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HEALTHCARE VALUE HUB

Welcome to

Healthcare Affordability: Developing a Universal Standard to Measure Progress

Support provided by
Robert Wood Johnson Foundation

www.HealthcareValueHub.org
@HealthValueHub

Welcome and Introduction

Lynn Quincy

Associate Director, Health Reform Policy

and

Director, Health Care Value Hub

Housekeeping

- Thank you for joining us today
- All lines are muted until Q&A
- Questions for the panelists? Click on the “raise hand” icon at the top of your screen
- Technical problems? Please text/call Tad Lee at 703-408-3204 or office at 202-462-6262

Agenda for Today

Welcome & Introduction – Lynn Quincy

U.S. Affordability Issues – Gary Claxton

Achieving a Uniform Standard – Sherry Glied

State Spotlight: Massachusetts – Marissa Woltmann

Universal Standards to Realize the Promise of Healthcare Affordability – Lynn Quincy

Q&A

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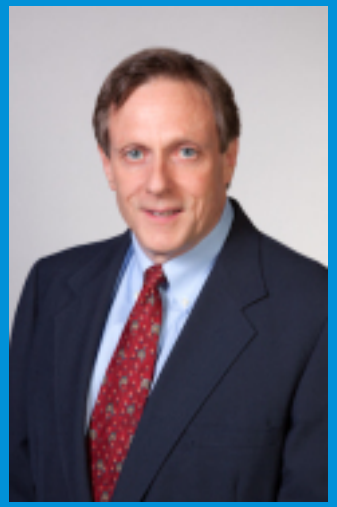
U.S. Affordability Issues

