



EXPLAINING HEALTH CARE REFORM: What Are Health Insurance Subsidies?

Good health insurance is expensive, and its cost is out of reach for many lower and moderate income families, particularly if they are not offered health benefits at work. Subsidies can make coverage obtainable for families that otherwise could not afford it, encouraging broad participation in health insurance. Subsidies can also assist lower-income people with insurance who may have difficulty meeting high out-of-pocket costs that can result from patient cost sharing.

Health reform proposals rely on several approaches to provide affordable coverage. One is the expansion of public health insurance programs, such as Medicaid, to the poor and near poor. Some reform proposals would extend Medicaid eligibility to new populations, such as poor adults without children, or raise eligibility limits for populations that now participate in the program. Another approach is to subsidize the premiums and out-of-pocket costs for private health insurance, usually for populations above the income cut off for Medicaid. Health reform proposals to expand Medicaid are described elsewhere;¹ in this explainer we focus on the subsidies for private health insurance.

Subsidies to help people pay for premiums and cost sharing for private health insurance are an integral part of most health reform plans, including the campaign proposal from President Obama, the Senate HELP Committee Affordable Health Choices Act, the America's Affordable Health Choices Act offered by key House committees, and the policy options distributed by the Senate Finance Committee. Premium subsidies (including the cost of Medicaid coverage for very low-income people) are important because they are the key determinant of how many people will gain coverage under reform options, and will likely comprise a very large portion of the total cost of any health reform proposal that substantially increases coverage. Cost-sharing subsidies address whether or not lower-income people will be able to use the health insurance they receive to gain access to important health services and whether or not they will be protected from financial difficulties if they become very ill.

This brief examines different ways of structuring subsidies for the purchase of health insurance and some of the key related questions that are being discussed as policymakers consider health reform. We focus on new subsidies being considered for people purchasing coverage on their own, perhaps through an insurance exchange, and do not address existing tax subsidies such as the employer-based coverage tax exclusion or tax deductions for medical expenses.²

Purpose and Function of Health Insurance Subsidies

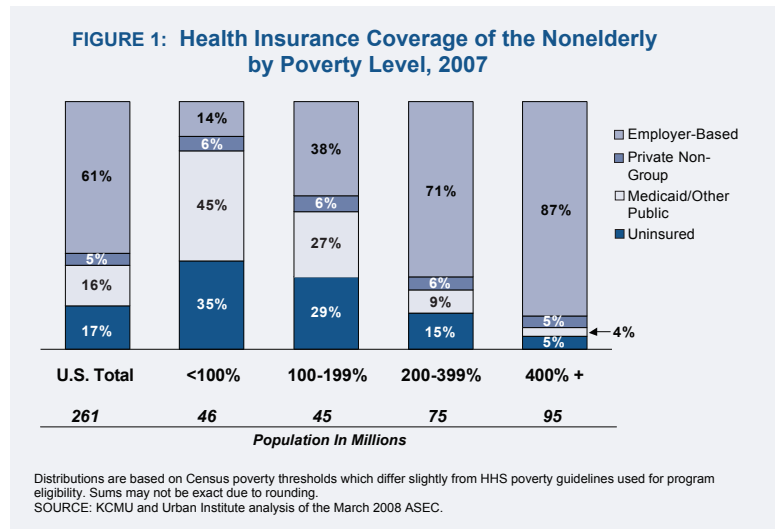
In the context of a comprehensive health reform plan, subsidies for health insurance could serve the following functions:

1. Make coverage more affordable. Health insurance is expensive and its cost can be a significant financial obstacle for families with lower incomes who are much less likely to have insurance than higher income people. In 2007, 35% of nonelderly people with family incomes under poverty and 29% of people with family incomes between one and two times the poverty level lacked coverage, compared to just 5% of people with family incomes of at least four times poverty (Figure 1).^{3,4} The issue is more acute for lower-income adults, who are less likely than children to be eligible for public coverage. Lower-income families are much less likely to be offered health insurance at work, and even when it is offered they are less likely to take it up.⁵

