



America's  
Health  
Insurance  
Plans

# **WE BELIEVE IN HIGH-VALUE HEALTH CARE**

## **The Value of Health Insurance Plans**



The challenges are well known. The United States devotes more resources to health care than any other nation. The cost of medical care outpaces inflation every year. Patients receive care that follows best practices only 55 percent of the time. Health care has not kept pace with the revolution in information technology. Most troubling of all, some 47 million Americans lack basic health coverage.

How can this be? And more importantly, what can be done about it? To answer those questions, it is worth reviewing some recent history.

In the 1990s, health insurance plans succeeded in achieving cost savings. Health care's share of the U.S. gross domestic product was stabilized. As recently as 1995, private per capita health spending actually fell. Though still far too high, the percentage of Americans who were uninsured began to decline. The downside to this progress was a perception that too much emphasis was placed on affordability. Patients welcomed cost containment but did not want anyone standing in the way of their health care.

Since then, health insurance plans have listened, adapted and innovated. While maintaining our focus on affordability, health insurance plans are also working to improve quality, support the doctor-patient relationship and make the health care system easier for patients to use.

We believe in high-value health care. Our mission is ensuring that every dollar spent on health care—by patients, by employers, by governments—is a dollar well spent. Health insurers have always provided financial protection against catastrophic medical costs. By negotiating with providers on behalf of patients and employers, health insurance plans also minimize health care cost increases. Now we are deploying a new generation of cost-saving strategies that make routine medical care and prescription drugs more affordable.

A healthier nation is ultimately the best strategy for making health care more affordable for everyone. Patients are active partners in our innovative prevention and wellness incentive programs that help them stay healthy in the first place. Those with chronic conditions such as diabetes, heart disease and asthma are embracing our disease management programs that help them follow their treatments and enhance their quality of life, while also reducing the need for costly emergency care and hospital stays.

In the public policy arena, we are collaborating with leaders from across the political spectrum to try to end the crisis of the uninsured. We are also supporting common-sense reforms that will enhance affordability and improve quality.

We believe high-value health care is within our nation's reach. And we welcome the opportunity to work with all stakeholders to make it happen.



KAREN IGNAGNI

*President and Chief Executive Officer,  
America's Health Insurance Plans*



# WE BELIEVE

**FILLING PRESCRIPTIONS SHOULDN'T EMPTY WALLETS.**

*Health insurance plans' prescription drug benefits save money for patients. Research shows that insurers' programs that encourage consumers to choose equally effective but less costly generic drugs are slowing the growth of health care spending. Health insurance plans also negotiate with pharmaceutical companies so that consumers save on brand-name drugs as well.*

## Helping people get the medicines they need while working to hold down prescription drug cost increases.

Prescription drugs enable millions of Americans to live healthier and more productive lives than would otherwise be possible. But the cost of prescription drugs sometimes makes them unaffordable – forcing people to make difficult choices between keeping up on their medications or paying for food and other necessities.

