

When Coverage Fails:

*Causes and Remedies for
Inadequate Health Insurance*

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COMMUNITY CATALYST



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About Community Catalyst

Community Catalyst is a national nonprofit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

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Executive Summary

Underinsurance is a growing problem in the United States.

- The underinsured are those who have insurance, but whose insurance does not adequately cover their health care needs.
- One-fifth of insured adults in the United States – 25 million people – were underinsured in 2007.
- That number has grown by 60 percent since 2003, even as premiums also rose, leaving people paying more for policies that cover less.

Underinsurance jeopardizes the financial and physical well-being of American families and threatens our economy.

- Underinsured adults delay or forgo needed tests, treatments and doctor's visits more frequently than adequately insured adults, and they are significantly more vulnerable to medical debt.
- Medical debt, in turn, drags down the economy. It is a factor in about one-half of all bankruptcies filed, and was the underlying cause of many delinquent mortgage payments.

Rising costs and gaps in coverage put families at a higher risk of being underinsured.

- **High cost-sharing requirements**
 - Families often must pay large deductibles, typically around \$2,700 for family coverage that's privately purchased, before their health plan will begin covering the cost of health services.
 - Co-insurance, often around 20 percent of the cost of a health service, is usually required when the care is provided.
 - Many policies have maximum out-of-pocket limits, but some of the most common types of out-of-pocket spending, such as deductibles and cost-sharing for prescription drugs, often do not count toward those maximums.
- **Poor coverage of essential health services**
 - All too often, families purchase a health insurance plan thinking they are fully covered, only to find that their plan doesn't pay for important services such as annual physicals.
 - Many plans have annual and lifetime limits, above which the policy stops covering health claims, leaving the sickest individuals responsible for the entire cost of care.

Government can help guarantee that insurance protects people.

- Leaders should set common sense rules to assure that families who purchase coverage can access and afford the health care they need. For example, the government can:
 - *Set minimum standards for coverage*, which include benefits and limits on deductibles and other cost-sharing, or
 - *Guarantee important benefits*, which ensures that all health insurance policies provide access to certain health services.
- Government also must avoid promoting "cheap" plans with hidden costs.
 - *Policies creating bare-bones plans* that do not cover essential services and *giving tax incentives for high-deductible plans* may lower premiums, but only by shifting costs to when families need care and are at their most vulnerable.



Introduction

Parallel trends are undermining the health security of middle-class families across the country. First, the number of Americans without insurance has grown dramatically over the past decade. Second, a rising number of families *with* insurance are facing burdensome health care costs.¹

The underlying expense of health care in the United States drives both of these trends. As health care costs skyrocket, some Americans are paying more for policies that cover less, while others are forced to go without insurance altogether.

Both trends reduce access to important health care services and can result in financial devastation for American families. But, until very recently, underinsurance was overshadowed by uninsurance in the public debate, and few have explored the government's role in guaranteeing that insurance provides families with the security of knowing they can get the health care they need.

This report examines the extent of underinsurance, analyzes insurance trends in the private market that contribute to underinsurance and discusses the role of government in solving this problem. Specifically:

- **The first section** reviews current estimates for the number of underinsured and examines the costs of underinsurance.
- **The second section** identifies the characteristics of insurance policies that put individuals at risk for high medical spending.
- **The third section** analyzes ways to help curb underinsurance.

Background: Defining the Problem

Who are the underinsured?

There is no single commonly accepted definition of underinsurance. Studies define it in different ways, resulting in estimates for the proportion of Americans who are underinsured ranging from 4 percent to 53 percent.²

One approach for measuring underinsurance looks at the relationship between out-of-pocket costs and income for people with insurance, and tries to determine the point at which those costs either create a barrier to care or jeopardize families' financial security. A survey from The Commonwealth Fund, a private foundation working to improve health care, uses that approach and classifies individuals as underinsured if they a) had insurance all year, and b) either spent more than 10 percent of income on out-of-pocket medical expenses, had an income below 200 percent of the federal poverty level (FPL) and spent more than 5 percent of income on out-of-pocket medical expenses, or had a deductible constituting 5 percent or more of their income.³

Using that definition, the survey found that one fifth of insured adults in the United States – 25 million people – were underinsured in 2007.⁴ And underinsurance is increasing rapidly: the number of underinsured adults, by that definition, has grown by 60 percent since 2003.⁵

Where people get their insurance affects their chances of experiencing inadequate coverage. People buying insurance on their own, as opposed to through their employer, are more likely to end up underinsured.⁶

Low-income adults are disproportionately affected by underinsurance: individuals below 200 percent FPL made up 55 percent of the underinsured in 2007 but are only 33 percent of the total adult population.⁷ However, underinsurance is spreading up the income ladder. Seventy-five percent of the increase in the underinsured between 2003 and 2007 occurred among individuals with incomes above 200 percent FPL (\$44,100 for a family of four).⁸

The scope of underinsurance may be broader than the Commonwealth Fund survey estimates. Consider two identical individuals, with identical chronic conditions, identical health plans and identical incomes. One of those individuals complies with the recommended care for his chronic condition: he visits the doctor regularly and fills all of his prescriptions. By the end of the year, he has spent more than 10 percent of his income on out-of-pocket health care costs. Unwilling or unable to go into debt, the other individual delays obtaining the necessary health services, so by the end of the year he has spent less than 10 percent of his income on out-of-pocket health care costs. Both individuals might seem underinsured, but by The Commonwealth Fund's criteria, the individual who went without the necessary health care would not be classified as underinsured because he never reached the spending thresholds (assuming his deductible was not worth 5 percent or more of his income).

