Statement of

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on

Are Mini Med Policies Really Health Insurance?

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Limited Benefit Plans Serve a Need

Mr. Chairman and Members of the Committee, I am Devon Herrick, a Senior Fellow at the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

Beginning in 2014 most U.S. residents will be required to have health insurance coverage. This provision of the Patient Protection and Affordable Care Act (ACA) is often referred to as an *individual mandate*. In addition to this requirement, new ACA provisions will limit the choice of health plans offered in the future and reduce Americans' ability to enroll in plans that meet their needs and fit their budget.

Costly Coverage. On September 23, 2010, a wide array of ACA provisions went into effect, creating new regulations on existing health insurance plans and phasing in new requirements for health plans offered in the future. Annual and lifetime caps on benefits will not be allowed by 2014. Beginning next year, insurers will be required to spend 80 percent to 85 percent of premium dollars on medical costs, referred to as the Medical Loss Ratio (MLR), or refund the excess to policy holders.

Once the individual mandate becomes effective on January 1, 2014, the ACA requires most policies sold to provide an *essential benefit package* that covers preventive services with no cost-sharing. For most plans the least comprehensive benefit plan allowed must cover 60 percent of medical costs — the so-called *Bronze Plan*. Insurers selling coverage in the individual market will not be allowed to deny coverage to applicants with pre-existing conditions or to charge them more than healthy applicants. In addition, insurers will only be allowed a 3-to-1 ratio for older applicants compared to premiums for younger applicants. Regulations requiring an essential benefit package, and a minimum MLR, largely preclude the sale of health insurance other than comprehensive coverage that more closely resembles pre-paid medical care than pure insurance.

Limited Benefit Plans.[1] Between one and two million Americans currently have a health insurance plan that features "limited benefits," sometimes called "mini-med" plans. Mini-med plans are increasingly popular among moderate-income workers, seasonal and part-time employees, as well as small firms that cannot afford comprehensive health benefits. A typical design for a limited benefit plan includes coverage for a number of physician visits, ancillary tests, limited hospital inpatient days and negotiated discounts on prescription drugs. The deductibles and copayments are relatively low. Depending on plan design, some mini-meds provide first-dollar coverage for some services. However, the maximum amount of medical benefits that can be claimed in a given year is capped, providing maximum benefits of anywhere from a few thousand dollars to $25,000 to $50,000 or more annually.

Mini-med plans are affordable. Premiums for family coverage can vary from $1,000 to $6,000 a year, or as little as $250 to $2,500 annually for single coverage. Plans like these can provide access to basic medical care after a copayment, such as physician visits, prescription drugs and hospital inpatient services.

Insurance involves the transfer of risk from the insured to the insurer. One reason mini-med plans cost less than comprehensive health insurance is because the risk underwritten by the insurer is lower than comprehensive coverage and capped at a predetermined level.

Mini-Med Plans Under the Affordable Care Act. The ACA prevents health insurers from capping annual limits on coverage at more than $750,000 in 2010, $1.25 million in 2011 and $2 million the following year. Most annual dollar limits on health coverage will be phased out by 2014. By design, a limited benefit plan cannot meet these requirements and remain affordable. Without waivers allowing enrollees to retain their plans, mini-med plans will essentially be banned from the marketplace. As a result, many people who rely on these plans

[1] David R. Henderson, "Mini-Med Plans," Brief Analyses No. 727, National Center for Policy Analysis, October 21, 2010.

will lose coverage and join the ranks of the 50.7 million people who are uninsured at any given time.[2]

In the short run, the only other option for affordable coverage is a high-deductible plan that provides little in the way of access to a doctor or prescription drugs without significant cost-sharing. High-deductible plans have a place in the market and provide a level of protection against catastrophic health conditions. But they are not popular among many moderate-income families precisely because they do not provide benefits below a high threshold in a manner that limited benefit plans do.

Another threat to the continued existence of limited benefit plans is the Medical Loss Ratio regulations requiring medical expenditures to be 80 percent to 85 percent of premiums. These regulations favor comprehensive, pre-paid medical plans, where a significant share of premiums dollars represents care the enrollee expects to receive in a given year. Health plans with limited benefits are more likely to run afoul of MLR requirements given that less of the premium represents pre-paid medical spending. By contrast, the owners of mini-med plans expect a lower level of medical spending. The overhead cost to market and administer a mini-med policy is likely to be a larger proportion of the premium dollars than is currently allowed by law. This is especially true of industries with high turnover of workers.