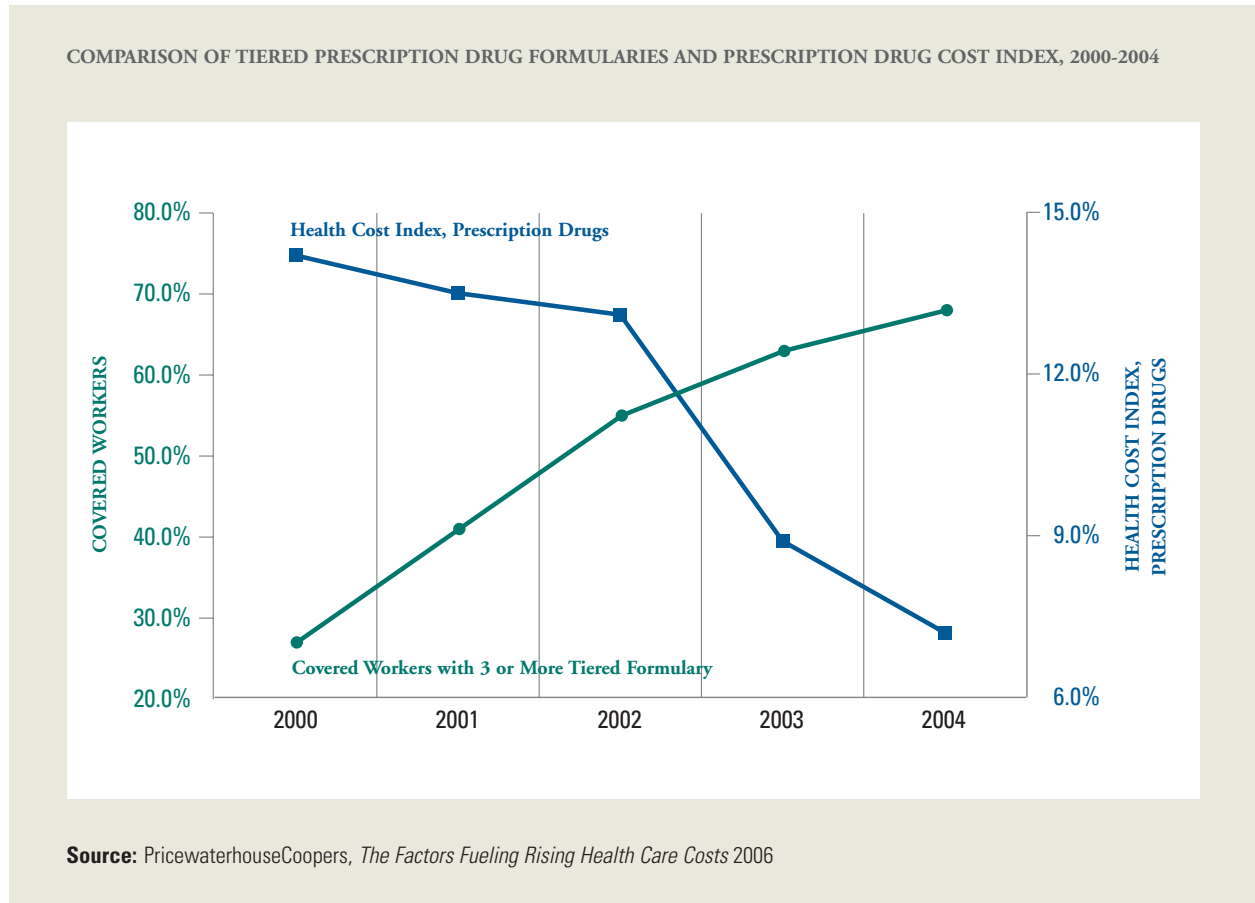
Health plans help consumers get the medications they need and, at the same time, help hold down the nation's prescription drug expenditures by encouraging patients and physicians to take advantage of less-costly generic drugs where appropriate and by working with health plan members to improve prescription drug access and affordability.

Sometimes a brand-name drug is needed. In many instances, however, a generic drug may have therapeutic value equivalent to a brand-name drug, but at substantially lower cost. Health plans' formularies (constantly updated directories of prescription drugs approved for coverage) encourage the substitution of generics where deemed appropriate by doctors, typically by providing for multi-tiered copayments. Formularies are designed not to bar the use of any prescription drug but to provide reasonable, clinically justified incentives to rely on the most cost-effective as well as therapeutically effective medications.

As an independent analysis published in the journal *Health Affairs* recently reported:

“For the fifth year in a row, the drug spending trend decelerated in 2004. Spending on prescription drugs per privately insured person grew 7.2 percent in 2004 compared with 8.9 percent in 2003. Moreover, this increase was less than half the 1999 increase of 18.1 percent. Growth in drug spending accounted for 21 percent of the total increase in health care spending, well below its contribution in the late 1990s. The continuing slowdown in 2004 is largely the result of slower growth in drug prices rather than a change in use. Prescription drug prices increased just 3.3 percent in 2004 compared with 5.2 percent in both 2002 and 2003. This likely reflects, in part, the movement toward three-tier copayments, which have now become common in health benefit offerings, as well as the continuing growth in those copayments across all of the three tiers. Three-tier designs encourage greater use of generic drugs, which have become increasingly prevalent in recent years and tend to be priced far below their brand-name equivalents. Also, differences in copayments for preferred versus nonpreferred brand-name drugs help create price competition among manufacturers that could be helping hold down price increases.”<sup>1</sup>

Moreover, a study by PricewaterhouseCoopers of the factors fueling health care cost increases found that prescription drug cost increases have fallen significantly as more Americans are covered by health plans' tiered prescription drug formularies:



Health insurance plans' cost-saving programs are yielding significant results as plans work with their members to obtain effective medications at an affordable cost. Two examples show how health plans' case managers are reaching out to patients (names have been changed to protect patient confidentiality):



