Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

Special Series: Health Reform Issues

July 1, 2009

SENATE FINANCE COMMITTEE FACES DIFFICULT CHOICES IN LOWERING COST OF HEALTH BILL

Subsidy Changes Could Leave Some Without Affordable Coverage

by Judith Solomon

The Senate Finance Committee is seeking to reduce the cost of its health reform bill to approximately $1 trillion over ten years. It faces difficult choices in doing so.

Among the modifications it is considering are changes in the subsidies intended to enable low- and moderate-income families and individuals to afford insurance. Some of those changes would make it more difficult for moderate-income households — principally those between 300 percent and 400 percent of the poverty line — to afford insurance, and thus would likely result in a number of people in that income range remaining uninsured. At the same time, these changes would be preferable to changes that would adversely affect people with incomes *below* 300 percent of the poverty line, where the consequences of rolling back subsidies or benefit packages would be still more severe.

Based on a June 18 draft of revisions that the Finance Committee is considering to reduce the legislation's cost, the changes being considered to earlier drafts of the legislation include the following (note: some of the information here may already be out-of-date, as the Committee's staff and Senators have continued to negotiate and refine the package since the June 18 draft was developed):

- **No subsidies above 300 percent of the poverty line.** Under previous drafts of the Finance Committee bill, families and individuals with incomes up to 400 percent of the poverty line could qualify for sliding-scale subsidies to help pay for health coverage. The June 18 draft drops the income eligibility limit for the subsidies to 300 percent of the poverty line. This means that an individual with income above $32,490, and a family of three with income above $54,930, would not receive any subsidy to help pay for coverage.

  Substantial numbers of people with incomes modestly above 300 percent of the poverty line could face difficulty paying the full price for coverage. The average job-based insurance policy today would cost a family of three at 300 percent of the poverty line about 23 percent of its income. This could leave the family short of funds for other expenses such as housing and child care.

- **A high affordability standard.** Under the June 18 draft, people who do not obtain coverage would have to pay a fine unless they could show that the premium for the lowest-cost plan available to them equals more than 15 percent of their income, in which case they would not have to pay a fine, but would remain uninsured.[1] For example, a family of three earning just over 300 percent of the poverty line (about $55,000 before taxes, as noted above) would have to spend as much as 15 percent of its income ($8,250) on coverage if it were available at that price, or else pay a fine. If the lowest-cost plan cost more than $8,250, the family would not have to purchase coverage or pay a fine, but the family would still be uninsured.

- **Much higher premiums for older people.** The June 18 draft Finance Committee proposal would allow insurers to charge older adults premiums that are *five times* larger than the premiums for younger people, a much greater disparity than under other leading health reform proposals. Because coverage would cost so much, many older people — particularly those between the ages of 55 and 64, who likely would be charged the most — would likely end up exempt from the requirement to purchase coverage and remain uninsured.

- **Substantial out-of-pocket costs.** The lowest-cost plan under the Finance Committee draft would cover 65 percent of the medical costs of a typical population, which means that overall, such a population would pay the other 35 percent of costs out-of-pocket. This is a coverage level well below the percentage covered under typical employer plans, even high deductible plans attached to Health Savings Accounts. All plans would include a cap on out-of-pocket costs for deductibles and other cost-sharing charges; the draft Finance Committee proposal would set those caps at $11,600 a year for a family and $5,800 a year for an individual. Charges for health insurance premiums would be in addition to those amounts. These are large sums for moderate-income families to pay.

By itself, each of these four elements of the Finance Committee's June 18 draft could make health coverage less affordable and accessible, especially for people modestly above 300 percent of the poverty line and the near-elderly. Their potential impact is of increased concern when one considers how they would interact with one another. For example, an older adult with income modestly above 300 percent of the poverty line would not qualify for any subsidies even though his or her premiums could be as much as five times higher than those for a younger person with the same income. Similarly, a family at that income level might spend as much as 15 percent of its income on premiums and still face as much as $11,600 in out-of-pocket costs if a family member experiences a serious illness or injury.