What Does It Mean To Be Underinsured?

A survey from The Commonwealth Fund classifies individuals as underinsured if they had insurance all year, and fit into one of these three categories:

- **Spent more than 10 percent of income on out-of-pocket medical expenses**
 - For a family of four earning 300 percent of the federal poverty level (\$66,150), that's over \$6,600 in medical expenses in one year
- **Had an income below 200 percent of the federal poverty level and spent more than 5 percent of income on out-of-pocket medical expenses**
 - For a family of four earning just under 200 percent of the federal poverty level (\$44,100), that's about \$2,200 in medical expenses in one year.
- **Had a deductible that's 5 percent or more of their income**
 - For a family of four earning 300 percent of the federal poverty level (\$66,150), that's a deductible just over \$3,300.
 - For a family of four earning just under 200 percent of the federal poverty level (\$44,100), that's a deductible slightly over \$2,200.

How does underinsurance affect individuals and our society?

Even before the current economic downturn, underinsured adults were significantly less likely than those who were adequately insured to visit a doctor when they experienced a health problem.⁹ They were also more than twice as likely to forgo needed specialist care and to skip tests, medical treatments or follow-up care recommended by a doctor.¹⁰ This pattern holds true even for those with chronic illnesses.¹¹ The current economic crisis has most likely magnified the effect of underinsurance on access to health services.

Underinsured adults are also significantly more likely to experience problems paying medical bills, to change their way of life because of medical bills, and to be contacted by a collection agency for medical bills than the fully insured.¹² Out-of-pocket medical expenses can have a domino effect on any family's financial stability, even among those who are not technically underinsured. Consumers facing increased medical expenses are likely to report decreasing their contributions to retirement savings plans (29 percent), taking on credit card debt (22 percent), and experiencing difficulty paying for basic necessities like food, heat and housing (27 percent) as a result of their medical costs.¹³

Underinsurance is intrinsically linked to the current economic crisis. Not only does the worsening economy contribute to the devastating effects of underinsurance, but underinsurance may contribute to the worsening economy. Medical debt is a factor in about one-half of all bankruptcies filed,¹⁴ and the rising number of bankruptcies has dampened the economy. Medical debt is also an underlying cause of home foreclosures,¹⁵ which have, in turn, fueled the recession. As reported in the Wall Street Journal, illness was the primary cause for 15 percent of delinquent mortgage payments to the Federal National Mortgage Association (Freddie Mac), in the first half of 2008.¹⁶

Breaking it Down: Components of Underinsurance

To get insurance, families are paying more and more. Average premiums have grown much more rapidly than average wages over the past decade.¹⁷ For people buying insurance on their own, through the individual market rather than through an employer, the average annual premium in 2006-07 was \$2,613 for a single policy and \$5,799 for a family policy. In other words, the average family's premium exceeds 10 percent of the median household income.¹⁸ And these premiums are 15 percent higher for single coverage than they were in 2004 and 31 percent higher for a family plan.¹⁹

But these growing premiums are not buying better coverage. An increasing number of insured families are also paying more out-of-pocket when they need to access care. Two insurance characteristics put families at risk for underinsurance: 1) large payments when enrollees need care, and 2) a lack of coverage for necessary services.

Cost Sharing

Deductibles

Many insurance policies require patients to spend at least the amount of their general annual deductible before the health plan will begin covering the cost of surgery, specialist care or other important health services. Additionally, many health plans have separate deductibles for prescription drugs.

Average deductibles are quite high, and are on the rise. For example, the average deductible is over \$2,700 for a "typical family plan"²⁰ purchased on the individual market.²¹

High deductible plans, sold in conjunction with Health Savings Accounts (HSAs) or Medical Savings Accounts (MSAs), are also rising. In 2006-07, about 23 percent of family plans sold on the individual market were designed to be sold with HSAs,²² up from about 16 percent in 2004.²³ The average deductibles for these plans are particularly high – \$5,329 for a family on the individual market in 2006-07.²⁴ If the percentage of individuals covered by HSA plans continues to grow rapidly, we can expect average deductibles to soar, contributing to an increasing rate of underinsurance.

Co-payments and co-insurance

Co-payments and co-insurance are two types of cost-sharing often required, in addition to deductibles and premiums. Co-payments require enrollees to contribute a fixed amount each time they visit the doctor, are admitted to the hospital, or seek care in the emergency room, while co-insurance requires enrollees to contribute a fixed percentage of the cost of their care.



The Jandris family before Kery's hospitalizations and operations.