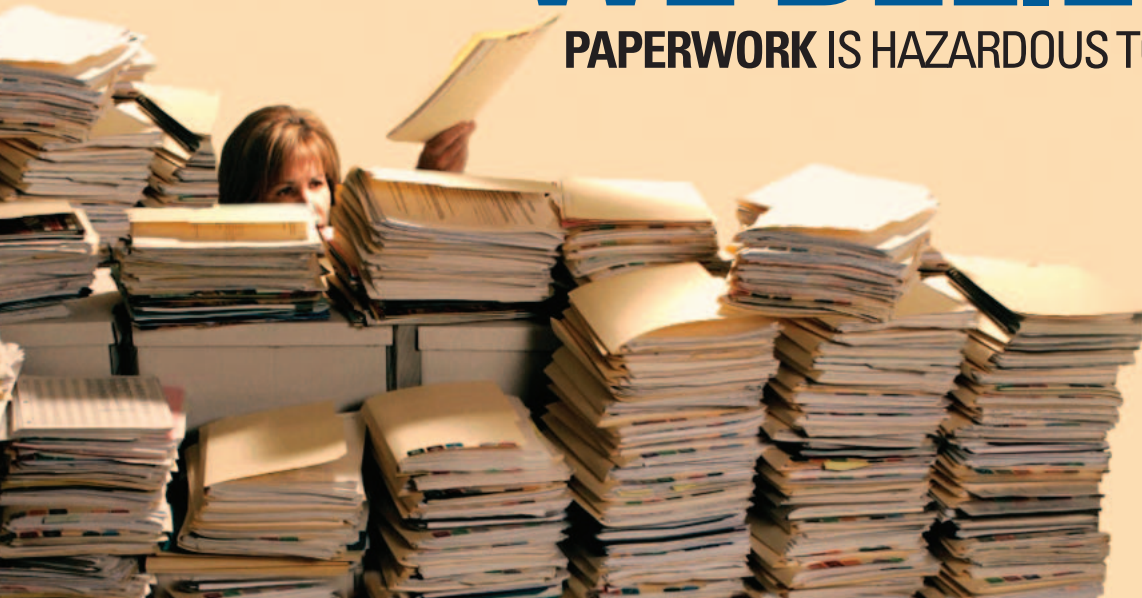
- **Barbara**, a 75-year-old participant in a Medicare Rx plan, was contacted by a case manager after returning a questionnaire indicating she needed help managing drug costs. She said she couldn't afford the monthly cost of her brand-name diabetes medication and was thinking about quitting the plan. The case manager explained about generic drugs and suggested that Barbara ask her doctor about getting the generic form of the drug she was taking. The case manager also arranged for mail-order drug service. Within a week after getting her new prescription, Barbara had received a three-month supply of the generic drug at an out-of-pocket cost of only \$10, an annualized savings of more than \$400.
- **Esteban**, who is legally blind, can walk around his neighborhood but depends on others for help obtaining products and services that are not locally available. He was relying on a mail-order pharmacy for a particular medication that he believed could only be obtained from that source. A call to a health plan's member services department prompted a case manager to investigate. She found that in this particular case the mail-order pharmacy's charges were higher than necessary and that a neighborhood pharmacy could supply the medication at lower cost – including the cost of delivery. Delighted, Esteban has been able to lower the cost still more by declining the delivery service, since he knows the neighborhood well and can get to the pharmacy on his own.

As these statistics and examples demonstrate, health insurance plans' marketplace leverage, prescription benefit management programs and personal service are holding down drug costs while helping people get the medicines they need.

In short, *health plans are adding value to every dollar spent on prescription drugs.*

# WE BELIEVE

**PAPERWORK IS HAZARDOUS TO YOUR HEALTH.**



*America is struggling under the burden of rising medical costs, and more paper won't help. Health insurance plans' investments in online technology are cutting paperwork, speeding claims processing and reducing costs. In fact, electronic forms have reduced paper claims by more than half since 2002. And today, 68 percent of electronic claims are paid within one week.*

## Investing in secure, cutting-edge information technology to cut paperwork, empower patients and providers, speed claims processing, and reduce costs.

Everyone complains about the needless paperwork involved in health care. We're doing something about it.

Health insurance plans' investments in online technology are cutting paperwork, speeding claims processing, improving care, making more information available to consumers, and cutting costs.

**Cutting paperwork:** Health plans' electronic forms – increasingly standardized and simplified – have streamlined claims processing, helping to cut the percentage of claims submitted on paper by more than 50 percent since 2002. And the average cost of processing a claim filed electronically is close to 50 percent lower than for a claim filed on paper.<sup>ii</sup>

**Speeding claims processing:** Thanks to online efficiencies, 70 percent of all medical claims are now being paid within 14 days, and 68 percent of all claims filed electronically are being paid within 7 days.<sup>iii</sup>

**Improving the quality of care:** Health plans' innovations in online technologies are bringing quality care to more patients. For example:

- A Florida health plan addressed a shortage of critical care physicians in its service area by creating an electronic intensive care unit (e-ICU) with three participating hospitals, allowing specially trained doctors and nurses to remotely monitor ICU patients' vital signs on a 24/7 basis. Result: fewer ICU patients experiencing cardiopulmonary arrest, more rapid responses by care teams, and reduced mortality – as well as lower costs.<sup>iv</sup>
- Three health plans in Massachusetts are working together to rapidly advance the use of e-prescribing technology by physicians statewide. A handheld PDA-type device enables doctors to access patients' medication histories, check for drug allergies and harmful interactions, and write and renew prescriptions electronically. Result: greater efficiency, enhanced patient safety, elimination of illegible-handwriting errors – and lower costs.<sup>v</sup>