Income Limit for Subsidies

Some have raised concerns about providing sliding-scale subsidies to households with incomes up to 400 percent of the poverty line. In part, the move to phase out subsidies at 300 percent of the poverty line reflects cost concerns. In part, however, it also reflects the debate in 2007 over the reauthorization of the Children's Health Insurance Program (CHIP), during which critics argued that families earning $88,000 a year (400 percent of the poverty line for a family of four) should not get help paying for health coverage for their children. Under the CHIP legislation enacted in 2009,

[1] The proposal exempts Native Americans, undocumented workers, and people with income below the poverty line from the requirement to have health insurance coverage.

states may receive federal CHIP matching funds to cover children up to *300 percent* of the poverty line.[2]

But the outcome of the CHIP debate ought not determine the income limit for subsidies in health care reform. This is because coverage for *families* is much more costly than coverage just for *children*. A family of four earning $70,000 before taxes would have to spend more than 18 percent of its pre-tax income to buy the average job-based insurance policy, which cost $12,680 in 2008.[3] In contrast, the average cost of coverage per child in CHIP is just $1,139 per year in 2009.

Coverage also costs more for single adults than for children. The average cost of coverage for a single person in 2008 was $4,704, which exceeds 13 percent of the income of an individual earning $35,000 per year. Under the June 18 draft Finance Committee proposal, this individual would be required to have coverage but would not receive help in paying for it.

Another difference between health care reform and CHIP is the design of the premium subsidies. In health care reform, the subsidies will decrease as family income rises, so if the subsidy limit is 400 percent of the poverty line, families with incomes between 300 and 400 percent of the poverty line will be expected to contribute substantially more to premiums than families with lower incomes, and thus will receive much smaller subsidies. In CHIP, by contrast, all eligible children, regardless of income, are protected by an aggregate cap on premiums and cost-sharing combined of 5 percent of family income.

While there is no agreed-upon standard for affordability in health insurance premiums, an analysis by the Urban Institute and the Blue Cross Blue Shield of Massachusetts Foundation used actual spending on health insurance premiums as a benchmark for affordability, because it provides information on what people are willing and apparently able to spend.[4] The analysis found that 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 health-insurance market. The analysis also concluded that affordability standards would need to be set lower than 8 percent of income 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 incomes on housing, food, and other basic needs.

For a family of four at 400 percent of the poverty line, 8 percent of income equals $7,056. This is well below the $12,680 average cost for family coverage in employer-based plans in 2008. It indicates why it would be desirable for health insurance subsidies to extend to families with incomes up to 400 percent of the poverty level, if the resources can be found to cover the cost.[5]

---

[2] States that expand coverage to families over 300 percent of the poverty line receive federal funding at the Medicaid matching rate, which is lower, to cover those children. However, the CHIP legislation permits New York and New Jersey, which already covered children above 300 percent of the poverty line, to continue receiving matching funds at the enhanced CHIP rate; both states include areas where the cost of living is high.

[3] "Employer Health Benefits Annual Survey," Kaiser Family Foundation and the Health Research & Educational Trust, September 2008.

[4] Linda J. Blumberg *et al.,* "Setting a Standard of Affordability for Health Insurance Coverage," *Health Affairs* web exclusive, June 4, 2007.

[5] Several studies have also found that families with incomes above 300 percent of the poverty line need help paying for health coverage. David Carroll *et al.*, "What Does It Take for a Family to Afford to Pay for Health Care?" UCLA Center for Health Policy Research, Revised August 2007; Christine Barber and Michael Miller, "Affordable Health Care for All: What Does *Affordable* Really Mean?" *Community Catalyst,* April 2007.

Federal Subsidies for Health Insurance Still Would Favor High-Income Families Over Those With Modest Incomes

The emerging health-care reform legislation would *not* introduce federal subsidies for health coverage for the first time, as some have mistakenly assumed. The federal government already provides substantial subsidies for health coverage through the tax exclusion for employer-sponsored insurance. The government provided $246 billion in subsidies through the tax exclusion in 2007, making this the largest subsidy in the federal tax code.

Consider the following.

