FOCUS on Health Reform

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EXPLAINING HEALTH CARE REFORM: What Is Health Insurance?

A key element in any comprehensive health reform plan is defining what health insurance is and the amount of insurance coverage people will have. There are two components to that coverage: the types of services covered (e.g., physician care, hospitalization, prescription drugs, etc.), and the cost sharing required of enrollees (e.g., the annual deductible, the copayments or coinsurance, and the maximum out-of-pocket costs for a year).

In a voluntary system like we have today, people receive coverage in a variety of different ways, and the scope of that coverage varies substantially. Low-income people who qualify for public programs like Medicaid and the Children's Health Insurance Program—primarily children, parents, and individuals who are disabled—generally receive a wide range of services at modest cost sharing, with specific benefits in some cases varying by state. Coverage in plans offered by large employers generally has comprehensive benefits, although cost sharing varies across employers and average deductibles have risen in recent years.[1] Small employers are less likely to offer health benefits, and when they do, the cost sharing is typically higher than in large employer plans. People who buy insurance on their own in the non-group market generally have substantially higher cost sharing, and in some cases certain services (e.g., maternity care and prescription drugs) are excluded. Also, in most states, non-group purchasers with pre-existing conditions can be excluded from coverage, charged higher premiums, or have benefits restricted.

The overall approach to reform drives the kinds of policy decisions that must be made concerning the level of coverage people will have. For example, tax-based approaches—where flat dollar tax credits are provided to people to help them buy health insurance—often do not specify any benefit requirements for the coverage people can purchase, though with substantial federal dollars at stake policymakers might look to define a minimum threshold of what constitutes coverage. Under a "shared responsibility" approach similar to what was proposed by President Obama during the campaign and in a white paper issued by Senate Finance Committee Chair Max Baucus, policymakers face a number of decisions about how to define the scope of coverage for a variety of groups, including: individuals buying insurance on their own, people receiving public coverage like Medicaid, people receiving income-related subsidies, and workers covered through their employers.

This brief explains the ways in which coverage might be defined under a health reform plan, and some of the policy issues raised by those determinations.

Defining Minimum Coverage

Regardless of where or how people get covered, a reform plan will need to lay out standards for determining a scope of coverage that moves one from being considered uninsured to insured. Such a standard could be as loose as being covered under a licensed insurance plan—with no requirements for covered services or cost sharing—or it could specifically define coverage as under Medicare, with many options in between.

Some of the ways in which a coverage standard gets applied under a health reform plan include:

- **Coverage under an individual requirement:** If the plan has a requirement that all individuals obtain coverage, then the minimum insurance that people would be required to purchase—in terms of covered services and cost sharing—would have to be specified.
- **Scope of public coverage:** If eligibility for public programs like Medicaid is expanded for those with very low incomes, decisions would need to be made about whether to standardize benefits across states, and whether states could supplement coverage with federal matching funds and specify what cost sharing will be permitted.

- **Scope of subsidized coverage:** Proposals typically include income-related subsidies for people not eligible for Medicaid or the Children's Health Insurance Program, often through tax credits. Recognizing that people with lower incomes may need additional help to afford deductibles and coinsurance, some proposals vary the minimum level of coverage by income or provide separate subsidies for cost sharing.
- **Standardized coverage offered by insurers:** Some proposals include a health insurance "exchange," which would create a more organized and competitive market for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them. Typically, an exchange proposal would also include some standardization in what insurers are required to provide, potentially requiring carriers to offer one or more standard plans. In addition, an exchange could create tiers of benefits that would facilitate understanding of different options.
- **Employer coverage:** If a proposal includes a "pay-or-play" requirement—where employers are required to offer coverage to workers or pay a fee to the government to offset the cost of insurance subsidies—employers would need to be told the minimum they have to do in order to avoid the fee. That minimum could include a defined package of benefits and cost sharing, a requirement to contribute at least a certain amount towards the premium for workers and their families, or a dollar threshold (e.g., expressed as a percentage of payroll).

KEY QUESTIONS

1. What is the minimum level of coverage individuals are required to obtain?

If a proposal requires all people to be covered, defining the details of the minimum coverage they have to buy is a fundamental decision that comes with some inherent tensions. Setting the minimum at a very low threshold could mean that even though everyone is covered, people might not feel that the coverage is worth the cost, and those purchasing only the minimum might still be considered under-insured and face high out-of-pocket costs. However, setting the minimum at a relatively high threshold would mean that some people who are already insured—particularly in the non-group market, where coverage tends to be less comprehensive—would be required to purchase a higher level of coverage than they are choosing today. Possible benchmarks for minimum coverage include:

- **Massachusetts definition:** In Massachusetts, which is implementing a plan that requires most individuals to obtain insurance, minimum coverage includes a broad range of services, a deductible of no more than $2,000 for an individual or $4,000 for a family, and an out-of-pocket maximum of $5,000 per individual or $10,000 per family. Some preventive services are covered prior to the deductible. This is quite a bit less comprehensive than a typical employer plan: the average deductible in a PPO-type plan (preferred provider organization) offered by large employers (200 or more workers) was $413 for individuals and $948 for families in 2008.
- **Coverage for federal employees:** Policymakers often reference that a goal of reform is to provide everyone with the kind of coverage federal employees have access to. The Blue Cross Blue Shield Standard option for federal workers has deductibles this year of $300 for individuals and $600 for families, plus an out-of-pocket maximum of $5,000 per family for preferred providers and $7,000 overall. The deductibles in this plan are generally lower than what most employers provide, though the out-of-pocket maximums are higher than a typical employer plan.
- **High-deductible health plan:** Federal law currently includes a definition of a high-deductible health plan that can be paired with tax-preferred Health Savings Accounts (HSAs). To qualify for an HSA in 2009, a plan must have deductibles of at least $1,150 for individuals and $2,300 for families, and out-of-pocket costs can be no more than $5,800 for individuals and $11,600 for families.

