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## **The Current Status of Employer Health Insurance Coverage in the United States**

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Current and Future Role of Federal Programs”

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# The Current Status of Employer Health Insurance Coverage in the United States

**Sara R. Collins, Ph.D.**  
**The Commonwealth Fund**

Thank you, Mr. Chairman, members of the Committee, for this invitation to testify today on the current status of employer health insurance coverage in the United States. My comments will focus on trends in enrollment, the share of employers offering health insurance to workers, the costs of insurance and health care for people who are enrolled in the plans, and policy options to improve workers' coverage.

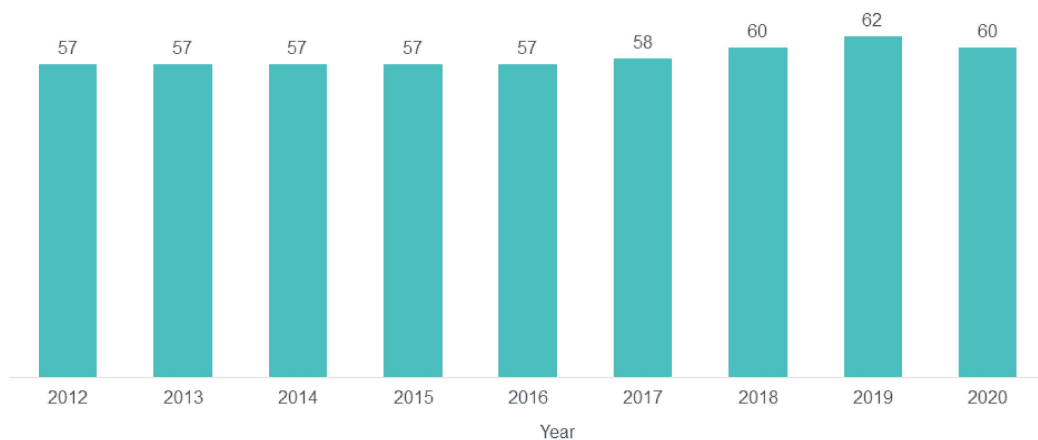
## Employer Health Insurance Is the Backbone of the U.S. Health Insurance System

Employer health insurance continues to be the primary source of insurance coverage for the majority of the U.S. population. More than half the population under age 65 — about 163 million people — get their health insurance through an employer, either their own or a family member's (Exhibit 1).<sup>1</sup>

Exhibit 1

More than half of the population under age 65 has coverage through an employer; there has been little change since the ACA became law.

*Employer-sponsored insurance (ESI) coverage (%), 0-to-64-year-olds, 2012–2020*



Note: Employer-sponsored insurance (ESI) estimates include single employer-sponsored insurance and dependent employer-sponsored insurance.  
Data: Current Population Survey (CPS), 2013–2021.



Source: Analysis of the Current Population Survey, 2013–2021, by Sherry Glied of New York University for the Commonwealth Fund.

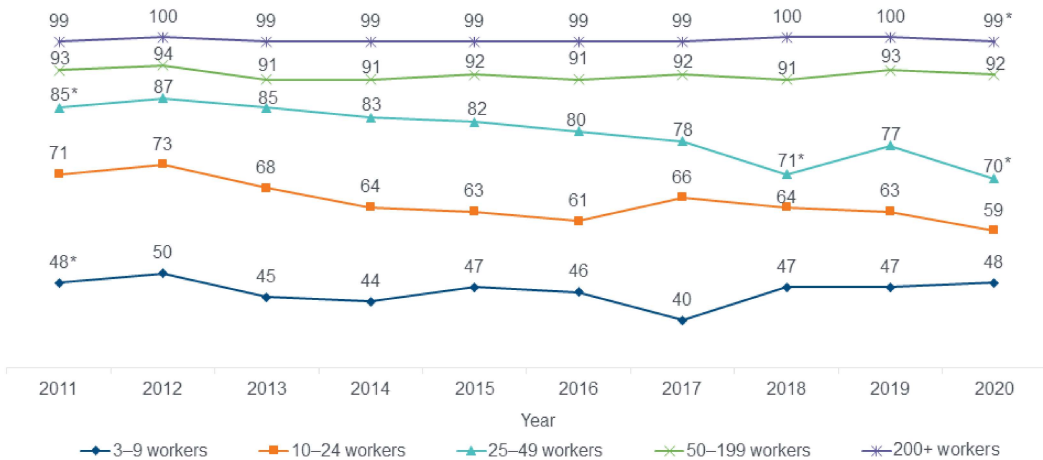
<sup>1</sup> Analysis of the 2021 Current Population Survey by Sherry Glied and Mikaela Springsteen of New York University for the Commonwealth Fund.

Enrollment in employer health plans has changed little over the past decade even as the federal government expanded coverage options through the Affordable Care Act (ACA). Nearly all companies with 200 or more workers offer insurance to their employees (Exhibit 2).<sup>2</sup> Small firms, however, are less likely to offer coverage and over the past decade there has been some decline in the share that offers. Employers in some sectors of the economy, including food services and retail, are far less likely to offer coverage than some others, such as manufacturing, finance, and insurance (Exhibit 3).<sup>3</sup>

Exhibit 2

While nearly all large firms offer health benefits to at least some workers, smaller firms are significantly less likely to do so.

Percentage of firms offering health benefits, by firm size, 2011–2020



\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: Estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

Data: Kaiser Family Foundation Employer Health Benefits Survey, 2018–2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011–2017.



Source: Gary Claxton et al., *Employer Health Benefits: 2020 Annual Survey* (Henry J. Kaiser Family Foundation, 2020).

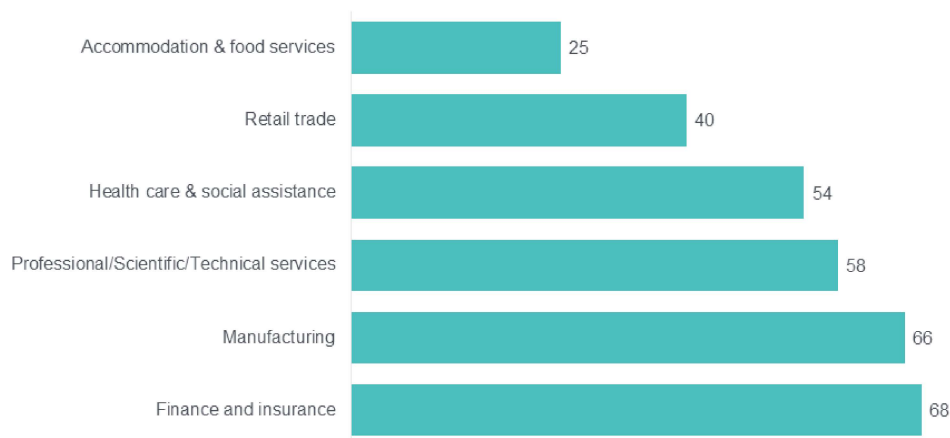
<sup>2</sup> Gary Claxton et al., *Employer Health Benefits: 2020 Annual Survey* (Henry J. Kaiser Family Foundation, 2020).

