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FINANCE COMMITTEE HEALTH REFORM BILL MAKES IMPROVEMENTS, BUT STILL FALLS SHORT OF WHAT IS NEEDED FOR MANY PEOPLE TO AFFORD HEALTH CARE

by January Angeles and Judith Solomon

The health reform bill that the Senate Finance Committee approved today includes significant improvements, compared to the original chairman's mark, in making health care coverage affordable to low- and moderate-income households. It could, however, still leave many such households facing fairly steep insurance premiums and cost-sharing charges that they would have difficulty affording.

The bill provides more limited assistance to people purchasing coverage in the new health insurance exchange than the Senate HELP Committee bill or the House health reform bill. The greatest concern relates to people with incomes below 200 percent of the poverty line (below $36,620 for a family of three in 2009). The amounts that families between 133 percent of the poverty line (where Medicaid eligibility generally would end) and 200 percent of poverty would have to pay for insurance purchased through the health insurance exchanges would be as much as *two to four times higher* as under the Senate HELP Committee or House bills and would constitute a substantial burden for many of these households.

Premium Credits to Help Families Afford Coverage

Under the Finance Committee bill, individuals and families with incomes between 100 and 400 percent of the poverty line would receive "premium credits" to help them pay the premiums for health insurance offered through the new health insurance exchanges.[1] The amounts that individuals and families would have to pay for premiums out of their own pockets would be set at 2 percent of income for people at 100 percent of the poverty line and would increase on a sliding-scale basis to 12 percent of income for people at 300 percent of the poverty line. The charge would

[1] Under the Finance Committee bill, states would be required to extend Medicaid eligibility to non-elderly individuals with incomes up to 133 percent of the poverty line starting in 2014, the second year the new system would be in effect. At that time, most non-elderly people with incomes between 100 and 133 percent of the poverty line would be able to choose between Medicaid and coverage purchased through the health insurance exchange with the help of a premium credit.

remain at 12 percent of income for people between 300 and 400 percent of the poverty line, which is the income level at which households would cease to qualify for premium credits.

Individuals and families with incomes between 100 percent and 200 percent of the poverty line also would receive assistance with cost-sharing, in the form of lower deductibles and co-payments.[2]

Credits Not Likely to Be Fully Adequate

The Finance Committee bill would require premium contributions from low- and moderate-income families and individuals that likely would exceed what many of them can afford. The premiums these households would face would be significantly higher than under the Senate HELP Committee bill or the House health reform bill. As noted, for people below 200 percent of the poverty line, premium contributions under the Finance Committee bill would be as much as two to four times higher than under those other bills. (See Table 1.)

For example, if health reform were in effect this year, a family of three at 150 percent of the poverty line — which would have gross income of $27,465 in 2009 — would pay $1,236 per year in premiums (or 4.5 percent of income) under the Finance bill, as compared to $824 and $275 under the House and HELP bills, respectively. A single individual at this income level, who would have income of only $16,245, would pay $731 per year toward premiums under the Finance bill, as compared to $487 under the House bill and $162 under the HELP bill.

People at this income level would pay these premiums or face a penalty. Under the Finance Committee bill, households would *not* face a penalty for failing to have health coverage if their share of the premium cost for the lowest-cost plan available in the exchange exceeded 8 percent of their income. Since households with incomes between about 220 percent and 400 percent of the poverty line would receive premium credits that would leave their share of the premium at levels above 8 percent of income, they would be exempt from the penalty if they decided not to purchase a policy and remained uninsured. In contrast, people with incomes below about 220 percent of the poverty line ($48,510 for a family of four in 2009) who found the premiums hard to afford could not escape the penalty.[3]

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[2] Because out-of-pocket charges would be lower, the coverage that people in this income range would receive would have a higher actuarial value. People with incomes between 100 and 150 percent of poverty would receive the "platinum" level of coverage, in which plans would have an actuarial value of 90 percent — meaning that plans would cover 90 percent of the costs for covered medical services of a typical beneficiary population, with beneficiaries paying the other 10 percent. Plans with a 90 percent actuarial value generally would have only modest deductibles and co-payments. People with incomes between 150 and 200 percent of poverty would receive coverage tied to the "gold" level of coverage, which would have an actuarial value of 80 percent — meaning that deductibles and co-payments would be somewhat higher but still below the deductibles and co-payments that people at higher income levels would face.