The high cost of health insurance means that many families may need assistance to afford private coverage. The average premium for group coverage exceeded \$4,500 for single coverage and \$12,500 for family coverage in 2008. Nongroup coverage sold directly to individuals often has lower premiums, but provides much less coverage and exposes families to high out-of-pocket costs if someone in the family becomes seriously ill.⁶

Given the cost of insurance, many lower-income families would need to spend substantial portions of their incomes to pay the full premium for nongroup coverage. For example, a family of three with income at 200% of the federal poverty level in 2008 (\$35,200) would have spent around 17% of their pretax income to purchase an average nongroup family policy, which would still leave them exposed to thousands of dollars of cost sharing if someone covered by the policy were to become seriously ill.⁷ Purchasing more comprehensive coverage with less cost sharing, similar to that provided by employers, would likely have required the family to pay closer to 30% of pretax income.⁸

The role that subsidies play in helping families is highlighted in health insurance proposals that emphasize personal responsibility by requiring individuals to purchase coverage. Even if required by law to buy coverage, many low- and moderate-income families may be unable to afford premiums for even modest policies without some financial assistance.



- 2. Protect lower-income people from high out-of-pocket costs.** While health insurance provides significant protection against health care costs, most policies require enrollees to pay a portion of costs at the point of service, and for people with serious illnesses, these costs can be thousands of dollars under even fairly generous insurance policies. Even more routine cost sharing can pose a strain on families with very low incomes, and may discourage them from seeking beneficial services. Subsidies can be provided to help people pay for some of the cost sharing required by insurance policies, enabling lower-income families to have the benefits of health insurance without facing high out-of-pocket costs when they seek care. Further, if families are required to have health insurance, requiring families to pay premiums for policies with high cost sharing may be counterproductive if the families cannot afford to pay the required deductibles and coinsurance when they need to use care.
- 3. Enabling reform of health insurance markets.** There has been widespread criticism of insurance market practices, in particular enrollment restrictions for people with health problems. By making coverage more affordable, subsidies allow many more people to buy health insurance, which in turn reduces or eliminates the need for the restrictive market practices insurers currently use. Health insurers in most markets today screen applicants based on their health, and may deny, limit, or charge more for coverage when they feel an applicant is higher risk. Insurers argue that, without health screening, people in poor health would disproportionately seek coverage, increasing premiums and discouraging people in better health from becoming insured. This is called adverse selection. While health screening keeps premiums low, it is administratively costly and can impose substantial hardships for people who need coverage but do not have it through work. Subsidies reduce the risk of adverse selection by encouraging many lower-income people in good health to be covered. Subsidies that make coverage affordable, particularly if combined with a requirement for people to have insurance, permit insurers to offer coverage without health screening while maintaining a reasonable mix of healthy and less healthy people in the market.

KEY QUESTIONS

1. Who is eligible for subsidies?

Subsidies may be available to all individuals who purchase coverage, or eligibility may be limited to lower-income individuals or to those that would be otherwise uninsured, such as those without an offer of coverage through an employer or those ineligible for public programs. Typically, the subsidies considered in the context of comprehensive health reform are targeted toward individuals and families with low to moderate incomes. Subsidies are often viewed as a way to make insurance more affordable for individuals without income low enough to qualify for Medicaid, but for whom purchasing health insurance or paying cost sharing may be a considerable financial burden, such as those below 400% of the federal poverty level.

2. How can premium subsidies be structured?

There are a number of ways to structure premium subsidies, with differing impacts on affordability for people at different incomes.

- **Premium costs as a share of income:** One subsidy approach, which is being considered in several of the proposed reform bills in the House and Senate, would subsidize families by limiting their health insurance premium costs to a specified percentage of income; for example, if health insurance costs for families at 200% of poverty were limited to 5% of income, a family of four with income at 200% of poverty (\$44,100 in 2009) would pay just over \$2,200 annually, and the government would pay the rest of the premium (e.g., if the total premium were \$12,500, the government subsidy would be about \$10,300). Subsidies might apply toward a specified benefit package or level of benefits, with families being required to pay a higher amount if they wanted more generous or expensive coverage. Income-related subsidies can be set at a constant percentage of income for all families, or may be structured on a sliding scale so that families with lower incomes pay a lower percentage of income for coverage.
- **Share of premiums based on income:** Another approach would limit the percentage of the premium for coverage that a family would be required to pay based on their income. For example, a family at poverty might be required to pay nothing or a nominal amount while a family at 200% of poverty might be required to pay 25% of the premium for coverage.

