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COBURN-RYAN HEALTH BILL WOULD JEOPARDIZE COVERAGE FOR MANY, WHILE FAILING TO REDUCE THE NUMBER OF UNINSURED SIGNIFICANTLY

by January Angeles

Summary

With President Obama's call for greater inter-party cooperation on health reform, and his announcement that the White House will hold a health care "summit" on February 25, Republican alternatives to the House- and Senate-passed Democratic plans are now receiving more attention. One such alternative is the Patients' Choice Act, which Senator Tom Coburn (R-OK) and Rep. Paul Ryan (R-WI) introduced last summer and which is similar in many respects to the health provisions in Rep. Ryan's more recent Roadmap for America's Future.[1] Unfortunately, the Coburn-Ryan plan would likely make comprehensive, affordable coverage less available to many who now have it while failing to significantly reduce the number of uninsured Americans.

Plan Would Significantly Erode Employer-Based Coverage

The bill (S. 1099 and H.R. 2520) would eliminate the main federal tax subsidy for employer-sponsored insurance — the income-tax exclusion for employer-sponsored insurance — and replace it with a refundable tax credit ($2,290 for individuals and $5,710 for families) that people could use to purchase coverage.[2] Many employers would almost certainly drop coverage as a result: since individuals could get the tax credit regardless of whether they obtained their coverage through their employer or on their own, many employers likely would conclude they no longer needed to provide coverage. (In contrast, *capping* rather than eliminating the tax exclusion, as the Senate Finance Committee has considered, can maintain substantial incentives for employers to continue to offer coverage.)

[1] Rep. Ryan's Roadmap includes health coverage and Medicaid provisions that are similar, but not identical, to those in the Coburn-Ryan bill. The Roadmap would also replace guaranteed Medicare benefits with a voucher to purchase private health insurance for everyone currently under age 55; the Coburn-Ryan bill does not alter Medicare. In addition, the Roadmap would make significant changes to Social Security and taxes. A Center paper analyzing the Roadmap is forthcoming.

[2] Families with incomes below the poverty line would also receive a flat $5,000 subsidy; families with incomes between 100 and 200 percent of the poverty line would receive smaller subsidies.

Even employers who wished to continue offering coverage might be unable to do so. As explained below, the new tax credit would encourage younger, healthier employees to opt out of employer-based plans, leaving older and sicker workers in the employer insurance pools and thereby driving up the cost per beneficiary of employer coverage. Many employers might ultimately conclude they could not afford to continue offering subsidized coverage.

Plan Fails to Create a Viable Alternative for People Losing Employer Coverage

Of particular concern, many of the people who would lose employer-based coverage would likely be unable to find affordable, comprehensive coverage on their own. The bill fails to address the significant shortcomings of the existing individual health insurance market that make it difficult for individuals who are older or have various medical conditions to obtain coverage.

Most states permit insurers to vary premiums based on a number of factors, including health status, age, and gender. For individuals with medical problems, insurers often charge very high amounts, refuse coverage for these individuals' pre-existing medical conditions, or refuse to sell them insurance altogether. The Patients' Choice Act, unlike the health reform bills crafted by the various Senate and House committees, would not modify these rules.

The bill would allow states to establish health insurance exchanges through which individuals could purchase private health insurance. But such exchanges would be unlikely to make coverage more affordable for many individuals. The bill would not *require* states to establish exchanges (in sharp contrast to the health reform bills developed by the Senate and House committees, which would establish a national exchange or require states to establish exchanges subject to federal rules).

Moreover, in states that did establish an exchange, insurers selling policies through the exchange would be allowed to charge higher premiums for sicker people and to exclude coverage of pre-existing conditions for up to one year (although they would not be allowed to refuse to sell insurance altogether to someone). In addition, the bill would *prohibit* exchanges from placing any limit on the premiums and cost-sharing amounts that insurers could charge. In short, the exchanges would suffer from most of the same problems that plague the individual insurance market.