[3] The Finance bill generally would require all citizens and legal immigrants to obtain health coverage or pay a penalty. The original chairman's mark set the standard for being exempt from the penalty at 10 percent of income. An amendment adopted in committee lowered the threshold to 8 percent of income. The amendment also lowered the amount of the penalty for not having coverage to $750 per adult in the household, which would be phased in between 2013 and 2017. The original chairman's mark applied a penalty of $950 per uninsured individual with a maximum penalty of $3,800 for a family for those earning more than 300 percent of the poverty line, and a penalty of $750 per individual with a family maximum of $1,500 for households with incomes between 100 and 300 percent of the poverty line.

TABLE 1 Required Family and Individual Premium Contributions Under House Reform Bill as Amended by Energy and Commerce, Senate HELP Bill, and Senate Finance Bill							
Income[a]		Family/Individual Premium Contribution					
		Senate HELP Bill[b]		House Bill as Amended by Energy and Commerce[c]		Senate Finance Bill[d]	
Percent of Poverty Line	Annual Dollar Amount	Percent of Income	Annual Dollar Amount	Percent of Income	Annual Dollar Amount	Percent of Income	Annual Dollar Amount
Family of Three							
133%	$24,352	1%	$243	1.5%	$365	3.7%	$889
150%	$27,465	1%	$275	3%	$824	4.5%	$1,236
200%	$36,620	3.3%	$1,208	5.5%	$2,014	7%	$2,563
250%	$45,775	5.6%	$2,563	8%	$3,662	9.5%	$ 4,349
300%	$54,930	7.9%	$4,339	10%	$5,493	12%	$6,592
350%	$63,085	10.2%	$6,435	11%	$6,939	12%	$7,690
400%	$73,240	12.5%	$9,155	12%	$8,789	12%	$8,789
Individual							
133%	$14,404	1%	$144	1.5%	$216	3.7%	$526
150%	$16,245	1%	$162	3%	$487	4.5%	$731
200%	$21,660	3.3%	$715	5.5%	$1,191	7%	$1,516
250%	$27,075	5.6%	$1,516	8%	$2,166	9.5%	$2,572
300%	$32,490	7.9%	$2,567	10%	$3,249	12%	$3,899
350%	$37,905	10.2%	$3,866	11%	$4,170	12%	$4,549
400%	$43,320	12.5%	$5,415	12%	$5,198	12%	$5,198

[a] For purposes of illustration, assumes health legislation in effect in 2009.

[b] The HELP bill assumes that most households with incomes below 150 percent of the poverty line would enroll in Medicaid. A specific family's actual premium contribution requirement under the Senate HELP Committee bill could be different. The maximum premium that people who receive premium credits would be required to pay under the HELP bill would be 12.5 percent of income for people at 400 percent of the poverty line, ratably reduced to 1 percent of income for those at or below 150 percent of the poverty line. This table assumes that the reduction in the premium credits would be on a linear basis; the actual percentages and amounts set by the Secretary could be somewhat different. The percentage of income that recipients of the credit would be required to contribute toward premiums would be adjusted annually by growth in the medical component of the Consumer Price Index.

[c] The initial premium contributions under the House bill start at 1.5 percent of income at 133 percent of the poverty line, rising to 12 percent of income at 400 percent of the poverty line. While the premium contributions are initially calibrated to income, the share of premiums that enrollees would be required to pay would be held constant over time, so premium contributions would increase over time as a percentage of a family's income. The amount of the premium credit would be tied to the cost of the three Basic plans with the lowest premiums in the area.