<sup>3</sup> Paul Fronstin and Stephen A. Woodbury, *How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?* (Commonwealth Fund, Oct. 2020).

Exhibit 3

## Workers in industries hardest hit by the pandemic were the least likely to have coverage through their own jobs.

Percentage of workers with employer sponsored insurance (ESI) coverage in own name, by industry, 2020



Data: Authors' analysis of state-level unemployment insurance claims, U.S. Department of Labor, Employment and Training Administration; and the 2019 Annual Social and Economic Supplement to the Current Population Survey.



Source: Paul Fronstin and Stephen A. Woodbury, [How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?](#) (Commonwealth Fund, Oct. 2020).

Employer coverage proved to be resilient during the COVID-19 pandemic. Despite the deepest recession since the 2008 economic downturn, a recent Commonwealth Fund survey found that only 6 percent of working-age adults reported they lost employer coverage during the pandemic (Exhibit 4).<sup>4</sup> Other research estimates about 3 million to 7 million people lost employer coverage.<sup>5</sup> This loss is limited compared to the large number of jobs lost in 2020 partly because industries hit hardest with pandemic-related job losses, such as hotel, food service, and retail, had among the lowest employer coverage rates before the pandemic. Other laid-off workers were more fortunate: about 42 percent of companies that dismissed workers during the pandemic continued to pay at least part of their insurance premiums.<sup>6</sup>

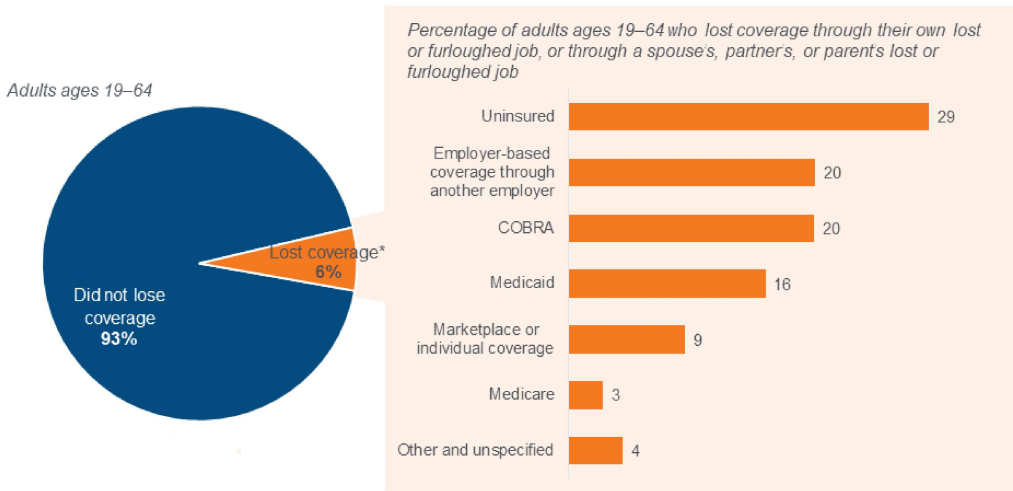
<sup>4</sup> Sara R. Collins, Gabriella N. Aboulafia, and Munira Z. Gunja, [As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021](#) (Commonwealth Fund, July 2021).

<sup>5</sup> Paul Fronstin and Stephen A. Woodbury, [“Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?”](#), *To the Point* (blog), Commonwealth Fund, Jan. 11, 2021.

<sup>6</sup> Paul Fronstin and Stephen A. Woodbury, [“Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?”](#), *To the Point* (blog), Commonwealth Fund, Jan. 11, 2021.

Exhibit 4

Six percent of adults reported that they lost employer coverage because of job loss related to the pandemic; 67 percent gained other coverage.



\* Includes respondents who lost coverage through their own lost or furloughed job, or through a spouse's, partner's, or parent's lost or furloughed job.

Note: Pie may not sum to 100% because of rounding and unknown respondents.

Data: Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021.



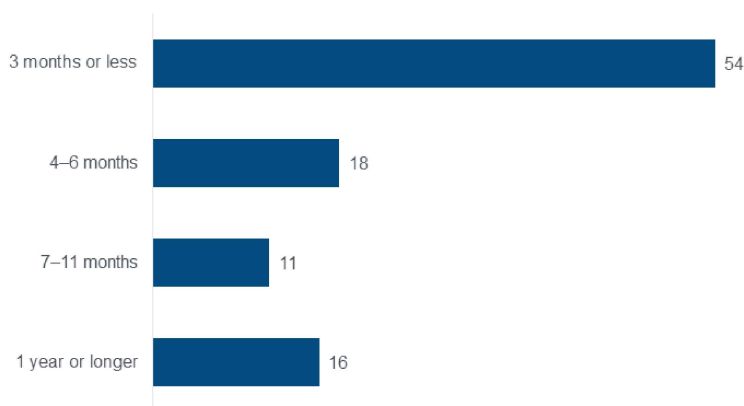
Source: Sara R. Collins, Gabriella N. Aboulafla, and Munira Z. Gunja, [As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021](#) (Commonwealth Fund, July 2021).

Unlike during prior recessions, the ACA’s coverage expansions provided a safety net for people who lost employer coverage. This safety net was enhanced by federal relief efforts to help people maintain their Medicaid coverage, a substantial increase in marketplace premium subsidies under the American Rescue Plan Act (ARPA), and extended special-enrollment periods in state-run marketplaces in 2020 and in the federal marketplaces in 2021. Among workers who did lose employer coverage, 20 percent gained insurance through another employer, 20 percent elected COBRA, 16 percent gained coverage through Medicaid, and 9 percent got covered through the marketplaces or individual market. Nearly three in ten — 29 percent — became uninsured, reflecting ongoing holes in our coverage system and lack of awareness of options. But the availability of affordable coverage options kept gaps in coverage relatively short for a majority of people who lost employer coverage (Exhibit 5).

Exhibit 5

For a majority of adults who lost employer health insurance during the pandemic, coverage gaps were brief.

*Percentage of adults ages 19–64 who lost coverage through their own lost or furloughed job, or through a spouse's, partner's, or parent's lost or furloughed job, did not get coverage through COBRA*



Data: Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021.



Source: Sara R. Collins, Gabriella N. Aboulafia, and Munira Z. Gunja, [As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.?](#) *Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021* (Commonwealth Fund, July 2021).

## **The U.S. Has a Health Care Spending Problem in Commercial Insurance Plans; Consumers Are Paying the Price**

The ACA's coverage expansions, market rules against underwriting, and mandates for employers to offer coverage have enabled millions of previously uninsured people to get comprehensive affordable coverage.<sup>7</sup> Research has shown that these provisions have led to an overall downward trend in out-of-pocket costs across the U.S. population.<sup>8</sup>

But the United States has a health care spending problem in commercial insurance. This is demonstrated by the amount that the 180 million people with employer and individual market plans pay for their insurance and health care. New research from the Health Care Cost Institute shows that among people with employer insurance, spending per person grew by 21.8 percent between 2015 and 2019, outpacing both inflation and GDP growth (Exhibit 6).<sup>9</sup> The data also

<sup>7</sup> Sherry A. Glied, Sara R. Collins, and Saunders Lin, "[Did the Affordable Care Act Lower Americans' Financial Barriers to Health Care?](#)" *Health Affairs* 39, no. 3 (Mar. 2020): 379–86.