While the bill's tax credit and low-income subsidy would help some low-income people purchase health insurance, the lack of strong insurance market reforms means the tax credit and subsidy would almost certainly be insufficient to enable many people who are older, in poorer health, or have special health care needs to purchase affordable coverage. The tax credit and subsidy would be *flat amounts* that do not take into account the actual cost of health insurance, including the higher premiums many people would have to pay due to the unlimited leeway that insurance companies would retain in many states to vary premiums based on health status, age, and other factors. As a result, millions of Americans who currently receive coverage though their employer but would lose that coverage would find that they either could not afford to buy coverage on their own or had to pay exorbitant amounts to do so.

Still another problem is that many of those who could afford health insurance premiums using the tax credit and subsidy would likely find that the coverage they purchased was inadequate. Unlike the health reform proposals that the House and Senate committees are developing, the Patients' Choice

Act does not set meaningful minimum standards on what benefits insurers must cover. Nor does it limit deductibles or out-of-pocket costs. As a result, low-income people could exhaust their subsidy just to pay the premiums and be left unable to afford deductibles, co-payments, or health services that their plan does not cover.

Plan Would Jeopardize Needed Care for Tens of Millions of Medicaid Beneficiaries

The bill's failure to make coverage affordable for many low-income people is especially serious because the bill would also *eliminate* Medicaid coverage for low-income children and parents. These vulnerable individuals would instead receive tax credits and subsidies to purchase insurance in the individual market. Low-income Medicaid beneficiaries tend to be in poorer health and are more likely to have chronic illnesses than people enrolled in private insurance; if forced to purchase coverage on their own, many likely would find the premiums unaffordable.

In addition, low-income seniors who are currently eligible for both Medicaid and Medicare would face substantially higher costs, because Medicaid would no longer pay their Medicare premiums and cost-sharing. Seniors would have to start paying out of their own pockets the Medicare Part B premiums (which now total $1,157 a year), Medicare co-payments (which equal 20 percent of the cost of many outpatient services), and Medicare deductibles (which can run as high as $1,100 in the case of a hospitalization). For many low-income seniors, these charges would be unaffordable. The bill would also turn Medicaid coverage for long-term care services into a capped block grant, placing vulnerable groups at risk for significant benefit and eligibility cuts.

Overall, the proposal is not likely to do much to reduce the ranks of the uninsured and would make matters worse for many people who currently have coverage. The remainder of the analysis examines these issues in more detail and is divided into three sections: the bill's effects on people who currently have employer-based coverage; the adequacy of the subsidies the bill would provide for lower-income families and individuals; and the effects on low-income children, parents, and elderly individuals who currently are insured through Medicaid.

I. Replacing the Tax Exclusion with a Tax Credit Would Significantly Weaken Employer-Based Coverage without Providing a Viable Alternative

The employer-based health insurance system, while highly imperfect, is the principal source of health coverage for most non-elderly Americans. It also is the principal mechanism for "pooling" healthy and sick workers and family members together so insurers can offset the high cost of covering sick people with the much lower cost of covering healthy people, and thereby keep premiums more affordable for everyone. The tax exclusion for employer-sponsored insurance provides a key support for the employer-based insurance system.

The Patients' Choice Act would repeal the income-tax exclusion for employer-sponsored health insurance (it would maintain the exclusion for payroll taxes), while creating a new, refundable tax credit of $2,290 for individuals and $5,710 for families. As discussed later in this paper, it would also provide subsidies, on a sliding scale, to families with incomes up to twice the poverty line. People could use the tax credit and subsidy to purchase health coverage through state-based health insurance exchanges, the existing individual health insurance market, or their employers.

By repealing the exclusion and establishing a refundable tax credit unrelated to employer-based coverage, the Patient's Choice Act would take away the main federal tax subsidy for employer-sponsored insurance and likely lead a large number of employers to discontinue offering coverage. Since individuals could claim the tax credit regardless of whether they obtained their coverage through their employer or on their own, many employers likely would conclude they no longer needed to provide coverage. Smaller employers, who are the least likely to offer health insurance today, would be the most likely to take this step. People who lost access to employer-based coverage would have to seek coverage either through a health insurance exchange (if an exchange were established in their state) or the existing individual insurance market.