- A Nevada health insurance plan has launched an advanced radiology program that captures X-rays in digital format and makes them immediately available for doctors in different locations to consult, review, and evaluate. X-ray images are accompanied by radiologists' notes transcribed electronically via voice recognition and stored as Word documents for easy access. Result: improved efficiency, better care – and lower costs.<sup>vi</sup>

**Providing more information to consumers:** Health insurance plans' innovations in online technologies are paying off for health care consumers. Typical examples include:

- **Secure, real-time access to personal information** on benefits, premiums, deductibles, claims status, and how to make the most effective use of coverage.
- **Personal health record (PHR):** Many insurers are in the forefront of developing electronic consumer-controlled PHRs capable of maintaining comprehensive medical information that can be accessed, if authorized by the PHR-holder, wherever and whenever care is needed. PHRs keep track of health conditions, treatments, medications, and health screening schedules, among many other advantages.
- **Web-based information:** Health insurance plans with interactive Internet sites are helping members search for hospitals and doctors based on location and specialties; compare hospitals; request appointments and communicate with health care providers; refill prescriptions; research information about specific health conditions; join discussion groups; manage chronic conditions; and provide feedback to health care providers and case managers, electronically transmitting vital signs such as heart rate and rhythm, blood pressure, etc.

The era of paperwork isn't over yet. But health insurers are leading the way toward a smarter, better system in which patients and providers have access to all the information they need to make safer, better and more cost-effective decisions.



# WE BELIEVE

**LOSERS CAN ALWAYS WIN.**

*Fending off heart disease and type 2 diabetes starts with losing weight. Early detection of emerging problems is also critical. So health insurance plans are encouraging fitness, providing extensive coverage for preventive screenings and urging patients to get check-ups. These programs help people stay healthy, and over the long-term they may also lower health care costs for everyone.*

## Promoting prevention and wellness to keep people healthy in the first place and reduce health care costs for everyone.

What's more effective, preventing illness or waiting until a condition becomes acute or chronic? The answer is obvious. Health insurance plans are reaching out to millions of at-risk Americans to systematically encourage preventive care and early intervention. With extensive preventive-care coverage and strategies in place to promote appropriate care when a condition does develop, health plans are working with Americans of all ages to make sure they receive the right care at the right time and in the right setting.

Take pediatric preventive screenings, for example. Nothing can mean much more to concerned parents than to know that their children are covered and protected against debilitating childhood diseases. And, across the board, health plans provide this kind of coverage today:

CHILDHOOD MEDICAL CONDITION	PERCENT OF HMO AND PPO PRODUCTS COVERING
Hepatitis B	100%
Diphtheria, Tetanus, Pertussis	100%
Haemophilis Influenza Type B	100%
Inactivated Polio	100%
Measles, Mumps, Rubella	100%
Varicella	100%
Influenza	100%

**Source:** *AHIP Coverage Magazine, January-February 2006*

Equally important is the **timely and appropriate care** facilitated by health plans' coverage, to help patients recover from an acute episode of illness and/or to reduce the risk of developing a debilitating chronic condition. Health plans have recorded significant progress in this area. For example:

- **Controlling cholesterol:** 68 percent of commercial health plan members received guideline-recommended care for cholesterol management after a heart attack in 2004, as measured by HEDIS® and reported to NCQA, an increase of 27 percent since 2000. Among Medicare and commercial patients, this resulted in an estimated 3,352 to 5,658 lives saved since 1999.<sup>vii</sup>
- **Controlling high blood pressure:** 69 percent of commercial health plan members received guideline-recommended care to control high blood pressure in 2005, as measured by HEDIS® and reported to the National Committee for Quality Assurance (NCQA), an increase of 34 percent since 2000. Among Medicare and commercial patients alone, this resulted in an estimated 47,800 to 83,000 lives saved since 1999.<sup>viii</sup>
- **Recovering from a heart attack:** 97 percent of commercial health plan members who experienced a heart attack in 2005 received guideline-recommended treatment with beta blockers, as measured by HEDIS® and reported to NCQA, an increase of 14 percent since 1999. Among Medicare and commercial patients, this resulted in an estimated 4,200 to 5,300 lives saved since 1999.<sup>ix</sup>
- **Diagnosing breast cancer:** A study by the Centers for Medicare and Medicaid Services (CMS) and the National Cancer Institute (NCI) found that women enrolled in health insurers' Medicare Advantage plans were more likely to have their breast cancer diagnosed and treated at an early stage than women with basic Medicare fee-for-service coverage.<sup>x</sup>
- **Screening and testing for diabetes:** An analysis of data compiled by NCQA and published in the *Journal of the American Medical Association (JAMA)* found that Medicare patients enrolled in Medicare Advantage plans were more likely to receive guidelines-recommended screening and testing for diabetes (as well as superior post-heart attack treatment, flu vaccinations, and breast cancer screenings).<sup>xi</sup>