So, if the premium for a family of four were \$10,000, a family at 200% of poverty would then have to pay \$2,500 annually, and the government would pay the remainder of the premium. As with the percentage of income subsidies, the percent of premium subsidy might apply to a specified benefit package or level of benefits, with families being required to pay a higher amount if they wanted more generous or expensive coverage. If premiums vary by age, subsidies set as a percentage of the premium will vary for people of different ages. In contrast, subsidies based on a percentage of income would be the same regardless of age.

- **Fixed-dollar subsidies:** Another approach would provide a fixed-dollar subsidy for families that purchase health insurance. For example, President George W. Bush proposed providing a \$1,000 subsidy for individuals purchasing nongroup insurance. Fixed dollar subsidies might vary by family size, age, income, or other factors.
- **Tax deductions and tax credits:** Subsidies can also be delivered as an income tax deduction. Under this approach, families purchasing coverage would be permitted to deduct some or all of the cost of coverage (or some other specified amount) from their income when determining their tax liability. What distinguishes this type of subsidy is that it varies across families based on their tax liability and tax bracket. For example, under an approach that makes nongroup premiums fully deductible, a family that pays a \$10,000 premium and has a marginal tax rate of 32% would receive a subsidy of about \$3,200, while a family with less income and a marginal tax rate of 15% buying the same plan would receive a subsidy of about \$1,500.

An alternative to tax deductions are tax credits, which can be designed to provide subsidies that do not vary based on the tax rates of the families receiving them. A tax credit can be designed to deliver a premium subsidy based on any of the approaches described above; in that regard, tax credits are more of a mechanism for delivering subsidies than a different subsidy approach. To provide subsidies to low-income families that do not owe income taxes, tax credits can be made refundable so that families eligible for subsidies that exceed their tax liability can receive payments back from the government.

KEY QUESTIONS (continued)**3. How can cost-sharing subsidies be structured?**

The purpose of cost-sharing subsidies is to protect lower-income families with health insurance from high out-of-pocket costs at the point of service. Subsidies can be structured in a number of ways:

- Government payments to health plans to reduce cost sharing. One approach for cost-sharing subsidies would be for the government to reimburse insurers for the costs they incur for limiting cost sharing for lower-income families to reduced levels. For example, a proposal may provide that families with incomes between 100% and 200% of poverty would enroll in a basic level of coverage, but that their cost sharing would be reduced so that deductibles were no more than \$200 and copayments were no more than \$10. The insurer would administer the reduced cost-sharing amounts, and the government would reimburse the plan for the difference between the normal plan cost sharing and the reduced level. The government may also reimburse the plan for the cost of the increased utilization that would occur as a result of the lower cost sharing. The reimbursements could be paid retrospectively based on the use of services by each subsidized enrollee (e.g., as is done in the low-income subsidy program under Medicare Part D) or prospectively based on the expected costs for subsidized enrollees. This approach is being used in the America's Affordable Health Choices Act offered by key House committees.
- Subsidize low-income families to enroll in plans with low cost sharing. Another way of delivering cost-sharing assistance would be to adjust premium subsidies so that people with lower incomes can enroll in higher value health plans with low cost sharing. For example, there could be a tiered structure of premium subsidies where families with incomes between 100% and 200% of poverty would receive premium subsidies that are sufficient to permit them to enroll in the highest value plans (i.e., plans with little cost sharing), families with incomes between 200% and 300% of poverty would receive less generous premium subsidies sufficient to permit them to enroll in the next highest tier of coverage, and so on. Under this structure, which is being used in the Senate HELP Committee reform bill, the cost-sharing assistance is delivered through the health plan, and no additional payments related to cost-sharing assistance are necessary.
- Permit eligible individuals to seek reimbursement for cost sharing. A third way of subsidizing cost sharing for lower-income people would be to partially or fully reimburse them for cost sharing they have paid. Under this approach, people would keep track of cost-sharing expenses and seek reimbursement periodically or at the end of the year. This approach is similar to how people seek reimbursement under flexible spending accounts, and could be administered as part of the tax system or separately. A variant of this approach would permit people to seek a waiver of future cost sharing once they have paid a required amount. Under this scenario, a person who has reached their maximum liability for the year would be able to receive care with no or with reduced cost sharing, and providers who treat them would bill the government for the cost sharing that otherwise would be owed.

