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The New Underinsured

While health reform is expected to add 31 million to the ranks of the insured, low-income families-and providers- may still face significant financial risk

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Health reform is expected to expand insurance to millions without it and offer households more protection from the financial distress of medical bills. But the law also leaves some newly insured vulnerable to expenses that will add stress to already strapped household budgets, health policy experts say.

The law, which bans insurers from excluding those already diagnosed with an illness and caps the amount households spend on care each year, does much to expand protection for consumers from policies that left patients struggling to afford care, policy experts say. But, they say, for low-income, chronically ill people, the law may not do enough, and upcoming regulations on benefits could significantly affect how much patients spend.

An estimated 24 million of the 31 million people expected to gain insurance under health reform will do so through insurance exchanges-set to begin operations in 2014-that will regulate the costs for low-income households and offset some of the financial burden with subsidies, according to the Congressional Budget Office.

For hospitals, which have seen more insured patients who struggle to pay medical bills, the push to expand insurance could bring with it newly underinsured people who are more likely than the insured to skip tests and medications and less likely to seek follow-up care or see a specialist.

Michael Miller, policy director for Community Catalyst, a patient advocacy not-for-profit based in Boston, says the law includes provisions that give consumers greater access to affordable insurance, but does not completely achieve what many consider affordable coverage for low-income patients-healthcare costs less than 5% of income for those with incomes below 200% of the federal poverty level, or $21,660 based on 2010 guidelines, and 10% of income for all others. We didn't get there, he says.

A big bite out of the underinsured

Miller stresses that the law represents a huge advance from the status quo. Out-of-pocket spending is capped and the limits are more restrictive for plans sold to low-income households within the exchanges, he notes. In that way, the law takes a big bite out of the underinsurance problem, Miller says. And under the law, insurers will be banned from setting a limit on the amount policies pay in a year or over a lifetime.

January Angeles, a policy analyst with the Center on Budget and Policy Priorities, a nonpartisan policy not-for-profit based in Washington, says the expansion of coverage alone will offer protection for some previously without benefits while subsidies will substantially reduce the cost of benefits for those with low incomes.

Of the 24 million expected to find insurance through an exchange, it is estimated that 19 million will be eligible for subsidies to pay for premiums or additional costs paid out of household budgets, known as out-of-pocket costs, such as deductibles, copayments or coinsurance.

Angeles says the law sought to take into account that low-income households must grapple with less discretionary income while at the same time fixed, necessary costs such as rent represent a bigger chunk of income.

Low- and moderate-income consumers inside the exchanges-or those earning below 400%, or $43,320 for 2010, of the federal poverty guideline but too much to enroll in Medicaid-qualify for subsidies that increase as income declines, she says. The subsidies include premium credits for those below 400% of the federal poverty level and the law offers further cost-sharing credits for households earning less than 250%, or $27,075 for 2010, of federal poverty.

Policymakers sought to limit patients' financial risk by using the premium credits to limit the percentage of household income that will be spent on medical care, based on one of four plans-the second least costly option of the four plans-to be offered through the exchange, Angeles says.

For those most financially vulnerable (at 133% to 150% of poverty level, or $14,512 to $16,245 a year for 2010), the law would limit premiums as a share of income to 3% to 4%, according to an outline of the law's exchange provisions by the Center on Budget and Policy Priorities.

Households with paychecks between 300% and 400% of the federal threshold for poverty (from $32,490 to $43,320 in 2010 for an individual) would see the share of income spent on medical costs capped at 9.5%. (Households' medical costs increase should they opt for two more comprehensive options within the exchange, Angeles says.)

But these protections have limits, and for some with chronic conditions who need regular medical care, the law could create a new wave of underinsured.

Most people are mostly healthy most of the time, Miller says, and for many newly insured, premiums represent the most significant financial burden. But those whose conditions require more medical care could see healthcare spending more significantly erode household income. The law caps the maximum amount low-income households must pay, but among the poorest, the amount exceeds 5% of income, which the Commonwealth Fund defines as underinsured among those with incomes below 200% of poverty, he says.

Miller stressed that health reform made very substantial progress, but says what remains to be done is also significant.

Less medical care, more debt

The underinsured are more likely to put off medical care and struggle to pay bills than those having higher levels of coverage, Commonwealth Fund researchers reported in the journal Health Affairs online in June 2008. Four out of 10 underinsured households told researchers they did not fill a prescription because of costs in the prior year; 30% did not seek a test, treatment or follow-up care recommended by a doctor for the same reason. Forty-five percent reported difficulties with medical bills.

Out-of-pocket spending grew faster than paychecks in the years leading up to the Great Recession and left a rising number of households to spend more than 10% of their incomes on medical costs, an amount health policy experts describe as a high financial burden.

