



Quality, Affordable Health Coverage
For Every Missourian

Defining Affordable Health Care for Missouri

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Introduction

More than 700,000 Missouri residents, or 13 percent of the population, currently have no health coverage. Most of the uninsured cannot afford health coverage. As Missouri wrestles with policy options to reduce the number of uninsured, it is critical to understand what Missourians can actually afford in terms of coverage. A health reform plan not grounded in the reality of what Missouri families can afford will not succeed in reducing the number of uninsured in our state.

A number of issues challenge an acceptable definition of affordability. Foremost is limited information and data identifying the price-point at which health care becomes affordable. A majority of studies assume that insurance is affordable to people at defined income levels, usually some percentage of the federal poverty level (FPL).¹ Starting with this assumption makes it very difficult to accommodate differences in demographics, geography and life circumstances, even though these factors often determine whether a family can afford health insurance.²

Responding to the lack of information on the role of affordability on health coverage, Community Catalyst created a methodology for defining health insurance affordability by drawing together several different studies.³ This paper applies the methodology to derive an affordability standard in Missouri. By looking at affordability standards for other public programs; the cost of essential needs for Missouri families; current spending on health care; and price sensitivity to health insurance, a clearer picture of affordability emerges for Missouri. This analysis uses updated information on health insurance in Missouri, as well as data from the Massachusetts experience, to create an affordability scale that takes into account the ability of families to pay for health care. Also, the paper compares the affordability scale against public polling data on perceptions of what is reasonably affordable health insurance.

Toward a Definition of Affordability

In this paper, affordability is defined as the percentage of annual household income that can be devoted to health care while maintaining sufficient resources to pay for other necessities. Since many health insurance plans in today's market have high cost-sharing requirements, this definition includes premiums and all out-of-pocket costs.

Based on Community Catalyst's methodology, the definition of affordability in Missouri is derived from the following:

- An examination of current affordability and eligibility guidelines for other public programs in Missouri. These programs serve as a guide in determining the income level at which basic necessities are unaffordable.
- An assessment of household budgets to contextualize the annual expenses for individuals and families with low-incomes (less than 300 percent FPL) and moderate-incomes (between 200-300 percent FPL). From this information, the paper considers different versions of budgets on the basis of region and family size.
- An evaluation of current health care spending as an index of affordability at the moderate income level. As part of the state's recent health reform, Massachusetts created an affordability schedule for health care. Preliminary data from Massachusetts's experience provides valuable information about what is affordable to families.

- An investigation of take-up rates (the price level at which a person decides to voluntarily enroll in insurance) and price sensitivity (how consumers respond to price changes for a particular good) for health insurance. This information indicates the price-point at which health care becomes affordable to individuals and families at varying income levels.
- An analysis of public opinion polls asking people whether certain amounts are reasonably affordable for health care. This data demonstrates a measure of affordability that will have political legitimacy and public acceptance.

Affordability and Eligibility Guidelines for Public Programs

Established public programs have recognized eligibility and affordability guidelines to determine income levels at which certain basic needs become unaffordable. While these levels may not exactly track health care affordability, they do illustrate the price-point at which low-income families cannot afford even basic necessities, and are therefore unlikely to pay toward health coverage. The following programs use affordability guidelines:

- *Missouri Low Income Home Energy Assistance Program*: This program assists low-income Missourians with heating costs during winter months. Qualifying applicants are required to meet certain predetermined income guidelines for eligibility: approximately 123 percent FPL (\$12,792) for an individual and 122 percent FPL (\$21,472) for a family of three.⁴
- *Food stamp program*: This program provides assistance to low-income families to purchase groceries. Federal eligibility guidelines are set at approximately 128 percent FPL (\$13,312) for an individual and 127 percent FPL (\$22,352) for a family of three.⁵
- *Earned Income Tax Credit (EITC)*: This federal tax credit program redistributes funds to low-income wage earners who meet program criteria because they have too little income to meet basic needs. For the 2007 tax filing year, an individual qualified for EITC if he/she earned less than 121 percent FPL (\$12,584); a qualifying family of four with two children earned less than 188 percent FPL (\$39,856).⁶

While eligibility guidelines for public programs may not be directly applied to the affordability of health coverage, they do provide guidelines for determining who cannot afford to pay health care costs. Because the fuel assistance, food stamp, and EITC programs provide aid to individuals below 130 percent FPL for individuals and up to 190 percent FPL for families, it seems unreasonable to ask individuals and families at these income levels to contribute income toward health insurance premiums or anything beyond nominal copayments for care.