This proposal to eliminate the tax exclusion differs substantially from proposals to *cap* the tax exclusion, such as those that the Senate Finance Committee has considered. If designed properly, a cap can maintain substantial incentives for employers to continue to offer health coverage.[3] In addition, the health care proposals that the House Energy and Commerce, Ways and Means, and Education and Labor Committees and the Senate Health, Education, Labor, and Pensions Committee have developed would require most employers to offer coverage or pay a fee, which would provide a further incentive for employers to continue offering coverage.

In cases where employers continued to offer coverage, the Patients' Choice Act would create another troubling set of problems. Many healthier employees would likely find that with the new tax credit, they could buy a policy in the individual market that costs them less than remaining in their employer-based plan, since the premiums for their employer's plan would reflect the higher cost of the less healthy employees with whom they are pooled. Healthier individuals would thus have strong incentives to opt out of employer-sponsored insurance, which would leave the older and sicker workers in the employer insurance pools and thereby drive up the cost per beneficiary of the employer coverage. Many employers would be forced to respond by raising employee contributions, leading still more of the younger, healthier workers to opt out.

An insurance "death spiral" could ensue in which many employers ultimately would not be able to afford to continue offering subsidized coverage, which would leave even more of the older and less healthy workers to fend for themselves in the individual market or the health insurance exchange, where they might not be able to find coverage at less than an exorbitant price.

Bill Fails to Institute Needed Market Reforms

Under the bill, many older and sicker workers whose employers dropped coverage due to the elimination of the tax exclusion would likely be unable to find affordable coverage on their own and end up uninsured or underinsured. This is because the bill fails to address the serious shortcomings of the existing individual health insurance market and because the new health insurance exchanges would face the same problems that plague the individual market.

[3] Paul Van de Water, "Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform: Universal Coverage May Be Out of Reach Otherwise," Center on Budget and Policy Priorities, revised June 4, 2009.

A major problem with the individual health insurance market is that most states permit insurers to vary premiums based on health status, age, gender, and other factors.[4] For individuals with medical problems, insurers often charge very high amounts, refuse coverage for these individuals' medical conditions, or refuse to sell them insurance altogether.[5] Unlike the health reform bills that the Senate and House committees have developed, the Patients' Choice Act would not modify these rules for the existing individual market.

The Patients' Choice Act would allow but not require states to establish health insurance exchanges through which individuals could purchase private health insurance.[6] But the bill would *prohibit* states that establish exchanges from setting or limiting the premiums or cost-sharing amounts that insurers could charge in the exchange. And although insurers could not refuse to sell a policy to someone with a pre-existing condition, they could exclude coverage of pre-existing conditions for up to one year.[7]

Of particular concern, *insurers would be allowed to vary premiums for coverage sold in the exchange based on health status* and other factors (subject to existing state insurance regulations). Plans in the exchanges could not refuse to sell a policy to an individual who applies for coverage irrespective of their health status or other risk factors. But insurers would be allowed to charge much higher premiums for sicker people.

Moreover, the Patients' Choice Act does not ensure that plans in the individual market or state-based exchanges offer adequate benefits. Unlike the health reform proposals designed by the House and Senate committees, it does not set meaningful minimum standards on what health insurers must cover. It merely contains general, rather vague requirements that plans sold through the exchange must offer some general categories of benefits such as hospital coverage and ambulatory care. It places no limits on the deductibles that plans can impose, the annual out-of-pocket amounts that individuals can be required to pay, or the out-of-pocket costs that lower-income individuals can incur (for example, as a percentage of family income). It also leaves insurers free to impose annual or lifetime limits on the amount of benefits an individual may receive.[8]

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[4] For a discussion of the flawed individual market, see Edwin Park, "Administration's Proposed Tax Credit for the Purchase of Health Insurance Could Weaken Employer-Based Health Coverage," Center on Budget and Policy Priorities, revised April 6, 2004.

[5] For example, one study found that 71 percent of individuals in poorer health who sought coverage in the individual market found it very difficult or impossible to find an affordable plan; one-third were rejected outright or charged a higher premium for their pre-existing conditions. See Sara Collins *et al.,* "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," The Commonwealth Fund, September 2006.