Success stories at the individual level (again, with names changed to protect patient confidentiality) further illustrate how health plans are adding value to preventive care and management of chronic conditions. For instance:

- **Robert** hadn't had a physical exam in years. When he finally did, his primary care physician warned him that he had dangerously high cholesterol and blood pressure and was borderline for diabetes. Robert's physician referred him to his health plan's Health Education and Wellness Division for counseling on how to develop a healthier lifestyle. He learned about nutrition, portion control, eating fewer carbohydrates and more vegetables and protein, and how to avoid foods containing preservatives, hydrogenated oils, high-fructose corn syrup and artificial flavors. Because Robert also had asthma, his counselor started him out slowly on his lifestyle plan, but stayed in touch and monitored progress. Result: Robert has lost 66 pounds; his cholesterol, blood pressure and blood sugar are under control, and he no longer has to take asthma medications.
- **Martha's** health plan contacted her about weight management after learning that she was at severe risk for several chronic conditions and encouraged her to enroll in Weight Watchers, offering a premium adjustment if she could reach her age-appropriate weight range and staying in touch with her as she developed her weight-loss plan. She achieved her goal and has become a lifetime Weight Watchers member as well.
- **Michael** had been trying for 10 years to control his cholesterol, taking different medications, but nothing seemed to work. Then he signed up for "Taking It to Heart," a class offered by his health plan. "It was a real eye-opener," he says. "I thought I was eating well and exercising enough, but I discovered that I was just plain eating too much. I learned how to calculate portion sizes and increase my fiber, vegetable, and fruit intake. I also started walking 3.5 miles a day." Thanks to the education and encouragement he received from his health plan, Michael's bad cholesterol levels have dropped into the recommended range, and today he's taking no cholesterol medications at all.



It's widely recognized that millions of Americans need to make lifestyle changes in order to improve their health and guard against developing debilitating or even life-threatening chronic conditions. What's perhaps less well known is that health plans are helping many of them to make the changes needed, often with a simple but effective mix of outreach, education, and guidance.

By helping many Americans live healthier lives than they might otherwise – and thereby avoid the often significant risks and costs of preventable illnesses – health insurance plans are stretching health care dollars throughout the system.

# WE BELIEVE

**CONTROLLING SUGAR LEADS TO A SWEETER LIFE.**



*Smart diet choices and close monitoring of blood sugar are essential to managing diabetes. So many health insurance plans offer nurses and counselors who help those with diabetes and other chronic conditions follow their treatments and lead fuller lives. In addition to their positive impact on patients' health, disease management programs can ease health care cost increases. Studies show that these programs can reduce the cost of caring for chronic illnesses by as much as 25 percent.*

## Helping people with chronic illnesses follow their treatments and lead fuller, healthier lives.

Health plans are adding value to the nation's health care expenditures by investing in disease management programs, which not only help their members with chronic conditions to maintain the highest possible level of health but also reduce costs by avoiding the need for catastrophic-level care.

Here are two examples from health insurance plans (again, with the patients' names changed to protect confidentiality):

- A coworker got **Gina**, who suffers from diabetes, to contact her personal health advocate available through her health plan. The nurse taking the call wasted no time getting her started in the disease management program. With help from her health plan, Gina started to work on improving her blood sugar level by doing regular exercise. The improvement she sees—and the encouragement she receives from her health plan is helping her get on a path to better health.
- **Hugh** is a 40-year-old man who is both blind and diabetic. While he was in the hospital following a hypoglycemic episode, he was contacted by the health plan's diabetic case manager, who offered to work with him to avoid further episodes requiring hospitalization. The case manager – we'll call her Donna – learned that Hugh was routinely experiencing three to four hypoglycemic episodes at night. She also learned that he lived with his mother, who, although working full-time, had to set her alarm clock to go off several times during the night so that she could check on him. That wasn't working well, and his hospitalizations were becoming more frequent. After he was discharged, Donna continued to call Hugh and suggested he see a specialist to help manage his unstable diabetes. But Hugh hadn't had very good experiences with doctors and

was reluctant to see an endocrinologist. Donna didn't insist, but she stayed in touch and gradually was able to convince him that it would be a good idea. "I'll go," he finally said – "but only if you'll go with me." To his surprise, Donna agreed – and Hugh kept the appointment despite a winter storm that dumped a foot of snow that day. Hugh's first visit convinced him that the endocrinologist could help him stabilize his diabetes, and since then he has been returning regularly to the specialist's office. He reports that his quality of life has greatly improved – and so has his mother's. He told Donna recently that he now has a hypoglycemic episode only about once a month, and he hasn't had to be hospitalized again. "None of this would have happened if you and [the health plan] hadn't gone out of your way to help me," he said. "You've made all the difference!"