Basic Household Budgets and Expenses in Missouri

Economic research supports examining the behaviors of people with similar incomes to evaluate affordability.⁷ This paper uses the data and findings from two studies of basic household budgets: the Missouri Women's Council study "Missouri Family Affirming Wages," and the Economic Policy Institute's (EPI) "Basic Family Budget." These studies examine basic household budgets to identify actual spending on essential necessities such as housing, food, and transportation, which can then be applied to determining the price at which health care becomes affordable to low-income Missourians.⁸

The Missouri Women’s Council’s study uses estimates of basic family needs such as housing, food, and child care to establish the amount a family needs to earn to be self-sufficient in various counties in Missouri.^{9,10,11} According to the analysis conducted by the Missouri Family Affirming Wages, a single adult in St. Louis would need an annual income of \$15,820 (about 152 percent FPL) to be self-sufficient. This analysis assumes the availability of employer-sponsored insurance (ESI). Removing the cost of health coverage, a single adult in St. Louis would need an annual income of \$15,028 (144 percent FPL) before accounting for health spending.

Table 1: Income Required to Meet Basic Needs in Missouri, Before Health Costs

Based on data from Missouri Family Affirming Wages

Location	Single adult	% FPL	Adult + Child (preschool)	% FPL	2 Adults + 2 Children (preschool, school age)	% FPL
<i>St. Louis City</i>	\$15,028	144%	\$27,015	193%	\$39,727	187%
<i>Jackson County (Kansas City)</i>	\$14,868	143%	\$25,302	181%	\$37,952	179%
<i>Butler County (rural)</i>	\$11,428	110%	\$18,938	135%	\$29,629	140%

The second study, EPI’s Basic Family Budget, is an indicator of poverty and expenses.¹² The budget consists of regional estimates of essential needs, including food, clothing, shelter, and transportation. As with the Missouri Women’s Council study, all expenses such as dining out, savings or debt payment are excluded.¹³ The EPI analysis does not consider a budget for an individual, so the ratio from the Missouri Women’s Council report must be applied to the estimate that an individual living in St. Louis would need to earn about 153 percent FPL (\$15,900) per year to be self-sufficient, before being able to pay for health care.¹⁴ A family of four living in a rural region of Missouri would need about 110 percent FPL (\$23,328) per year.

Table 2: Income Required to Meet Basic Needs in Missouri, Before Health Costs

Based on data from EPI Basic Family Budget

Location	Single adult	% FPL	Adult + Child	% FPL	2 Adults + 2 Children	% FPL
<i>St. Louis</i>	\$15,900	153%	\$27,888	199%	\$38,352	181%
<i>Kansas City</i>	\$16,254	156%	\$26,688	191%	\$37,272	176%
<i>Rural area</i>	\$14,174	136%	\$21,684	155%	\$23,328	110%

While these studies do not necessarily specify what is affordable to families, they do provide insight into what is not affordable. At certain income levels, individuals and families in Missouri, after covering very basic needs, do not have sufficient income to spend more than a nominal amount on health care.

Analyzing the data, this paper concludes:

- Individuals earning below about 150 percent FPL in the St. Louis region have only marginal incomes available for health costs. Individuals earning just over 150 percent FPL begin to be able to afford some health care spending.
- For a family of three in the St. Louis region costs are more expensive. Families with children have greater housing, food, and child care costs. Therefore, a different affordability scale is needed to account for these costs. To afford more than a nominal amount of health care costs, families need to earn about 200 percent FPL.
- Rural Missourians have very different household budgets, mainly due to housing costs. An individual needs about 125 percent FPL to be self-sufficient before accounting for health care; a family in a rural area needs to earn about 150 percent FPL.

Current Spending on Health Care

Having established guidelines to determine who cannot afford to pay anything for health care in Missouri, it is important to examine the amounts people can pay. One measure of affordability comes from a report by The Urban Institute. Holahan, Hadley, and Blumberg conducted an analysis of affordability of health care in Massachusetts.¹⁵ The study used national data from the Medical Expenditure Panel Survey (MEPS) for premiums and for out-of-pocket costs. MEPS defines affordability as the amount that moderate-income individuals spend on insurance coverage plus cost-sharing. Although out-of-pocket spending can vary greatly among people with different types of coverage and health needs, the study used the 50th percentile of out-of-pocket costs as a benchmark.

