Statement by

Stephen Finan
American Cancer Society Cancer Action Network

Before
Senate Commerce, Science and Transportation Committee
December 1, 2010

Hearing: Are Mini-Med Policies Really Health Insurance?

Introduction

Good afternoon, Mr. Chairman, Ranking Member Hutchinson and distinguished members of the Committee. My name is Stephen Finan, Senior Director of Policy at the American Cancer Society Cancer Action Network (ACS CAN). We are the advocacy affiliate of the American Cancer Society, a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and services.

ACS CAN is grateful for the committee's interest in so-called "mini-med" health insurance plans. Throughout the health care reform debate over the past two years, ACS CAN's goal was to use the "cancer lens" to bring national attention to significant problems in the nation's health care system. One of the less visible but very significant problems that we see among cancer patients is being "underinsured" – having insurance that offers too little coverage to fully address the needs of a serious medical condition like cancer.

Today, I'd like to share with you what our organization has learned about the underinsured and paint a picture – all too common in America – of how cancer patients and survivors with inadequate insurance face barriers to and financial burdens from getting the quality health care they need to fight their disease.

American Cancer Society's Commitment to Access to Care

Cancer death rates have decreased by 21 percent among men and 12 percent among women since the early 1990s. Despite this significant progress, the American Cancer Society realizes that its long-term goals of reducing the incidence and mortality of cancer cannot be achieved unless the coverage gaps that exist within the current health care system are addressed. The challenge lies in the fact that even among those who are considered insured, more than 25 million are underinsured. Many underinsured are left with the extraordinary dilemma of either incurring serious and potentially ruinous out-of-pocket financial expenses to obtain

necessary treatment, or curtailing essential treatment, thereby putting their health and possibly their lives in jeopardy.

Defining Adequate Health Insurance

The issue of underinsurance is an under-appreciated, and at times overlooked, problem of adequacy of coverage. As defined by the American Cancer Society, adequate health insurance ensures timely access to the full range of evidence-based health care services, including prevention and primary care necessary to maintain health, avoid disease, overcome acute illness, and live with chronic illness. These services encompass the complete continuum of evidence-based cancer care for treatment and support needs, including clinical trials. Coverage should be comprehensive and protect the individual from incurring catastrophic expenditures.

Cancer and the "Underinsured"

So what does being underinsured really mean for a cancer patient with a mini-med health insurance policy?

Cancer is approximately 200 separate diseases, and not surprisingly, the costs of treatment can vary enormously. However, it is possible to provide examples of costs that illustrate the problem of underinsurance.

In 2009, ACS CAN commissioned a study by the Georgetown Health Policy Institute to examine the adequacy and transparency of coverage under the Blue Cross Blue Shield standard option plan offered through the Federal Employees Health Benefit Program for four serious medical conditions: stage II breast cancer; stage III colon cancer; myocardial infarction (heart attack); and type I diabetes. It compared coverage features to simulated claims scenarios developed to illustrate potential care needs of patients with serious and chronic conditions, and estimated what patient out-of-pocket treatment costs would be under the plan.

In the scenario used in the study for the breast cancer case, the disease was detected following a routine screening mammogram. Approximately 30 percent of breast cancers are diagnosed as stage II.[3] Standard treatment for this patient would include breast conserving surgery (lumpectomy), chemotherapy, radiation therapy, and hormone therapy, as well as various medications and a wig are prescribed for treatment side effects. The patient also receives short-term counseling for depression. From start to finish, these treatments would take place over 87 weeks. Hormone therapy (taken orally) and other follow-up care and screening would continue beyond this time frame.

Under this scenario, estimated allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, institutions, and suppliers total approximately $111,300.

For the stage III colon cancer case, the male patient undergoes surgery to remove the affected part of his colon. He then undergoes 12 rounds of chemotherapy, involving a combination of drugs at two-week intervals. As often happens with colon cancers diagnosed at later stages, the cancer does come back and screening indicates it has spread to the liver.[3] The patient is

hospitalized for a second surgery to remove the tumors, and then resumes chemotherapy. A series of subsequent treatments fail and active treatment then ceases. The patient is referred to hospice care and he dies eight weeks later.

From diagnosis to date of death, care takes place over 124 weeks at an estimated cost of $252,433.

The two other scenarios in the study cover coronary artery disease and diabetes. Under the scenarios outlined in the study for the heart disease patient the estimated allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, institutions, and suppliers total about $77,800. For the diabetes scenario, the patient has well controlled diabetes. For a patient with this type of diabetes self-management needs, the charge for any single item or service is relatively modest, but ongoing. For example, test strips cost approximately $1 each, but the patient would use about 1,400 strips per year. Under this scenario, allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, labs, and pharmacies total over $7,100 for one year.