[d] Households' premium contributions would range from 2 percent of income at 100 percent of the poverty line to 12 percent of income at 300 percent of the poverty line and would remain at 12 percent for households between 300 and 400 percent of the poverty line. This table assumes (as does the CBO estimate) that individual and family premium contributions would rise between 100 percent and 300 percent of the poverty line on a linear or "straight line" basis. While the premium contributions would initially be calibrated to income, the share of premiums that enrollees would be required to pay would be held constant over time, so premium contributions would rise over time as a percentage of a family's income. The premium credit would be tied to the cost of the silver plan, which has an actuarial value of 70 percent.

As these figures suggest, many people with incomes somewhat above 200 percent of the poverty line also could encounter difficulty affording insurance under the Finance Committee bill. A family of three making $46,000 per year — approximately 250 percent of the poverty line — would have to pay approximately $4,300, or 9.5 percent of its income, to purchase insurance. This would impose considerable burdens on many families, particularly in view of what they already have to spend on necessities. By comparison, under the HELP bill, a family at that income level would pay about $2,600 (5.6 percent of income). Under the House bill, such a family would pay $3,700 (or 8 percent of income). These figures are for the premiums alone; deductibles and co-payments would represent additional costs.

Consider an illustrative family of three in which the father earns $35,000 from a small retailer and the mother earns $11,000 as a part-time sales clerk. Neither receives health care through his or her employer. The couple has a daughter in elementary school. The couple has avoided accruing credit card debt but has no life insurance or retirement savings. After paying basic expenses,[4] this family has about $650 a month to cover costs for clothes, car repairs and maintenance, various other household expenses, restaurant meals, and any hobbies or activities — *as well as* the family's health care expenses. Under the Finance Committee bill, this family could pay $360 — 55 percent of the remaining monthly amount — to cover the cost of premiums. In comparison, under the Senate HELP bill, this family would pay $214, or 33 percent of its remaining monthly budget, for premiums. Under the House bill, the family would pay monthly premiums of about $305, or 47 percent of its remaining monthly income.

Given the high amounts that moderate-income people like the family described above would have to pay for coverage under the Finance bill, a substantial number of these people might decide they would be better off remaining uninsured. As noted, people with incomes between 220 and 400 percent of the poverty line, who would be eligible for premium credits to help pay for coverage but be required to pay more than 8 percent of income in premium costs, would be exempt from the penalty if they declined to purchase coverage.

Many such families and individuals might opt either to remain uninsured or to take up the option added during Finance Committee deliberations to purchase a "young invincible plan" in lieu of more comprehensive coverage. Such a plan was initially included in Finance Committee chairman Max Baucus' proposal as an option only for people 25 years old or younger, but the Finance Committee broadened it to allow anyone whose premium costs would exceed the 8-percent-of-income threshold to buy such a plan. The "young invincible plan" would be a catastrophic health insurance policy that would provide coverage only after beneficiaries met a deductible of $5,800 for individual coverage and $11,600 for family coverage (although the policy also would cover some preventive health services, which would be exempt from the deductible).

[4] In this example, we assume that the family pays $1,400 a month in rent and $300 in utilities. The family's yearly tax bill includes $312 in federal income taxes, $3,519 in Social Security and Medicare taxes, and $596 in state income taxes. A car bought "on time" requires payments of $300 a month, plus $1,000 a year in car insurance and $1,000 a year for gasoline. The family spends $150 a week on groceries.

Percentage of Income That Low- and Moderate-Income Households Would Pay for Premiums Would Edge Up Over Time

In the initial year that it is in effect, the Finance Committee bill would cap premium costs for people receiving premium credits so that these people would pay no more than a specified percentage of their income for health insurance. The table on page 3 shows these initial percentages.

