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ENSURING AFFORDABLE HEALTH COVERAGE AND HEALTH CARE SERVICES IN AN INSURANCE EXCHANGE

by Judith Solomon

A health care reform proposal that requires everyone to obtain health insurance must establish mechanisms to make both health coverage *and* health care services affordable. Low- and moderate- income people who receive subsidies to help them afford the premiums for coverage can still end up not getting the health care they need if they cannot afford the deductibles, co-payments, and other out-of-pocket costs.¹

Designing a subsidy system that provides low- and moderate-income people with both coverage and access to care is far easier if the entities that will offer consumers a choice of health insurance — most often called health insurance exchanges — are properly structured. An earlier Center on Budget and Policy Priorities analysis² outlined the four elements of a well-structured exchange. (See the text box on the next page.) This report

KEY FINDINGS

- Most uninsured people cannot afford to pay for health coverage on their own, so they will need subsidies to help them pay for coverage.
- Low- and moderate-income people also need protection against high deductibles and co-payment charges. Even relatively modest changes cause such individuals to forgo needed care, research shows.
- Accordingly, a cap should be placed on the total out-of-pocket costs that low-and moderate-income families must bear (as is done under the Children's Health Insurance program). These families should have access to health plans without high deductibles, so people who are sick can afford health services that they need.
- Costs of health services that a health plan does not cover don't count against an out-of-pocket cap. This is another reason that all health plans should be required to provide at least a basic, comprehensive package of essential benefits.

¹ Most people who are uninsured cannot purchase health coverage on their own. Four out of five people who are uninsured have incomes at or below 300 percent of the poverty line, or \$32,490 for an individual and \$54,930 for a family of three in 2009. Henry J. Kaiser Family Foundation, "The Uninsured: A Primer," October 2008 at <http://www.kff.org/uninsured/upload/7451-04.pdf>.

² Sarah Lueck, "Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Enrollees," Center on Budget and Policy Priorities, March 31, 2009. Requiring that health insurers offer coverage to all who want to purchase it ("guaranteed issue") and prohibiting insurers from charging more to individuals based on their health status and other characteristics such as gender ("community rating") also make it easier to design an effective subsidy system by making coverage available and affordable.

examines one aspect of the first of those elements: the need for an annual cap on the combined premiums and out-of-pocket costs that low- and moderate-income beneficiaries must pay.³

Key Components of an Effective Insurance Exchange*

To ensure that an exchange provides affordable, comprehensive coverage to all enrollees, enables people to make informed choices among competing health plans, and fosters competition based on price and quality (rather than on which plans do best at deterring sicker, more costly enrollees and attracting healthier ones), the exchange will need four key components:

- *Minimum standards for benefit design* to ensure that individuals get the care they need at an affordable price. Without being overly prescriptive, the standards should assure that plans provide coverage for a comprehensive set of necessary services, such as physician visits, inpatient hospital care, and prescription drugs, and should define the scope of coverage. The standards should also include a limit on beneficiaries' total out-of-pocket costs. With these protections in place, individuals would not have to worry about having chosen the “wrong” insurance if they subsequently develop a medical condition or illness.
- *Limits on the degree of variation in different benefit designs* to prevent insurers in an exchange from creating benefit packages designed to deter less-healthy enrollees and attract only individuals in good health. Such limits — which are a basic feature of the Massachusetts health reform system as well as of the Medigap market, in which private insurers sell supplemental coverage to Medicare beneficiaries — also better enable consumers to compare the price and quality of different plans.
- *A limit on the number of different plan choices* in an exchange, which is crucial to helping individuals make intelligent decisions about coverage, rather than being overwhelmed by a bewildering number of choices.
- *A requirement that insurers in an exchange offer the full range of different benefit designs and that they base premiums for a geographic area on a single pool of all people in the area who are enrolled in any of the insurer's plans.* This requirement, which Massachusetts' Commonwealth Choice program includes, would allow premiums to be higher for plans that provide additional coverage. However, sicker individuals would not have to pay more than healthier people simply because they are enrolled in a plan that disproportionately enrolls sicker individuals.

*Adapted from “Fact Sheet: Using a Health-Insurance Exchange to Pool Risk and Protect Enrollees” Center on Budget and Policy Priorities, April 14, 2009.