Income in 2006 was unchanged from 2004, but out-of-pocket spending-largely premiums-rose 8.5% during the same period, after adjusting for inflation, research published online in May 2010 by Health Affairs shows, using data from the Agency for Healthcare Research and Quality.

By 2006, nearly one in five households (19.1%) grappled with a high financial burden from medical expenses, up from 16.4% in 2004, even as the nation's economy was relatively strong and unemployment was relatively low, wrote Peter Cunningham, the senior fellow at the Center for Studying Health System Change who conducted the research for the Health Affairs study.

Hospitals have responded to households' growing share of medical bills with heightened efforts to collect payments from patients, including efforts to collect bills before or when patients arrive and use of increasingly sophisticated credit-analysis tools to determine which patients are able and likely to pay bills.

However, the households that will be newly insured through the exchanges could be at risk for financial distress despite the subsidy relief, policy analysts say.

The Center on Budget and Policy Priorities, in a July research paper, says that the income protection from subsidies may begin to erode shortly after taking effect in 2014 because

income is not projected to keep pace with rising premiums. Starting in 2015, income is projected to climb more slowly than premiums while subsidies will increase at the rate of the average premium. In 2018, the premium subsidy will increase with inflation, a rate projected to be more sluggish than premium growth.

How much patients pay out of pocket will also be determined by which care gets covered by insurance, says Sabrina Corlette, a research professor at Georgetown University's Health Policy Institute in Washington. The reform law requires insurers to include essential benefits, such as hospitalization, prescription drugs and preventive and wellness services, but leaves further details to the HHS secretary. Corlette says that how regulations ultimately put limits on visits or services will determine patients' financial risks.

Corlette says she believes the subsidies should be raised, but lawmakers must also get a lot more aggressive about reducing healthcare costs for reform to succeed.

Mitigation strategy

James Gravell, senior vice president and chief financial officer at Catholic Healthcare Partners, says the Cincinnati-based system has started to estimate the financial impact of reform's payment and coverage changes, but does not yet have enough information to so do for the law's expansion of private insurance. Gravell says the system is waiting for more clarity. The uncertainty over what will happen to revenue has affected the 32-hospital system's planning, postponing some capital expenses and heightening focus on improved operations, he says. The answer isn't go borrow more money.

In Massachusetts, where the state mandated insurance coverage in 2007, unpaid hospital bills, or bad debt, remained flat through 2009, says Joe Kirkpatrick, senior vice president of healthcare finance for the Massachusetts Hospital Association, though hospitals report more difficulty collecting deductibles and coinsurance. The Massachusetts Division of Health Care Finance & Policy reported that one in five residents surveyed between March 2009 and June 2009 say they did not seek care because of healthcare costs, and another 15% reported difficulty paying medical bills during the prior year.

Kirkpatrick says financial barriers to patient access could jeopardize efforts to reform healthcare payments and curb healthcare spending-such as accountable care organizations-which are designed to pay hospitals based on cost control and quality outcomes.

Sisters of St. Francis Health Services, Mishawaka, Ind., expects to see revenue drop by $300 million during the next decade as newly insured patients fail to offset lost direct financial aid to hospitals with high numbers of uninsured patients and reductions from Medicare, according to one estimate, says Jennifer Marion, senior vice president of finance and CFO.

Marion says not one of the Sisters of St. Francis' 10 Indiana and Illinois hospitals stands to gain, using a calculator created by the American Hospital Association to create a rough estimate.

The system would lose $300 million in revenue should those newly insured through the insurance exchanges have plans that pay hospitals roughly as much as Medicare, which is not as much as employer-sponsored private insurance, she says. Insurers are expected to curb hospital rates as regulators pressure insurers to hold down premium increases, Marion says.

It's unclear what insurers will pay, Marion says, who describes the exchanges as reform's biggest wild card. She does expect to write off bills for out-of-pocket costs from the newly insured through exchanges, though to what degree she says she is uncertain.

The Sisters of St. Francis typically collects 3% to 5% of outstanding bills from those without insurance and 40% to 60% from insured patients with copayments, coinsurance or deductibles, she says. (Its charity-care policy provides financial aid to low-income insured; patients may also pay off debt on payment plans at no interest, Marion says.)

Established efforts to improve quality and reduce costs will help position the system, which reported operating income of $115 million on revenue of $2.3 billion in fiscal 2009, for expected revenue losses under health reform, Marion says. Executives are pushing to improve operations to earn a profit on Medicare's rates, which are lower than commercial rates, as a target for greater efficiency and lower costs. The system last year hired a consultant for a nonlabor cost-control initiative, she says.

Health reform is going to have a negative impact, Marion says, but there are things that we have done and are doing to mitigate that negative impact.

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