
HOW SHOULD PUBLICLY SPONSORED HEALTH INSURANCE BE STRUCTURED?

Policymakers considering how to structure a program of publicly sponsored health insurance for low-income Americans face a set of fundamental issues about its design. This section addresses seven core elements that play a large part in determining the scope, shape, impact, and sustainability of a publicly financed health coverage program. In the following pages, we outline the issues and present the evidence relevant to these defining policy dimensions:

- **Eligibility**
- **Participation**
- **Use of Premiums**
- **Scope of Benefits**
- **Use of Cost-Sharing**
- **Access to Care**
- **Financing**

Use of Premiums

The issue

For health insurance to achieve coverage of the low-income population, it must be affordable. Historically, Medicaid has largely prohibited premiums for its low-income beneficiaries and it subsidizes the Medicare premium on behalf of low-income Medicare beneficiaries. State Children's Health Insurance Program (SCHIP) plans that are separate from Medicaid can charge premiums and other cost-sharing amounts up to 5% of family income; there are limits on the premiums permitted for children in families with income below 150% of the poverty level.

Some state and federal policy officials support increased flexibility to charge premiums for publicly sponsored health insurance, both to reduce public costs and to promote individual responsibility. The use of premiums is also viewed by some as a way to accustom beneficiaries to features typical of private health insurance.

The evidence

Studies show that low-income families strain to meet their costs for housing, transportation, and food, and have little income for other needs, including health care. For people living near poverty, even modest premiums present a financial hardship. In recent years, increases in health insurance premiums have dramatically outpaced increases in workers' earnings. Research shows a strong relationship between the affordability of health insurance premiums and coverage rates.

A substantial body of research documents that participation in public health insurance declines sharply as premiums rise. Restrictive premium payment policies, such as a lack of payment grace periods and lock-out periods for families who miss a payment, also contribute to coverage losses. The impact of premiums on family budgets and coverage is largest among the poorest in the population. Increases in emergency department use and heightened pressure on safety-net providers that may follow enrollment declines associated with premiums affect both personal health and the health care delivery system.

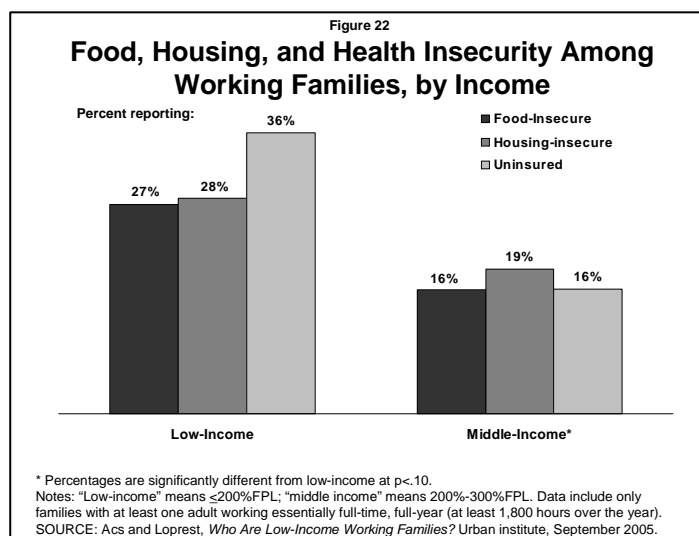
States also face increased administrative burdens associated with implementing and collecting premiums. Finally, findings that premiums lead to reduced enrollment suggest that states may realize savings from premiums, but that the savings may be due not to increased premium revenues, but to enrollment declines.

The progressive decline of private health insurance reveals that affordability is a major barrier to coverage. Premiums are most difficult to afford for those with the most limited finances. Few people living in or near poverty, if they have access to coverage, can manage to pay for it; if they do, the cost burden is great and they retain scant resources for other needs. Because premiums can be expected to depress participation in health coverage by low-income people, the use of premiums to contain public costs needs to be balanced carefully against the goal of increasing coverage of this population. Premium schedules that scale premiums to income and flexible application of payment policies are both important to mitigate adverse effects on participation and current coverage.

Key Evidence

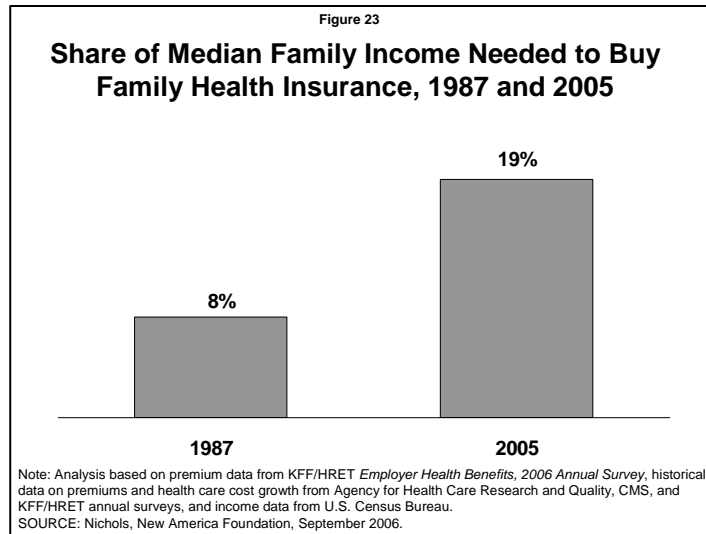
Low-income families devote the majority of their budgets to basic living expenses, with a small share available to meet other costs, including health care costs.