Stories like these may not make headlines, but they are good news for patients with chronic conditions. Dedicated case managers like Donna, despite having responsibility for keeping track of many patients, are often able to help arrange the kind of individualized care that pays a double dividend: improving a patient's quality of life while at the same time avoiding the high costs and attendant risks of hospitalization.

There's strong evidence that health plans' disease management programs pay off for participating patients:

- In its first year of operation, an **asthma management** program run by a Florida health plan reduced emergency room visits among members participating in the program by 22 percent – from 18.6 visits per 10,000 to 14.0 visits per 10,000.<sup>xii</sup>
- Among 5,100 members participating in a health plan's **back care** program, the percentage reporting their pain as “mild” or better increased from 28.2 percent at enrollment to 44.3 percent a year later, and the percentage reporting that their back pain did not interfere with work increased from 10.9 percent to 22.9 percent.<sup>xiii</sup>
- Several thousand men and women have participated in a health plan's **depression management** program. A comparison of health care experience among high-risk participants and a control group not participating in the program found that use of outpatient behavioral health services was 7 percent higher among program participants; emergency room visits were 5 percent lower; and hospitalized days were 22 percent lower.<sup>xiv</sup>
- A study of health plans' **diabetes management** programs found that participants experienced significantly fewer long-term complications affecting their eyes, kidneys, cardiovascular systems and nervous systems. The study also found that the patients with the longest involvement in the programs had the best health outcomes.<sup>xv</sup>



Studies have also found that health plans' disease management programs show promise in slowing the growth of the nation's overall health care costs:

- A study of a health plan's **diabetes management** programs in 10 urban areas found that treatment costs were 24.7 percent lower for participants than for non-participants, with a 22 percent to 30 percent reduction in hospitalizations providing the most important source of savings.<sup>xvi</sup>
- A study of a health plan's **heart disease management** program serving older women found that participants experienced 46 percent fewer hospitalized days and 49 percent lower hospitalization costs than non-participants, and that hospital cost savings exceeded program costs by a ratio of nearly 5:1.<sup>xvii</sup>
- A study of the cost savings associated with a disease management program for three conditions – **asthma, diabetes, and coronary artery disease** – found that the program produced cost savings amounting to a return on investment of \$2.84 per \$1.00 invested.<sup>xviii</sup>
- A study of a large **multiple-conditions disease management** program, comparing the costs of caring for participants versus non-participants, found that first-year savings amounted to a return of at least \$2.90 for every \$1.00 invested; average overall savings of \$41 per program participant per month; 14 percent fewer hospitalizations; 18 percent fewer emergency room visits; and a significant (7 percent to 11 percent) reduction in absenteeism from work or school.<sup>xix</sup>
- A study of the effectiveness of health plans' **end-stage renal disease (ESRD)** management programs for Medicare enrollees found that enrollees had better outcomes at lower cost than ESRD patients with traditional Medicare fee-for-service coverage: 45 percent to 54 percent lower hospitalization rates and 19 percent to 35 percent higher survival rates.<sup>xx</sup>
- A health plan's members enrolled in a **congestive heart failure management** program had total per-member per-month costs 33 percent lower than for members with congestive heart failure who were not enrolled in the program, and emergency room visits and inpatient admissions were also 33 percent lower.<sup>xxi</sup>

Not surprisingly, health plans' disease management programs are popular with participants. For example, a major plan's annual member satisfaction survey found that 96 percent of participating members and 92 percent of physicians were satisfied with the plan's chronic heart failure management program.<sup>xxii</sup>

It's clear: patients and physicians alike increasingly recognize and appreciate that *health plans' investments in disease management are adding value to health care.*



# WE BELIEVE

**COMMON SENSE**  
IS THE BEST CURRENCY.

*Rising medical costs are a strain on families, employers and taxpayers. Health insurance plans provide protection against catastrophic medical expenses, while their cost-containment strategies and negotiations with health care providers stretch health care dollars. In addition, insurers' prevention and wellness initiatives help keep people healthy in the first place, which eases cost pressures throughout the system.*

Taking unnecessary costs out of the system and finding savings for patients, employers and taxpayers.

*“My health insurance premium – just where does that money go?”*

Consumers and employers have every right to ask that question. And the answer is that, on average, more than 80 cents of every health insurance dollar go directly to pay for medical services such as doctor visits, prescription drugs, hospital costs, and other services.

## Where Does Your Health Insurance Dollar Go?



\*Includes prevention, disease management, care coordination, investments in health information technologies and health support.

\*\*Includes the inpatient costs of hospitals and the outpatient costs of hospitals and free-standing clinics.