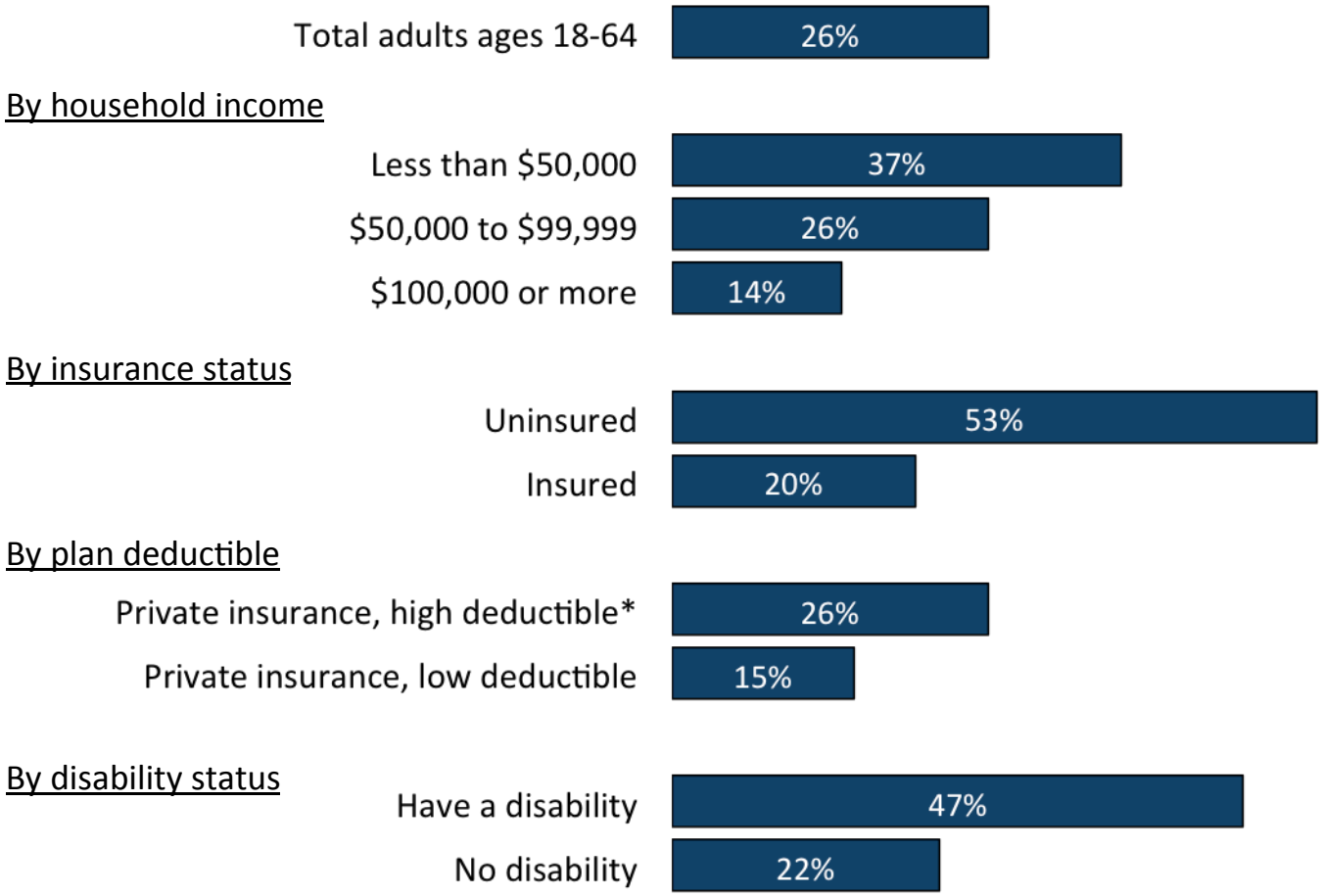
Gary Claxton

Vice President,
The Kaiser Family Foundation



Shares Reporting Problems Paying Medical Bills In Past Year

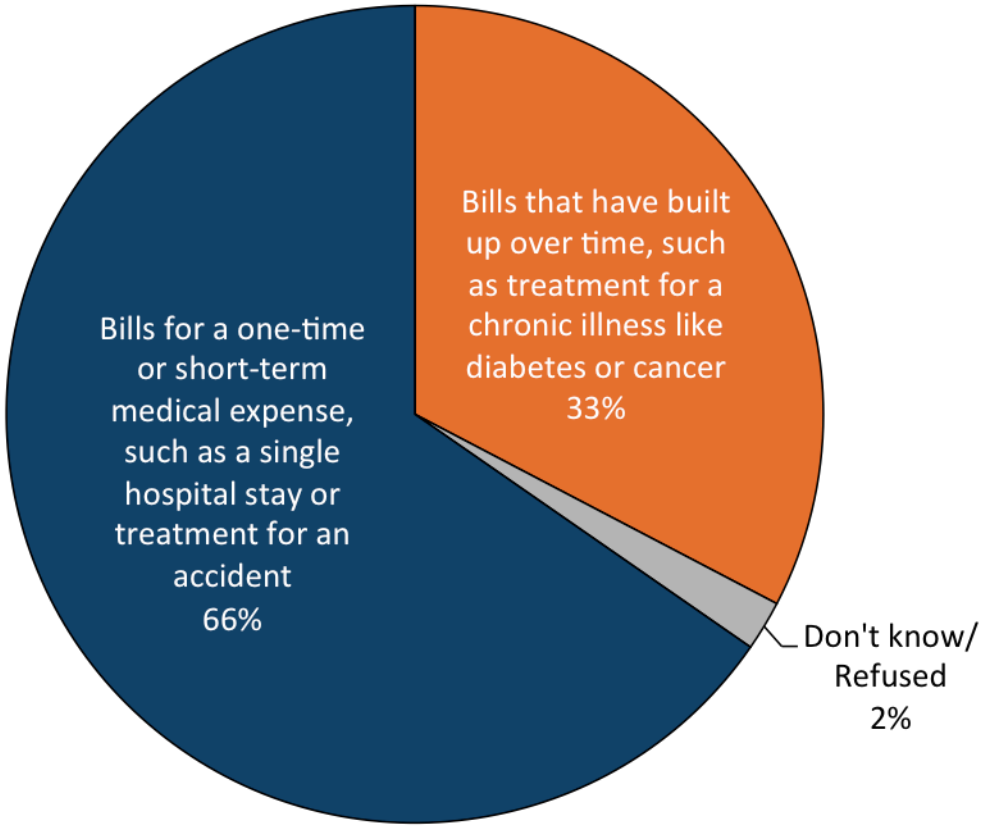
Percent who say they or someone in their household had problems paying medical bills in the past 12 months:



*High deductibles defined as $1,500 and above for an individual or $3,000 and above for a family.
SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

More Say Medical Bill Problems Stem From One-Time Events Than Treatment For Chronic Illnesses