In the individual market, the majority of the most common types of family plans require co-insurance of 20 percent or more for health services.²⁵ But, many families pay even more. Nearly 10 percent of these families face co-insurance of 50 percent or more.²⁶ These co-insurance rates are only for in-network hospitals; the rates for out-of-network hospitals are typically much higher.²⁷

This level of cost-sharing can very quickly translate into medical debt, as Maryann and David Jandris of Leehigh Acres, Fla., have experienced firsthand. They have private health insurance, and they earned a combined income of \$120,000 a year before Maryann quit her job to care for their daughter, Kery, who has ulcerative colitis. In 2007, Kery required 10 hospitalizations and four surgeries, including one to remove her entire large intestine. Kery's treatments totaled over \$1.3 million, and although the insurance covered a significant portion of those costs, the \$30-\$50 co-payments for prescription drugs and 20 percent

co-insurance left the Jandris family swimming in debt. As a result of their plan's cost-sharing requirements, this once-solidly middle-class family has recently lost its home to foreclosure and has drained its retirement plan.

Maximum out-of-pocket spending limits

Maximum out-of-pocket limits are meant to provide protection for patients by limiting the amount they must spend on health care above the cost of premiums. However, not all types of out-of-pocket spending count toward the maximum. Although there is no data available from the individual market, the trend there is likely similar to the employer market, where 33 percent of Preferred Provider Organization (PPO) plans don't count annual deductibles toward the maximum out-of-pocket limits, and 86 percent don't count prescription drug cost-sharing.²⁸ (PPOs offer patients lower price care if they choose participating providers, but do not restrict coverage to those providers.)

In addition, out-of-pocket limits are often high. For example on the individual market, over 40 percent of typical family plans had out-of-pocket maximums equal to or greater than \$5,000²⁹ – that's about 10 percent of the average household income in 2007.³⁰

Limited coverage for services

Coverage exclusions for specific services

Coverage for specific services varies by state, largely because of differing state requirements. However, families all too often purchase a health insurance plan, thinking they will be covered for essential services, only to find that their plan doesn't cover their most basic health care needs.

Data on typical family plans on the individual market, illustrates this problem. For example, in 2006-07:

- 33 percent did not cover adult physicals,
- 40 percent did not cover normal deliveries, and
- 82 percent did not cover vision care.⁴⁰



Susan Braig,

a self-employed artist and grant writer, wanted to do the right thing. Nine years ago, when she looked into the price of health insurance policies, she realized she couldn't afford a comprehensive plan. So, she purchased a Blue Cross PPO "catastrophic coverage" plan. The plan

covered in-hospital services only. It cost her about \$2,500 a year in premiums, had a \$1,000 deductible, 20 percent co-insurance for covered treatments and a \$3,500 out-of-pocket limit.

Even though it wasn't a comprehensive plan, she thought it would be better than nothing. "I can pay for the minor illnesses and doctor trips on my own, and at least if I get hit with a catastrophic illness, I'll be covered," she remembers thinking to herself. Four years later, a catastrophic illness did hit: Susan was diagnosed with stage 2 breast cancer. She felt secure that she had made the right insurance choice. Surely, the treatments she needed to battle this potentially terminal illness would be covered, right? Wrong.

Her plan covered none of the countless required medications, lab tests, scans or specialist visits. Since the nearby hospital did not offer chemotherapy, Susan faced a one-hour drive to UCLA Medical Center to get her chemotherapy covered. After her first infusion, Susan struggled with nausea and a bad steroid reaction on the long drive home, and that night she ended up in the emergency room, followed by a two-night hospital stay. At least that, she said, was covered by the health plan. After that experience, Susan enrolled in a little-known state benefits program, which covered her last three infusions at her oncologist's office, 15 minutes from home.

Without Susan's two-year state benefits, she would have been responsible for approximately \$25,000 for medical care and insurance. Since her state benefits expired, Susan has had to pay \$6,000-\$8,000 a year for follow-up care, plus \$2,500 for health insurance. Unable to work full time, Susan's credit card balances quickly escalated, and last year she was hit with \$6,000 in finance and cash advance fees. Fortunately, Susan is now cancer-free, but she still faces the financial consequences of her cancer every day.

"My cancer didn't metastasize, but my debt did."

Some plans are even more restrictive, covering only very narrowly defined services. For example, when Californian Susan Braig was diagnosed with stage 2 breast cancer, she discovered that the “catastrophic health plan” for which she had been paying premiums for four years would not pay for most of the required treatments because it covered hospital services only (see page 6 for Susan’s story).

A Snapshot: What Families Pay for Employer-Sponsored Insurance

People who get coverage through their employer are at less risk of underinsurance than those who buy on their own. But they, too, face increasing costs. The following data is for workers with family PPO plans in 2008, unless otherwise noted.