- Currently, an investment banker making $800,000 a year who has an employer-sponsored health plan for his or her family that costs $20,000 in premiums receives a federal tax subsidy of nearly $7,300 each year.[a]
- The Finance Committee is considering capping at $17,000 the amount of premiums for employer-sponsored insurance that can be excluded from income tax. This would reduce the health insurance subsidy the banker receives to about $6,200.
- But the family of three making $55,000 that lacks access to employer insurance and purchases coverage through the new health insurance exchange would receive a subsidy of zero.

Policymakers and journalists have tended to treat as separate issues the questions of: 1) whether Congress should cap the tax exclusion for employer-sponsored coverage; and 2) at what income level Congress should cut off subsidies for people who lack employer-sponsored insurance. These actually are two parts of the same question: what level of subsidies should the government provide — and to whom — to help people obtain coverage, while making sure that insurance coverage is provided through large purchasing pools that pool risk (so healthier and sicker people are not separated into different insurance plans).

[a] The $20,000 in premiums is excluded from both the income tax and the payroll tax. If the $20,000 was included as compensation to the banker, he or she would pay $7,290 in income and employee payroll taxes on it.

Proposal Would Leave Many Older Adults Uninsured

While all of the major health reform plans now being drafted in Congress would allow insurers to charge older individuals higher premiums, the Finance Committee draft appears to allow insurers to charge older individuals five times as much as younger ones.[6] (Other proposals would cap the difference in premiums at a 2 to 1 ratio.[7]) This provision, when combined with an eligibility limit for subsidies set at 300 percent of the poverty line, would make it very difficult for many near-elderly adults with modest incomes to be able to afford coverage.

Massachusetts currently allows older people to be charged twice as much for health insurance as younger people. In Massachusetts, the least-expensive "bronze" plan, which has the lowest

[6] The latest draft states that variation in rates can be no more than 7.5 to 1. The policy options for coverage released by the committee on May 19 also capped variation at 7.5 to 1, with maximum variation for age set at 5 to 1.

[7] Draft legislation released by three House committees and the Senate Committee on Health, Education, Labor and Pensions (HELP) allow rates to vary by no more than a 2:1 ratio.

premiums but the highest cost-sharing, costs $5,100 for a 64-year-old or twice the $2,550 premium for a 25-year old.[8]

If health reform permits insurers to charge older adults much larger premiums than younger adults, the top income level for subsidies needs to be high enough to make coverage affordable for them or many older adults will remain uninsured.

Moderate-Income People Could Face High Out-of-Pocket Costs

Under the June 18Finance Committee draft, families with modest incomes who buy the lowest-cost coverage could face significant challenges if they experience a serious illness or injury, because their plans could leave them subject to steep out-of-pocket costs.

The lowest-cost plan under the Finance Committee proposal would have an actuarial value of 65 percent, which means it would cover 65 percent of the medical costs of a typical population. In comparison, the Federal Employees Health Benefits Program (FEHBP) Blue Cross-Blue Shield Standard Option has an actuarial value of 87 percent.[9]

A plan with an actuarial value of 65 percent is likely to have high deductibles and other cost-sharing charges. The Finance Committee draft proposal would cap out-of-pocket costs, but the cap would, as noted, be set at a high level — $11,600 for a family and $5,800 for an individual in 2009. These are the same out-of-pocket caps that apply under current law to high-deductible health plans then can be paired with a Health Savings Account. The actuarial value of the typical employer-sponsored high-deductible health plan that can be used with an HSA is 76 percent, however, which is significantly higher than the actuarial value for the lowest cost plan in the draft Finance Committee proposal.[10]

Studies have shown that out-of-pocket costs can cause lower-income people to forgo needed health care.[11] Moderate-income families can experience problems as well, depending on their need for health care services. In 2007, over 20 percent of *insured* families with incomes between 200 percent and 400 percent of the poverty line reported problems paying medical bills.[12] When out-of-pocket spending reached levels between 5 and 7.5 percent of family income, 44 percent of families with incomes in this range reported problems paying medical bills.[13]

---

[8] Quotes obtained from Commonwealth Connector website on June 16, 2009.

[9] Chris L. Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service, April 6, 2009.

[10] Peterson, note 9.

[11] 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.

[12] 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.

[13] Peter J. Cunningham, *et al.*, "Living on the Edge: Health Care Expenses Strain Family Budgets," Center for Studying Health System Change, December 2008.