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The Healthy Americans Act (HAA) Makes Health Care More Affordable for Middle Class Americans

Staff Working Paper

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Families who now have health insurance will save an average of $300 per family under the Healthy Americans Act (HAA). For example, insured families earning under $30,000 annually would save an average of at least $700 per year. Even currently insured families with incomes between $100,000 and $150,000 would save an average of nearly $100 per family.

The HAA reduces family health care costs by improving benefits, assisting lower- and moderate-income families in paying for private insurance and providing new opportunities for people to save from competition among health plans. The bill provides true portability of coverage, targets assistance to those most in need, encourages preventive and needed care, provides health security when people lose their jobs and ends discrimination against the sick and older Americans.

1. Reduces Out-of-Pocket Costs

The Kaiser Family Foundation (KFF) reports that nearly 20 percent of nonelderly Americans paid more than ten percent of family income for health insurance premiums and co-payments for health services (e.g., deductibles and co-insurance).[1] The HAA on average reduces family out-of-pocket spending for health care among currently insured Americans with incomes below $150,000 (***Figure 1***).[2] In fact, families with incomes below $150,000 per year would on average see a net reduction in spending.

The HAA achieves these savings through a combination of improved benefits, new income-related premium subsidies, a new standard income tax deduction for health care and broadened access to cost saving coverage alternatives.[3] The plan reduces out-of-pocket spending for health services by guaranteeing that all families have access to coverage that is at least as comprehensive as the plans offered to federal workers and members of Congress. In fact, we estimate that the standard coverage option offered to members of Congress would represent an improvement in coverage for about 60 percent of workers who now have employer coverage.[4]

The Act also provides an income-related premium subsidy for people living below 400 percent of the federal poverty level (FPL) (about $80,000 for a family of four). The plan would pay 100 percent of the premium for people living below the FPL. The percentage of the premium paid by the family increases to 100 percent on a sliding scale with income for people with incomes between the FPL and 400 percent of the FPL. These subsidies are designed to assure the affordability of coverage for both the poor and those with moderate income levels.

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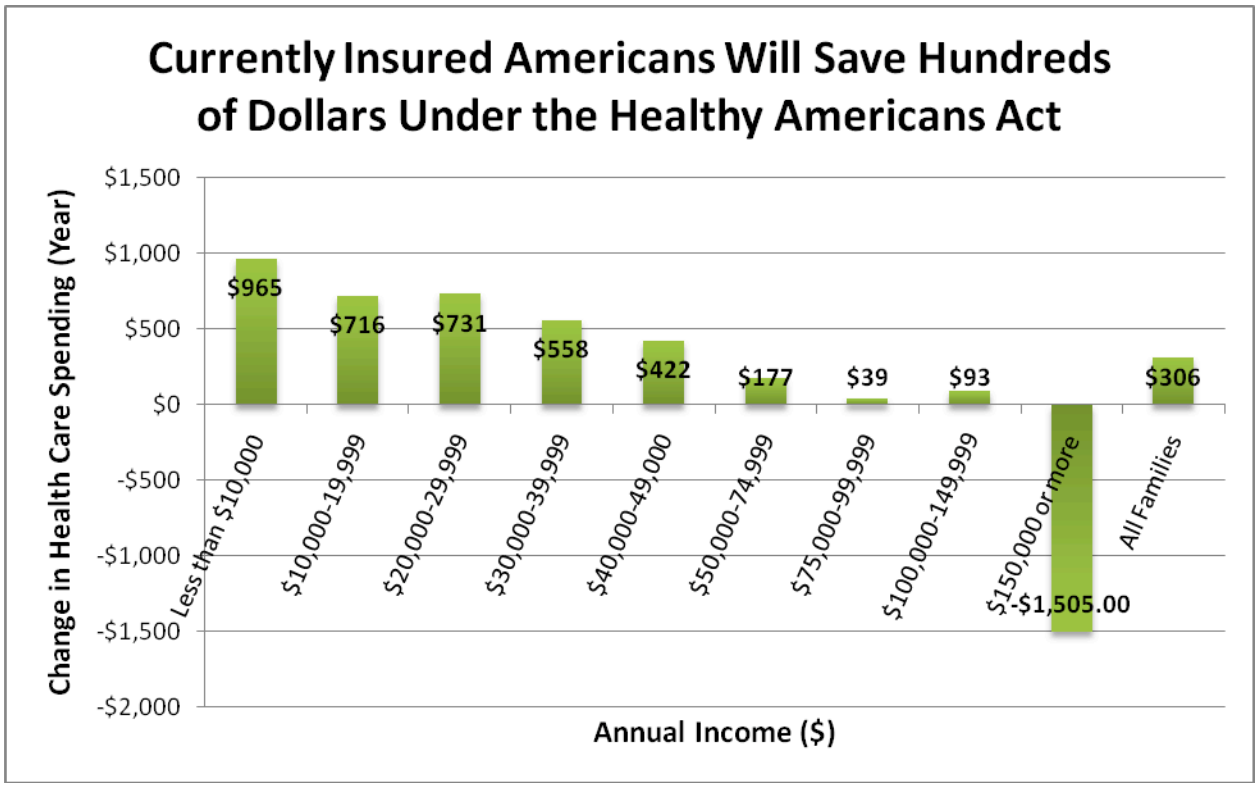
1 Kaiser Family Foundation, January 2007 Ways and Means Committee testimony (citing AHRQ, 2003 data).