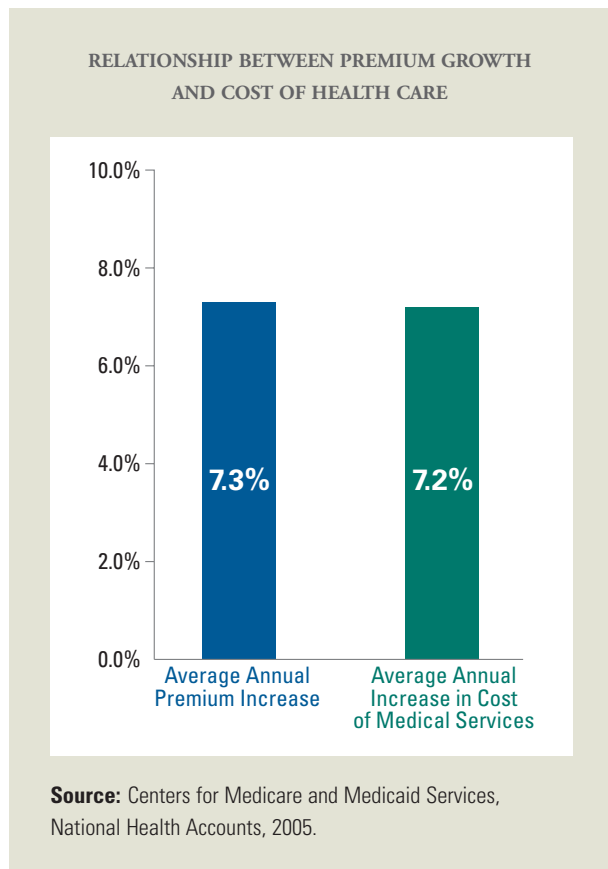
Based on a PricewaterhouseCoopers' analysis, *Factors Fueling Rising Healthcare Costs 2006*. © 2006 America's Health Insurance Plans



Of the remainder, 5 cents go to important consumer services such as prevention, disease management, care coordination and investments in health IT, as well as provider support and marketing. About 6 cents go to insurers' administrative costs including claims processing and compliance with government regulations. Three cents go to insurance industry profits.<sup>xviii</sup>

It's also worth noting that the medical liability system continues to exacerbate the problem of rising medical costs. The same report found that approximately 10 cents out of the 86 cents spent on medical services is attributable to medical liability and the practice of defensive medicine.

Health insurance premiums increase every year for two principal reasons: Americans are utilizing more medical care and some medical services are getting more expensive. Indeed, as researchers have noted, increases in health insurance premiums track very closely with increases in the underlying cost of medical services.



Health plans are using a variety of tools and techniques to drive unnecessary costs out of the health care system. From a consumer's perspective, perhaps the most important of these is insurers' strong emphasis on covering – and encouraging – preventive care and proactive management of chronic conditions. As previously noted, this investment strategy yields a double dividend: helping people to live healthier lives while avoiding the high costs and attendant risks of hospitalization.

Health plans also drive unnecessary costs out of the system – and thereby add value to the dollars spent on health care – through such techniques as encouraging the substitution of cost-effective generics for brand-name drugs when warranted, and by working with health care providers and policymakers to rein in the runaway costs of defensive medicine, opportunistic litigation, and arbitrarily mandated benefits that drive up costs without improving the overall quality of care.

Further, health insurers work to improve the quality and affordability of care by supporting, encouraging and implementing 'pay-for-performance' arrangements based on measuring outcomes and rewarding practitioners accordingly. This strategy promises to yield increasingly significant cost-saving benefits as the tools available to compare physicians' and hospitals' performance are refined over time and as consumers become more committed to making performance comparisons as part of the process of making informed health care choices.

Finally – and importantly – health insurance plans are driving unnecessary costs out of the system by negotiating with hospitals and doctors on behalf of employers and consumers. As a result, costs are being kept significantly lower than if employers and consumers had paid full retail price for medical services.

For example, recent data indicates that PPO networks provide significant discounts to their members across all provider types. Specifically, the data revealed that:<sup>xix</sup>

- 13 percent of PPO networks negotiate average discounts of up to 20 percent;
- 46 percent of PPO networks negotiate average discounts of 21 percent to 35 percent;
- 30 percent of PPO networks negotiate average discounts of 36 percent to 50 percent; and
- 10 percent of PPO networks negotiate average discounts of more than 50 percent.



Insurers' ability to negotiate discounts for employers and consumers is a unique and critically important role within the health care system. And they are increasingly able to target their resources to achieve cost savings by working to improve care and avoid the unnecessary costs associated with delayed, inappropriate, or ineffective care. This new generation of cost-containment strategies focuses on making sure consumers get the care they need in the most cost-effective manner, helping to ease cost pressures throughout the system.