After the first year, the plan would shift to a cap that requires households receiving premium credits to pay a set percentage of the *insurance premium amount,* rather than a set percentage of their income. Since health insurance costs — and hence premiums — are expected to rise faster than incomes, the percentage of income that people receiving premium credits would pay for premiums would increase over time.[a]

For example, a family of three making $40,282 per year (220 percent of the poverty line) would initially have to contribute $3,223 — 8 percent of its income — toward the premium. Assuming that the silver plan costs $11,083 (which is the average cost of family coverage through an employer-sponsored high-deductible health plan in 2009), the family's contribution in future years would be set at 29 percent of the premium ($3,223 divided by $11,083). If the family's income kept pace with inflation and thus remained at 220 percent of the poverty line but premiums continued to climb faster than inflation, the percentage of income the family paid for the cost of premiums would rise above 8 percent and edge a bit higher each year.

The 8 percent affordability exemption — i.e., the percentage of income above which a household would be exempt from the penalty if it did not have insurance — would be adjusted annually in the same way. Initially, families and individuals who would have to spend more than 8 percent of their income for coverage would not face a penalty if they remained uninsured. In subsequent years, this threshold would gradually edge up, increasing at the same rate as the increase in premium contributions that households would be required to make. Thus, if the family's income kept pace with inflation and health insurance premiums continued growing faster than inflation, the percentage of income that premium charges would have to reach for uninsured households to be exempt from the penalty would edge above 8 percent over time.

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[a] The House bill contains a similar indexing provision, but the percentage of income that people who receive the credit would have to contribute towards premiums starts at much lower levels.

People Eligible for Premium Credits Also Could Face Substantial Out-of-Pocket Costs

In addition to these substantial premium contributions, low- and moderate-income households would face higher cost-sharing requirements under the Finance Committee bill than under the other bills. Cost-sharing subsidies would be available to people earning up to 200 percent of the poverty line. They would be more limited, however, than the assistance the House bill and the Senate HELP Committee bill would provide.

That is reflected in the fact that the insurance plans available in the exchange would have lower actuarial values under the Finance bill than under the other two bills (see Table 2). Plans with lower actuarial values require beneficiaries to pay a larger share of the costs for the health services that the plans cover and hence typically carry higher deductibles and co-payments. (A plan with a 90 percent actuarial value would cover 90 percent of the costs for covered medical services for a typical

beneficiary population, with beneficiaries paying the other 10 percent of the costs out of pocket. A plan with a 70 percent actuarial value would cover 70 percent of covered medical costs, with the beneficiary population paying the other 30 percent.)

For example, under the Finance Committee bill, people receiving premium credits whose incomes are at 250 percent of the poverty line would have coverage under the "silver plan," which would have an actuarial value of 70 percent. While it is difficult to determine precisely what kind of cost-sharing a silver plan would entail, one point of reference is high-deductible plans that are attached to Health Savings Accounts (HSAs) offered through employers. The Congressional Research Service (CRS) estimates these plans have an actuarial value of 76 percent, with a deductible of $1,500, cost-sharing of 20 percent for office visits, labs and other services, and a $3,000 limit on out-of-pocket spending for covered services for an individual.[5] Deductibles and cost-sharing in the silver plan likely would be roughly comparable to the HSA plan described in the CRS report. (The annual out-of-pocket *cap* on how much people at 250 percent of the poverty line would have to pay in deductibles and co-payments if the plan were in effect in 2009 would be set at $2,600 for an individual and $5,800 for a family.[6]) These amounts would be in addition to the premium costs households would pay.