2. How is the minimum level of coverage established?

A reform proposal would have to identify who determines the minimum level of coverage. The determination is far-reaching in that it establishes a mandate on all individuals in the country, as well as a floor for what kind of insurance protection people will have. Some argue that such a major federal policy decision should be specified in legislation, though others have suggested that an independent body would be better equipped to handle the complex issues involved (e.g., the Independent Health

KEY QUESTIONS (continued)

Coverage Council under the Baucus proposal). If the determination is delegated to an administrative body, there could be provisions for Congress to review its determination on an expedited basis. In either case, the requirements could provide some degree of flexibility by, for example, allowing insurers to offer packages that are actuarially equivalent to the minimum coverage (as is the case in Massachusetts). This would allow for a wider variety of choices, but also make decision-making more complicated for consumers.

3. Is there a different level of coverage for people receiving premium subsidies?

Particularly if the minimum level of coverage is reasonably low, there may be a need to supplement that coverage for lower income individuals who could not afford the out-of-pocket expenses required. That could be done in a variety of ways, including: providing wrap-around coverage for people receiving subsidies (e.g., by having Medicaid cover some or all of the cost sharing in coordination with the enrollee's private health plan), guaranteeing subsidized individuals access to a plan with lower cost sharing, or capping out-of-pocket costs as a percentage of income (e.g., through a tax credit). In addition, people below a defined income level (e.g., 100% of the poverty level) could be made eligible for Medicaid, which provides comprehensive coverage with modest cost sharing.

4. What degree of standardization is required for insurance above the minimum level of coverage?

One goal of a health insurance exchange is to organize choices for consumers and encourage competition over price. From this perspective, fully standardized benefits are preferred, making comparisons across plans as simple as possible for consumers. However, a uniform benefits package could discourage innovation by plans and limit choice for consumers wanting to purchase less or more coverage. Benefits and cost sharing could alternatively be standardized in tiers (e.g. low, medium, and high option plans). In addition, plans could be allowed to vary benefits and cost sharing so long as the actuarial value—that is, the average level of coverage provided to enrollees—meets a defined threshold and plan variation does not discriminate against the very sick. This approach complicates choices for consumers, however, and may require greater oversight by the exchange or a regulatory agency.

5. Are there minimum coverage requirements for employers?

There are a variety of ways to structure the role of employers under a reform proposal, including: the current voluntary system could be retained, with many employers likely continuing to offer coverage, though they would not be required to do so; a pay-or-play requirement could be imposed on employers, but without a minimum level of coverage specified (e.g., employers might be required to contribute at least a certain percentage of payroll towards coverage, either by providing it directly or paying a fee to the government); or employers could be required to provide a minimum level of coverage to workers or pay a fee. If there is a requirement on individuals to purchase insurance, it's likely the case that any employers that do offer health benefits—even if not mandated to do so—would provide at least the minimum level of coverage, since their workers would otherwise be forced to buy alternative or supplemental insurance.

Related to what is required of employers is the question of whether workers whose employers offer health benefits can instead choose to get coverage in the exchange. If the employer coverage requires high out-of-pocket costs or large premium payments, workers could be permitted to switch to exchange coverage, particularly those with low incomes who would be eligible for subsidies.

6. Is there a mechanism for transitioning to new coverage requirements?

Particularly if new requirements mean that a significant number of people would have to obtain coverage that is more comprehensive—and, likely more expensive—than they have today, policymakers may look for ways to provide a more gradual transition. For example, current policies could be "grandfathered" for a period of time, or minimum coverage requirements could be phased in over several years. In Massachusetts, the individual requirement to obtain health coverage could initially be satisfied through the purchase of essentially any health plan, and specific coverage requirements became effective later.

Conclusion

Determining what kind of coverage people will have lies at the heart of a health reform plan. In defining what benefits people receive and how much they pay for them, it will help to define how people assess what reform means to them and their families.[2] The issue reflects longstanding ideological differences over what the nature of insurance should be, with conservatives typically advocating more limited insurance that places greater financial responsibility on individuals, and liberals generally promoting more comprehensive coverage, such as that provided to federal employees. Defining the minimum level of coverage under a shared responsibility approach to reform, in particular, involves difficult tradeoffs between the level of protection offered to people; the cost to individuals, the government, and employers; and the degree of disruption relative to the insurance people have today.

Resources

2009 Presidential Campaign video clips: http://kaisernetwork.org/health_cast/health2008hc.cfm?&hc=2974

Federal Employees Health Benefits Program – Blue Cross Blue Shield Standard Option: http://www.fepblue.org/

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

Kaiser Family Foundation/Health Research & Educational Trust – Employer Health Benefits Survey, 2008: http://www.kff.org/insurance/7790

Massachusetts Connector: http://www.mahealthconnector.org/portal/site/connector/

President Obama's Health Reform Principles: http://www.whitehouse.gov/issues/health_care/

Senator Max Baucus White Paper — Call To Action: Health Reform 2009: http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf

U.S. Department of the Treasury – Health Savings Accounts: http://www.ustreas.gov/offices/public-affairs/hsa/

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[1] Kaiser Family Foundation/Health Research & Educational Trust, "Employer Health Benefits Survey, 2008," available at http://www.kff.org/insurance/7790.

[2] Altman, D. "Pulling It Together, From Drew Altman: What Will Health Reform Do for Me?" Kaiser Family Foundation, February 2009, available at http://www.kff.org/pullingittogether/022609_altman.cfm.

This publication (#7906) is available on the Kaiser Family Foundation's website at www.kff.org.