- **Premiums**
 - The average annual employee contribution to coverage for all plan types is \$721 for single coverage and \$3,354 for family coverage.³¹ These amounts have more than doubled since 1999.³²
- **Deductibles**
 - 68 percent of workers have a deductible.³³
 - Among workers with one aggregate deductible for the entire family (48 percent of workers), the average deductible is \$1,344.³⁴
 - The average aggregate family deductible increased 29 percent between 2007 and 2008.³⁵
- **Co-insurance and co-payments**
 - About half of workers pay co-insurance for hospital visits, averaging 17 percent of the total cost of care.³⁶
- **Out-of-pocket maximums**
 - 12 percent of workers had no out-of-pocket limit at all.³⁷
 - Among workers with one aggregate out-of-pocket limit for the entire family (68 percent of workers), a quarter had limits at or above \$6,000.³⁸
- **Lifetime benefit limits**
 - Two-thirds of employees with single PPO coverage in 2007 had lifetime benefit limits, and over a quarter had lifetime benefit limits below \$2 million.³⁹

Those with plans that don’t cover necessary services must pay out of pocket when they need them, and this spending never counts toward their deductible or their out-of-pocket maximum. Even if plans cover a specific service, they may impose a cap on the amount they will pay for that service, leaving the patient to pay the rest. These types of benefit caps can quickly translate to medical debt.

Caps on overall benefits

In addition to caps on specific services, many plans also cap overall annual⁴⁰ or lifetime benefit payments, leaving the most sick and vulnerable patients accountable for all their health care costs above that limit. For example, most typical family plans in the individual market have a cap, and over a quarter of those policies have a lifetime cap below \$3 million.⁴² Because health care costs have been rising, more families are at risk of hitting those lifetime caps.

Diane and Bill Pickles of Haverhill, Mass., know how terrifying that risk can be. The couple had a PPO policy with a \$1 million lifetime cap when their son, Jake, was born with severe heart damage. In his first two years of life, Jake required three open heart surgeries, and countless other tests, doctors’ visits and prescription drugs. By the time he was 4 years old, Jake was already halfway to his \$1 million dollar benefit cap. Diane remembers making the horrifying realization that they could easily hit their benefit cap within the next few years and be left with no protection for Jake’s life-saving medical treatments. Fortunately, after Jake’s three surgeries, Diane was able to return to work and was offered the opportunity to switch to her new employer’s insurance plan with no lifetime limit. “I never thought we would need a million dollars in medical care,” she said, “but all it takes is one diagnosis like Jake’s before you realize one million might not take you so far.”

How Government Can Help Curb Underinsurance

Skyrocketing health care costs are a key factor driving underinsurance. As underlying health care costs rise, average premiums rise, typical deductibles increase and many benefit packages develop larger gaps. These trends, in turn, have led to a rising number of families that go into medical debt to pay for their health care needs, and who delay important treatments due to cost concerns. To solve this problem in the long term, government

ultimately must tackle these growing health care costs head on. State and national leaders, medical professionals and consumers must work together to cut the waste in our health care system and maximize the value of our health care dollar.

In addition to this long-term strategy, government can do more in the short term to guarantee that people who buy insurance can access and afford the health care they need.

Setting Rules for Fair Coverage

Minimum standards for coverage

By setting limits on out-of-pocket costs and by guaranteeing that all insurance covers basic health care services, government can protect people like the Jandris family and Susan Braig from medical debt and deceptively skimpy insurance.

For example, in its 2008 legislative session, California came within one vote of adopting a bill that would have set a basic floor on insurance products on the individual market, and legislators are considering the bill again in 2009. This bill would require that all individual insurance policies cover physician services, hospitals and preventive services, at a minimum. It would also require that all individual policies specify a maximum dollar limit on out-of-pocket costs that includes at least co-payments, co-insurance and deductibles for covered benefits.

Finally, this bill would facilitate “apples to apples” comparisons among health plans by sorting all individual insurance products into five categories, ranging from “comprehensive” to “basic.” The bill would then allow experts to define minimum coverage standards for plans in each of those five categories. This would help consumers to understand exactly what is covered in each plan, and to choose the plan that best suits their families’ health care needs.⁴³

Massachusetts set minimum coverage standards for an even broader population – both people who purchase insurance on their own and through an employer – in its health reform law passed in 2006. As part of what is called an “individual mandate,” Massachusetts required individuals to purchase insurance that meets a minimum standard. That threshold, defined subsequently by a state agency, guarantees basic consumer protections that limit families’ financial liability, but still allows variation in benefits and requirements that families assume some financial responsibility. It includes:

- coverage of a “broad range of medical benefits” (including doctor’s visits, emergency services, hospitalization, prescription drugs, mental health care and substance abuse),
- maximum deductibles of \$2,000 for an individual or \$4,000 for a family,
- coverage for preventive care doctor visits without a deductible,
- annual out-of-pocket maximums of \$5,000 for an individual and \$10,000 for a family, and
- a prohibition on annual benefit limits.⁴⁴

Initial evidence in Massachusetts suggests that these minimum coverage standards, along with subsidized insurance coverage and other market reforms that were passed at the same time, have been successful at reducing underinsurance. According to a report from the Urban Institute, in the first year of health reform, the percent of working-age adults in Massachusetts without insurance dropped by 4 percentage points, while the share of adults who were underinsured dropped by 2 percentage points.⁴⁵ Lower-income adults and those with health problems – those most vulnerable to underinsurance – saw even larger drops in underinsurance rates.⁴⁶ In 2007, 20 percent of insured adults nationally were underinsured, compared with 6 percent in Massachusetts.⁴⁷

Out-of-pocket spending for services that aren't covered can be as burdensome as high premiums for low-income and even middle-income families.