<sup>8</sup> Sherry A. Glied and Benjamin Zhu, [Catastrophic Out-of-Pocket Health Care Costs: A Problem Mainly for Middle-Income Americans with Employer Coverage](#) (Commonwealth Fund, Apr. 2020).

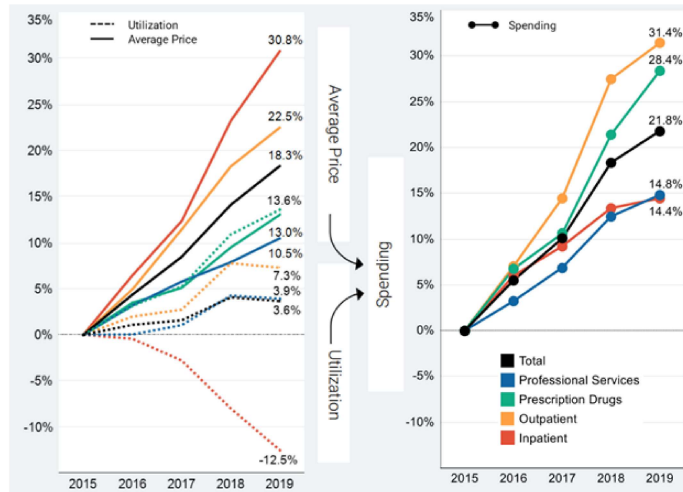
<sup>9</sup> Health Care Cost Institute, [2019 Health Care Cost and Utilization Report](#) (HCCI, Oct. 2021).

show that average prices paid for health care services and prescription drugs were the primary drivers, accounting for nearly two-thirds of overall growth.

Exhibit 6

Prices accounted for nearly two-thirds of per-person spending growth in employer plans, 2015–2019.

Cumulative change in utilization, average price, and per-person spending, 2015–2019



Notes: Utilization and average prices account for changes in the type or intensity of services used, with the exception of prescription drugs. Prescription drug spending is the amount paid on the pharmacy claim, which reflects discounts from the wholesale price, but not manufacturer rebates.



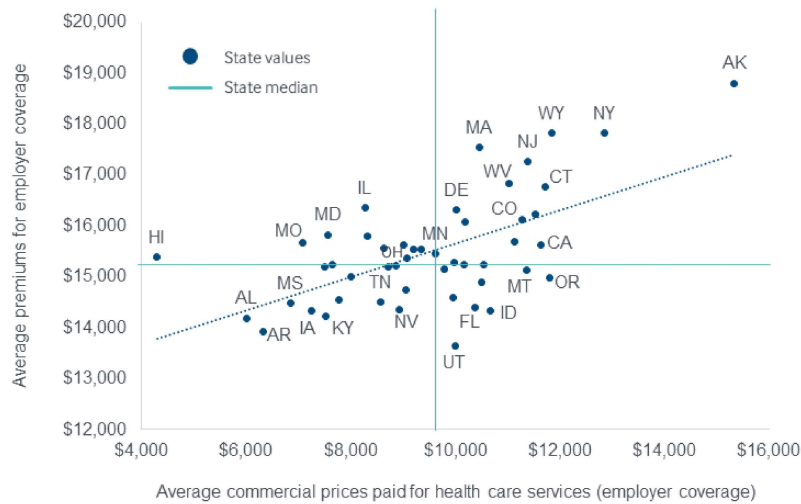
Source: Health Care Cost Institute, [2019 Health Care Cost and Utilization Report](#) (HCUI, Oct. 2021).

These high prices are associated with higher employer premiums (Exhibit 7).<sup>10</sup> Because employers share these costs with their workers in the form of premium contributions and deductibles, workers’ costs also are rising. In most states, they are rising faster than median income.

<sup>10</sup> David C. Radley, Sara R. Collins, and Jesse C. Baumgartner, [2020 Scorecard on State Health System Performance](#) (Commonwealth Fund, Sept. 2020).

Exhibit 7

Higher prices are associated with higher employer premiums.



Source: David C. Radley, Sara R. Collins, and Jesse C. Baumgartner, [2020 Scorecard on State Health System Performance](#) (Commonwealth Fund, Sept. 2020).

New data on employer plans released by the federal government this fall and analyzed by the Commonwealth Fund show that worker premium contributions and deductibles in employer plans have taken up a growing share of workers' incomes over the past decade. These costs accounted for 11.6 percent of median household income in 2020, up from 9.1 percent a decade earlier (Exhibit 8).<sup>11</sup>

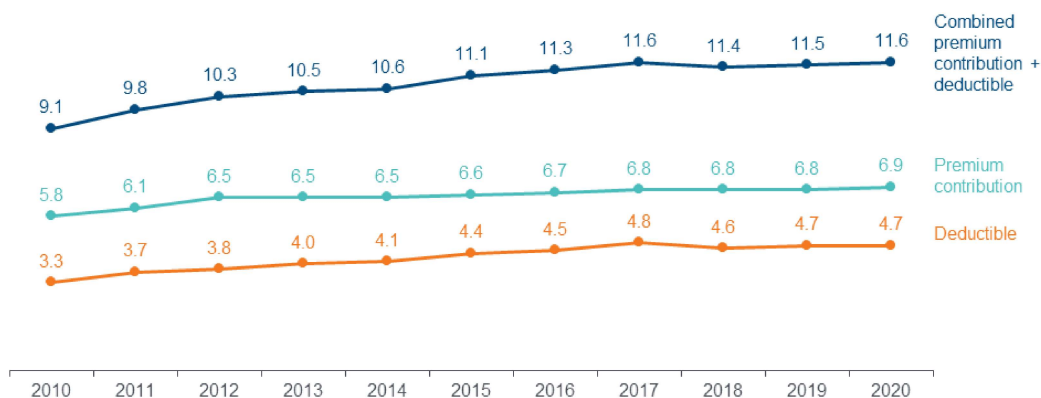
<sup>11</sup> Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2020* (Commonwealth Fund, forthcoming Dec. 2021).



Exhibit 8

## Workers' premium contributions and deductibles increase with overall spending growth, adding up to 11.6 percent of median income in 2020.

Share of median income (%)



Note: Combined estimates of single and family premium contributions and deductibles are weighted for the distribution of single-person and family households in the state.  
 Data: Premium contributions and deductibles — Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2010–2020; Median household income and household distribution type — analysis of the Current Population Survey (CPS), 2010–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.