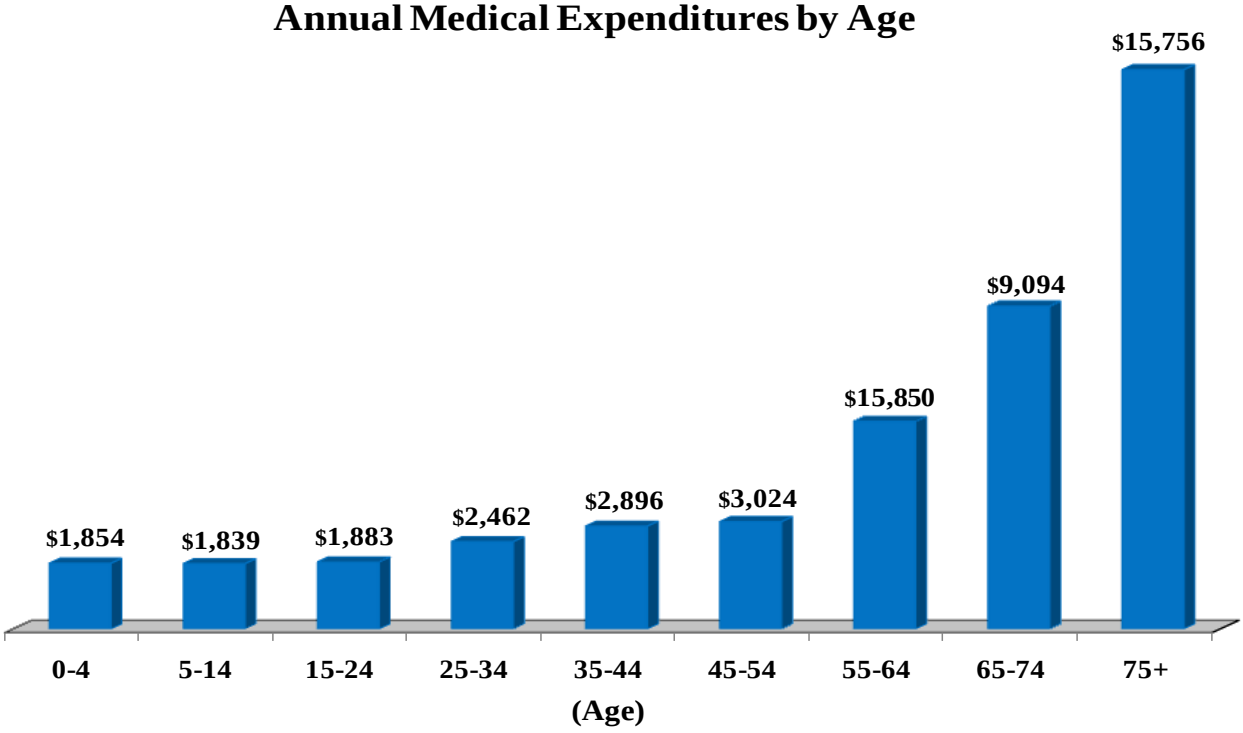
An unintended consequence of efforts to require a MLR of 80 percent for individual and small group plans is that mini-med plans will cease to be an affordable option for moderate-income Americans. Public health advocates often deride limited benefit plans as inadequate to protect Americans against the most serious health problems and view the demise of mini-meds as necessary and in the interest of public health. However, in any given year most people covered by health insurance experience very low claims. Especially for young people just starting out, a plan providing a less comprehensive package of benefits is often sufficient to meet all their medical needs. For instance, per capita annual medical expenditures do not approach $3,000 per year until around 50 years of age [see Figure I].[3] Moreover, for most people age 40 years and

[2] Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2009," P60-238, U.S. Census Bureau, United States Department of Commerce, September 2010.

[3] Ellen Meara, Chapin White and David M. Cutler, "Trends in medical Spending by Age, 1963-2000," *Health Affairs*, Vol. 23, No. 4, July/August, p. 179.

under, the percent of U.S. health care expenditure consumed by the sickest 5 percent of the group does not exceed 10 percent of medical costs for that cohort.[4]

Figure I
Annual Medical Expenditures by Age



Source: Calculations based on Ellen Meara, Chapin White and David M. Cutler, "Trends in Medical Spending by Age, 1963- 2000," *Health Affairs*, Vol. 24, No. 4, July /August 2004, p. 179.