So what does this mean for a patient with a mini-med policy that has a $2,000 or $10,000 annual limit? Recognizing that these expenses will likely occur over two years, a person with the stage II breast cancer who received the full course of treatment could face over $90,000 in out of pocket expenses, and the colon cancer patient could face $220,000 in out of pocket expenses. Obviously, such expenses are not financially viable for middle-income families.

The problem of paying costly medical bills affects middle-class families, particularly those with chronic diseases such as cancer. Often insurance policy deductibles, co-payments and limits on health services may leave cancer patients without access to the timely, lifesaving treatment they need. Cancer patients may have to deal with major financial burdens because of out-of-pocket costs in addition to their cancer diagnosis.

Earlier this year, ACS CAN commissioned a nationwide poll among households with a cancer patient age 18 or older. Among the findings:

- Half of families with someone under 65 with cancer (49%) say they have had difficulty affording health care costs, such as premiums, co-pays, and prescription drugs in the past two years.

- Nearly one-third of families with someone under 65 with cancer (30%) have had trouble paying for basic necessities or other bills, and 23% have been contacted by a collection agency. About one in five (21%) has used up all or most of their savings, and one in six (18%) has incurred thousands of dollars of medical debt.

- As a result of costs, one in three individuals under age 65 diagnosed with cancer (34%) has delayed needed health care in the past 12 months, such as putting off cancer-related tests or treatments, delaying cancer-related check-ups, not filling a prescription, or cutting pills. Of those currently in active cancer treatment, one in three (33%) has put off some type of health care in the past due to costs.

- Four in ten families (42%) with insurance say their premiums and/or co-pays have increased in the past 12 months for the family member with a cancer diagnosis, and one in four (25%) says his or her deductible has gone up.

- One-third (34%)of those under age 65 said they had problems with insurance coverage of cancer treatment such as the plan not paying for care or less than expected, reaching the limit of what the plan would pay, or delaying or skipping treatment because of insurance issues.

A 2006 study analyzed data from the Medical Expenditures Panel Survey (MEPS).[1] The MEPS household survey, sponsored by the Agency for Health Care Research and Quality (AHRQ), collects information from the non-elderly, non-institutionalized U.S. population. The survey asked American families questions about health insurance coverage, health care utilization, and health care expenditures. In this study, the researchers defined "underinsured" as people with insurance spending 10 percent or more of their tax-adjusted family income on health care services, including insurance premiums. Nearly 1 in 3 (28.8 percent) cancer patients who are insured have an out-of-pocket health care burden that exceeds 10 percent of their family income. More than 1 in 9 cancer patients with insurance have out-of-pocket health care burdens exceeding 20 percent of their family income in health care expenditures. It is important to note that this definition of underinsured only measures those who actually spent more than 10 percent of their income on health services. There are undoubtedly many more people who didn't spend more than that for financial reasons but instead chose to curtail necessary services. Though uncounted, these people, too, are underinsured.

Cancer patients with inadequate coverage have higher medical costs and must deal with the additional stress of financial instability. A 2006 survey of cancer patients and their families found that one in five cancer patients with insurance uses all or most of their savings when dealing with the financial costs of cancer.[2] Medical debt is an important cause of bankruptcy filing in the U.S. Another study examined the causes of bankruptcy and found that 1.9-2.2 million Americans experienced bankruptcy related to medical problems in 2001.[3] Among those with illnesses that led to bankruptcy, their out-of-pocket costs average $11,854 and three-quarters had insurance at the time of their diagnosis. Among those interviewed with medical bankruptcy, 1 in 10 of the families had a cancer diagnosis.

Despite having insurance, many cancer patients and survivors experience major financial burdens. The situation of the underinsured is difficult to measure because wide variation exists among health insurance plans and people do not realize they are underinsured until they have a health crisis such as cancer. Furthermore, studies like the one I previously mentioned

---

Facing Cancer in the Health Care System. Lake Research Partners and Bellwether Research & Consulting, June, 2009. The sample size was 1,011.

[1] Banthin JS, Bernard DM. Changes in financial burdens for health care: National estimates for the population younger than 65 years, 1996 to 2003. *JAMA* 2006; 296: 2712-19.

[2] *USA Today*, the Kaiser Family Foundation, the Harvard School of Public Health. National survey of households affected by cancer, August 1 – September 14, 2006.

[3] Himmelstein DB, Warren E, Thorne D, Woolhandler S. Illness and injury as contributors to bankruptcy. *Health Aff* 2005; Web exclusive: 63-73.

use a narrow definition to measure the number of underinsured. While we use these studies to talk about the underinsured, they do not illustrate the whole picture.