TABLE 2

Actuarial Value of Coverage in the House Reform Bill as Amended by Energy and Commerce, Senate HELP Bill, and Senate Finance Bill

Income for a Family of Three		Actuarial Value of Coverage		
Percent of Poverty Line	Annual Dollar Amount	Senate HELP Bill	House Bill	Senate Finance Bill
133%	$24,352	93%	97%	90%
150%	$27,465	93%	97%	90%
200%	$36,620	93%	93%	80%
250%	$45,775	84%	85%	70%
300%	$54,930	84%	78%	70%
350%	$63,085	76%	72%	70%
399%	$73,057	76%	70%	70%

[5] The Federal Employees Health Benefits Program (FEHBP) Blue Cross-Blue Shield Standard Option has an actuarial value of 87 percent, while a high-deductible health plan attached to Health Savings Accounts has an actuarial value of 76 percent. Note that the methodology the Congressional Research Service used to measure actuarial value may be different from the methodology the Finance Committee bill may use, which means that comparisons are inexact. See Chris L. Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service, April 6, 2009.

[6] The out-of-pocket limits would be pegged to current law limits for HSA plans, which are $5,800 for an individual and $11,600 for a family in 2009. For households earning between 100 and 200 percent of the poverty line, the out-of-pocket limit for medical services the policy covers would equal one-third of the HSA limit, or $1,933 for an individual and $3,867 for a family in 2009. For households with incomes between 200 and 300 percent of the poverty line, the out-of-pocket limit would be set at half of the HSA limit, or $2,600 for an individual and $5,800 for a family in 2009. Between 300 and 400 percent of the poverty line, the out-of-pocket limit would equal two-thirds of the HSA limit, or $3,867 for an individual and $7,733 for a family in 2009.

Another Significant Danger: Weakening the Individual Mandate Too Much Will Cause the Cost of Insurance to Rise Significantly and Threaten the Ability of the Legislation to Work

All of the health reform bills that Congress is considering would require Americans to obtain health coverage or pay a penalty. The bills include exemptions from the penalty for people who cannot afford coverage; the Finance Committee bill would exempt people from paying a penalty if their share of the premium costs for the lowest-cost plan available to them exceeded 8 percent of their income.

With limited resources available to strengthen the premium credits, policymakers will face the temptation to relax the affordability exemption and lower the amount of the penalty for not having coverage, so that fewer people will be penalized for failing to have coverage and those who are penalized pay a more modest fee. Going too far in this direction, however, would be unwise, as it could unravel the reform effort.

Key to health reform is the requirement that insurers sell insurance to anyone seeking to purchase it, and not refuse coverage for pre-existing conditions or charge higher amounts to people with medical conditions. For these requirements to work without causing insurance premiums to spike, most people must be in the insurance system. Thus, an enforceable mandate for people to have insurance is essential.

The reason for this is clear. Without a sufficiently strong mandate, many healthy individuals likely will elect to remain uninsured rather than pay a substantial amount for coverage. If those who buy insurance are significantly less healthy as a group than the population as a whole, the health costs of those who purchase insurance will be higher than average, and insurance premiums will have to rise to cover those costs. If that occurs, a "spiral" can set in — as premium costs rise to higher levels, more of the healthy people may decline to buy coverage rather than pay the higher costs, which in turn would cause the pool of insured beneficiaries to become even less healthy on average and thus push premium costs still higher.

State experience offers some guidance. Five states have tried to seriously restrict or eliminate insurers' ability in the individual health insurance market to deny coverage to less healthy people and to vary premiums based on individuals' health status *without* requiring everyone in the state to have coverage (and without providing subsidies to make coverage affordable). Consequently, less-healthy people tended to seek coverage while healthy individuals tended not to. This contributed (along with other factors) to these states becoming some of the most expensive in the country in which to buy non-group insurance.

This experience is relevant to national health reform legislation. If the mandate is too weak — because the penalty for not having coverage is too small or the exemption from the penalty is too broad — and the premium credits to make coverage affordable are not adequate, a substantial number of healthy individuals may decline to purchase insurance and remain uninsured. Meanwhile, less-healthy individuals without coverage will likely take advantage of the premium credits available and obtain coverage in the exchange. Over time, if the population enrolling in the exchange is in significantly poorer-than-average health, this will drive up the cost of the plans in the exchange — forcing both individuals and the federal government to pay more for coverage and possibly causing the exchanges to unravel.