The biggest political battle involved with setting minimum coverage standards is in deciding how high to set the criteria. More comprehensive minimum coverage standards can both lower underinsurance rates and lead to higher premiums, which can increase uninsurance. Striking the right balance between comprehensive and affordable coverage is challenging and has been contentious. In Massachusetts, for example, advocates and business groups debated whether or not to require prescription drug coverage, with business groups arguing that it would add too much to the cost of insurance,⁴⁸ and consumer groups countering that prescription drugs are essential to modern health care.⁴⁹ When assessing which benefits should be included in a minimum standard, it is important to consider that out-of-pocket spending for

services that aren't covered can be as burdensome as high premiums for low-income and even middle-income families.

Guaranteeing important benefits

In states where setting minimum standards for coverage is not politically feasible, leaders can still help prevent underinsurance by guaranteeing that insurers at least cover basic health services in every product. The number and type of benefit mandates currently in effect varies widely from state to state. For example, as of 2008:

- all states except Utah mandate that insurers cover breast cancer screening,⁵⁰
- 24 states mandate coverage of contraceptives,⁵¹
- 11 states require coverage of autism spectrum disorders,⁵² and
- 13 states require insurers to cover osteoporosis screening.⁵³

Opponents argue that benefit mandates have the unintended effect of increasing the cost of coverage, thus pricing individuals out of the insurance market and contributing to the growing ranks of the uninsured.⁵⁴ While mandates almost certainly contribute to a rise in premiums, this effect is often overstated.

According to a 2003 Government Accountability Office report on coverage mandates in the “small group market,” where small businesses purchase insurance for their employees, most studies assessing the cost of benefit mandates on insurance premiums report the total cost of providing the benefit, without taking into account that some employers chose to offer products including that benefit before the mandate was in place.⁵⁵ For example, in Maryland in 2003, 40 mandates added only 1.6 percent to the cost of health care policies, rather than the 15 percent in some estimates because many people had this coverage already.⁵⁶

It's also important to remember that state benefit mandates do not affect all insured families. Federal law prohibits states from regulating self-insured health plans, leaving approximately 73 million American workers and their dependants unprotected by state benefit mandates.⁵⁷

Avoiding “cheap” plans with hidden costs

In attempting to provide affordable health coverage for the uninsured, states sometimes propose stripping plans of certain health services or creating incentives to purchase high-deductible plans. Policies that create gaps in coverage may lower the upfront costs of health insurance somewhat, but they do so only by delaying the costs until the family needs care. These policies put more families at risk for underinsurance.

Limited-benefit plans

Some states contribute to the growing rate of underinsurance by allowing insurers to offer products not subject to some or all of the state's mandated benefits. These plans are called "limited-benefit," "mandate-lite," "mandate free," or "barebones plans." According to State Coverage Initiatives, a national program of the Robert Wood Johnson Foundation that provides assistance to state leaders on health policy issues, 13 states currently allow some form of "limited-benefit" plans.⁵⁸

Policies that create gaps in coverage may lower the upfront costs of health insurance somewhat, but they do so only by delaying the costs until the family needs care.

For example, Florida began allowing insurance companies to offer limited-benefit plans in 2009. Under this law, all plans must cover certain screenings, preventive care, office visits, and diabetes supplies, among other services. Insurers must also offer at least one plan that covers catastrophic coverage, but may also offer plans that do not cover inpatient hospital stays and emergency care. Insurance policies may also offer "drug discount cards" rather than meaningful prescription drug coverage. In addition, plans may impose limits on the number of services covered and low caps on benefit payments.⁵⁹

States create limited-benefit plans, despite the risk it poses for individuals, in the hope of increasing access to insurance coverage by lowering premiums. Limited-benefit plans have reduced premiums by 5 to 9 percent on average.⁶⁰ But other costs rise as a result, including patients' out-of-pocket spending

and the expense of state or hospital free-care programs for services not covered by insurance.

Limited-benefit plans do not significantly increase access to coverage. A 2004 review of state experiences found that almost every state that allows limited-benefit plans experienced problems: few carriers offer the plans and few individuals enroll.⁶¹

Providing tax benefits for high-deductible plans

Through its tax system, Georgia has given individuals and businesses incentives to purchase inadequate health insurance.