4. How are subsidies administered?

Methods for administering subsidies cover a broad spectrum. Existing programs, such as Medicaid or CHIP, could administer subsidies, or new programs, such as a health insurance exchange, could be responsible for determining eligibility and providing coverage options. The tax system is already a common way to provide subsidies, but has the limitation that some low-income uninsured do not currently file tax returns.

An important consideration for health insurance subsidies is at what point during the year they are available for eligible people to use. Given the high cost of coverage, and the potential of incurring thousands of dollars of cost-sharing expenses for a serious illness, many lower-income families cannot afford to pay premiums and cost sharing and wait for reimbursement under a subsidy program. To address this concern, many proposals provide subsidies to eligible people at the time they apply. Subsidy eligibility may be determined based on projected income (with reconciliation at the end of the year if the projected income changes substantially), or it may be based on income over a previous period, which can be known with greater certainty.

5. How do subsidies affect the cost of reform?

The cost of subsidies (either for expanded public coverage or subsidized private health insurance) is by far the mostly costly part of comprehensive reform proposals. The cost of subsidies is a function of: (1) how many people are eligible for subsidies (e.g., how far up the income scale are subsidies provided?), and (2) how generous the subsidies are (e.g., how much are families required to pay? how comprehensive is the coverage that is being subsidized?). There also is some tradeoff between the cost of premium subsidies and the cost of subsidies that reduce cost-sharing expenses. For example, a reform proposal that provides generous premium subsidies to allow low-income people to buy comprehensive coverage may not need an additional component to help those families with out-of-pocket costs because the policies that they are purchasing have low cost sharing. On the other hand, a reform proposal that provides premium subsidies for more basic coverage may also provide for additional subsidies to help people who face high out-of-pocket costs.

6. How do subsidies change over time?

Regardless of whether tax subsidies are a fixed-dollar amount, or are a percentage of premium cost or income, policymakers designing reform proposals to make health insurance affordable will need to address the fact that health insurance premiums are likely to grow faster than income over at least the next few years. If subsidies are set at a percentage of income that remains the same over time, families are sheltered from increasing premium costs, and the government is responsible for any additional premium cost growth. Alternatively, families and the government could share any excess premium growth if the share of the premium remained at the same level over time (as is the case in the bill passed by the House Energy and Commerce Committee). For example, consider a family with \$60,000 in income and with an initial subsidy that capped the family payment at 9% of income. At a \$10,000 premium, the family would pay \$5,400, or 54% of the premium. If the 9% of income cap remained constant over time, then after 10 years—assuming premiums grew at 5% per year and income at 3%—the family's share of the premium would decline to 45% (\$7,046). If instead the policy called for

KEY QUESTIONS (continued)

the family's share of the premium to remain constant over time, then after 10 years the family's payment would rise to \$8,377 (almost 11% of income). If subsidies are provided as fixed-dollar amounts, there are significant cost differences for families and the government if the rate of growth is set to wage growth, premium growth, or somewhere in between. Over the short run, assuming that premiums continue to grow faster

than family income, how policymakers structure subsidies will have important implications for the affordability of coverage for families over time and how the government expense for health reform grows from year to year. Over the longer term, moderating premium growth to bring it closer to increases in family income may be key in keeping government and family costs at sustainable levels.