In fact, 80 percent of the population consumes less than $3,220 annually in medical care [See Figure II]. High medical spenders tend to be concentrated among older individuals.[5] McDonalds has reported that 85 percent of its enrollees spend less than $5,000 annually.[6]

[4] Leslie J. Conwell and Joel W. Cohen, "Characteristics of People with High Medical Expense in the U.S. Civilian Noninstitutionalized Population, 2002," Statistical Brief No. 73, Agency of Healthcare Research and Quality, March 2005.

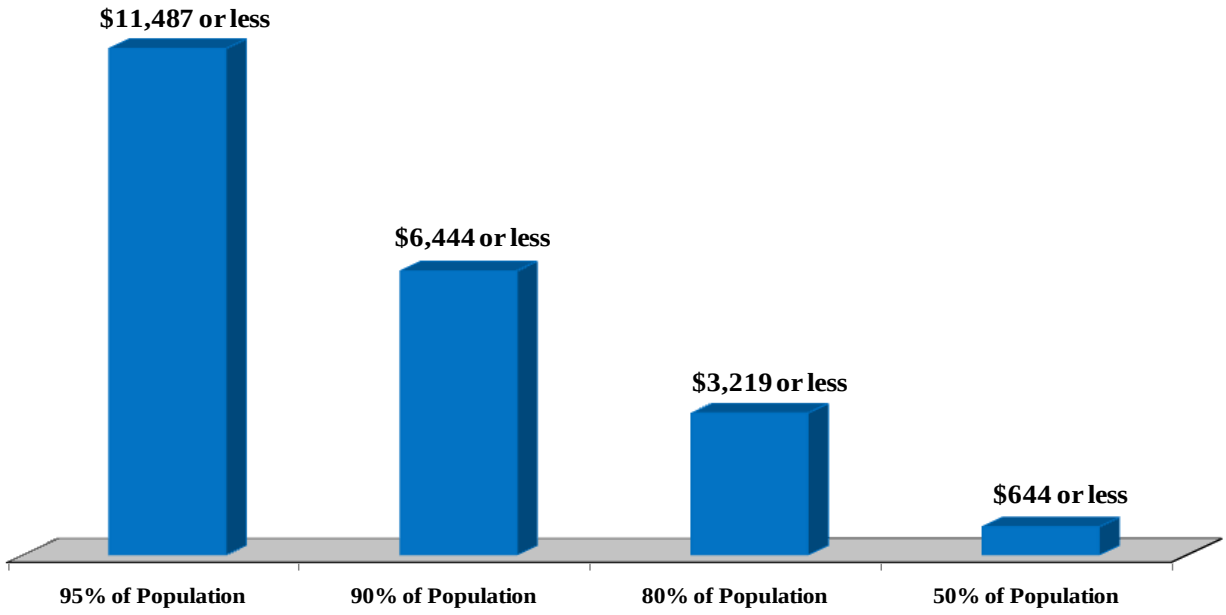
[5] Mark W. Stanton, "The High Concentration of U.S. Health Care Expenditures," Issue No.19, Agency of Healthcare Research and Quality, June 2006.

[6] Janet Adamy, "McDonald's May Drop Health Plan," *Wall Street Journal*, September 30, 2010.

Figure II

Annual Per Capita Medical Expenditures

(% of Population Spending ≤)



Note: Figures are expenses per person.

Source: Leslie J. Conwell and Joel W. Cohen, "Characteristics of People with High Medical Expense in the U.S. Civilian Noninstitutionalized Population, 2002," Statistical Brief No. 73, Agency of Healthcare Research and Quality, March 2005.

For example, in 2006 the state of Tennessee created *CoverTN* for families with incomes too high for Medicaid and too low to afford private coverage. *CoverTN* is a low-cost option that features limited benefit health plans, with benefits capped at $25,000 — only $15,000 of which can be put toward hospital bills. Benefits consultant Milliman estimated about 98 percent of enrollees would not exceed their annual benefit cap in a given year.[7]

For moderate-income Americans, an insurance plan providing a lower level of benefits fills a need. For most of these, insuring against the risk of medical expenses — that could reach a few thousand dollars — is worth insuring against.[8]

Other Advantages. Our health care system is not set up for cash paying patients. When a patient enters their doctor's office third-party insurers pay about 90 cents on the dollar toward the cost, on average. For the health care system as a whole the proportion of third-party payment

[7] Chad Terhune, "Covering the Uninsured, But only up to $25,000," *Wall Street Journal*, April 18, 2007.