[6] States also would have the option to enter into interstate compacts and form multi-state purchasing pools.

[7] The bill would apply the HIPAA (Health Insurance Portability and Accountability Act) rules on pre-existing conditions that currently exist in the group market. For those who currently lack creditable coverage, insurers could refuse coverage of pre-existing conditions that were diagnosed within six months of enrollment. Pre-existing condition exclusions could not extend beyond one year.

[8] For a discussion of the benefit standards needed to protect against high out-of-pocket costs, see Sarah Lueck, "Designing Benefit Standards for a Health Insurance Exchange," Center on Budget and Policy Priorities, May 21, 2009.

Optional State Exchanges Would Be Highly Vulnerable to Adverse Selection

Adding to these problems, the new health insurance exchanges would be highly vulnerable to "adverse selection," which occurs when healthy and sick people separate into different insurance plans.[9] If people purchasing coverage through the exchange tend to be sicker on average than those purchasing coverage through the individual insurance market, premiums for exchange-based coverage could be driven higher and become less affordable over time.

Although the Patients' Choice Act would require insurers to accept all applicants for coverage through the exchanges, it would *not* apply this requirement to plans offered outside the exchange (i.e., in the individual health insurance market). This arrangement would put plans offered in the exchange at a disadvantage in the majority of states that do not also apply a "guaranteed issue" requirement in the individual insurance market; plans in the individual market could simply refuse to cover costly, high-risk individuals, enabling them to offer lower premiums than the plans in the exchange, which would have to accept the less healthy people. Over time, the exchanges could be left with pools of people less healthy than the people covered outside the exchange, with the result that plans offered through the exchange would be more and more expensive.

The bill requires the exchanges to implement risk adjustment, high-risk pools, or reinsurance for health insurance plans *within* the exchange. However, these features would not address the issue of adverse selection *against* the exchange that would occur because plans in the exchange and those in the individual market would not be subject to the same rules.

II. Tax Credit and Subsidies Would Be Inadequate to Purchase Comprehensive Coverage

In addition to the above-mentioned tax credit, the bill would provide families that have incomes below the poverty line with a flat $5,000 subsidy, which they could apply toward premiums and cost-sharing or toward the direct purchase of health care services. Families with incomes between 100 and 200 percent of the poverty line would receive a sliding-scale subsidy that declines from $4,000 to $2,000 as income rises.[10] To be eligible for these subsidies, families would have to include at least one dependent under 19 years of age and lack health coverage.[11]

The tax credit and subsidies would help some low-income people purchase health insurance. But they would not be sufficient to enable others to obtain coverage and avoid high out-of-pocket costs, particularly less-healthy people with significant health care needs.

The tax credit and subsidy would be flat amounts that do not take into account the actual cost of health insurance, including the higher premiums many people would have to pay due to the unlimited leeway that insurance companies would retain in many states to vary premiums based on

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[9] For a discussion of how to structure a health insurance exchange to prevent adverse selection, see Sarah Lueck, "Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Employees," Center on Budget and Policy Priorities, March 31, 2009.

[10] Families also would receive an extra $500 for each child under age 1 and an extra $1,000 if a woman is pregnant.

[11] The bill does not seem to prohibit people from opting out of employer-based coverage to receive the subsidies.

health status, age, gender, and other risk factors.[12] Without strong insurance market reforms that eliminate or moderate variations in premiums that are based on these factors, the tax credit and subsidies provided under the Patients' Choice Act would almost certainly be insufficient for many people who are older, in poorer health, or have special health care needs.

