholesterol; depression or anxiety; chronic kidney disease or kidney failure; cancer, not including skin cancer; or a stroke.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

NOTES

[1] With the exception of cost-sharing subsidies, these requirements also apply to health plans sold outside the marketplaces in the individual and small-group markets.

[2] S. Beutel, M. Gunja, and S. R. Collins, *How Much Financial Protection Do Marketplace Plans Provide in States Not Expanding Medicaid?* (The Commonwealth Fund, June 2016).

[3] Congressional Budget Office, *Updated Budget Projections: 2015–2025* (CBO, March 2015).

[4] The major insurance reforms in the Affordable Care Act are directed at the individual and small-group insurance markets where underwriting practices left many consumers and small businesses with poor health coverage or no coverage at all. But the law also extends some requirements to large-employer-based plans, including coverage of preventive services without cost-sharing, limits on out-of-pocket costs, and bans on lifetime and annual benefit limits. Low- and moderate-income workers in health plans with high cost-sharing are eligible for subsidized coverage through the marketplaces. Those with incomes under 138 percent of poverty are eligible for Medicaid in states that have expanded eligibility for their programs.

[5] S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel, *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch* (The Commonwealth Fund, Oct. 2016).

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

[7] This reflects the fact that most Americans have health insurance through an employer (see Table 2).

[8] People under age 65 may become eligible for Medicare if they are disabled and are receiving Social Security Disability Insurance or have been diagnosed with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS).

[9] M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *Insurance Coverage, Access to Care, and Medical Debt Since the ACA: A Look at California, Florida, New York, and Texas* (The Commonwealth Fund, March 2017).

[10] S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel, *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch* (The Commonwealth Fund, Oct. 2016).

[11] Sample is limited to those who knew their deductible amount.

[12] S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel, *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch* (The Commonwealth Fund, Oct. 2016).

[13] S. R. Collins, M. Z. Gunja, and M. M. Doty, *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? — Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017* (The Commonwealth Fund, Sept. 2017).

[14] Respondents had at least one of the following health conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

[15] S. R. Collins, M. Z. Gunja, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016* (The Commonwealth Fund, Feb. 2017); and B. W. Ward, T. C. Clarke, and J. S. Schiller, *Early Release of Selected Estimates Based on Data from the January–June 2016 National Health Interview Survey* (National Center for Health Statistics, Nov. 2016).

[16] C. Schoen, K. Davis, and A. Willink, *Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status* (The Commonwealth Fund, May 2017).

[17] D. Palanker, K. Lucia, and E. Curran, "New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market," *To the Point,* The Commonwealth Fund, Oct. 11, 2017; and T. Jost, "Trump Executive Order Expands Opportunities for Healthier People to Exit ACA," *Health Affairs Blog,* Oct. 12, 2017.

[18] S. R. Collins, "A One-Two Punch to the Health Insurance Marketplaces and the People They Cover," *To the Point,* The Commonwealth Fund, Oct. 13, 2017.

[19] S. R. Collins, M. Z. Gunja, and M. M. Doty, *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? — Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017* (The Commonwealth Fund, Sept. 2017).

[20] M. Z. Gunja, S. R. Collins, and S. Beutel, *How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services* (The Commonwealth Fund, March 2016).

[21] J. Liu and C. Eibner, *Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults* (The Commonwealth Fund, July 2017).

[22] J. Gabel, H. Whitmore, M. Green et al., *Consumer Cost-Sharing in Marketplace vs. Employer Health Insurance Plans, 2015* (The Commonwealth Fund, Dec. 2015).

[23] E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care* (The Commonwealth Fund, July 2017).

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