THE CASE FOR AFFORDABLE HEALTH CARE

Financial Security & Peace of Mind for Utah Families

A Utah Health Policy Project Issue Brief – National Reforms July 2009

INTRODUCTION

By now, we have all either experienced or heard the horror stories of the uninsured and under-insured: Individuals excluded from coverage because of preexisting conditions, families going bankrupt because a single illness wiped out their savings. Everyone agrees the health system is broken, and now is the time to put aside party politics and fix it.

But the devil is in the details, and most of those details are undecided. We want to call your attention to one critical question which – until now – has gotten little substantive attention. *What can Utah families actually afford to pay for health insurance?* The answer to this question will fundamentally shape the sort of change we end up with and how many families will benefit as a result. Quite simply, if we want "affordable health care for all," we need to figure out what "affordable" really means. But this is harder than it looks.

Utah families are balancing a wide range of competing concerns when they make decisions about their health care: How much can I afford to pay out of pocket for the monthy premium, and then co-pays and medications on top of that? What are the chances that I or a member of my family will become seriously ill this year? Families at different points along the income spectrum will make different decisions, as will families with preexisting conditions, those with many children, or those who are caring for an elderly parent. To be successful, health reforms must achieve the right mix of affordable options, employer incentives, state assistance programs, and subsidies.

This brief provides background on why the affordability question is fundamental to any reform effort, and ends with recommendations for affordability standards that should be used to maximize participation in coverage options.

Affordability Hits Home…

In Utah health care costs have been increasing at double digit rates over the past several years.

Families such as S.M.'s of Taylorsville, who are expecting their first child, face greater financial strain from the combined pressures of increasing premium costs and out of pocket costs. With a $300 a month premium and $5,000 deductible S.M. explained that all of their money is going towards this pregnancy and deductible…

"It's hard enough to find the money to buy food, let alone everything we need for the baby."

Employers, for their part, respond to rising costs by dropping coverage altogether or passing more of the costs onto their employees. For example, small businesses like M. Smith's car, truck and tractor detailing company in Murray, can't afford to match the insurance premiums needed to offer a health benefit.

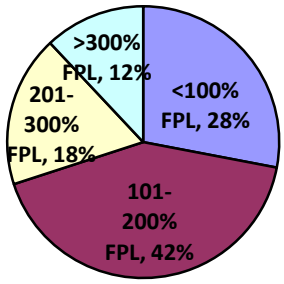
"*But even if we could,*" M. Smith explains, "*our employees wouldn't be able to afford their portion of the premium.*"

With the recession the focus shifts to keeping the company afloat, so offering insurance is completely off the table. And they are not alone… Affordability is the number one barrier to Utahns' access coverage and care.

THE CASE FOR AFFORDABILITY STANDARDS

There is no doubt that affordability lies at the heart of the health care crisis. A 2008 Utah Healthcare Access Survey found that over 50% of uninsured Utahns say they simply cannot afford healthcare coverage. Over 70% of Utah's uninsured population lives below 200% of the federal poverty level (FPL) and almost 90% fall below 300% FPL.[i] To put that in perspective, keep in mind that at 200% FPL, a family of 4 would be getting by on a gross annual income of $44,100 or $3,675 a month before taxes. After paying for food, rent and other household bills, there is not much left over to pay for premiums and co-pays.

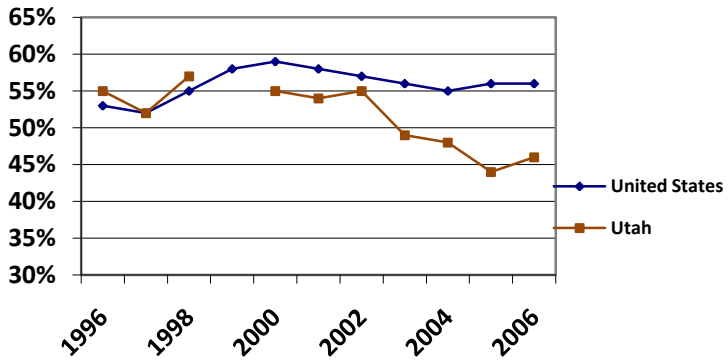
Total Uninsured by Poverty Level (FPL), Utah 2008



Source: Utah Department of Health, *Healthcare Access Survey*, 2008.