2 Lewin Group Estimates using the Health Benefits Simulation Model (HBSM). See: Sheils, J. et al. "Documentation to the Lewin Group Health Benefits Simulation Model (HBSM)," The Lewin Group, 2008 Washington DC.

3 Sheils, J., "Cost and Coverage Estimates for the Healthy Americans Act," Staff Working Paper, The Lewin Group, August 2008.

4 The Lewin Group estimates that the Blue Cross/Blue Shield Standard Option under FEHBP ranks at the 60th percentile among all employer health plans (weighted by workers).

Figure 1
Average Change in Family Health Spending for Currently Insured Families under the Healthy Americans Act in 2008 [a/]



a/ Estimates show the net change in spending for health care including co-payment premiums, premium subsidies, the standard health deduction, the employer cash-out of health benefits and changes in tax payments.
Source: Sheils,J., et al., "Cost and Coverage Estimates for the "Healthy Americans Act," Staff Working Paper, The Lewin Group, revised August 8, 2008.

2. Savings Through Increased Consumer Choice

The HAA also enables consumers to choose from alternatives to their employer sponsored plans that may be less costly or better tailored to the needs of the individual consumer. The Act requires employers to convert their spending for worker health benefits to increased wages for workers. Families would then pay the full premium. Families could choose between the coverage offered by their employer, or opt for coverage offered by other competing health plans available through a regional insurance clearing house called the "Health Help Agency."

This gives families an opportunity to shift to other lower cost health plans available in the area. Because the consumer pays the full premium with the employer cash-out, the consumer actually retains the full amount saved by enrolling in a lower-cost plan. For example, the typical cost of a family policy today is about $12,000 per year. If the consumer selects a more efficient plan through the HHA that costs only $10,500, the consumer retains the full $1,500 in savings.

The cash-out of employer provided benefits is designed to assure that the consumer receives the full benefit of seeking out more efficient health plans. It also creates strong price incentives for

insurers to compete on the basis of their ability to provide high quality coverage at a competitive price. Strong incentives to control costs are essential to long-term access to health care for all Americans.

A final ingredient to the HAA is a new standard health deduction for all taxpayers. Because the amount of the employer cash-out would be counted as taxable wages, the plan provides a standard deduction that reduces net family taxable income to roughly what it would have been in the absence of the cash-out. The deduction also is not dependent upon the amount actually paid for insurance, which means that consumers can opt for lower-cost coverage without forfeiting any of their tax benefit from the deduction.

3. Targeting Subsidies to Those Needing Help

The HAA replaces the current tax exclusion for employer provided health benefits with a new program of premium subsidies and a standard health deduction that is far more effective than today's system in targeting help to those most in need. Our current tax system subsidizes the cost of employer provided health insurance by exempting the amount spent for health benefits from taxation as a form of income to the worker. The total amount of personal income tax revenues lost will be over $271 billion in 2010 (***Figure 2***).

The tax exclusion is widely criticized for favoring higher-income people while providing little or nothing to lower-income groups. For example, a KFF study shows that only 39 percent of families with incomes between 100 percent and 200 percent of the FPL (between $20,000 and $40,000 for a family of four) have employer based coverage and can potentially benefit from the exclusion.[5] Also, the value of the exclusion will be greatest among higher-income people in higher tax brackets.