In 2009, Georgia began offering tax breaks for high-deductible plans. Those plans sold with health savings accounts (HSAs) are exempt from the premium taxes that Georgia imposes on insurers. Small businesses that pay at least \$250 per year toward employees' premiums for high-deductible plans (sold with HSAs) receive a \$250 tax credit for each employee enrolled. And, individuals who purchase high deductible plans in the individual market can deduct the cost of their premiums from their incomes for state income tax determination.⁶²

This law was passed in the hope of creating more affordable coverage options for the uninsured, and the proponents of the bill claimed it could provide coverage to an additional 500,000 uninsured Georgian residents.⁶³ However, a Center on Budget and Policy Priorities analysis suggested that the number of high-deductible policies would only increase by 65,000 by 2013, and that many of those new policies would actually be purchased by individuals who were already insured in a different type of health plan.⁶⁴

The Georgia law gives employers and individuals who already offer or purchase comprehensive coverage an incentive to switch to high deductible plans. Although there is no data yet about the law's effect on the underinsurance rate, it is clear that by leading individuals to purchase high-deductible plans, this law will put more families at risk for medical debt and reduced access to needed health care services.

Community Catalyst's Policy Recommendations

1. Eliminate or restrict limited-benefit plans.

Limited-benefit plans can create underinsurance, and should be considered only in the handful of states where they are the only politically feasible option for expanding coverage. In those states, leaders should introduce meaningful consumer protections, such as maximum annual out-of-pocket limits, and should strengthen coverage requirements. Before permitting new limited-benefit plans, leaders should commission an independent study that gathers the following information:

- The expected annual costs of the limited-benefit or high-deductible plan (including premiums, deductibles, cost sharing, and the cost of services not covered) for the average healthy enrollee and for the average enrollee with a chronic condition
- The extra costs the state and hospitals will likely face as a result of increased demand on charity care
- The expected reduction in uninsurance resulting from this policy, and the number of currently insured individuals that are likely to shift from full-coverage to limited-benefit or high-deductible plans

2. Guarantee minimum standards for health insurance.

Minimum standards should set limits on families' financial liability and guarantee that basic services are covered, but still allow for significant cost-sharing and benefit variation. They should include:

- Annual out-of-pocket maximums inclusive of all cost-sharing (such as deductibles, co-payments and co-insurance)
- Coverage of basic health services such as hospital, physician, emergency care, and prescription drugs

These minimum coverage standards should be much more comprehensive in the context of an individual mandate.

3. Set clear standards for how hospitals meet their free care obligations.⁶⁵

Hospitals, particularly those that receive tax-exemptions, have obligations to provide free or discounted care to people who cannot afford the cost of their medical services. Free care offers critical protection for the underinsured against the worst consequences of inadequate coverage. At a minimum, hospitals should be required to:

- Establish free care policies with clear eligibility guidelines
- Widely notify their patients and the public about the availability of free care
- Limit charges for uninsured or underinsured patients to what Medicare pays

4. Work to eliminate waste in our health care system.

Controlling health care costs is an essential ingredient in reducing underinsurance. Potential cost-containment strategies include:

- Paying hospitals and doctors for improvements in health, not quantity of services delivered
- Banning gifts to prescribers from medicine and medical device manufacturers, in order to curb industry financial incentives and aggressive marketing that distort prescribing decisions and increase costs
- Coordinating care to ensure that the sickest individuals are getting the right care at the right time to prevent further complications

Conclusion

Underinsurance is a growing problem in this country. Each year, families spend more of their paychecks for health insurance premiums, yet they face higher deductibles and too often find themselves uncovered for important health care services. And each year, inadequate insurance leads more individuals to forgo needed health care treatments and burdens more families with insurmountable medical debt.

Government must guarantee that people who buy insurance can access and afford the health care they need. In the long term, it is essential that both state and national leaders work with medical professionals and consumers to control the costs of health care in this country. In the short term, government can set basic consumer protections that limit families' financial liability, or at least guarantee that essential benefits are included in all insurance products.

Government must also avoid "cheap" plans with hidden costs, such as permitting "limited-benefit plans" or providing incentives to purchase high deductible plans. If limited-benefit plans are the only politically feasible option for expanding coverage, government should guarantee strong consumer protections, such as limits on out-of-pocket spending. Only by taking such a conscious and deliberate approach can we begin to control the parallel trends of uninsurance and underinsurance.

For Advocates: Ingredients for a Successful State Campaign to Reduce Underinsurance

Whether fighting against a proposed limited-benefit policy or introducing minimum standards for policies sold on the individual market, advocates organizing a campaign to reduce underinsurance should consider the following campaign strategies.

1. Build a coalition of groups and stakeholders that have been particularly affected by underinsurance. For example:

- *Disease groups and organizations that represent special-needs populations* – Their constituencies, due to their high-cost health conditions, are often most affected by poor coverage. For example, in a 2005-06 survey, 33 percent of insured families with children with chronic illnesses and disabilities reported having insurance that did not adequately cover their needs.⁶⁶ As a starting point for reaching out to these groups, contact your state attorney general's office for a list of all disease organizations in your state.
- *Small business groups and artists organizations* – Those who purchase insurance on the individual market tend to be most vulnerable to inadequate coverage. Since many small business owners and artists rely on this market for coverage, they are especially affected by underinsurance.
- *Some provider groups, especially certain specialists* – Some specialists may resist limited-benefit plans that would restrict coverage for their services. They may also be interested in helping to set minimum coverage standards that assure coverage for their services.
- *Senior organizations* – Individuals who retire before they qualify for Medicare may have few affordable choices for coverage and are therefore at high risk of purchasing inadequate insurance.