Furthermore, the subsidy would extend only to families making less than 200 percent of the poverty line. This means that a family of three making $36,700 — which is just over 200 percent of the poverty line — would receive a tax credit of $5,710 to purchase insurance but be ineligible for a subsidy. In some states, family coverage in the individual market can cost as much as $16,897,[13] so such a family could have to pay a significant share of its modest income to purchase coverage. Large numbers of people with low or moderate incomes would continue to face difficulty paying for coverage and remain uninsured.[14]

This problem would worsen over time. The value of the tax credit and the subsidy would rise more slowly than health care costs, so their value would decline each year as a share of the costs of health coverage.[15]

Even if the tax credit and low-income subsidy were sufficient to allow some people to afford health insurance *premiums*, the coverage these individuals purchased could be inadequate.[16] As noted previously, the bill fails to require plans in the individual market or state-based exchanges to cover a comprehensive array of services. Insurers would be free to offer benefit designs that omit or severely limit services needed by people with serious medical conditions. Low-income people, especially those in below-average health, might not be able to afford to pay for deductibles, co-payments, or the health services that their insurance plan does not cover. Many would likely go without needed health care services as a result.

III. Tens of Millions of Medicaid Beneficiaries Would Be at Risk of Becoming Uninsured or Underinsured

The bill's failure to make coverage in the private market affordable is especially serious because the Patients' Choice Act would also eliminate Medicaid coverage for many low-income beneficiaries.

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[12] States could supplement the subsidy but would be responsible for the full cost of doing so. Thus, it is unlikely that many states would take up the option.

[13] America's Health Insurance Plans, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.

[14] Families earning more than 200 percent of the poverty line are likely to still need help to afford health care coverage. See Judith Solomon, "Ensuring Affordable Health Coverage and Health Care Services in an Insurance Exchange," Center on Budget and Policy Priorities, May 21, 2009.

[15] Under the bill, the value of the tax credit and the subsidy would be increased annually by the average of the rates of increase in the overall Consumer Price Index (CPI) and the medical component of the CPI. Between 1990 and 2007, health care costs grew an average of 6.2 percent per year, while the medical CPI grew 4.9 percent per year and the overall CPI rose 2.7 percent per year. Health care costs consistently rise faster than the medical CPI, which accounts only for increases in the *price* of health care goods and services and does *not* include the impact of increased health care utilization.

[16] Studies have shown that out-of-pocket costs can cause lower-income people who have insurance to forgo needed health care. For a summary of the research, see 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.

The bill would eliminate Medicaid coverage for millions of low-income children and parents, who would have to seek health coverage elsewhere using their tax credits and subsidies. In addition, Medicaid would no longer cover low-income seniors who are not in long-term care (though coverage would continue for low-income people who have serious disabilities). While Medicare covers basic health services such as physician and hospital care for seniors, millions of "dual eligible" beneficiaries — the low-income seniors who qualify for both Medicaid and Medicare — rely on Medicaid to provide certain benefits that Medicare does not cover such as transportation to the doctor, vision and dental care, or benefits that Medicare covers to a lesser extent than Medicaid such as home health care and therapy services. The bill would eliminate this important benefit that Medicaid provides for low-income seniors, thereby raising their out-of-pocket costs substantially and likely causing them to forego needed care.

The bill also would convert federal Medicaid funding for long-term care services and supports into a capped block grant to states, which could lead to substantial reductions in long-term care services over time. This represents a major change in policy that could shift large costs to the states and place vulnerable groups at risk for significant benefit and eligibility cuts.

The bill's termination of most of Medicaid would have serious consequences, as explained below.

Some Current Medicaid Beneficiaries Could End Up Uninsured

Low-income Medicaid beneficiaries tend to be in poorer health and are more likely to have chronic illnesses than people enrolled in private insurance. If forced to purchase coverage on their own, many likely would find the premiums unaffordable. As discussed previously, the legislation would allow insurers in the new exchanges and the individual market to vary premiums based on health status and other risk factors. As a result, the tax credit and subsidies would likely be inadequate for many of these individuals who are in poor health, and they could end up uninsured or underinsured.

Low-Income Families and Seniors Would Lose Essential Medicaid Benefits and Protections

In recognition of the limited budgets that its low-income beneficiaries have, Medicaid limits premiums and cost-sharing to levels well below those that private insurance typically requires. It also provides benefits that are tailored to meet the needs of low-income children and families. The Patients' Choice Act would push parents and children now on Medicaid into the private insurance market without establishing cost-sharing protections or setting meaningful benefit standards for plans offered through the exchange or the individual market. Even if these low-income families were able to purchase coverage, they still could find the costs they incur under their private insurance plans for deductibles, co-payments, and uncovered services to be unaffordable.