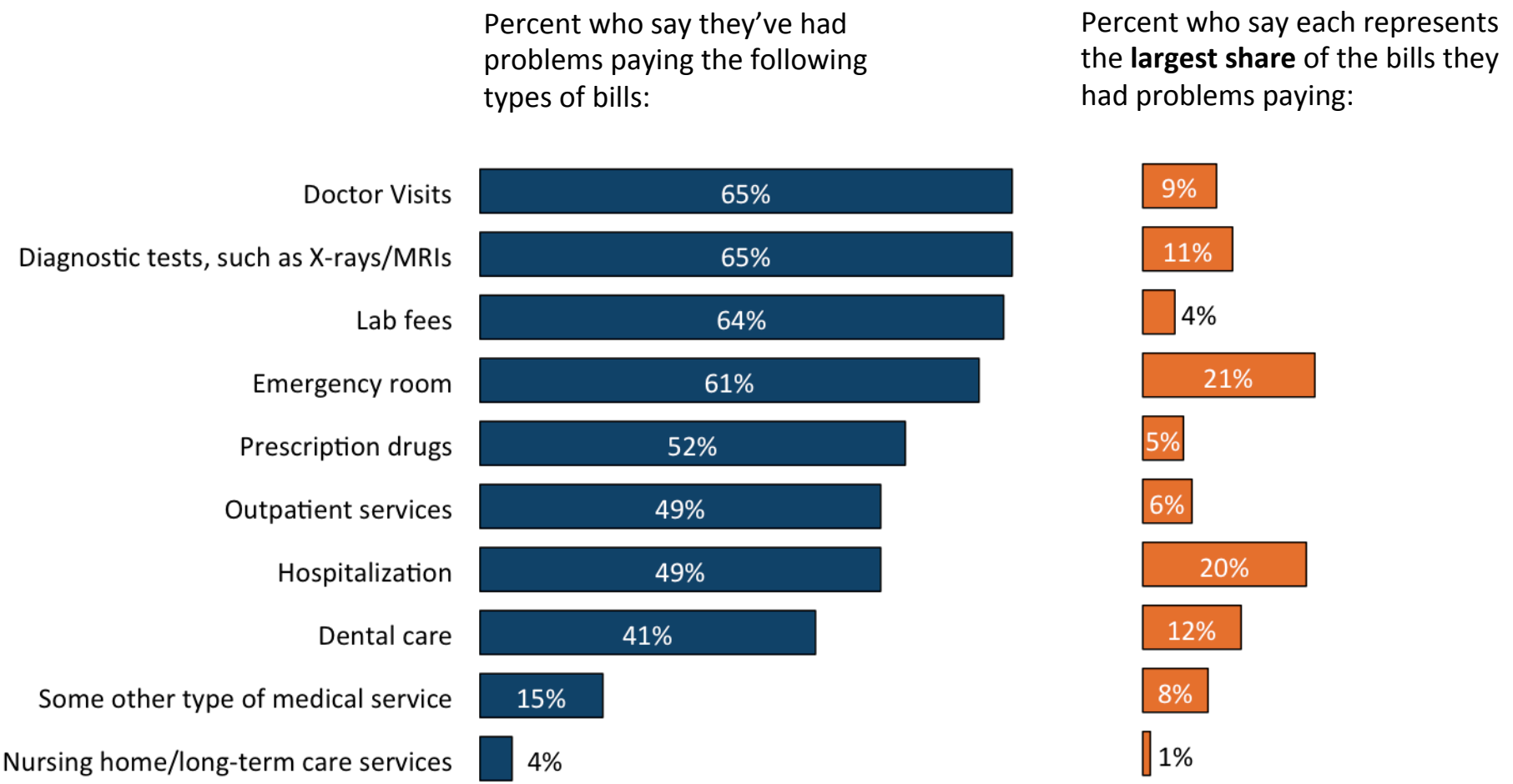
AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS: Which of the following comes closer to describing the medical bills you've had problems paying:



SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

Doctor Visits, Tests, Lab Fees Are Most Common Source Of Bills, But Hospital And ER Make Up Largest Dollar Amount