Table 3: Health Costs as Percent of Income, Above 300 Percent FPL

Based on data from Holahan et al.¹⁶

	Non-group	Employer Sponsored Insurance (ESI), employee portion	Employer Sponsored Insurance (ESI), Total cost – employer and employee portion
Individuals			
<i>Premium</i>	6.4%	1.5%	10.4%
<i>Out of pocket</i>	1.2%	0.6%	0.6%
<i>Total spending</i>	8.2%	2.3%	11.0%
Families			
<i>Premium</i>	6.0%	3.0%	14.1%
<i>Out of pocket</i>	2.2%	1.2%	1.2%
<i>Total spending</i>	8.5%	4.6%	15.3%

The Holahan et al. report looks at health spending for people with both low- and moderate-incomes. Families with low incomes often spend more on health care costs than is affordable or

they forgo health insurance altogether.¹⁷ For the purpose of this paper, it is more practical to look at spending levels only for families with moderate incomes.

Also, Holahan et al. examines different ways of defining current health spending, including employee contributions to ESI, the combination of employer and employee costs, and non-group insurance costs. Employee contributions to premiums are an inexact measure of the actual cost of health care because they disregard the employer contribution. But the combination of both employee and employer costs of ESI fails to account for favorable tax treatment employers receive for contributing to premiums (and possible reductions in employee wages due to health care benefits). Neither of these spending amounts are an accurate account of total health costs. As a result, the average costs for non-group insurance are a more useful benchmark for determining current health care spending.

Holahan et al. provides data on what middle-income individuals typically pay for health insurance (including cost-sharing): 8.5 percent of their after-tax income. Based on the assumption that an affordability schedule should be progressive, 8.5 percent becomes the “upper bound” of the affordability scale. Lower income individuals and families should be expected to pay less than this amount. This data point also enables us to calculate how much a person would need to earn so that 8.5 percent of his/her income would cover both typical premiums and cost-sharing.

In Missouri, estimates indicate that a typical individual health care plan including cost-sharing is approximately \$363 per month.¹⁸ In order to afford a health care plan within the 8.5 percent of income affordability standard, a single Missouri resident would need to earn approximately \$51,050 annually (490 percent FPL) and a three-member family would have to earn \$85,850 per year (500 percent FPL) to remain within this affordability scale.

Massachusetts’ Experiences in Determining Affordability

While Massachusetts has a very different political and economic environment than Missouri, early data from the Commonwealth’s recent health reform may be useful in determining affordable health care in Missouri. As part of Massachusetts health care reform law, a state agency develops and updates an “affordability schedule” for health care costs each year.¹⁹ The state’s health reform includes an individual mandate, which requires residents to purchase health insurance if it is affordable to them. The affordability schedule sets the definition of affordable insurance for the mandate. Even though the individual mandate alters the significance of affordability, data from Massachusetts can provide information about affordable health costs.

The Massachusetts affordability schedule sets standards for people earning up to 600 percent FPL.²⁰ People with the lowest incomes (below 150 percent FPL) are not required to pay any premium on the affordability scale. For people earning between 150 and 300 percent FPL, the scale is set at the premium levels for the state’s new subsidized health plans, between \$39 and \$116 per individual per month. For people between 300 and approximately 600 percent FPL, the state set a sliding scale of affordability for health premiums.²¹ The state determined that all people earning more than 600 percent FPL must purchase insurance, no matter the cost.

Even at 600 percent of FPL, certain people (especially older citizens) may have difficulty affording premiums. Because Massachusetts allows insurers to vary premiums based on age and geography, a younger person may purchase the same insurance for much less money than

an older person. Also, Massachusetts affordability scale does not consider cost-sharing. As a result, people with chronic health needs are also likely to find health costs unaffordable regardless of income.

Early data from Massachusetts suggests that some of the subsidized premiums may be unaffordable for low-income families. Of the 175,617 people enrolled in the new subsidized health plans, it is estimated that about 46 percent of the uninsured between 200 and 300 percent FPL have enrolled (compared to between 90-100 percent of people earning less than 200 percent FPL).²² Based on the lower enrollment numbers of the in the 200-300 percent FPL range, premiums for these plans may actually be unaffordable for this group.²³ Individuals between 150-200 percent FPL pay about 2.6 percent of annual incomes in premiums, but individuals between 250-300 percent FPL pay about 4.9 percent of income. The difference in percent of income may explain why fewer people in the 200-300 percent FPL range enroll in insurance.