As shown in ***Figure 2***, over 40 percent of the tax benefit from the exclusion goes to taxpayers with incomes of $100,000 or more, while less than 3.0 percent goes to people with less than $20,000 income. The Joint Committee on Taxation reports that the average tax benefit from the exclusion varies from $2,502 per tax payer between $30,000 and $49,000 compared with an average of $4,634 for those earning between $200,000 and $499,000.[6]

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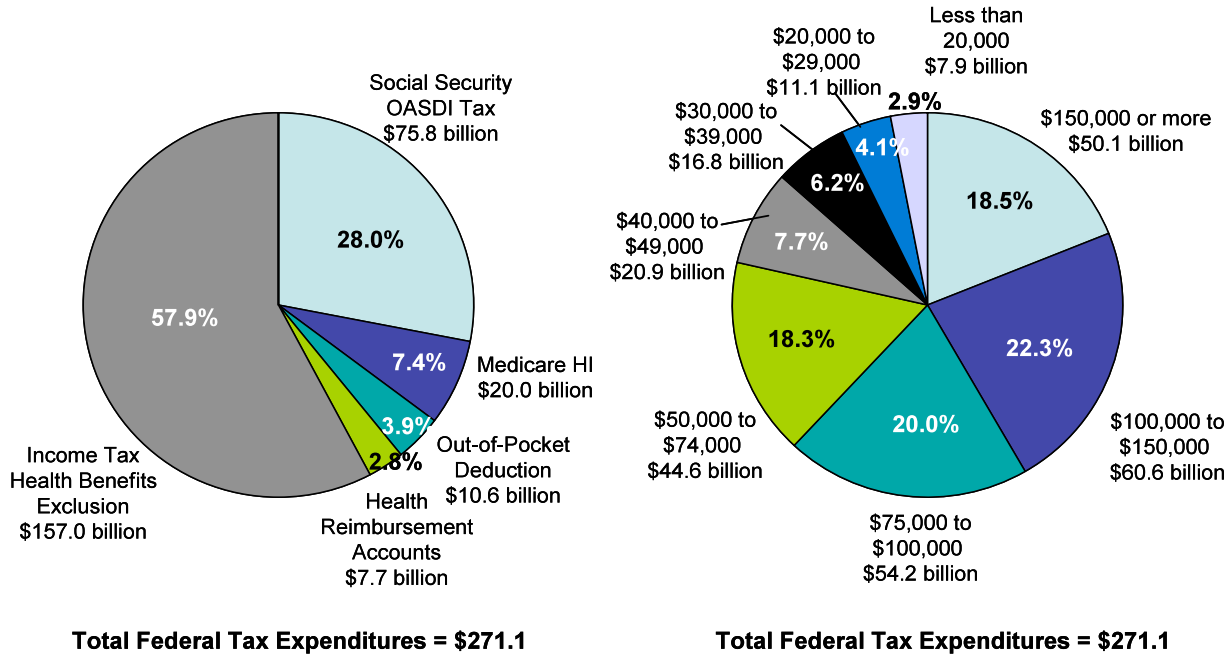
5 Kaiser, Ways and Means Committee Testimony January 2007.

6 Joint Committee on Taxation, "Tax Expenditures for Health Care," Prepared for Hearing of US Senate Committee on Finance, July 31, 2008.

Figure 2
Federal Tax Expenditure for Employer-Sponsored Insurance: 2010



Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM)

Another criticism of the employer benefits tax exclusion is that it provides no benefit to people who do not have the good fortune to be working for an employer who provides coverage. Thus, people who must purchase coverage on their own in the individual market get no tax assistance in paying the premium.

The HAA rectifies these inequities by providing income-related subsidies to families with incomes below 400 percent of the FPL. As shown in ***Figure 1***, savings are nearly $1,000 per family with an annual income of less than $10,000. Net savings decline as income rises, reflecting the targeting of subsidies to those most in need under the HAA. These premium subsidies are available to all income eligible people regardless of whether they take employer coverage or purchase coverage as individuals through the HHA.

4. Encourages Prevention and Other Needed Care

A survey conducted by the KFF reports that 42 percent of respondents have foregone care, such as having postponed care, skipped a test or not filled a prescription because of cost.[7] Sixty-six percent of these people indicated that their condition worsened as a result. The HAA addresses these shortfalls in care by requiring all Americans to have insurance that is at least as comprehensive as that provided to members of Congress.

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7 Kaiser Ways and Means Testimony, January 2007.