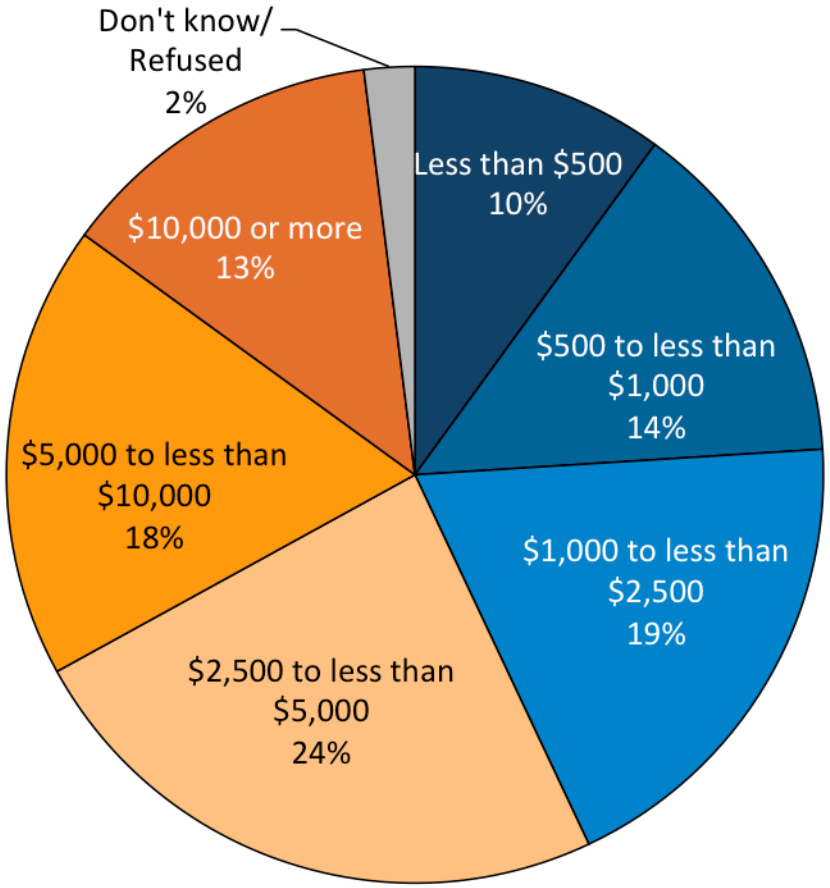
AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS:



SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

People Report Problems Paying Medical Bills Of Varying Dollar Amounts

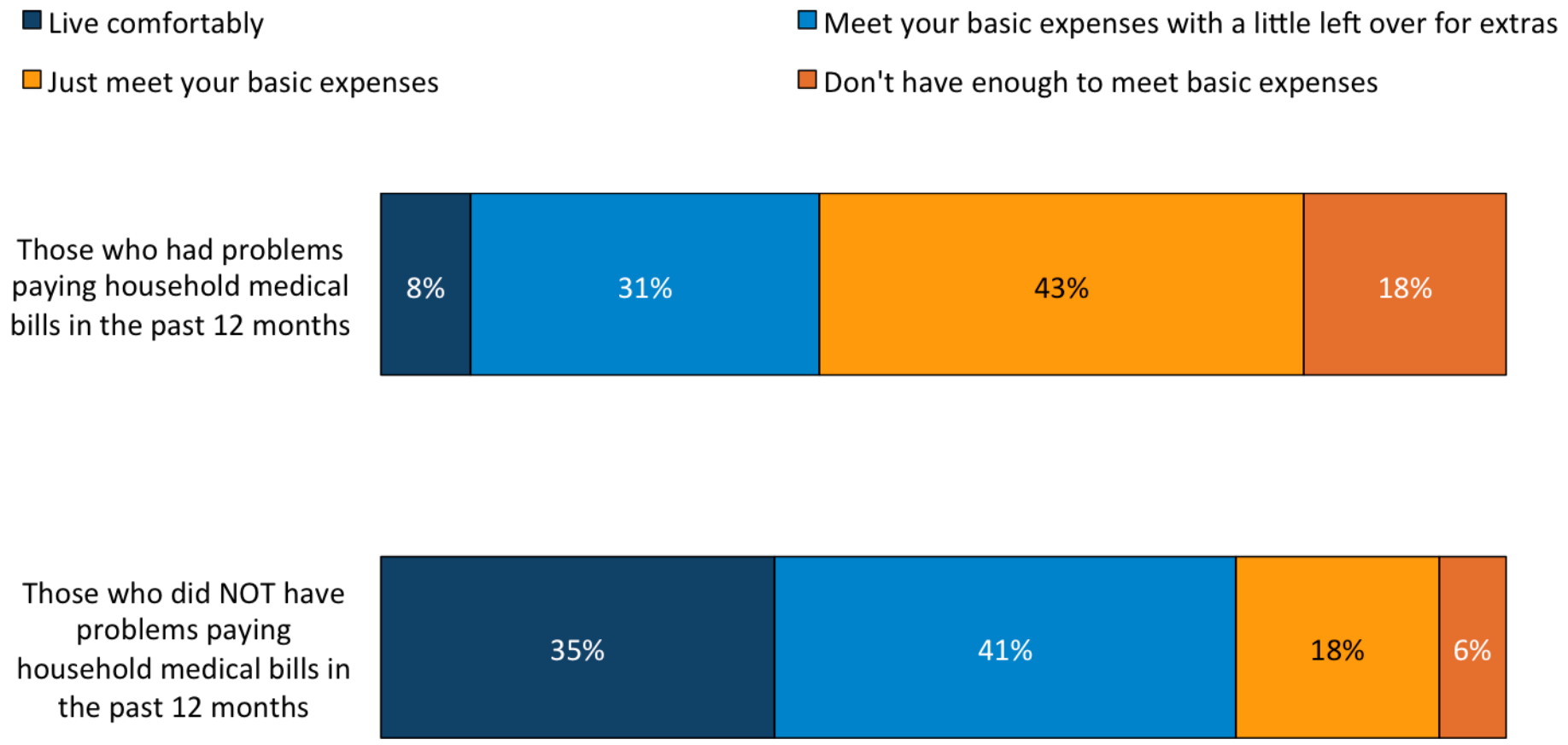
AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS: What was the TOTAL amount owed for the medical bills you've had problems paying?



SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

Most Of Those With Medical Bill Problems Report Just Making Ends Meet

How would you describe your household's financial situation?

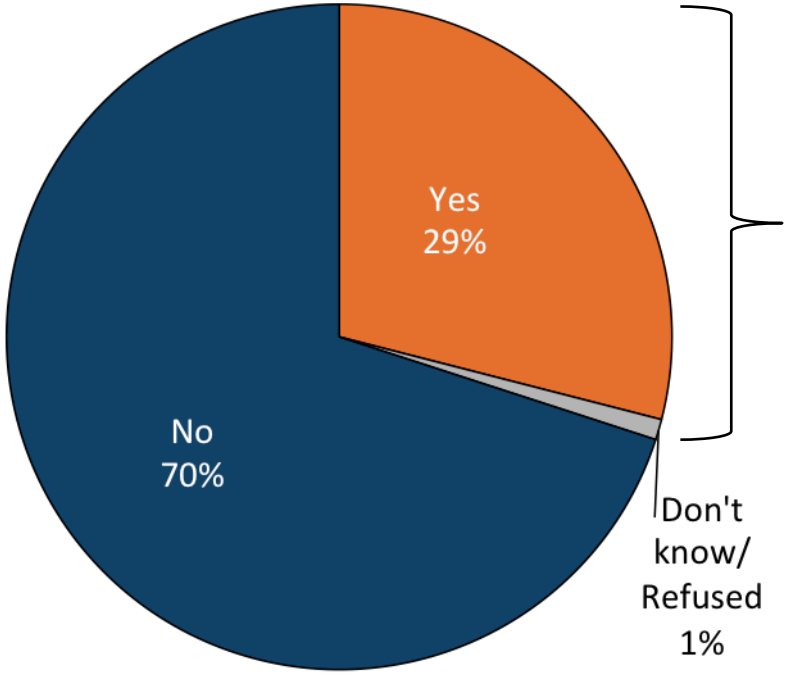


NOTE: Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

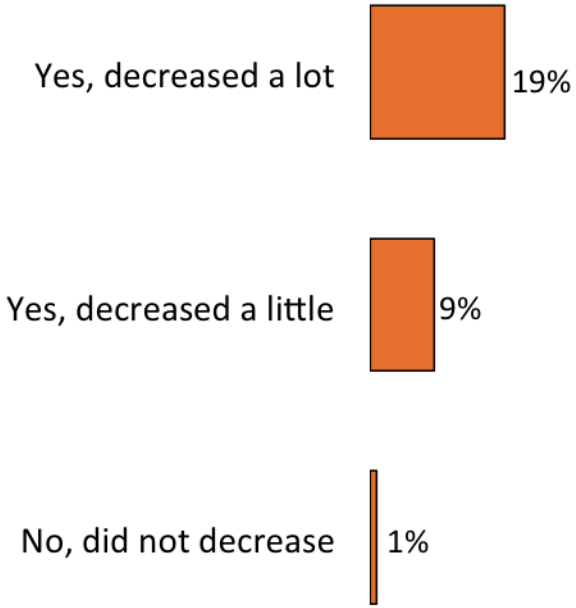
About Three In Ten Report Job Loss Or Pay Cut Due To Illness That Led To Medical Bill Problems

AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS:

Did you or anyone else in your household lose a job or have to take a cut in pay or hours due to the illness or injury that led to these bills?