Growing Numbers of People Need Help Affording Health Coverage

The number of people who are unable to pay for coverage on their own is growing. Some 46 million Americans were uninsured in 2007, and the number has increased since then as millions of Americans have lost their jobs. For each percentage-point increase in the unemployment rate, an estimated 1 million people turn to Medicaid for coverage and an additional 1.1 million become

³ For a discussion of the importance of minimum benefit standards, see Sarah Lueck, “Designing Minimum Benefit Standards for a Health Insurance Exchange,” Center on Budget and Policy Priorities, May 21, 2009.

uninsured.⁴ A recent analysis found that 2.4 million workers have lost employer-sponsored coverage since the beginning of the recession.⁵

An in-depth study in 2005 found that only about 20 percent of uninsured people could afford coverage.⁶ Moreover, this study assumed that people with incomes at 300 percent of the poverty line could purchase coverage on their own. When the researchers used 400 percent of the poverty line — the cut-off for premium subsidies in the plan proposed by Senate Finance Committee Chairman Max Baucus — as the threshold of affordability, they found that even larger numbers of people would need assistance.⁷

The vast majority of people who are uninsured and not eligible for public coverage are adults. Seven in ten uninsured children are currently eligible for Medicaid or the Children’s Health Insurance Program (CHIP).⁸

What Premiums Can Low- and Moderate-Income People Afford to Pay?

There is no agreed-upon standard for affordability in health insurance premiums. However, several benchmarks suggest what is affordable:

- Research has shown that as premiums rise, fewer low-income people participate in health insurance voluntarily. In a multi-state study, participation in public health insurance programs dropped by *half* among eligible low-income individuals when premiums reached 3 percent of a family’s income and by more than 90 percent when premiums exceeded 8 percent of income.⁹
- In the Deficit Reduction Act of 2005, Congress prohibited state Medicaid programs from imposing premiums on individuals with incomes below 150 percent of the poverty line.
- The Massachusetts Commonwealth Care program provides subsidized health coverage to people with incomes below 300 percent of the poverty line who are not eligible for Medicaid and do not have access to employer-sponsored insurance. It charges no monthly premium for people with incomes below 150 percent of the poverty line, \$40 for people with incomes

⁴ J. Holahan and A. B. Garrett, “Rising Unemployment, Medicaid and the Uninsured,” Kaiser Commission on Medicaid and the Uninsured, January 2009.

⁵ Nayla Kazzi, “More Americans Are Losing Health Insurance Every Day,” Center for American Progress, May 4, 2009.

⁶ Some 25 percent of the uninsured were eligible for public coverage, while 56 percent were ineligible for public coverage but would need assistance purchasing coverage. L. Dubay, J. Holahan, and A. Cook, “The Uninsured and the Affordability of Health Insurance Coverage,” *Health Affairs* web exclusive, November 10, 2006.

⁷ Senator Max Baucus, “Call to Action: Health Reform 2009,” November 12, 2008. The policy options for expanding health care coverage issued by the Senate Finance Committee on May 14, 2009 also would provide subsidies to individuals and families with incomes up to 400 percent of the poverty line.

⁸ “Quick Facts About Child and Family Coverage,” Georgetown Center for Children and Families, <http://ccf.georgetown.edu/index/quick-facts>. (This publication cites an analysis by L. Dubay of the Urban Institute of March 2005 Current Population Survey using July 2004 state eligibility rules.)

⁹ Leighton Ku and Teresa Coughlin, “Sliding Scale Premium Health Insurance Programs: Four States’ Experiences,” *Inquiry*, Winter 1999/2000. In this study, the low-income criteria varied for each state’s program.

between 150 and 200 percent of the poverty line, \$79 for people in the 200-250 percent of poverty range, and \$118 for people between 250 and 300 percent of the poverty line.¹⁰

- People with incomes between 300 and 500 percent of the poverty line spend about 8 percent of their incomes on premiums in the non-group market, according to an analysis by the Urban Institute and the Blue Cross Blue Shield of Massachusetts Foundation. The authors concluded that affordability standards would have to be lower than this for people with incomes below 300 percent of the poverty line (and substantially lower for those with the lowest incomes) because low-income families spend a very large share of their income on housing, food and other basic needs.¹¹

These benchmarks suggest that most low-income people (those with incomes below 200 percent of the poverty line) cannot afford to pay more than a nominal amount for health coverage. As a family's income rises, so does its ability to pay for health care, but family contributions need to be scaled to income so that households with lower incomes pay a smaller percentage of their incomes for health coverage.