- Nationally, low-income families spend 7 of every 10 dollars on basic living expenses including housing, transportation, and food. Their remaining money is split among many categories, with health care spending ultimately amounting to about 7% of their total spending.¹
- An analysis of data from the 1997 and 1999 National Survey of America's Families (NSAF) found high levels of food, housing, and health care hardship among non-elderly adults in the U.S., particularly among the uninsured and low-income. Nearly three-quarters of low-income adults reported hardship of at least one of these kinds, compared with 31% reported by adults with income at or above 200% of the poverty level.²
- Data from the 2002 NSAF show that more than one in four low-income “high-work” families – that is, low-income families with at least one full-time, full-year worker – are food-insecure and a similar share is housing-insecure. More than one-third of these families lacked some health insurance coverage. These rates of food, housing, and health hardship are significantly higher than the rates experienced by middle-income high-work families – those with income between two and three times the poverty level (Fig. 22). Low-income high-work families are also more likely than middle-income high-work families to put off needed care due to lack of coverage or money and to have a child in poor health.³

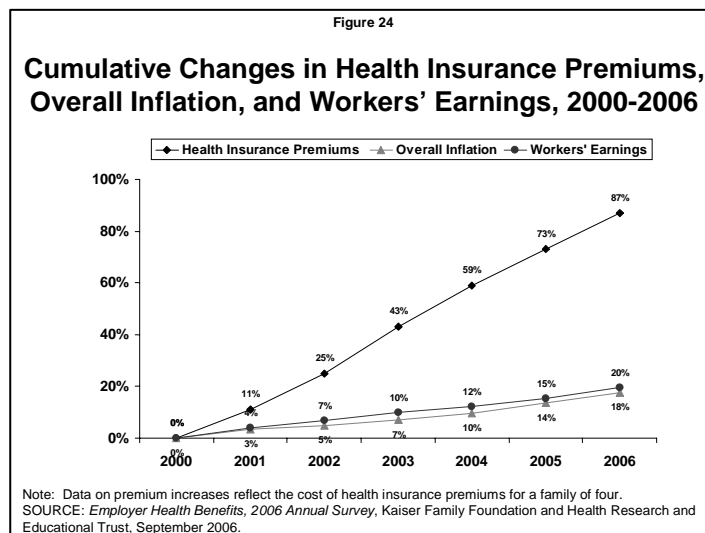


The premiums for employer-sponsored insurance (ESI) are often unaffordable for low-income families.

- Among all (not only low-income) uninsured workers who have access to job-based coverage, the reason most frequently given for declining to enroll is that the coverage is too expensive. Between 2001 and 2005, employee participation in ESI declined more among poor workers than other workers, suggesting a growing problem of affordability.^{4 5}



- In 2006, the worker's share of the average premium for job-based family coverage was \$2,973, or \$248 per month. This equates to more than one-quarter of a minimum wage worker's total earnings. The share of median family income required to purchase family health insurance rose from 8% in 1987 to 19% in 2005 (Fig. 23).^{6 7 8}
- Over the period 2000-2006, workers' earnings grew by 20%, while health insurance premiums grew by 87% (Fig. 24).⁹

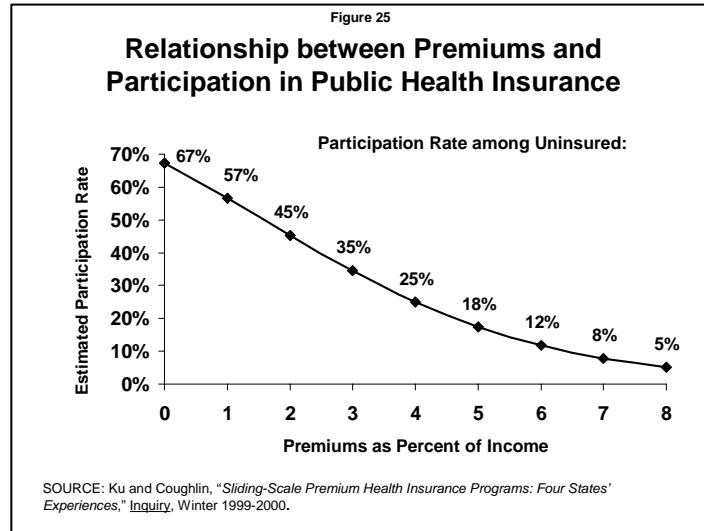


Premiums deter low-income individuals and families from participating in health insurance.