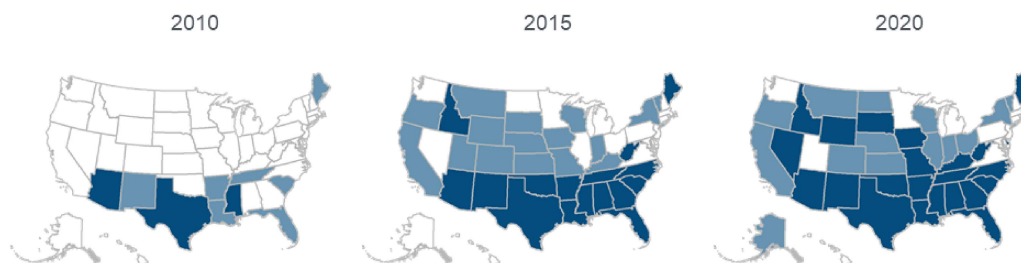


Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *Trends in Employer Health Care Coverage, 2010–2020* (Commonwealth Fund, forthcoming, Dec. 2021).

There is wide variation in what workers pay for employer coverage relative to their incomes across the country. Premium contributions and deductibles were 10 percent or more of median income in 37 states in 2020, up from 10 states in 2010 (Exhibit 9). In nine states (Florida, Georgia, Louisiana, Mississippi, Nevada, New Mexico, Oklahoma, South Carolina, and Texas) the average combined costs of premium contributions and deductibles amounted to 14 percent or more of median income in 2020. Middle-income workers in Mississippi and New Mexico faced the highest potential costs relative to income (19.0% and 18.1%, respectively).

Exhibit 9

The number of states where workers spend 10 percent or more of median income on premiums and deductibles has grown over the decade.



**Average employee share of premium plus average deductible as a percentage of median state incomes**



Note: Combined estimates of single and family premium contributions and deductibles are weighted for the distribution of single-person and family households in the state.  
 Data: Premium contributions and deductibles — Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2010–2020; Median household income and household distribution type — analysis of the Current Population Survey (CPS), 2010–2021, by Mikaela Springsteen and Sherry Gled of New York University for the Commonwealth Fund.



Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *Trends in Employer Health Care Coverage, 2010–2020* (Commonwealth Fund, forthcoming, Dec. 2021).

These costs add to already considerable burdens for families. For example, housing and food consumed 34 percent of average family income in 2020.<sup>12</sup> Among families with children under age 5 who pay for childcare, average spending on childcare took up 13 percent of family income in 2017.<sup>13</sup>

Workers across the income spectrum have experienced steady growth in their insurance costs. But people living in states with lower median incomes are doubly burdened. On average, workers in states with median incomes lower than the national median face higher absolute costs compared to people in states with higher median incomes (Exhibit 10).

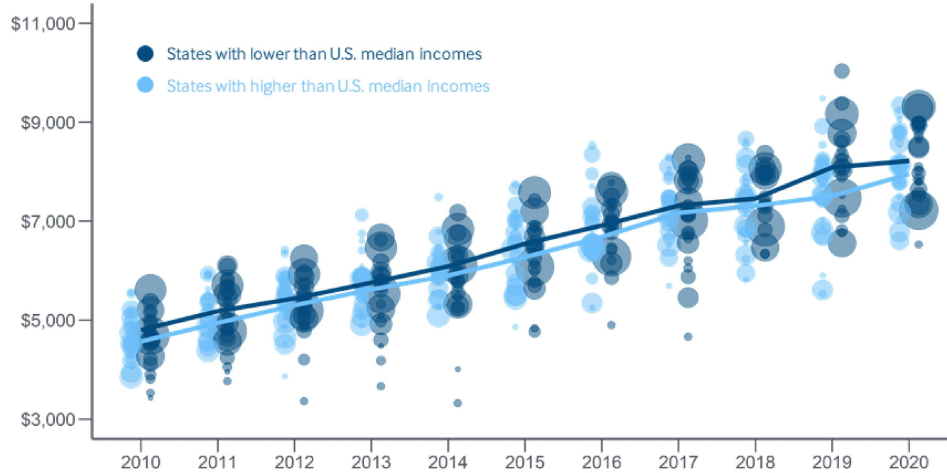
<sup>12</sup> Bureau of Labor Statistics, “[Consumer Expenditures — 2020](#),” news release, Sept. 9, 2021.

<sup>13</sup> U.S. Department of the Treasury, [The Economics of Child Care Supply in the United States](#), Sept. 2021.

Exhibit 10

## Workers in states with lower median incomes face higher combined premium contributions and deductibles.

Combined premium contribution + deductible (\$)



Note: Bubbles are proportionate to the States' population. Lines represent the average among the associated group of states, weighted by population.

Data: Premium contributions and deductibles—Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2010–2020; Median household income and household distribution type—analysis of the Current Population Survey (CPS), 2010–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.



Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *Trends in Employer Health Care Coverage, 2010–2020* (Commonwealth Fund, forthcoming, Dec. 2021).

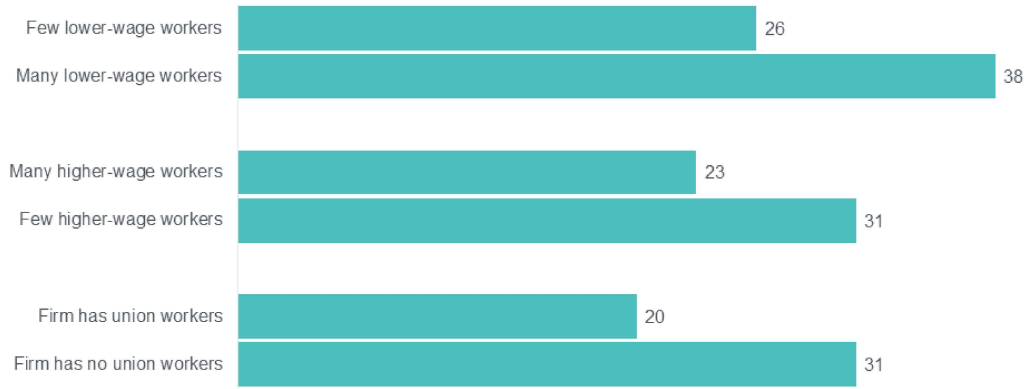
The Kaiser Family Foundation's annual survey of employer benefits finds that in lower-wage firms, insured workers contribute a larger share of the premium for family plans than those in higher-wage firms (Exhibit 11).<sup>14</sup> Nonunionized workforces contribute a larger share of the premium than do unionized workforces.

<sup>14</sup> Gary Claxton et al., *Employer Health Benefits: 2020 Annual Survey* (Henry J. Kaiser Family Foundation, 2020).

Exhibit 11

## Covered workers in firms with many lower-wage workers contribute more toward their premium than workers in firms with few lower-wage workers.

Average percentage of family premium paid by covered workers, by firm characteristics, 2020



Note: Small firms have 3–199 workers and large firms have 200+ workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more of national earnings (\$64,000 in 2020). Firms with older workers are those where at least 35% of the workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger. Data: Kaiser Family Foundation Employer Health Benefits Survey, 2020.