In short, the requirement for individuals to obtain coverage is a crucial part of health reform. To be sure, it is important not to impose burdens that people with modest incomes cannot afford. But weakening the mandate and the mechanisms for enforcing it is *not* the appropriate solution — strengthening the premium credits is. There is no substitute for, or short-cut around, the need to make the premium credits adequate so individuals and families are not forced to pay more for coverage than they can afford.

As this analysis explains, the premium credits in the Finance Committee bill do not appear adequate for this purpose. The Finance Committee essentially acknowledged this when it lowered the penalties for not having insurance and broadened the exemption from the mandate. Whether these actions go too far and pose the risks discussed here is beyond the scope of this analysis. But a number of health analysts are concerned that the Committee's actions pose risks on this front and believe that it would be prudent for the Senate to make a correction by strengthening *both* the mandate *and* the premium credits — so that coverage is affordable *and* an adequate mandate can be put in place and enforced.

In contrast, under the House bill, households with incomes at 250 percent of the poverty line would be enrolled in a plan that has an 85 percent actuarial value. The figure would be 84 percent under the Senate HELP Committee bill.[7] Plans with these actuarial values could be similar to a typical employer-sponsored PPO plan, according to the Congressional Research Service.[8] Such plans typically have cost-sharing that includes a $700 family deductible and 20 percent coinsurance for office visits, hospitalizations, and other services.

Because the benefits and cost-sharing protections are less generous under the Finance Committee bill than under the HELP or House bills, families with modest incomes could encounter significant challenges if they experience a serious illness or injury. They could be forced to choose between paying for health care and meeting other necessities.[9]

Some families could end up having full coverage largely on paper, because they might forgo using various needed health care services out of concern they are already stretched to their limits and cannot afford the deductibles and co-payments. It is of note that the Commonwealth Fund defines people as "underinsured" if their out-of-pocket medical expenses (excluding premiums) exceed 10 percent of income for people over 200 percent of the poverty line or exceed 5 percent of income for people below 200 percent of poverty.

Structure of Premium Credits Needs Strengthening

A key goal of health care reform is to make comprehensive coverage affordable for the millions of Americans who are uninsured. Members of the Finance Committee deserve commendation for significantly improving the affordability provisions in the original chairman's mark. But despite these changes, a large number of low- and moderate-income families and individuals may still have to pay amounts for coverage and care that squeeze their budgets tightly.

Comprehensive health reform that requires people to purchase insurance should ensure that people receive adequate premium credits to make such coverage affordable. As Congress moves forward, the structure of the premium credits and cost-sharing assistance in the Finance Committee bill should be strengthened to provide people of modest means with the help they will need to make coverage and needed health care services affordable and enable them to comply with the new mandate to secure coverage. Efforts to improve the affordability of health coverage should place particular emphasis on families and individuals in the lower part of the income scale who would be forced to pay hefty premiums that could be difficult for them to afford and would face a penalty if they remained uninsured.

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[7] The legislative proposals each calculate actuarial value differently, so the actuarial value percentages may not be strictly comparable. For further discussion, see Sarah Lueck, "What Level of Coverage Would Health Reform Likely Provide? The Basics of Actuarial Value," Center on Budget and Policy Priorities, October 13, 2009.

[8] The Congressional Budget Office similarly estimates that a typical employer-based plan has an actuarial value of 88 percent. Congressional Budget Office, "An Analysis of Premiums Under the Chairman's Mark of the America's Healthy Future Act," Letter to the Honorable Max Baucus, September 22, 2009.

[9] Many insured families with moderate incomes report problems paying medical bills. See Peter J. Cunningham, "Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007," Center for Studying Health System Change, September 2008.