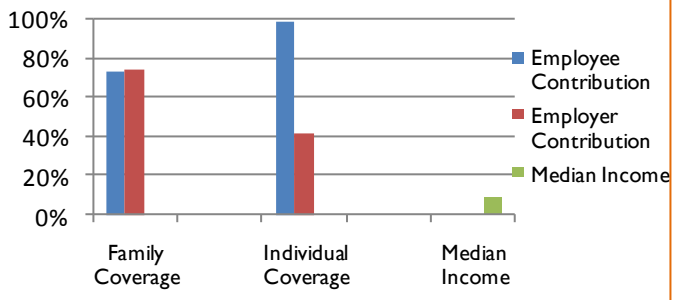
Coverage is obviously cheaper and easier to obtain through an employer, though this is becoming less and less of an option. Over 30% of uninsured Utahns work for companies that do not offer coverage of any kind,[ii] and only 17% of uninsured parents have access to employer-based coverage.[iii] Unfortunately, these numbers are likely to get worse: Over the past decade the number of Utah employers offering health insurance *decreased by almost 9%*, with the bulk of cuts coming from small business (where many uninsured Utahns work!).[iv] Even if an employer does offer coverage, it's a pretty tenuous arrangement. If just one employee experiences a serious illness, the entire group can be priced out of the system.

Employers Offering Health Insurance 1996-2006



Source: Medical Expenditure Panel Survey, 1996-2006.

Percent Increase in Utah 1996 to 2006*



Source: the Brink: *Trends in America's Uninsured*, Robert Wood Johnson Foundation and State Health Access Data Assistance Center, March 2009.
*Median Income data is for full-time workers (18-64 years), 1994/95 and 2006/07.

Over the past decade, Utah families' share of premium costs increased by 73% and individuals' share increased by nearly 100%; meanwhile, the median income in Utah only increased by 10% over the same period.[v] *And, these increases do not account for co-pays or other out of pocket costs people experience when seeking medically necessary care.* This ever widening gap between what is *available* and what is *affordable* helps to explain why the number of non-elderly Utahns purchasing private insurance for themselves, or covered by their employers, has declined by over 12% in the past decade, a rate of decline much faster than the national average.[vi]

Further, as the following chart illustrates, just paying for coverage, *again before co-pays and deductibles,* takes up a significant portion of a family's gross income.

Average Family Premium in UT	**Percent of Income Consumed by Average Family Premium** *for a family of 3*				
	50% FPL	**100% FPL**	**200% FPL**	**300% FPL**	**400% FPL**
$10,975	120%	60%	30%	20%	15%

Source: Kaiser Family Foundation. State Health Facts. Average Family Premium for Employer-Based Health Insurance, 2006.

While a family with employer-sponsored insurance usually shares premium costs with their employer, low-wage workers typically are not offered health benefits at all; in Utah only 33% of low-wage earners (those earning less than 150% of poverty) have an offer of employer sponsored insurance.[vii] Even if low-wage earners are offered benefits, they often cannot afford their portion of the premiums.

This is exactly why state assistance programs are so critical – employer-based coverage simply cannot go the distance. Medicaid, the State Children's Health Insurance Program (SCHIP) and the Utah Premium Partnership (UPP) have played a key role in providing coverage, but their reach is limited. Utah has particularly stringent rules for eligibility: A low-income adult can only qualify for Medicaid if they have a disability, are pregnant, or if they are parents with dependent children. "Low income," too, is defined restrictively. Utah is one of 12 states where eligibility for working parents to qualify for Medicaid is set at 50% of the poverty level or below. For a single mother of two, this means bringing home only $762 a month. Further, UPP, Utah's premium subsidy program, is underutilized due to a number of factors including income eligibility levels and a requirement that the enrollee have employer sponsored insurance, which is not typical for this population.