Even if Premiums Are Affordable, Out-of-Pocket Costs May Not Be

In determining how much low- and moderate-income people can afford to pay for health coverage, it is important to consider the *type* of coverage they will be able to purchase. If a health plan has high deductibles or co-payments — or fails to include essential benefits such as inpatient care and prescription drugs — even those who have coverage may not get the health care they need.

A substantial body of research shows that even modest out-of-pocket costs cause low-income people to forgo needed care.¹² For example, almost 11 percent of people with employer-sponsored insurance and 13 percent of those with non-group insurance reported they did not fill a prescription in 2007 because they could not afford the medication.¹³

In addition, a recent study found that more than half of the people at all income levels who are “underinsured” (meaning that they face substantial out-of-pocket medical costs)¹⁴ went without needed care during the year. The study found that 25 million people between the ages of 19 and 64 who had some form of health insurance were underinsured in 2007.

¹⁰ Commonwealth Connector, “2009 CommCare Premium Contributions and Affordability Schedules,” March 12, 2009.

¹¹ Linda J. Blumberg *et al.*, “Setting a Standard of Affordability for Health Insurance Coverage,” *Health Affairs* web exclusive, June 4, 2007.

¹² The research on cost-sharing and premiums is summarized in Leighton Ku and Victoria Wachino, “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings,” Center on Budget and Policy Priorities, July 7, 2005.

¹³ Laurie E. Felland and James D. Reschovsky, “More Nonelderly Americans Face Problems Affording Prescription Drugs,” Center for Studying Health System Change, January 2009.

¹⁴ Specifically, the study identified as “underinsured” those whose out-of-pocket costs exceed 10 percent of their income (5 percent of income for people with incomes below 200 percent of the poverty line) or those whose deductibles alone exceed 5 percent of their income. Schoen *et al.*, “How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007,” *Health Affairs* web exclusive, June 10, 2008.

While it is not surprising that out-of-pocket costs can cause problems for lower-income families, families at somewhat higher income levels can experience problems as well. This is because out-of-pocket costs — unlike premiums — vary greatly among individuals depending on their need for health care services. In a recent study, 62 percent of people with incomes *above* 400 percent of the poverty line reported problems paying medical bills when their out-of-pocket spending on health care was between 7.5 and 10 percent of family income. Thus, middle-income people who can afford premiums still need protection against steep out-of-pocket costs.¹⁵

An Aggregate Limit on Premiums and Out-of-Pocket Costs Would Help Make Health Care Affordable

Requiring all plans offered by a health insurance exchange to cover a comprehensive package of essential benefits is an important step toward ensuring that low- and moderate-income people receive the health care services they need. But it alone is not sufficient. Some people with greater health care needs may not be able to afford their plan's deductibles or other cost-sharing charges.

For example, if the government subsidy to purchase health coverage is based on the lowest premium charged by any of the health care plans in the exchange, most low-income people would likely choose that lowest-cost plan because that is what they can afford. Plans with lower premiums are likely to have higher deductibles and/or cost-sharing charges than plans with higher premiums. Sicker beneficiaries, who need more health care, might experience problems getting care because of those higher out-of-pocket costs.

Even if subsidies are based on the premium for a more costly plan with lower cost-sharing, low- and moderate-income people who use a lot of health care services still need protection from high out-of-pocket costs. A recent study estimated the out-of-pocket costs for breast cancer treatment in different Massachusetts health plans. The estimate for out-of-pocket costs in the “silver plan,” which is the medium-cost plan, was \$4,039, and the estimate for the highest-cost “gold plan” was \$2,004.¹⁶ Even in the gold plan, out-of-pocket costs would be a large share of income for a woman with income at 200 percent of the poverty line (\$21,660 for an individual in 2009).

To protect low- and moderate-income people from excessive out-of-pocket costs, an aggregate limit should be placed on beneficiaries' costs that takes into account both their premiums and the out-of-pocket costs they face. Once that annual limit is reached, the insurer would pay the full cost of health care services the family needs.

Such a cap already exists in CHIP. Families with children enrolled in CHIP pay no more than 5 percent of their incomes for premiums and cost-sharing. (Most states that require premiums in

¹⁵ Peter J. Cunningham, Carolyn Miller, and Alwyn Cassil, “Living on the Edge: Health Care Expenses Strain Family Budgets,” Center for Studying Health System Change, December 2008.