Conclusion

Subsidies to make insurance more affordable and increase insurance coverage are a key element of any health reform plan. However, the structure of the subsidies can vary widely as will the level of assistance provided. The policy decisions made about subsidies are critical to the number of people eligible for subsidies, how much assistance is provided, and the cost of reform. Subsidies may be available only to those meeting specific criteria, such as those without another source of coverage or to those with low or moderate incomes, or they may be made available to all individuals who purchase insurance. Subsidies for health insurance require a fine balance between the cost of providing the subsidies and the gain in the number of people with insurance. As the subsidy level moves up the income scale, more individuals who would have purchased coverage on their own benefit from the subsidy. Because subsidies make up the majority of the cost of comprehensive health reform, they are a key element of reform in terms of both policy and politics.

Resources

Center for Health System Change – Living on the Edge: Health Care Expenses Strain Family Budgets: www.hschange.org/CONTENT/1034/?topic=topic05

Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured – Approaches to Covering the Uninsured: A Guide: www.kff.org/uninsured/upload/7795.pdf

Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured – President Obama's Campaign Position on Health Reform and Other Health Care Issues: www.kff.org/uninsured/kcmu112508oth.cfm

Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured – The Coverage and Cost Impacts of Expanding Medicaid: www.kff.org/medicaid/7901.cfm

Kaiser Family Foundation – Explaining Health Care Reform: What is Medicaid?: www.kff.org/healthreform/upload/7920.pdf

Kaiser Family Foundation – Health Reform Side-by-Side: www.kff.org/healthreform/upload/healthreform_tri_full.pdf

Kaiser Family Foundation – Tax Subsidies for Health Insurance: www.kff.org/insurance/upload/7779.pdf

¹ For more information, see Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, "The Coverage and Cost Impacts of Expanding Medicaid," May 2009, available at www.kff.org/medicaid/upload/7901.pdf.

² For more information, see Kaiser Family Foundation, "Tax Subsidies for Health Insurance," July 2008, available at www.kff.org/insurance/7779.cfm.

³ Kaiser Family Foundation, "The Uninsured – A Primer," October 2008, available at www.kff.org/uninsured/upload/7451-04.pdf.

⁴ The federal government uses two different definitions of poverty that yield somewhat different results. This explainer uses the U.S. Census poverty thresholds when discussing the health insurance coverage of people by poverty level and the U.S. Department of Health and Human Services (HHS) poverty guidelines in examples discussing family eligibility for subsidies. The poverty thresholds, released each year by the Census, are the basis for official poverty population statistics such as the percentage of people living in poverty. The poverty guidelines, released by HHS, are a simplified measure that is used to determine eligibility for federal programs. For 2007, the Census weighted average poverty threshold for a family of four was \$21,203 and HHS poverty guideline was \$20,650. See <http://aspe.hhs.gov/poverty/faq.shtml#differences>.

⁵ Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, "The Fraying Link Between Work and Health Insurance: Trends in Employer-Sponsored Insurance for Employees, 2000-2007," November 2008, available at www.kff.org/uninsured/upload/7840.pdf.

⁶ Kaiser Family Foundation, "Comparison of Expenditures in Nongroup and Employer-Sponsored Insurance," February 2007, available at www.kff.org/insurance/snapshot/chcm111006oth.cfm.

⁷ We used an average family premium of \$5,799 for family nongroup coverage for 2006/2007 from "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," America's Health Insurance Plans, Center for Policy and Research, December, 2007 www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf. The average number of family members for family policies in the AHIP survey is 3.05, so we compared the cost to income for a family of three. We inflated the premiums to 2008 levels by using the average increase in personal private health spending from 2007 to 2008 (5.8 percent) from the Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, available at www.cms.hhs.gov/NationalHealthExpendData/.

⁸ The average premium for a family of four for employer-based coverage in 2008 was \$12,680. The premium for a family of three may be lower: if the premium for a family of three were \$10,000, the family would have to pay 28 percent of pre-tax income for coverage; if the premium were \$10,500, the family would pay 30 percent of pretax income.

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