The Health Insurance Assistance Service

The Health Insurance Assistance Service (HIAS) is a service offered through the American Cancer Society's National Cancer Information Center (NCIC) in Austin, Texas. HIAS is a free resource that connects callers with health insurance specialists who work to address their needs. The health insurance specialists at NCIC handle inquiries about health insurance, coverage dynamics, and state programs – all specific to the caller's needs. To date HIAS has logged more than 30,000 calls from all 50 states and the District of Columbia. Unfortunately, HIAS is able to help relatively few people to actually find coverage because the current health insurance coverage is often unavailable to cancer patients due to pre-existing condition clauses and when available, is often unaffordable for middle-class Americans.

Many calls received by HIAS are from people recently diagnosed or in treatment for cancer. The primary problem for these people is affordability—the accumulation of co-pays and deductibles has reached a level that they can no longer afford. Few programs exist that alleviate the financial burdens of out-of-pocket costs or provide care when a patient reaches a benefit limit within their insurance policy. In addition, the Society receives calls from patients that have reached the limit of their benefits or need additional services that are not covered by their plan. Among the calls from insured cancer patients, nearly three-quarters (71%) stated their insurance was inadequate to meet their medical needs.

Within the HIAS database, we are seeing callers who are reaching annual or lifetime limits on coverage. With the variation in insurance policies, there are many types of caps on coverage, including overall limits on benefits and limits on specific types of benefits such as outpatient visits.

The following are just two examples of patients we've heard from who are having the make the tough choice between saving their life or their lifesavings:

Orlin is a 61-year-old Iowa man who was recently diagnosed with recurrent prostate cancer. His insurance plan through his job at an international security company has a $3500 annual cap on benefits and a $250 annual maximum on prescriptions. Orlin quickly exceeded these limits and now pays out-of-pocket for his treatment. He and his wife have already amassed $25,000 in medical debt.

Brian is a 25-year-old man from South Carolina who was recently diagnosed with testicular cancer. He is a full-time college student and works part time at a big box retail store. The employer-sponsored benefit plan he has from his job has a $10,000 annual limit on benefits. While he has already exceeded that limit and now has to pay for his treatment out of pocket, he continues to pay the premiums, so he can keep his limited-benefit plan in the new year.

Underinsurance and the Affordable Care Act

The Affordable Care Act (ACA) makes tremendous strides toward eliminating the kinds of problems that arise from mini-meds and other plans that offer inadequate coverage. The law

provides a framework for an essential benefits package; it eliminates lifetime limits and phases out annual limits by 2014; and most importantly for many of today's enrollees in mini-med plans, it offers subsidies to assist individuals and families below 400% of the federal poverty level, and there will be out-of-pocket limits in all plans, except those that are grandfathered. And finally, the ACA makes great strides in empowering consumers with information, such as enhancing consumer disclosures, rating plans in the exchanges, and standardizing administrative processes.

Last June, HHS issued an interim final regulation regarding annual limits. It set a minimum limit of $750,000 for plans years after September 23, 2010, and those limits will rise each year through 2013 until they reach $2 million. There is no annual limit in plans after 2014 The regulation also recognized that some plans which currently have much lower annual limits might not be able to comply without imposing significant premium increases or reductions in benefits. Thus, plans can request a waiver. In September, HHS issued guidance on waivers, and since then, it is our understanding that over 100 plans with approximately 1.2 million enrollees have been granted waivers as of November 1.

We recognize the dilemma that exists. Clearly, plans with limits as low as $1,000 are of little value to a person with cancer. Such plans provide the appearance of insurance, but they provide no protection against potential financial ruin. Nonetheless, no one wants to see massive disruptions in the market as we transition to the full insurance reforms in 2014,and therefore, waivers may be warranted for some plans.

A waiver, though, should come with some obligations on the part of the plans. Last month, HHS issued guidance requiring plans to notify enrollees of a waiver including an explanation of the reason for it and the protection that would otherwise have applied. This is a critical step toward consumer education and empowerment. We commend HHS for taking this step toward consumer education and transparency, and we strongly believe the administration should be even more expansive in increasing disclosures and insurer transparency in the coming months and years. However, we strongly believe that HHS must take steps to require plans with waivers to improve their products between now and 2014; a waiver this year should not be a free ride until then.

The mini-meds are a perfect example of why health care reform is so crucial. Adequate coverage at affordable prices is no longer attainable for many Americans. If we want all Americans to have meaningful access to quality health care, we need to change the insurance market rules, provide subsidies, streamline administrative processes and greatly increase transparency and accountability. The Affordable Care Act provides a solid framework for achieving these goals, and it is ACS CAN's intent to work with all interested parties to implement the law successfully so that the health system works for people with cancer and other serious medical conditions. We know we must find ways to work together with pragmatic intent to assure implementation helps improve health care for cancer patients and other groups.