Massachusetts compiled preliminary data from the first year regarding people who did not comply with the individual mandate. A proxy measure for affordability can be derived from an examination of the number of people choosing not to purchase an “affordable” insurance plan, but instead opting to pay a penalty to the state. Preliminary information shows that 97,000 people, 2.5 percent of residents, did not comply with the mandate.²⁴

There are lessons to be learned from the Massachusetts experience. First, the state’s affordability scale does not take into account cost-sharing and, as a result, it is likely that health care can become unaffordable for people who are older and less healthy. Individuals with chronic health needs are likely to pay more than they can afford in out-of-pocket costs for office visits, procedures and prescriptions.

Second, information from Massachusetts suggests that people with low- to moderate-incomes cannot afford premiums (before cost-sharing) that are up to 5 percent of their income. Even with subsidies and an individual mandate, a smaller percentage of people are enrolling in health insurance at these income levels, which indicates that these plans are not truly affordable.

Finally, an affordability scale should extend up the income ladder. Individuals with chronic health needs may face difficulty in affording health care costs at levels, regardless of their income.

Price Sensitivity and Take-up Rates

Most people will buy health insurance if they consider it affordable.²⁵ A number of analysts and policymakers have used estimations of take-up rates or price sensitivity to set subsidy levels and to estimate program enrollment and costs of various reform proposals. This paper uses price sensitivity to develop points along the affordability scale for people with incomes just above the level at which no amount is affordable up to moderate income levels.

Kenneth Thorpe of Emory University developed a formula to project enrollment in Vermont’s recent health reform estimates take-up rates, but there are limitations to this methodology.²⁶ Thorpe assumes that even with a 100 percent subsidy not all of the uninsured would enroll in insurance. This residual population does not provide useful information on affordability. Another limitation is that at higher income levels, information about what people would voluntarily pay provides a less useful guide to what they could afford to pay. For people at these

higher income levels, other information (e.g., current health spending and public opinion data) is a more helpful guide. Also, it is difficult to agree on a precise definition of “most” people choosing to enroll at a certain price-point. For a public program to successfully reduce the number of uninsured, it must be affordable enough for “most” people to choose to purchase it.

Given that the literature on price sensitivity is limited and there is no consensus among economists or policymakers on price sensitivity models for the take-up of health insurance, this paper assumes that it makes sense to aim for more robust take-up rates at lower incomes, progressively relaxing take-up rate levels as income increases.²⁷ A sample affordability scale based on these principles would contain premiums of about 1.8 percent of income for people at 150 percent FPL and premiums would be about 4.6 percent of income for people at 300 percent FPL.

Table 4: Enrollment of Insurance at Certain Premiums and Income Levels

Based on Thorpe’s take-up formula for subsidized insurance²⁸

% FPL	Target monthly premium	Premium as % income
150% FPL	\$23	1.8%
225% FPL	\$70	3.6%
300% FPL	\$121	4.6%

Thorpe’s formula helps to fill in points along the affordability scale for people with incomes above the point at which people cannot afford any contribution and the point at which they can afford the full cost of insurance. For people with incomes just above 150 percent FPL, Thorpe’s analysis projects a “lower bound” of affordability at about 1.8 percent of income. The scale indicates that people can pay a greater percentage of earnings in health costs as their income level increases, up to 8.5 percent of income for people with income above 500 percent FPL.

Public Opinion Research as a Check on Affordability Analyses

Surveys of public opinion provide important information about what is perceived as a fair and reasonable amount to spend on health care costs. This perception can impact the public support and political viability of any health coverage proposal. As affordability is largely based on the experiences of others with similar income and expenses, this paper uses data from two public opinion polls to affirm the paper’s findings on affordability related to public perception.

A survey conducted by Robert Blendon on public support for Massachusetts health care reform asked respondents: what monthly health care costs were “reasonable” for people at certain income levels?²⁹ While health care costs in Massachusetts may be higher than in Missouri, the data tracks with the cost of living in urban areas in Missouri. When surveyed, people were likely to place these health costs around what they currently pay for health care.³⁰ The price-points in Blendon’s poll generally agree with the findings of this paper: respondents supported health costs between 4 and 7 percent of an individual’s income. (*Table 5*)

Table 5: Polling on Reasonable Monthly Health Care Costs for an IndividualBased on data from Blendon, et al.³¹