The HAA also places special emphasis on preventive care and chronic care treatment by requiring insurers to cover all such services with no patient cost-sharing. About 75 percent of all health spending in the US is for the chronically ill. Yet Thorpe (2007) has estimated that 56 percent of the chronically ill are not receiving the appropriate preventative services.[8] Consistent with Thorpe's finding, Thier et al. (2008) found that adherence to evidence-based medicine averaged about 59 percent among the chronically ill.[9] Eliminating cost-sharing for these services will remove financial barriers to timely care

In addition, the increased price competition among health plans under the HAA will require the plans to become more efficient by preventing expensive treatments for avoidable conditions.

5. End Discrimination Against Sick and Older Americans

One of the greatest fears people have about the health care system is that they will become ill, lose their employer coverage and be unable to find affordable coverage. The HAA eliminates these fears by guaranteeing that all Americans will be able to retain their coverage even if they become ill or unable to continue working.

In most states, insurers currently can deny coverage or charge a higher premium due to health status. While federal law requires guaranteed renewal of coverage, most states permit plans to increase premiums at renewal due to a change in health status (typically capped at 15 percent plus health cost growth). In 34 states, people who have been denied coverage can enroll in a high-risk pool, although some states have waiting lists. However, premiums in these pools usually are 50 percent or more costly than average costs for people in their age group with comparable insurance.

The HAA guarantees that every American will be able to enroll in their chosen plan regardless of age or health status at the same community rated premium - less any subsidies they are eligible to receive - that all other Americans in their area would pay. Insures are prohibited from denying coverage for anyone on the basis of age or health status, and premiums can not be increased due to a change in an individual's health status.

6. Health Security and Work

People covered in one of the HHA plans would be assured of remaining with their health plan regardless of changes in employment. This is designed to end the phenomenon of "job lock" by making it possible for people to leave a job for another without disrupting their coverage, even if their new employer does not offer a plan. People with employer coverage are also guaranteed coverage under their new employer's plan or under any of the plans offered through the regional HHA.

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[8] Thorpe (2007), "Potential Savings Under the AdvaMed Plan Associated with Health Reforms Focusing on Chronic Care Management, Prevention and Health Information Technology" found at: http://www.advamed.org/NR/rdonlyres/03AE0ADD-3472-4F29-BC58-32EC0575AB67/0/healthreformsavingsthorpeFINAL.pdf

[9] Thier, et al., "In Chronic Disease, Nationwide Data Show Poor Adherence by Patients to Medication and by Physicians to Guidelines," Managed Care, February 2008.

The HAA also offers new security to those who become unemployed. Under existing federal law, people who become unemployed have the option of continuing coverage under their former employer's plan for 18 months. However, they must pay the full premium themselves, thus leaving them strapped with a major new expense when they can least afford it.

Under the HAA, workers who become unemployed are guaranteed access to an HHA sponsored plan. Also, the worker is instantaneously excused from paying anything for their coverage while unemployed. This is because premiums will be collected through employee withholding under the HAA. Thus, when people stop working, withholding for coverage also stops. It then restarts instantly when they become reemployed.

The worker's coverage is uninterrupted and they do not need to apply separately to a government agency for assistance in paying their premium. There would be an end of year reconciliation on each consumer's tax form so that the amount paid in premiums over the year is consistent with their total income in the year. However, most people in this circumstance will actually qualify for a refund, depending upon their income level.

7. Ending the Cost-Shift

In today's health care system, much of what we pay in private health insurance premiums is used to pay for uncompensated care provided to the uninsured and shortfalls in reimbursement under Medicare, Medicaid and other government programs. The reason for this is that providers must recover the cost of providing care to uninsured people who can not pay for their care. Also, payment levels under both Medicare and Medicaid are now well below the cost of providing the care for people in these programs.

Providers typically recover these shortfalls in reimbursement by increasing prices to privately insured people through a process called the "cost-shift." In fact, one source estimates that the cost shift for the uninsured and reimbursement shortfalls for Medicare and Medicaid will account for one out of every four dollars private payers spend on hospital care in 2009.[10]

The HAA eliminates most of the cost shift for the uninsured by covering all but about 2.5 million of those who are now without coverage. The HAA also covers all of the non-Medicare population now covered under Medicaid through the HAA system of private insurance. Enrolling this population in private insurance eliminates payment shortfalls for this population. (Medicaid would be retained to cover services now covered under Medicaid that would not be covered under the HAA system.)

[10] Price Waterhouse Coopers, "Behind the Numbers: Medical Cost Trends for 2009," Health Research Institute, June 2008.