¹⁶ The estimate for out-of-pocket costs in the lowest-cost “bronze plan” was \$7,641. K. Pollitz *et al.*, “Coverage When It Counts: What Does Health Insurance in Massachusetts Cover and How Can Consumers Know?” Robert Wood Johnson Foundation, May 2009.

CHIP set them at a level well below the 5 percent limit.¹⁷) This limit protects children with very serious health care needs who might otherwise be forced either to pay cost-sharing charges that exceed what their family can afford or else to forgo needed care.

An aggregate cap on premiums and out-of-pocket costs for families using subsidies to purchase coverage in the exchange could work the same way it does in CHIP, though policymakers may want to assign different percentage limits to families at different income levels.

To calculate a particular family's limit on out-of-pocket costs for the year, the exchange or entity responsible for determining the amount of a subsidy would:

1. determine the amount the family will pay in premiums based on its income and the cost of the plan it chooses;¹⁸
2. calculate the family's aggregate limit for premiums and cost-sharing by multiplying the family's income by the percentage limit set for a family in that income range; and
3. subtract the amount the family will pay in premiums from the aggregate limit to get the limit on out-of-pocket costs.¹⁹

Over the course of the year, the insurer would track the amount the family pays toward co-payments and other cost-sharing charges. If the family reaches its out-of-pocket limit, it would face no further cost-sharing charges for the rest of the year.

In addition, some individuals and families with incomes above the level at which eligibility for subsidies ends (which is 400 percent of the poverty line under the Senate Finance Committee's options paper) will need protection against the excessive out-of-pocket costs that can result from serious illness or injury. To provide this protection, all insurance plans should have maximum deductibles and a cap on out-of-pocket costs that apply to everyone in the plan. The cap on out-of-pocket costs should apply to deductibles and to cost-sharing charges for all covered care.²⁰

¹⁷ Donna Cohen Ross and Caryn Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured, January 2009.

¹⁸ There could be a separate limit on the premium contribution that is counted toward the aggregate cap so that individuals and families who expect to reach the cap due to their health care needs do not choose the most costly plans, knowing that the premium contribution will be counted toward the cap. People who do not expect to use a lot of health care would have an incentive to choose less expensive plans that they could afford with their subsidies.

¹⁹ To simplify the calculations, tiers of income could be established and the dollar amount of the aggregate limit could be based on the lowest income in the tier. For example, the limit on aggregate out-of-pocket costs for families with incomes between 250 and 300 percent of the poverty line (between \$45,775 and \$54,930 for a family of three) could be set at 5 percent of family income equal to 250 percent of the poverty line, or \$2,289 for families of three in that income range.

²⁰ Only one of ten plans in a study of plans offered in Massachusetts had an out-of-pocket limit that counted all forms of cost-sharing for all covered services. The other plans allowed cost-sharing charges for some services to accumulate without any limit. K. Pollitz et al., "Coverage When It Counts: What Does Health Insurance in Massachusetts Cover and How Can Consumers Know?" Robert Wood Johnson Foundation, May 2009.

Comprehensive Benefits Requirement Still Essential

It is important to note that an aggregate cap on premiums and out-of-pocket costs would *not* protect low-income people whose plans do not provide a comprehensive package of essential benefits. This is because *any costs that a beneficiary incurs to obtain services not covered by the plan would not count toward the cap*. For example, if a plan limits the number of physician's visits it covers, beneficiaries would have to pay the full cost of any visits above that limit.

Thus, if the plans that low-income people can afford with their subsidies do not cover essential health care services, they could still end up having to forgo care they need even with an aggregate cap.

Nor would an aggregate cap fully protect low-income people whose plans have high deductibles. Even with such a cap, the up-front cost of health care that a low-income family or individual would have to pay before meeting the deductible could be a barrier to getting necessary health care services. As a result, people of limited means who rely on subsidies to purchase coverage should receive subsidies sufficient to enable them to purchase a plan that does not carry a high deductible.

Conclusion

The design of the subsidy system is a critical component of health care reform. Both health coverage and health care need to be made affordable for low-income people; this is particularly important for those who are sicker and need more care. Accordingly, the plans offered by the exchange should provide comprehensive benefits, and the subsidy system should take both premiums and other out-of-pocket costs into account and include an overall limit on these costs.