There's persuasive evidence that many consumers appreciate how health plans are striving to make health care more accessible, affordable, and effective. We see that appreciation reflected in consumers' comments and in the consumer satisfaction surveys regularly conducted by health plans and independent researchers:

- Industrywide data from 2005 show that 89 percent of Americans are satisfied with their current health insurance plan. More than half describe themselves as

either 'extremely satisfied' (17 percent) or 'very satisfied' (37 percent).<sup>xv</sup>

- The percentage of Americans who describe themselves as 'extremely satisfied' with their health plan has increased for four straight years.<sup>xvii</sup>
- A 2007 survey sponsored by the *New York Times* and CBS News found that 87 percent of respondents with private or public insurance said their health care coverage gives them access to good medical care at an affordable cost.<sup>xviii</sup>
- By more than a 5-to-1 margin, insured voters have a favorable opinion of their own health plan.<sup>xviii</sup>

Consumers are increasingly on the same page with health plans in understanding that our health care system will be sustainable only if it is strengthened to make it as results-oriented and affordable as possible.

# WE BELIEVE

GETTING ON THE SAME PAGE

MEANS STARTING A NEW CHAPTER.



*Health insurance plans have developed a comprehensive, common-sense plan to make health care coverage accessible to more than 40 million uninsured Americans. This plan includes a stronger and smarter health care safety net, new tax-free health care accounts, and a helping hand for working families. It builds on what works and changes what doesn't. It's a plan that voters support and our country can afford.*

## Leading the effort to ensure access for all Americans.

Our health care system performs miracles of care every day. At its best, it's the best in the world. But its flaws leave far too many Americans out in the cold, without adequate protection – and drive up costs for everyone else.

More than 46.6 million people in the United States – including 8.3 million children – currently lack health insurance. In 2007 that should be unacceptable.

*We believe every American should have access to affordable health care coverage.*

In November 2006, America's Health Insurance Plans (AHIP), representing health insurers providing health benefits to more than 200 million Americans, launched a bold new initiative to extend health insurance coverage to all Americans. The plan is designed to provide access to coverage for all children within three years and to 95 percent of adults within 10 years. It would expand eligibility for public programs, enable all consumers to purchase health insurance with pre-tax dollars, provide financial assistance to help working families afford coverage, and provide incentives for states to develop and implement innovative access initiatives.

Key elements of the AHIP proposal include:

- Expanding the **State Children's Health Insurance Program (SCHIP)** to cover all uninsured children from families with incomes under 200 percent of the federal poverty level.
- Establishing a **tax credit** of up to \$500 annually for low-income families who purchase health insurance for their children.

- Improving and expanding **Medicaid** to make eligible all uninsured adults, including single adults, with incomes under 100 percent of the federal poverty level.
- Establishing a **Universal Health Account (UHA)** to allow all individuals to purchase any type of health care coverage and pay for qualifying medical expenses with pre-tax dollars, with federal matching grants for contributions to UHAs by working families.
- Establishing a new \$50-billion **Federal Performance Grant** to assist states in expanding access to coverage.

With this approach, health insurers propose to move beyond the political stalemate of recent years and build on the strengths of both the public and private sectors. Steps such as those we propose *can* swiftly and effectively break down the barriers to coverage that have thwarted other approaches, without imposing needlessly complex or inflexible solutions. They demonstrate that we can get there from here – if we put aside political partisanship and work together toward a common goal.

Our approach can work – because it:

- Provides a roadmap for reform;
- Builds on the strengths of the current system;
- Shares responsibility between the private and public sectors;
- Expands access in phases; and
- Resonates with voters across the political spectrum.



# WE BELIEVE

**STARTING SMALL REQUIRES THINKING BIG.**

*Covering every uninsured child within three years. It's the cornerstone of health insurance plans' comprehensive framework for making health care coverage accessible to more than 40 million uninsured Americans. By strengthening the health care safety net and rewarding working parents who cover their kids, we can make sure that all children have the health care coverage they need.*

## Rallying support for children's health care coverage.

One goal on which nearly everyone agrees is making sure all children are covered by health insurance.

It's no surprise that studies show that children without health insurance tend to be less healthy than children who do have coverage. But a child's health is not the only thing at stake. Research indicates that lack of health care coverage can lead to further absences from school—potentially setting children back academically and, ultimately, hindering their ability to compete in the workforce.

Public-private partnerships already provide coverage to millions of children whose families lack access to private coverage. By strengthening SCHIP and Medicaid and providing tax incentives for working parents to cover their kids, we can close that gap and ensure that all kids have the coverage they need.

The public has made it clear this is a top priority. More importantly, the public has rallied behind these proposals

as an effective vehicle to extend coverage to children. In fact, a recent survey found that:

- 77 percent of Americans support increasing funding for a health insurance program for children from low-income families that would be paid for by the federal and state governments, and
- 85 percent support giving a tax credit to any low- and moderate-income parents who can show that their children are covered by health insurance.

In a country that is divided along partisan political lines on many issues, these findings demonstrate that covering kids brings the country together. Moreover, progress on this unifying issue could lay the groundwork for broader reforms.

That's why our comprehensive plan to cover the uninsured starts with covering all kids. It's the right goal and the right time.

# SOURCES

The stories involving individuals in this report were provided by members of America's Health Insurance Plans.

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