2. Gather stories of underinsured individuals. Use your grassroots networks to identify a list of underinsured individuals who are willing to share their stories. Stories of insured individuals who go into medical debt to pay for their health care needs, or who delay important treatments due to cost concerns, can powerfully illustrate the need for stronger minimum benefit standards (or the harm of limited-benefit plans.) These individuals may be effective spokespeople to:

- *testify at hearings,*
- *visit their legislators in support of the legislation,*
- *write letters to the editor, and*
- *be on hand to speak to reporters who are writing stories about the issue*

3. Create concise talking points to counter opponents' messages and to create a sense of urgency. Ideas for effective messaging include:

- *"Half a parachute is not better than no parachute."* Even progressive policy-makers may be susceptible to the misleading claim that limiting "junk insurance" harms low-income individuals by taking away the most "affordable" insurance. It's critical to remind them that high out-of-pocket costs can be as burdensome as high premiums for middle-class families.
- *Underinsurance affects Americans of all income levels.* Legislators from higher-income areas may believe that their constituencies are unaffected by underinsurance. In fact, the biggest increase in underinsurance is among those with incomes above 200 percent FPL.
- *Underinsurance is worsened by the current economic downturn; both are undermining the financial security of American families.* Emphasizing the link between underinsurance and the economic downturn can help create a sense of urgency around the issue.

¹Schoen, Cathy, Sara R. Collins, Jennifer L. Kriss, and Michelle M. Doty. 2008. How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007. *Health Affairs* 27:w298-w309.

²Blewett, Lynn A., Andrew Ward, and Timothy J. Beebe. 2006. How much health insurance is enough? Revisiting the Concept of Underinsurance. *Medical Care Research and Review* 63: 663-700.

³Schoen et al, 2008.

⁴Ibid

⁵Ibid

⁶Ibid

⁷Ibid

⁸Ibid

⁹Ibid

¹⁰Ibid

¹¹Ibid

¹²Ibid

¹³Helman, Ruth, Matthew Greenwald & Associates, and Paul Fronstin. 2008. The 2008 Health Confidence Survey: Rising Costs Continue to Change the Way Americans Use the Health Care System. EBRI Notes 29, No. 10 (October 2008), http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-2008.pdf (accessed March 19, 2009).

¹⁴Himmelstein, David U., Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler. 2005. Illness and Injury as Contributors to Bankruptcy. *Health Affairs* 24: w63-w73 (February 2, 2005), <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>.

¹⁵Robertson, Christopher Tarver, Richard Egelhof, and Michael Hoke. 2008. Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures. *Health Matrix* 18: 65-105 (August 18), http://works.bepress.com/cgi/viewcontent.cgi?article=1001&context=christopher_robertson.

¹⁶Rubenstein, Sarah. 2008. Facing a Choice Between Home And Health Care: Housing Rout Cuts Off Source of Funds to Pay Medical Bills; Chemo, and Then Foreclosure. *The Wall Street Journal*, November 25, <http://online.wsj.com/article/SB122754689689653489.html>.

¹⁷Kaiser Family Foundation. 2009. Health Care Costs: A Primer. March. http://kff.org/insurance/upload/7670_02.pdf.

¹⁸Author's calculations based on data from U.S. Census Bureau. 2008. Income, Poverty, and Health Insurance Coverage in the United States: 2007. August, <http://www.census.gov/prod/2008pubs/p60-235.pdf>.

¹⁹Author's calculations based on data from Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits and Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits (AHIP Center for Public Policy and Research, 2005, http://www.ahipresearch.org/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf)

²⁰Throughout this report, "typical family plans" refers to both Preferred Provider Organization plans (PPO) and Point of Service (POS) plans that were purchased on the individual market. PPOs offer patients lower price care if they choose participating providers, but do not restrict coverage to those providers. POS plans are similar, but they typically impose more restrictions on the choice of providers.

²¹AHIP Center for Policy and Research. 2007. Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits. December, http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.

²²Ibid

²³AHIP Center for Policy and Research. 2005. Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits. August. http://www.ahipresearch.org/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf.

²⁴AHIP Center for Policy and Research. 2007.

²⁵Ibid

²⁶Ibid

²⁷AHIP Center for Policy and Research. 2005.

²⁸Kaiser Family Foundation and Health Research and Educational Trust. 2008. Employer Health Benefits 2008 Annual Survey. <http://ehbs.kff.org/>.

²⁹AHIP Center for Policy and Research. 2007.

³⁰Author's calculations based on data from U.S. Census Bureau. 2008. Income, Poverty, and Health Insurance Coverage in the United States: 2007. August. <http://www.census.gov/prod/2008pubs/p60-235.pdf>

³¹Kaiser Family Foundation and Health Research and Educational Trust. 2008.