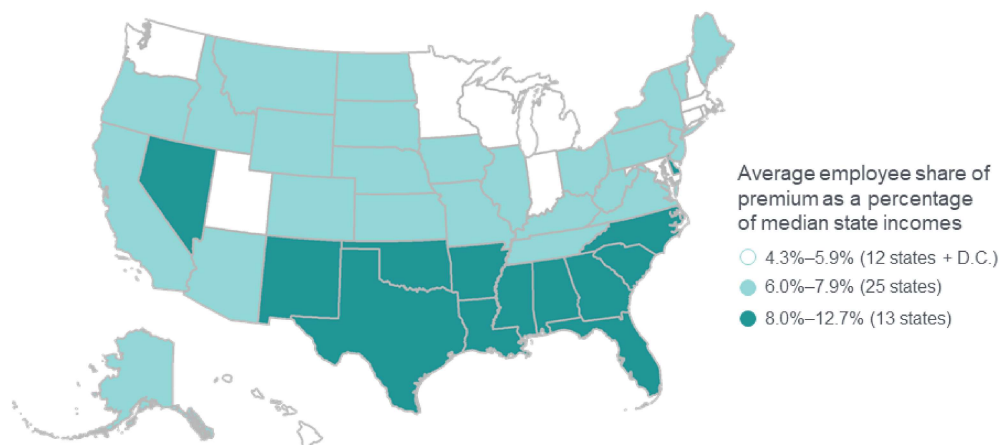


Source: Gary Claxton et al., *Employer Health Benefits: 2020 Annual Survey* (Henry J. Kaiser Family Foundation, 2020).

Workers with the largest premium contributions relative to median income were concentrated in southern states. In Alabama, Arkansas, Delaware, Florida, Georgia, Louisiana, Mississippi, Nevada, New Mexico, Oklahoma, North Carolina, South Carolina, and Texas, premium contributions were 8 percent or more of median income, with a high of 12.7 percent in Mississippi (Exhibit 12).

Exhibit 12

Workers spent 8 percent or more of median income on premium contributions in 13 states.



Note: Single and family premium contributions are weighted for the distribution of single-person and family households in the state.

Data: Premium contributions and deductibles — Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2020; Median household income and household distribution type — analysis of the Current Population Survey (CPS), 2020–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.



Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *Trends in Employer Health Care Coverage, 2010–2020* (Commonwealth Fund, forthcoming, Dec. 2021).

## Deductible Growth Is Leaving Millions Underinsured

The Commonwealth Fund has found that insured people who have high out-of-pocket costs and deductibles relative to their income are more likely to face problems accessing care and paying medical bills than those who do not. We have defined someone who has been continuously insured over the past year as “underinsured” if their plan’s deductible equals 5 percent or more of income or if their out-of-pocket costs over the past year are equal to 10 percent or more of income (5 percent or more if low income).<sup>15</sup>

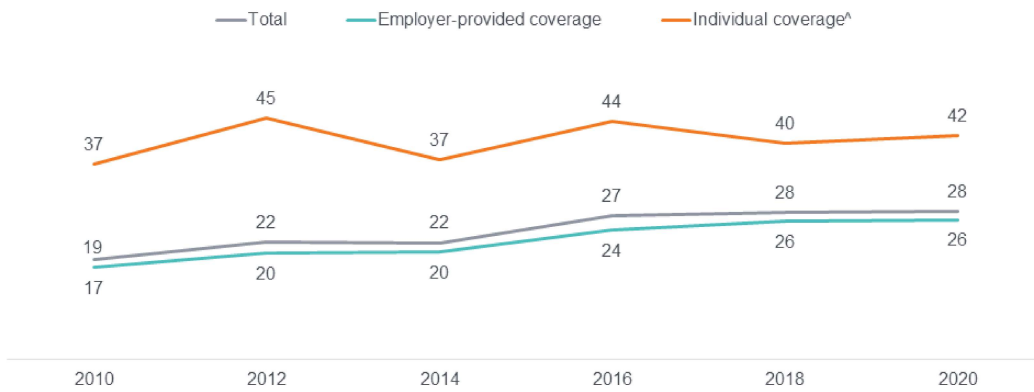
In 2020, about one-quarter of people in employer plans were underinsured by this measure (Exhibit 13). While rates were higher in the individual market, the largest growth has occurred in employer plans. This growth has been driven by growth in the size of deductibles relative to family income (Exhibit 14).

<sup>15</sup> Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, Aug. 2020).

Exhibit 13

## One-quarter of adults in employer plans are underinsured; the individual market continues to be challenging.

Percentage of adults ages 19–64 insured all year who were underinsured



Notes: "Underinsured" refers to adults who were 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. Respondents may have had another type of coverage at some point during the year but had coverage for the entire previous 12 months. <sup>^</sup> For 2014–2020, individual coverage includes adults who got coverage in the individual market and the marketplaces.

Data: Commonwealth Fund Biennial Health Insurance Surveys (2010, 2012, 2014, 2016, 2018, 2020).



Source: Sara R. Collins, Munira Z. Gunja, and Gabriella N. Abouloffia, [U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020](#) (Commonwealth Fund, Aug. 2020).

Exhibit 14

## Deductibles have grown faster than income, taking up larger shares of household budgets, and leaving more people underinsured.

Percentage of adults ages 19–64 with private coverage who had deductibles that were 5% or more of income	2010	2012	2014	2016	2018	2020
<b>Total</b>	7	11	13	15	16	15
<b>Insurance source at time of survey<sup>*</sup></b>						
Employer-provided coverage	6	9	11	13	15	14
Individual and marketplace coverage <sup>^</sup>	18	29	22	24	23	27
<b>Firm size (base: full- or part-time workers with coverage through their own employer)<sup>^^^</sup></b>						
2–99 employees	7	15	20	13	18	16
100 or more employees	5	6	9	13	14	14

<sup>\*</sup> Respondents may have had another type of coverage at some point during the year. <sup>^</sup> For 2014–2020, individual coverage includes adults who got coverage in the individual market and the marketplaces. <sup>^^^</sup> Does not include adults who are self-employed.

Data: Commonwealth Fund Biennial Health Insurance Surveys (2010, 2012, 2014, 2016, 2018, 2020).

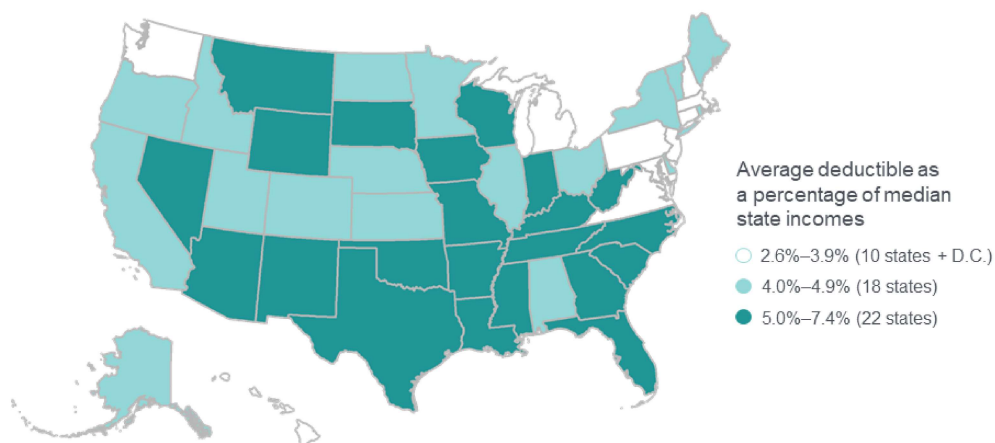


Source: Sara R. Collins, Munira Z. Gunja, and Gabriella N. Abouloffia, [U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020](#) (Commonwealth Fund, Aug. 2020).