[8] David R. Henderson, "Mini-Med Plans," Brief Analyses No. 727, National Center for Policy Analysis, October 21, 2010.

is about 88 percent.[9] Cash-paying patients who inquire about the price of a medical procedure are likely to be disappointed. Typically, neither the hospital nor the doctor will know the cost until the procedure is completed.[10] Indeed, the same procedure may have many different prices, because each health insurer may have negotiated a different discount. In fact, the cash price is often the highest. A cash-paying patient is often charged exorbitant "list prices" because they are receiving care without a health plan. Instead of paying cash, mini-med patients are able to benefit from negotiated, in-network discounts and discount drug cards.

Burden on Workers. Health benefits are a non-cash portion of workers' total compensation package. We estimate the cost of the minimum benefit package that everyone will be required to have under the ACA at about $4,750 for individuals and $12,250 for families. That translates into a minimum health benefit of $2.28 an hour for full time workers (individual coverage) and $5.89 an hour (family coverage) for fulltime employees. In four years' time, the minimum cost of labor will be a $7.25 cash minimum wage and a $5.89 health minimum wage (family), for a total of $13.14 an hour or about $27,331 a year.

Economists agree that workers themselves ultimately bear the cost of their own health coverage through direct contributions and wage reductions in lieu of take-home pay.[11] When the cost of health benefits rise, employers tend to pass on the costs or constrain wage increases.[12] In addition, total employee compensation tends to equal the value of what workers produce — that is what they add to overall output, at the margin. If the minimum compensation required is higher than what workers are able to produce, they will be priced out of the labor market. Thus, to deprive workers access to these low-cost limited benefit plans ultimately means many workers will lose coverage — or lose their jobs.

The real purpose of insurance is asset protection for people who anticipate needing medical care and have assets to protect or income to protect. Moderate-income people and those who are young have few accumulated assets and many don't expect to experience costly medical bills. It is

[9] Centers for Medicare and Medicaid Services, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2006-1960," U.S. Department of Health and Human Services, 2008.

[10] Devon M. Herrick and John C. Goodman, "The Market for Medical Care: Why You Don't Know the Price; Why You Don't Know about Quality; And What Can Be Done about It," National Center for Policy Analysis, NCPA Policy Report No. 296, February 2007.

[11] David M. Cutler, "The Cost and Financing of Health Care," Vol. 84, No. 2, Papers and Proceedings of the Hundredth and Seventh Annual Meeting of the American Economic Association Washington, DC, January 6-8, 1995, *American Economic Review*, May 1995, p. 35.

[12] For instance, see "Employer-Based Health Insurance: High Costs, Wide Variation Threaten System," Government Accountability Office, HRD-92-125, September 22, 1992.

a hardship to ask them to spend sums that could amount to one-half their annual income on health insurance and then fine them or their employer when they cannot afford to do so.

Individuals who purchase health insurance in the Exchange beginning in 2014 can expect to receive subsidies that in some cases will be worth about $19,400 annually. However, the ACA provides no new subsidies to low-income employees of large firms. A moderate-income family earning $30,000 per year could expect to only receive about $2,800 in federal subsidies for a comprehensive health plan purchased through their employer.[13] This is too little to make comprehensive health coverage affordable. It is a hardship to deprive moderate-income workers access to a health plan that meets their needs and fits their budget.

How Government Can Help. A better way to help moderate-income workers afford health coverage would be to provide a uniform tax credit as Senator McCain, Senator Coburn and Representative Ryan have all proposed. This would provide the same subsidy to all families regardless of their tax bracket or where they receive their coverage. This would allow them to set some of the tax credit aside in a Health Savings Account for later use or purchase whatever coverage meets their need and fits their budget.

Conclusion. Plans that feature limited benefits in return for a lower insurance premium are not for everybody. Indeed, these plans cap benefits at a predetermined level and are not intended to provide protection in the event of a catastrophic illness. However, they are an affordable choice for many Americans. During the health reform debate, the President told the American people "And if you like your insurance plan, you will keep it. No one will be able to take that away from you. It hasn't happened yet. It won't happen in the future."[14] Limited benefit plans provide a level of benefits many Americans rely on and the loss of coverage would make them worse off.

[13] Stephen Entin, "Health Insurance Exchange Subsidies Create Inequities," Brief Analyses No. 696, National Center for Policy Analysis, March 03, 2010.

[14] Office of the Press Secretary, "Remarks by the President on Health Insurance Reform in Portland, Maine," The White House, April 01, 2010.