Income	% FPL	Reasonable costs, by most respondents	Health costs as % of income
\$25,000	245% FPL	\$100 or less	4.8%
\$35,000	343% FPL	\$200 or less	6.9%

The Community Service Society of New York (CSS-NY) commissioned a statewide poll to gauge public opinion on the health care system.³² Like the Blendon study, CSS-NY asked respondents about certain price-points for health care at various income levels. The questions were worded: would you favor or oppose charging families \$X amount? Again, while New York City's cost-of-living is higher than Missouri, the responses from rural and urban upstate New York are used as a point of comparison for Missouri. The public opinion data from both the Blendon and CSS-NY polls generally fit with this paper's findings on reasonable scales of affordability for families between about 1.8 and 8.5 percent of income.

Table 6: Polling on Charging Families Different Amounts for Health Care, by RegionBased on data from CSS-NY poll³³

Family earnings	Price-point per month	Approx. % FPL for family of three	Health costs as % of income	% Support		
				Urban upstate	Rural upstate	New York state average
\$34,000	\$45	200%	1.6%	80%	87%	80%
\$52,000	\$125	300%	2.9%	78%	85%	77%
\$69,000	\$350	400%	6.1%	56%	61%	58%

Conclusion

This paper develops an affordability scale for Missouri by examining income guidelines for non-health public programs; research on household budgets; current health spending; the Massachusetts experience; and costs and willingness to purchase insurance. Research into health care reform in other states suggests that how affordability is defined and enacted into policy greatly affects the viability of the proposed programs. To accommodate variations in demographics, geography and life circumstances, policymakers should consider the following when designing health coverage policies for Missouri:

- Any affordability schedule should utilize a progressive scale as incomes increase. A progressive sliding scale will prevent people with lower incomes from paying a disproportionately higher share of their income for health insurance. Using an affordability scale with assumptions about the ability to pay will lead to a higher rate of take-up of insurance.
- People with very low incomes can pay only small amounts toward health care. Research shows that many low-income people struggle to pay for basic necessities and are likely to have negative cash flow. Studies of household budgets in Missouri indicate that individuals below about 150 percent FPL (\$15,600) and families below about 200 percent FPL (\$35,200 for a family of three) may not earn enough to cover their basic needs. People at these income levels should pay only nominal amounts of health costs and will need public programs and subsidies to obtain insurance.³⁴
- The upper bound of affordability should be set at about 8.5 percent of income. Data suggests that people with higher incomes can reasonably afford health insurance at 8.5 percent of income. In Missouri, this point corresponds to incomes above 500 percent FPL (\$52,000). People with un-subsidized, non-group premiums currently pay an average of 8.5 percent of income. After meeting basic needs, most people at a higher income level have sufficient discretionary income to cover health expenses. Because premium and cost-sharing variations may render insurance unaffordable for some people with incomes above this level, it is recommended that 8.5 percent of income be used as the upper limit for people with incomes above 500 percent FPL.
- A progressive sliding scale of affordability is needed. For those earning enough to make some contribution to their health care (although not necessarily the full cost), a sliding scale of affordability is recommended as a protection from financial hardship. In Missouri, this scale should progress from 1.8 percent to 8.5 percent of income for individuals earning between 150 and 500 percent FPL (\$15,600 and \$52,000).

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- 16 All percentages are at the 50th percentile for each aggregate health expenditure type. Therefore, premium plus out-of-pocket spending does not necessarily equal total spending.
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- 18 Author's calculation based on weighted average of non-group market HMO plans (with limited deductibles) in Missouri in 2007, plus average cost-sharing from Holahan et al data. HMO annual financial statements for Missouri nongroup market in 2007. Email from Molly White, Health Care Specialist, Managed Care Section, Missouri Department of Insurance, Financial Institutions & Professional Registration, June 30, 2008.
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- 21 The Massachusetts law also requires that insurance coverage meet minimum creditable standards of comprehensive benefits. The Massachusetts Health Connector offers both subsidized plans for people below 300 percent FPL and standardized, unsubsidized plans for people earning more than 300 percent FPL.
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- 31 "Most" people is defined as 70% of respondents, or higher. Respondents also found premiums at lower price-points reasonable.
- 32 The Community Service Society and Lake Research Partners conducted phone interviews of 1620 New York residents in November 2007. Community Service Society of New York and Lake Research Partners, *"Health Reform in New York: Findings from a Statewide Poll,"* February 2008.
- 33 Respondents claiming "strongly favor" and "not so strongly favor" are recorded as support.
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