Across the country, average deductibles in employer plans relative to median income were 5 percent or more in 22 states (Arizona, Arkansas, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, Nevada, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, and Wyoming) and ranged as high as 7.4 percent in New Mexico (Exhibit 15).

Exhibit 15

Average deductibles were 5 percent or more of median income in 22 states.



Note: Single and family deductibles are weighted for the distribution of single-person and family households in the state.  
 Data: Premium contributions and deductibles — Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2020; Median household income and household distribution type — analysis of the Current Population Survey (CPS), 2020–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.



Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *Trends in Employer Health Care Coverage, 2010–2020* (Commonwealth Fund, forthcoming, Dec. 2021).

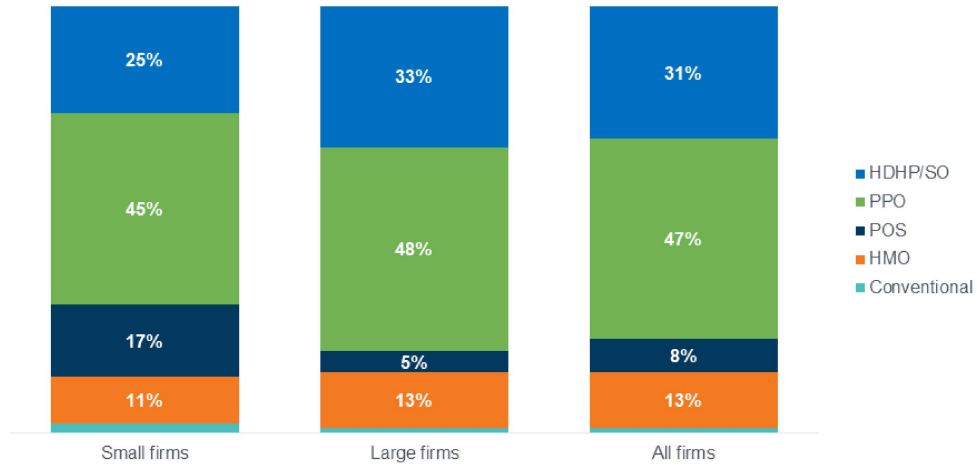
One reason for the growth in average deductibles is more workers are enrolled in high-deductible plans with savings accounts, either health reimbursement arrangements (HRAs) or health savings accounts (HSAs). About three of 10 workers are enrolled in such plans (Exhibit 16).<sup>16</sup> About half of workers with HRAs and a quarter of those with HSAs receive employer contributions that reduce their deductibles to between zero and \$1,000. Still, accounting for these contributions only reduces the share of workers across all single-coverage plans with deductibles of \$1,000 or more from 57 percent to 47 percent (Exhibit 17).

<sup>16</sup> Gary Claxton et al., *Employer Health Benefits: 2020 Annual Survey* (Henry J. Kaiser Family Foundation, 2020).

Exhibit 16

## About 3 of 10 workers with employer coverage are enrolled in a high-deductible health plan with a savings option, either an HRA or HSA.

Distribution of health plan enrollment for covered workers, by plan type and firm size, 2020



Note: Small firms have 3–199 workers and large firms have 200+ workers. HMO = health maintenance organization; PPO = preferred provider organization; POS = point-of-service plan; HDHP/SO = high-deductible health plan with a savings option, such as a health reimbursement arrangement (HRA) or health savings account (HSA).  
Data: Kaiser Family Foundation Employer Health Benefits Survey, 2020.

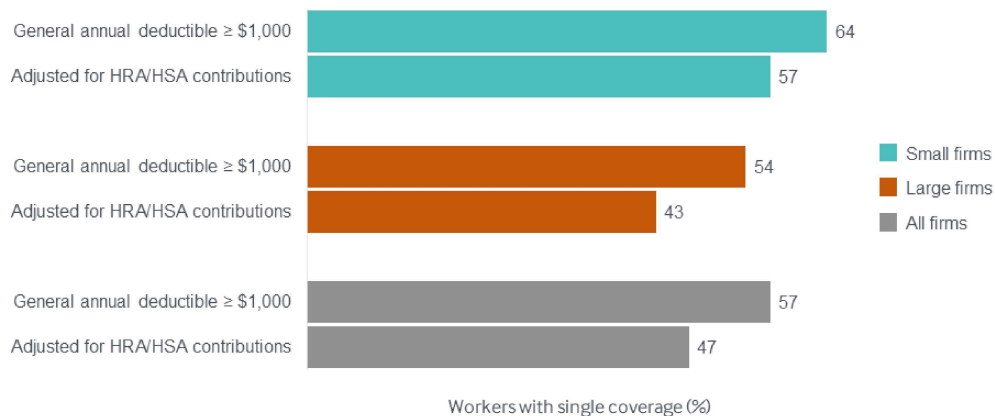


Source: Gary Claxton et al., *Employer Health Benefits: 2020 Annual Survey* (Henry J. Kaiser Family Foundation, 2020).

Exhibit 17

## Percentage of workers with deductibles of \$1,000 or more, after adjustment for employer account contributions in HDHPs with HRAs and HSAs.

Percentage of covered workers enrolled in a plan with a general annual deductible of \$1,000 or more for single coverage, by firm size, 2020



Note: Small firms have 3–199 workers and large firms have 200+ workers. These estimates include workers enrolled in high-deductible health plans with a savings option and other plan types. Average general annual deductibles are for in-network providers.  
Data: Kaiser Family Foundation Employer Health Benefits Survey, 2020.



Source: Gary Claxton et al., *Employer Health Benefits: 2020 Annual Survey* (Henry J. Kaiser Family Foundation, 2020).



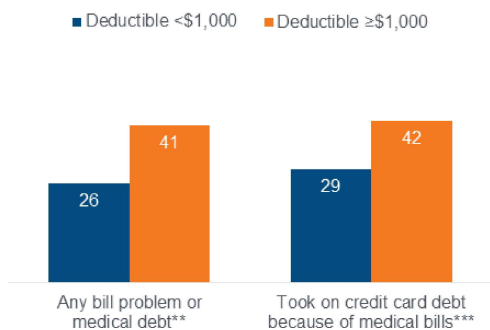
## High Cost Exposure in Commercial Plans Distorts Consumers' Health Care Decisions and Leads to Financial Problems

Research indicates that people who face high deductibles often avoid getting needed health care. A 2020 Commonwealth Fund survey found that among people in commercial plans, more than one-third of those with a deductible of \$1,000 or more said they had not gotten needed health care because of the cost, including not filling a prescription, not going to the doctor when sick, not getting a follow up test or treatment recommended by a doctor, or not seeing a specialist (Exhibit 18).<sup>17</sup>

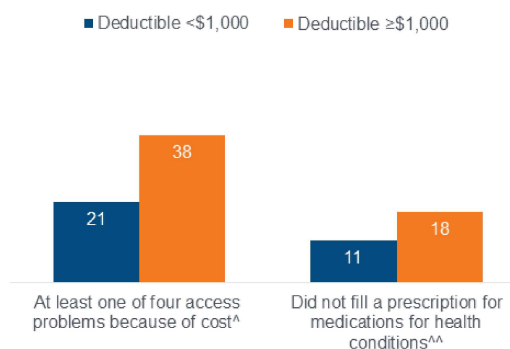
Exhibit 18

### People with higher deductibles more frequently report financial problems because of medical bills or delaying care because of cost.

