Heart Disease and Stroke. You're the Cure.

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FACTS

Reforming Health Care:

If It Isn't Affordable, It Isn't Fixed

OVERVIEW

The American Heart Association supports meaningful health reform that produces available, affordable, and adequate care. Simply providing people access to an insurance plan is meaningless if families can't afford the premiums and the policy doesn't cover the care they need.

A vast majority of Americans (85%) are concerned about their family's health care costs in the future[1] – and understandably so. Employer-sponsored health insurance premiums have more than doubled since 2000, growing four times faster than wages. Without addressing rising costs and making care more affordable, health care spending will nearly double to $4.4 trillion by 2018. The result: nearly one-in-five U.S. businesses plan to stop providing health benefits to their employees in the next three to five years, and the number of uninsured will rise to 61 million by 2020.[2]

The Association believes that the following reforms are necessary to make quality health care a real choice for Americans.

MAKING PREMIUMS AFFORDABLE

The biggest barrier to affordable coverage for most Americans is their monthly premium. More than half of the uninsured with heart disease and stroke cite cost as the reason they are uninsured.[3]

Individuals and families must be able to afford premiums. Subsidies should be available for low- and middle-income families making up to 400% of the federal poverty level to help make premiums affordable. In addition, families shouldn't be expected to pay more than 8 percent of their income on their health insurance premiums.

To put the affordability of premiums into context, the average cost of an employer-based family insurance policy was $12,680 in 2007.[4] Currently, the typical worker with employer-sponsored family coverage spends 5-6% of their income on insurance premiums.[5] The average federal employee pays 6% of his or her income on coverage through the Federal Employees Health Benefits Program.

LIMITING AGE DISCRIMINATION

The additional amount that insurance companies are allowed to charge older Americans ages 50-64 should be strictly limited so that their premiums are no more than twice as much as the premiums of younger adults.

Currently, insurance companies charge older consumers up to five times more than younger adults for their health insurance. As a result of this practice known as "age rating", a growing number of older adults lack insurance coverage or are more likely to spend a much larger portion of their income on health care. According to an AARP study, two-thirds of adults ages 50-64 who buy their coverage in the individual insurance market spend 10% or more of their income on health care.[6]

The average age of a patient with cardiovascular disease is 57 years old so age rating has enormous consequences for heart disease and stroke patients. Without placing a 2-to-1 limit on age rating, older Americans will find that affordable coverage is still out of reach. For example, if 5-to-1 age rating was allowed in Massachusetts, the basic health benefits ("bronze") package would cost up to $16,020 a year – which is more than half of the average annual

income of $30,000 among older *uninsured* Americans ages 50-64 today.

Conversely, at the other end of the spectrum, young adults should be allowed to stay on their parents' policy until age 26. Such a feature would help reduce "rate shock" for young adults required to purchase insurance for the first time and would help ensure that young and healthy adults join the insurance pool.

CHUCK AND KATHLEEN

Chuck and Kathleen are in their late 50's and they share a long history of medical complications associated with cardiovascular disease and stroke. Both have had to undergo cardiac bypass surgery. For many years the couple worked hard and stayed covered. But a medical disability forced Chuck into early retirement and he was unable to obtain Medicare coverage until the end of the two-year waiting period. Kathleen was laid off from her job (which provided medical coverage) and the couple is now relying on COBRA. Their combined monthly income of $2,700 has to cover the COBRA premiums ($750), other out-of-pocket medical expenses ($350), their mortgage payment and condo fees ($1,400). Buying food and paying for all other bills is quickly depleting their life savings. Chuck is amazed at how quickly their financial situation changed. "We worked so hard to save what we have for our golden years," he said. "This whole situation has been a drain – emotionally, physically and financially."

LOWERING OUT-OF-POCKET COSTS

To fulfill the promise of health reform, families should be protected from catastrophic health care costs by limiting cost-sharing and capping the total amount that patients should have to pay out-of-pocket for both in-network and out-of-network care.

Even for those with health insurance, more and more Americans are facing difficulties meeting their out-of-pocket health care costs. In fact, 62% of all bankruptcies filed in 2007 were due in part to medical expenses,[7] and cardiovascular disease was one of the top reasons cited by families for medical bankruptcy.[8] Notably, nearly 80% of those who filed medical bankruptcies had insurance.[7]

Heart disease and stroke cause among the highest out-of-pocket expenses, with stroke resulting in average out-of-pocket spending of $23,380 and heart disease $21,955 in 2007.[7] A recent study found that people who had trouble paying their medical bills did significantly worse after a heart attack than patients who were not under financial pressure.[9]

THE AHA ADVOCATES

In summary, the American Heart Association and its American Stroke Association division support the following policies to help ensure that health care is affordable for all Americans:

- Subsidies should be available for low- and middle-income families making up to 400% of the federal poverty level to help make premiums affordable.
- No one should be asked to pay more than 8% of their income on their health insurance premiums.
- There should be a 2-to-1 limit on the difference that insurance companies are allowed to charge older adults for their premiums, compared to their younger counterparts.
- Young adults should be allowed to continue their coverage on their parents' policies until age 26.
- Cost-sharing in the basic benefits package should be no more than 13% of the value of the coverage, based on income.
- Out-of-pocket spending for care received both in-network and out-of-network should be capped at $5,000 for individuals and $7,000 for families.

References
[1] Washington Post-ABC News Poll, June 21, 2009.
[2] "Health Care By The Numbers." June 19, 2009.
[3] Skorton DJ, Garson, Jr. A, Fox JM, Truesdell SC, Webb, GW, Williams RG. Task Force 5: adults with congenital heart disease – access to care. J Am Coll Cardiol 2007;37:1093-1198.
[4] Kaiser Family Foundation & Health Research and Educational Trust (2008). "Employer Health Benefits 2008 Annual Survey."
[5] Community Catalyst. "How Much Can Families Really Afford for Health Care? A Comparison of Current Congressional Proposals." July 2009.
[6] AARP Public Policy Institute. "Health Care Reform: What's at Stake for 50- to 64-Year Olds?" March 2009.
[7] Himmelstein D, Thorne D, et al. "Medical Bankruptcy in the United States, 2007: Results of a National Study." Am. Journal of Medicine 2009.
[8] Himmelstein D, Warren E, et al. "Illness and Injury as Contributors to Bankruptcy." *Health Affairs* Web Exclusive. February 2, 2005.
[9] Rahimi AR, Spertus JA, Reid KJ, et. al. Financial barriers to health care and outcomes after acute myocardial infarction, JAMA 2007; 297:1063-1072.