- Researchers have found a strong relationship between declines in affordability of health care – defined as the ratio of per capita health spending to median personal income – and increases in the uninsured rate among non-elderly workers.¹⁰

- An analysis of the decline in health insurance coverage among non-elderly Americans in the 1990s indicates that premium increases explain two percentage points of the 3.1 percentage point decline in coverage over the decade. The researchers suggest that the number of uninsured people could increase by 1.9 to 6.3 million in the decade ending 2010 if premiums rise at a rate of 1 to 3 percentage points per year, holding income and other variables constant.¹¹
- The Congressional Budget Office estimated that provisions of the Deficit Reduction Act of 2005 that authorize broader use of premiums in Medicaid would result in 45,000 enrollees losing coverage in 2010 and 65,000 losing coverage in 2015; about 60% of those losing coverage would be children.¹²
- A large body of research examining states' experiences shows that participation in Medicaid and SCHIP falls off sharply with premiums (and also in response to one-time fees charged for enrollment), and that even relatively low premiums led to significant coverage losses. State studies show that premiums most affect enrollment among those with the lowest income, but also lead to disenrollment among those with income above 150% of the poverty level.^{13 14 15 16 17 18 19 20 21}
- A seven-state study of the reasons eligible children lose or leave SCHIP found that almost 4 in 10 families whose children remained eligible for SCHIP but became disenrolled had problems paying their premiums. Families who paid more than \$20 per month in premiums were more likely to have trouble than those who paid less.²²
- When Oregon, under a recent Medicaid waiver, increased premiums for poor adults to \$6-\$20, established a lock-out period for non-payment of premiums, abolished premium waivers for extenuating circumstances, and introduced copayments, enrollment among those subject to premiums fell by nearly half, or roughly 50,000 people, in less than a year. Nearly one-third of surveyed disenrollees reported premium costs as a primary reason they lost coverage. In focus groups, disenrollees cited problems adhering to the strict payment policies as well as trouble affording the premium as primary factors leading to their loss of coverage.²³
- In July 2003, Maryland began charging premiums for about 6,400 children with income between 185% and 200% of the poverty level in its SCHIP program. In the first few months following the change, about 1,800 children – 28% of those subject to the premium – were disenrolled. A state survey of parents of disenrolled children showed that, in a majority of cases, the reason for disenrollment was that the children had obtained other insurance, but 1 in 5 parents cited a premium-related reason.²⁴

- A study examining the relationship between premium levels and participation in publicly subsidized health insurance programs found that, as the share of family income required for premiums rises from 1% to 3%, expected participation rates among the uninsured decrease from 57% to 35%. When premiums cost 5% of family income, expected participation is 18% (Fig. 25).²⁵



Strict or burdensome premium payment policies also affect participation adversely.

- Policies that result in termination of coverage when a family misses a premium payment or that impose a penalty period before the family can re-enroll can produce disruptions in the continuity of coverage.^{26 27}
- Penalty periods following missed premium payment, during which affected individuals are barred from enrolling in coverage, appear to have a significant impact on some of the most vulnerable families, such as those with the least income. An analysis of Georgia's three-month penalty period revealed that about 59% of children "locked out" of coverage came from families with income below 150% of the federal poverty level. A disproportionate number of the children subjected to the penalty period were African-American. There is evidence that disallowing hardship exceptions and other provisions for leniency also contributes to coverage losses.²⁸

While some people who are disenrolled from public insurance obtain other coverage, many become uninsured.

- Results from surveys conducted following premium increases in Oregon showed that 67% to 82% of those who left the rolls became uninsured. Over half of disenrollees in Rhode Island became uninsured after the state began charging premiums of around \$50 to those above 150% FPL, a higher-income group than in Oregon. And in Utah, survey results indicate that 63% of individuals disenrolled from the state's Medicaid waiver program became uninsured.^{29 30 31 32}

Losses of coverage contribute to increased emergency room use and increased pressures on safety-net health care providers.

- Some states that experienced coverage losses following the imposition of new or increased premiums for public insurance reported increased emergency room use by uninsured patients, increased pressure on clinics, and increased demand for charity care.^{33 34 35}

Premium payment policies impose administrative burdens and costs on states.

- Administering penalty periods following nonpayment of premiums has been shown to be costly. Michigan determined that the six-month penalty period it applied in its SCHIP plan, MICHild, was a drain on SCHIP resources and incompatible with the goal of reducing the number of uninsured children. The state found that nearly half its administrative reviews resulted from disputes related to the penalty period, and an estimate put the cost of such reviews at more than \$83,000 per year.³⁶
- In a June 28, 2005 hearing held by the Senate Special Committee on Aging, the Secretary of Human Services from New Mexico testified that, although the state legislature had directed the Department to seek federal authority to implement an annual enrollment fee in Medicaid, the costs of implementing such a fee were expected to roughly offset any savings from it.³⁷

Premiums may lead to savings for states, but the savings may accrue more from reduced enrollment than from increased revenues.

- Study findings that premiums lead to reduced enrollment suggest that states may realize savings from premiums but the savings may be due to not to increased premium revenues, but to enrollment declines.³⁸

Endnotes

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