Percentage of adults ages 19–64 with private coverage who were insured all year and said “yes” to any of the following happening to them in the past two years\*



Percentage of adults ages 19–64 with private coverage who were insured all year and said “yes” to any of the following happening to them in the past 12 months\*



\* Base is those with private coverage who specified their deductibles. \*\* Includes any of the following: had problems paying or unable to pay medical bills; contacted by collection agency for unpaid medical bills; had to change way of life to pay bills; medical bills/debt being paid over time. \*\*\* Base is limited to those who said they had a medical bill problem or debt. ^ Includes any of the following because of cost: did not fill a prescription; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic; did not see a specialist when needed. ^^ Health problems include hypertension or high blood pressure, heart failure or heart attack, diabetes, asthma, emphysema, or lung disease, high cholesterol, or depression, anxiety or other mental health problem.  
Data: Commonwealth Fund Biennial Health Insurance Survey (2020).



Source: Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, [U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020](#) (Commonwealth Fund, Aug. 2020).

When people in high-deductible plans do get care, they are susceptible to racking up medical debt. Forty-one percent of adults with a deductible of \$1,000 or more reported they had experienced problems paying medical bills, including not being able to pay a bill, being contacted by a collection agency about an unpaid bill, having to change their way of life to pay

<sup>17</sup> Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, [U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020](#) (Commonwealth Fund, Aug. 2020).

their bills, or paying off debt over time. Among those who were paying off medical debt, 63 percent said they were paying off bills worth \$2,000 or more (data not shown).

Medical bill problems and debt have become endemic in our health system. The media is awash in stories of patients receiving outlandish, uncovered bills.<sup>18</sup> A recent *JAMA* article found that 17.8 percent of people in the U.S. had medical debt in collections, with the highest shares in the South and in predominantly poor zip codes.<sup>19</sup> Between 2009 and 2020, the amount of medical debt in collections overtook that of nonmedical debt.

Medical debt has spillover financial implications. In a 2021 Commonwealth Fund survey, one-third of adults in employer-based plans reported problems paying their bills or that they were paying off debt over time (Exhibit 19).<sup>20</sup> Of those who reported these difficulties, 40 percent said that they had received a lower credit score because of their medical bills; 40 percent had taken on credit card debt to pay their bills; 35 percent had used up most or all their savings to pay their bills; 23 percent had been unable to pay for basic life necessities like food, heat, or rent; and 21 percent had delayed education or career plans (Exhibit 20).

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<sup>18</sup> See for example Kaiser Health News and National Public Radio’s ongoing “Bill of the Month” series at <https://khn.org/news/tag/bill-of-the-month/>

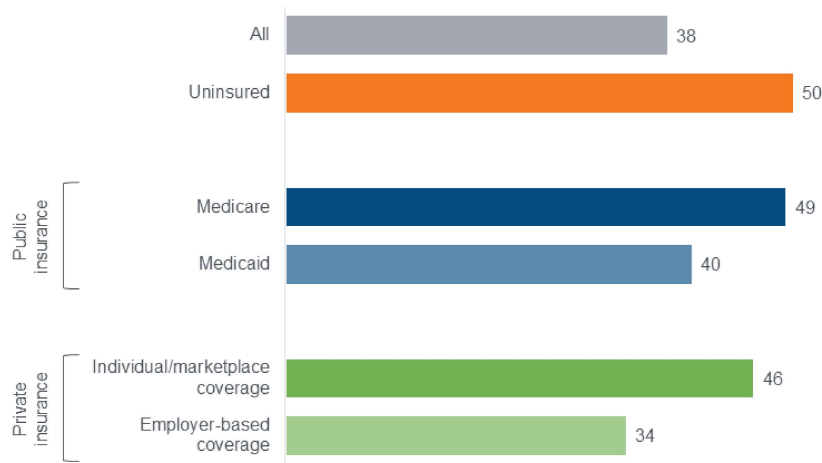
<sup>19</sup> Raymond Kluender et al., “[Medical Debt in the U.S., 2009–2020](#),” *JAMA* 326, no. 3 (July 20, 2021): 250–56.

<sup>20</sup> Sara R. Collins, Gabriella N. Aboulafia, and Munira Z. Gunja, [As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021](#) (Commonwealth Fund, July 2021).

Exhibit 19

## One-third of adults with employer coverage reported problems paying medical bills or that they were paying off medical debt over time.

Percentage of adults ages 19–64 who had medical bill or debt problems in the past year



Data: Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021.

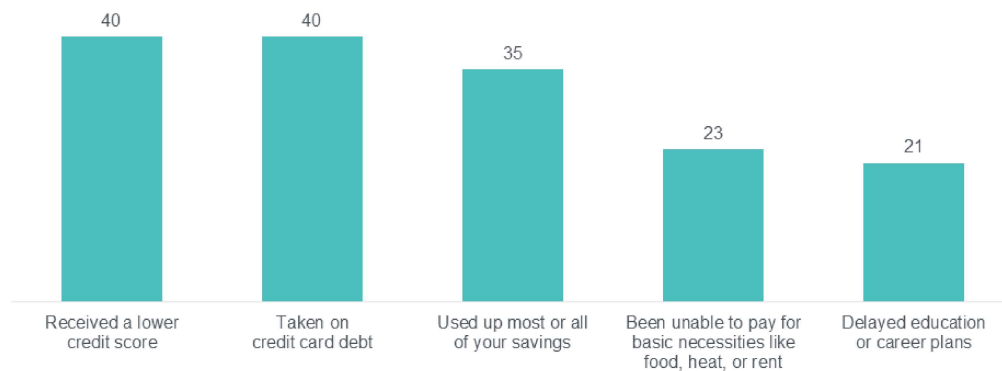


Source: Sara R. Collins, Gabriella N. Aboulafla, and Munira Z. Gunja, [As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021](#) (Commonwealth Fund, July 2021).

Exhibit 20

## Medical bill problems lead to a number of other financial problems.

Percentage of adults ages 19–64 with employer coverage in 2021 who had the following financial problems in the past two years because of medical bill problems or debt<sup>a</sup>



<sup>a</sup> 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.

Data: Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021.