Income thresholds for current medical assistance and premium subsidy programs are *not* based on a true analysis of what families can and should be able to afford. These standards are largely historical artifacts, based on legislative decisions that were made 44-years ago using 44-year-old assumptions about the cost of living. Shouldn't public programs' eligibility and subsidy levels be based on the cost of living TODAY, and on current analyses of what families at different levels of income can reasonably be expected to pay? **If we want to build a health care system that provides families with financial and health security – a system so effective that individuals will be highly motivated to enroll without the need for mandates – then we have to build it around current economic realities in Utah.**

At the end of the day, there are many factors underlying families' ability to afford health coverage and care. An offer of reasonable coverage is necessary but not sufficient; one must also have a decent salary to support cost sharing obligations. And of course, it is helpful to have a clean bill of health. Given worrisome trends around these and other factors, it's no wonder that Utah's non-elderly uninsured rate jumped from 12% in 1994-1996 to 16% in 2006-2007. This increase is 3% faster than the national average.[viii] And of Utah's uninsured, well over half (68%) are employed part or full time.[ix]

Yet, figuring out "who can afford what" is not just a low income question. The question applies to families with more stable incomes. A recent Kaiser Family Foundation study found that although families with higher incomes are more likely to opt for health insurance than families with lower incomes, their rates of coverage are still dramatically lower than they should be, based on take-home pay. Even among families at 1,000% of the federal poverty level – yes, one *thousand* percent – only 50% chose to purchase insurance in the individual market.[x] This astonishing fact reminds us that, after all is said and done, it is

not enough to make coverage affordable. In Massachusetts where affordability standards are very conservative, they realized they needed to create a 'culture of coverage' where everyone embraces the value and importance of coverage and personal responsibility for health care decisions. If a mandate can be avoided—and it probably can't—then we must establish conservative (as in generous) standards of affordability along with a "culture of coverage."

RECOMMENDATIONS

To ensure that *all* Utah families benefit from national health reforms, conservative affordability standards should be established on a regional or state-by-state basis. While it is essential that there be consistent nationwide rules governing the *application* of affordability standards, the standards *themselves* must be state-specific, reflecting regional variations in the cost of living and the cost of health care. The following national parameters should govern the design and application of regional affordability standards[xi]:

- **Affordability should be defined as a percentage of income** that a household can devote to health care while still having sufficient income to address other basic necessities.
- **Out of-pocket-costs, co-pays and deductibles must also be considered in the equation.** Premium costs are only one part of the cost of health care. If families cannot afford co-pays or deductibles, then their coverage will not motivate them to seek primary and preventive care.
- **A progressive sliding scale that goes up to a minimum of 400% FPL should be developed to determine subsidy and co-pay levels.** As noted above, affordable health coverage and care is an issue for moderate-income families as well as low-income families.
- **The affordability scale should be conservative**. This will encourage higher take-up rates and lend much-needed political legitimacy to the otherwise controversial concept of personal responsibility for obtaining insurance coverage. The public, even the so-called "young immortals" who think they are healthy enough to go without coverage, will respond to incentives to seek coverage if that coverage is truly affordable.
- **Finally, an affordability standard should not include an asset test**. Health care costs can prevent people from breaking out of the cycle of poverty. Families should be encouraged to save for their future and not penalized for taking responsibility for their health care and coverage.

These standards will make it possible to close the current gaps in coverage by achieving the right balance of public programs and premium subsidies. With the right incentives in place, most consumers will enter the private health care market of their own free will and businesses will be able to count on healthy employees. It's a win-win for families and for Utah's economy.

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[i] Utah Department of Health, *Healthcare Access Survey*, 2008.
[ii] Medical Expenditure Panel Survey, 1996-2006.
[iii] Dubay, L. and Kenney, G. *Addressing Coverage Gaps for Low Income Parents*," *Health Affairs* 22, No. 2 (Mar./Apr.2004).
[iv] Medical Expenditure Panel Survey, 1996-2006.
[v] At the Brink: *Trends in America's Uninsured*, Robert Wood Johnson Foundation and State Health Access Data Assistance Center, March 2009.
[vi] Ibid.
[vii] Medical Expenditure Panel Survey – Insurance Component 2001 & 2006
[viii] Ibid.
[ix] Utah Department of Health, *Healthcare Access Survey*, 2008.
[x] Jacobs, Paul and Claxton, Gary. *How Non-Group Health Coverage Varies with Income*. Kaiser Family Foundation, February 2008.
[xi] Ibid.

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