³²Ibid

- ³³ Ibid
- ³⁴ Ibid
- ³⁵ Author's calculations based on data from Employer Health Benefits: 2008 Annual Survey.
- ³⁶ Kaiser Family Foundation and Health Research and Educational Trust. 2008.
- ³⁷ Ibid
- ³⁸ Ibid
- ³⁹ Kaiser Family Foundation and Health Research and Educational Trust. 2007. Employer Health Benefits 2007 Annual Survey. <http://www.kff.org/insurance/7672/index.cfm>.
- ⁴⁰ AHIP Center for Policy and Research. 2007.
- ⁴¹ Data on the frequency and size of annual caps in either the individual market or in employer-sponsored plans is unavailable.
- ⁴² AHIP Center for Policy and Research. 2007.
- ⁴³ Assembly (2009 CA Assembly Bill AB786). http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_1501-1550/sb_1522_bill_20080815_amended_asm_v94.pdf.
- ⁴⁴ Commonwealth Connector. Health Care Reform: Key Decisions. News: The Minimum Benefits You'll Need In 2009. <http://www.mahealthconnector.org/portal/site/connector/menuitem.gccd4bd144d4e8b2dbef6f47d7468aoc/?fiShown=default> (accessed March 20, 2009).
- ⁴⁵ Long, Sharon K. 2008. The Impact of Health Reform on Underinsurance in Massachusetts: Do the Insured Have Adequate Protection? Massachusetts Health Reform Survey Policy Brief (October 2008), http://www.urban.org/UploadedPDF/411771_mass_underinsurance.pdf
- ⁴⁶ Ibid
- ⁴⁷ Ibid
- ⁴⁸ Lord, Dick. 2008. Rethinking Prescription Drug Mandate. Commonhealth Blog (January 11), <http://commonhealth.wbur.org/richard-lord/2008/01/rethinking-prescription-drug-mandate-by-richard-c-lord/>.
- ⁴⁹ Rosman, Brian, and Lisa Kaplan Howe. 2008. A Healthy Blog (September 22), <http://blog.hcfama.org/?p=1870>.
- ⁵⁰ State Health Facts Online. State Mandated Benefits: Cancer Screening for Women, 2008. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=488&cat=7>.
- ⁵¹ State Health Facts Online. State Mandated Benefits: Contraceptives, 2008. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=637&cat=7>.
- ⁵² The Council for Affordable Health Insurance. 2008. Trends in State Mandated Benefits, 2008. May 2008. http://www.cahi.org/cahi_contents/resources/pdf/TrendsEndsMandatedBenefits2008.pdf.
- ⁵³ State Health Facts Online. State Mandated Benefits: Osteoporosis Screening, 2008. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=491&cat=7>
- ⁵⁴ See, e.g., Council for Affordable Health Insurance, CAHI Issues: State Mandates, http://www.cahi.org/cahi_contents/issues/article.asp?id=491
- ⁵⁵ United States General Accounting Office. 2003. Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses. <http://www.gao.gov/new.items/do31133.pdf>.
- ⁵⁶ Maryland Health Care Commission. 2004. Study of Mandated Health Insurance Services: A Comparative Evaluation. http://mhcc.maryland.gov/health_insurance/studyofmandateeval03.pdf.
- ⁵⁷ Employee Benefit Research Institute. 2008. 73 million Americans Are in Self-Insured Health Plans. Fast Facts from EBRI 84, <http://www.ebri.com/pdf/publications/facts/fastfacts/fastfacto5282008.pdf>.
- ⁵⁸ State Coverage Initiatives. States with Limited-Benefit Plans Strategy. http://www.statecoverage.org/node/47/cs_states (accessed March 20, 2009).
- ⁵⁹ Florida Gen Laws. Chapter No. 2008-32. http://laws.flrules.org/files/Ch_2008-032.pdf.
- ⁶⁰ State Coverage Initiatives. Limited Benefit Plans. <http://www.statecoverage.net/matrix/limitedbenefitplans.htm> (accessed March 20, 2009).
- ⁶¹ State Coverage Initiatives. 2005. Limited-Benefit Policies: Public and Private-Sector Experiences. Issue Brief 5 (July), <http://www.statecoverage.org/files/Limited-Benefit%20Policies%20-%20Public%20and%20Private-Sector%20Experiences.pdf>.
- ⁶² Assembly (2008 GA Assembly Bill HB977.) http://www.legis.state.ga.us/legis/2007_08/pdf/hb977.pdf.
- ⁶³ Sheinn, Aaron Gould. 2008. Perdue signs high-deductible insurance plan bill. The Atlanta Journal-Constitution, May 7, Metro Section.
- ⁶⁴ Solomon, Judith. 2008. New Georgia and Florida Health Plans Unlikely to Reduce Ranks of Uninsured. <http://www.cbpp.org/cms/?fa=view&id=474> (accessed March 20, 2009).
- ⁶⁵ For more information on how to enforce standards and oversight for hospitals' free care obligations, see Community Catalyst's Hospital Accountability Project website at <http://www.communitycatalyst.org/projects/hap/>.
- ⁶⁶ Child and Adolescent Health Measurement Initiative. 2007. National Survey of Children with Special Health Care Needs (2005-2006), Data Resource Center on Child and Adolescent Health website. www.cshcndata.org