Source: Sara R. Collins, Gabriella N. Aboulafla, and Munira Z. Gunja, [As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021](#) (Commonwealth Fund, July 2021).

## Policy Options

The ACA’s subsidized marketplaces and Medicaid expansion have provided a safety net for people in unaffordable or skimpy employer health plans. Improving the affordability and cost-protection of marketplace plans and expanding Medicaid in all states, increasing awareness of these coverage options among workers, and making it easier for eligible workers to enroll in them will relieve some of the problems highlighted in this testimony. Specific improvements include:

- Make the temporary ARPA marketplace subsidies permanent.
- Provide a zero-premium, zero-cost-sharing insurance option for Medicaid-eligible adults in the coverage gap in the 12 states that have not yet expanded their programs.
- Inform workers with employer coverage of their options to enroll in subsidized marketplace plans and Medicaid and, if they lose employer coverage, that they are eligible for a marketplace special-enrollment period.
- Fix the “family coverage glitch.” Under the ACA, families are ineligible for marketplace premiums if a family member has an offer of single employer coverage that is affordable, (i.e., premiums less than 9.83 percent of family income).<sup>21</sup> About 5 million people are caught in this glitch: they are in family plans with premium contributions that exceed that threshold, but are ineligible for marketplace subsidies.<sup>22</sup> The Biden administration could fix this administratively, saving families that switched to marketplace plans an average of \$400 per person; families with incomes under 200 percent of the federal poverty level could save \$580 per person.
- Lower the “employer firewall” threshold from 9.83 to 8.5 percent of income (i.e., the ARPA premium contribution cap). When combined with the fix to the family coverage glitch, this change would mean that no one would have to spend more than 8.5 percent of income for their health insurance. Commonwealth Fund analyses indicate one-quarter of people with low incomes in employer plans who are not eligible for Medicaid in their states spend more than 8.5 percent of their household income on premiums (Exhibit 21).

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<sup>21</sup> Timothy S. Jost, “[Eliminating the Family Glitch](#),” *To the Point* (blog), Commonwealth Fund, May 18, 2021.

<sup>22</sup> Matthew Buettgens and Jessica Banthin, [“Changing the ‘Family Glitch’ Would Make Health Coverage More Affordable for Many Families](#)” (Urban Institute, May 2021).

- Rein in deductibles and out-of-pocket costs in marketplace plans. One proposal could eliminate deductibles for some people and reduce it for others by as much as \$1,650.<sup>23</sup>
- The historic No Surprises Act passed by Congress in 2020 and set to go into effect in January 2022 will protect most consumers from surprise medical bills from out-of-network providers and some emergency transportation providers.<sup>24</sup> Other measures to protect consumers from the devastating consequences of medical debt include expanding the reach of the ACA’s financial assistance policies for nonprofit hospitals to cover all hospitals and a broader range of providers, imposing stronger consumer protection rules for medical debt collection such as grace periods following illness or during appeals processes, and placing bans or limits on medical debt interest rates.<sup>25</sup>
- Address the high commercial provider prices that are the primary driver of employer premiums and deductibles. This could be pursued by adding a public plan option to the marketplaces, among other approaches.<sup>26</sup>
- Develop an autoenrollment mechanism to help people enroll and stay enrolled in comprehensive coverage. Creating a public plan as a default option would be essential to a national autoenrollment program.<sup>27</sup>

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<sup>23</sup> [Improving Health Insurance Affordability Act of 2021](#), S. 499, 117th Cong. (2021); Linda J. Blumberg, et al., *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Urban Institute, Oct. 2019).

<sup>24</sup> Jack Hoadley and Kevin Lucia, “[Putting Surprise Billing Protections into Practice: Biden Administration Releases First Set of Regulations](#),” *To the Point* (blog), Commonwealth Fund, July 14, 2021.

<sup>25</sup> Chi Chi Wu, Jenifer Bosco, and April Kuehnhoff, *Model Medical Debt Protection Act* (National Consumer Law Center, Sept. 2019).

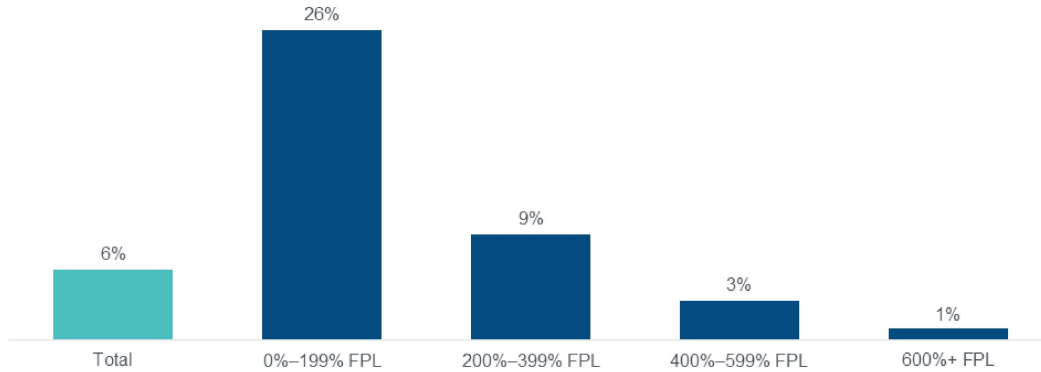
<sup>26</sup> Linda J. Blumberg et al., *Comparing Health Insurance Reform Options*; John Holahan, Michael Simpson, and Linda J. Blumberg, *What Are the Effects of Alternative Public Option Proposals* (Urban Institute, Mar. 2021); Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices: The Role of States* (Urban Institute, Jan. 2020); and Sherry A. Glied and Jeanne M. Lambrew, “[How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Health Insurance Plans](#),” *Health Affairs* 37, no. 12 (Dec. 2018): 2084–91.

<sup>27</sup> Linda J. Blumberg, John Holahan, and Jason Levitis, *How Auto-Enrollment Can Achieve Near-Universal Coverage: Policy and Implementation Issues* (Commonwealth Fund, June 2021).

Exhibit 21

One-quarter of people with low incomes in employer plans who are not eligible for Medicaid in their states spend more than 8.5 percent of their income on premium contributions.

*Percentage of people with employer coverage where more than 8.5 percent of household income goes toward after-tax premium contributions*



Notes: FPL = federal poverty level. People below 138% FPL in states that have expanded Medicaid are excluded from the analysis sample.  
Data: Analysis of U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, Sept. 2019 and 2020 data releases (2018 and 2019 data years).



Source: Jesse C. Baumgartner, Sara R. Collins, and David C. Radley, [Removing the Firewall Between Employer Insurance and the ACA Marketplaces: Who Could Benefit?](#) (Commonwealth Fund, Dec. 2020).

The cost burden in commercial insurance is an enduring problem in U.S. health care that is undermining America’s overall economic well-being. This year’s U.S. Supreme Court decision reaffirming the constitutionality of the ACA paves the way for Congress to use the tools provided by the law to cover the remaining uninsured and make health care affordable to people covered by both public and commercial insurance. Doing so will help facilitate the country’s postpandemic recovery and its future prosperity.

Thank you.