Poor children now insured through Medicaid would be at particular risk, because they would lose coverage for important health care services. Medicaid covers an array of services for children that are especially important for children with special health needs — and that private insurance typically does not cover. Specifically, Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit guarantees low-income children coverage for any service needed to treat any diagnosed health condition they are found to have, even if the state's Medicaid program does not

otherwise cover that condition. These services, which are important to achieving healthy development, include physical and speech therapies, hearing services, and vision exams and eyeglasses.[17] Poor families whose children are now covered through Medicaid generally would find it challenging to pay for health services that private insurance typically does not cover.

For seniors, the bill's elimination of the component of Medicaid coverage that pays the cost of their Medicare premiums and cost-sharing would create serious problems; many low-income seniors cannot afford these costs without assistance. Medicare Part B premiums cost $96.40 per month in 2009 — $1,157 per year — and many outpatient services under Medicare require co-payments of 20 percent. The deductible for a hospitalization alone could consume nearly 10 percent of the total annual income for an elderly person at the poverty line. Seniors in Medicare would not be eligible for the subsidy the bill otherwise would provide to low-income people and thus would not receive any additional assistance with out-of-pocket costs.

Block-Granting Long-Term Care Benefits Would Burden States And Pose Risks for Seniors and People with Disabilities

The bill also would convert the long-term care component of Medicaid into a capped block grant. Instead of the current financing arrangements, under which the federal government pays a fixed *percentage* of states' Medicaid long-term care costs, the federal government would provide only a fixed *dollar amount* to states each year, regardless of the actual level of expenses a state incurred for long-term care. During the first fiscal year of the block grant, the cap would be based on the state's historical Medicaid spending levels for long-term care. This amount would increase 4 percent in each subsequent year, irrespective of actual increases in long-term-care costs.[18]

The bill's authors argue that block-granting Medicaid long-term care services would lead states to adopt innovative ways to deliver care. Whether or not that is the case, the bill would likely lead to reductions in eligibility and reduced access to long-term-care services for frail seniors and people with serious disabilities, because the cap would not account for the increased need for long-term-care services that is likely to occur as the U.S. population ages and health care costs continue to rise. A number of states would likely end up with inadequate federal funding,[19] and as funding fell increasingly short of needs, states would have to cut services, take people off the program, lower provider payment rates, or raise taxes or cut other state programs. Long-term care services would no longer be an individual entitlement under Medicaid.

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[17] See, for example, The Commonwealth Fund and George Washington University, "Comparing EPSDT and Commercial Insurance Benefits," September 2005.

[18] To receive the grant, a state would be required to maintain 95 percent of its level of Medicaid spending on long-term-care services in 2009.

[19] At best, assuming the federal funding cap is equal to what a state would otherwise have received under the current Medicaid financing structure, the proposal would provide no additional federal funding to help states improve the provision of long-term care and services. Greater federal resources are likely to be necessary, however, if states are to make significant progress in promoting the use of home- and community-based care in their Medicaid programs and in further shifting away from traditional institutional-care settings such as nursing homes.

IV. Conclusion

The Patients' Choice Act is deeply flawed. It would likely cause many people who now are insured — including millions of workers who are in below-average health and currently are covered through their employer, as well as millions of poor children and parents — to lose their current coverage. In many cases, these people would end up uninsured, paying substantially more for insurance than they now do, or purchasing insurance that provides inadequate coverage and has high cost-sharing. The bill also would sharply increase costs for many low-income elderly individuals.

To be sure, the bill would enable some individuals who currently are uninsured to obtain coverage. But it would do so at the very high cost of putting many insured people at a significant risk of losing their coverage or becoming underinsured. Overall, the proposal is not likely to do much to reduce the ranks of the uninsured, and it would make matters significantly worse for many currently insured people who are poor, elderly, have significant medical conditions, or otherwise are in below-average health.