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REDUCING HEALTH INSURANCE TAX CREDITS WOULD JEOPARDIZE MARKET REFORMS AND COST CONTROLS

by Paul N. Van de Water

To help reduce projected budget deficits, some have suggested paring back the tax credits that the Affordable Care Act (ACA) of 2010 provides to help low- and moderate-income families afford health coverage through new state-based health insurance exchanges. Those deficit hawks recommending this course should set their sights on other prey: the credits are not generous (even with the credits, families will pay a substantial and growing share of their income on health insurance premiums with each passing year), and shrinking them would put the law's insurance market reforms — and its cost-control measures — at serious risk.

Insurance Reforms, Mandate, and Premium Credits Are Inextricably Linked

The Affordable Care Act takes important (and long overdue) steps to assure access to health insurance for people at all income levels. Insurance companies will no longer be able to deny coverage or charge higher premiums to people with health problems. Insurers will be limited in their ability to charge higher premiums to individuals simply because they are older. And new insurance plans will no longer be able to exclude coverage of pre-existing health conditions.

If enacted in isolation of other reforms, however, these measures would tend to make health coverage *less,* not *more,* affordable.[1] Knowing that coverage would always be available, people in good health could wait until they became sick to purchase insurance. Those most likely to enroll would be older people and those with pre-existing conditions. Premiums would rise significantly since less healthy people cost more to treat and insure, further discouraging healthy uninsured people from buying coverage.

To avoid this result, the new law requires individuals to have health insurance or pay a penalty, unless the cost of insurance would exceed a specified percentage of their income. This "individual mandate" will assure that those signing up for coverage represent a typical mix of healthy and less healthy people, thereby holding down costs and premiums. It will also encourage insurance

[1] Shannon Spillane, *Key Health Insurance Market Reforms Not Achievable Without an Individual Mandate*, Center on Budget and Policy Priorities, April 7, 2010, http://www.cbpp.org/cms/index.cfm?fa=view&id=3147.

companies to focus on reducing costs and improving quality, rather than devoting resources to efforts to enroll the healthiest and most profitable enrollees and avoid sicker ones.

An individual mandate, in turn, will not work unless coverage is affordable to families with low and moderate incomes. The Affordable Care Act therefore provides premium credits for people of modest means to help them purchase insurance through the new health insurance exchanges, as well as subsidies that effectively reduce their deductibles and co-payments.[2] Without these subsidies, the individual mandate would place an extreme financial burden on millions of low- and moderate-income people, who would be forced to choose between buying health insurance and other necessities. Thus, the individual mandate and adequate health insurance credits are both essential to the success of the heath insurance market reforms.

The Premium Credits Are Already Very Modest

Under the Affordable Care Act, individuals and families with incomes above 133 percent of the poverty line (the new eligibility limit for Medicaid) and below 400 percent of the poverty line will receive premium credits to help them purchase health insurance.[3] The credits, which will begin in 2014, are designed to insure that families will not have to pay more than a certain portion of their income to purchase coverage in the exchanges. Those with incomes at 133 percent of poverty (about $29,500 for a family of four) will pay no more than 3 percent of their income for insurance in 2014, and families with incomes at 400 percent of poverty ($88,200 for a family of four) will pay no more than 9.5 percent of income. The required premium contribution for families with incomes between these amounts will be computed on a sliding scale. In addition, individuals and families with incomes below 400 percent of poverty will face lower cost sharing.

From 2015 through 2018, the premium credits will increase annually at the same rate as average premiums in the exchanges, so that families at each income level (computed as a percentage of the poverty level) will pay the same *share of their insurance premium* as a comparable family paid in 2014.[4] But since health insurance premiums are projected to grow more rapidly than incomes, *low- and moderate-income families will thus be required to spend an increasing share of their income on health insurance each year.*

After 2018, the premium credits will only increase at the same rate as consumer prices, which are projected to grow less rapidly than premiums. From that point on, families at each income level will pay a growing share of their insurance premium each year — and *an even more rapidly increasing share of their income* on health insurance.

Moreover, even in 2014 — before these families' out-of-pocket premium costs start rising as a share of their income — the amounts that these low-income families would have to pay themselves are substantial. Consider a family of four with income just above 250 percent of poverty (currently around $55,000): in 2014 the required premium contribution will be 8.1 percent of income, or about $4,500 at today's income levels, for a policy that would carry a quite high deductible and require

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[2] January Angeles, *Making Health Care More Affordable: The New Premium and Cost-Sharing Credits*, Center on Budget and Policy Priorities, May 19, 2010, http://www.cbpp.org/cms/index.cfm?fa=view&id=3190.

[3] Section 36B(b)(3)(A)(i) of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act.

[4] Section 36B(b)(3)(A)(ii) of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act.

substantial co-payments. Co-payments and deductibles would average 30 percent of the cost of covered medical services, up to an annual limit of $7,933.[5] And as noted, required premium and out-of-pocket spending costs will consume a growing share of the family's income in years after 2014 — and especially after 2018, when the subsidies will not keep pace with increases in health care costs.

Reducing Premium Subsidies Would Place Key Reforms at Risk

Reducing premium subsidies would place the overall health reform legislation at risk, including its health insurance market reforms and cost containment measures. If the subsidies were smaller, more people would go without insurance. The penalty for not meeting the individual mandate is limited to 2.5 percent of income in 2016 and thereafter, so a growing number of families in relatively good health would likely choose to pay a relatively small penalty for going without coverage rather than pay a much larger and ever-increasing share of their income to obtain coverage. If they later develop a serious illness or have a bad accident, they may find themselves unable to pay their medical bills.

In addition, such families' exit from the insurance pool would drive up premiums for those remaining, encouraging even more people to drop coverage. If this process proceeded very far, the individual mandate and market reforms could prove difficult or impossible to maintain. The survival of the entire legislation — including its substantial cost-reduction measures in Medicare and elsewhere, which powerful elements of the health industry accepted only with the prospect of gaining millions of new customers as a result of the individual mandate — could be in serious jeopardy.

Even if the legislation survived, reducing premium subsidies could make other cost-control measures in the Affordable Care Act less effective. The act includes an extensive array of provisions that hold considerable potential for slowing the growth in general health care costs over time. The new health insurance exchanges, for example, should foster competition among insurance companies based on the price and quality of their products. The act also begins to restructure the health care payment and delivery system in ways that will reward effective, high-value health care.[6] These innovations are less likely to be successful if large numbers of people lack health insurance coverage, however, since most of the efforts rely on people maintaining an ongoing relationship with a health care provider who will monitor their condition and direct their care.

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[5] All plans offered through the exchanges must include a limit on out-of-pocket medical costs equal to the limits for high-deductible health plans attached to Health Savings Accounts, with these limits reduced on a sliding scale for households with incomes below 400 percent of the poverty line. Sections 1302(c)(1) and 1402(c)(1) of the Affordable Care Act.

[6] Sarah Lueck, January Angeles, Paul N. Van de Water, Edwin Park, and Judith Solomon, *Health Reform Package Represents Historic Chance to Expand Coverage, Improve Insurance Markets, Slow Cost Growth, and Reduce Deficits,* Center on Budget and Policy Priorities, March 19, 2010, http://www.cbpp.org/cms/index.cfm?fa=view&id=3126.