ASKED OF THE 29% WHO SAY SOMEONE LOST A JOB OR TOOK A CUT IN PAY/HOURS: Did your overall household income decrease as a result of this change in work status, or not? Would you say it decreased a little or a lot? *(Percentages shown based on total who had problems paying medical bills)*

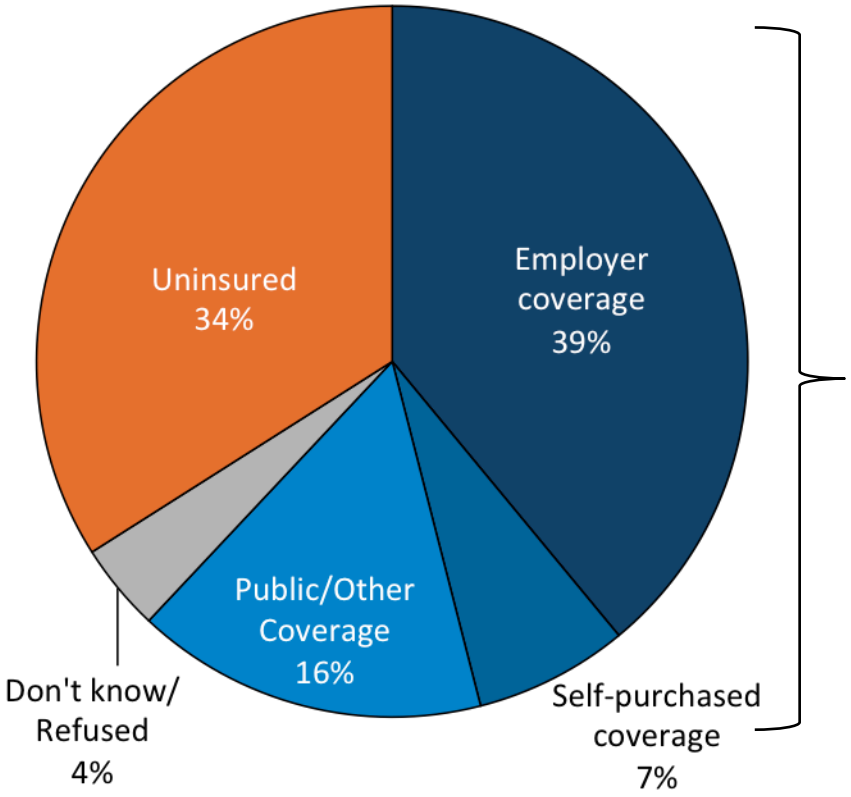


SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

Insurance Status Of Those Who Had Problems Paying Medical Bills

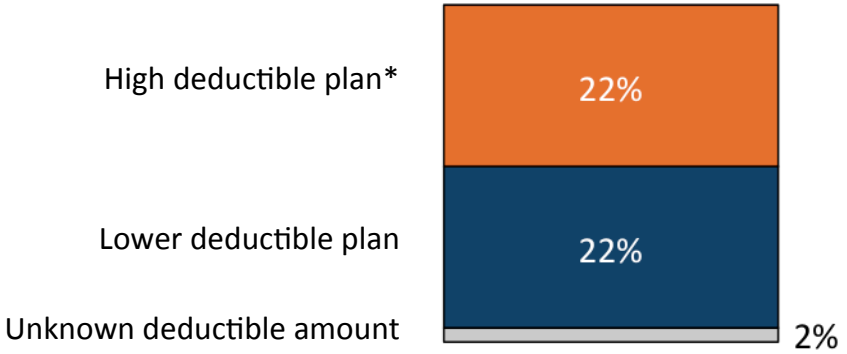
AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS:

Insurance status of the person who was the main source of the bills at the time treatment began:



ASKED OF THE 46% WITH EMPLOYER OR SELF-PURCHASED COVERAGE: *Percentages shown based on total who had problems paying medical bills*

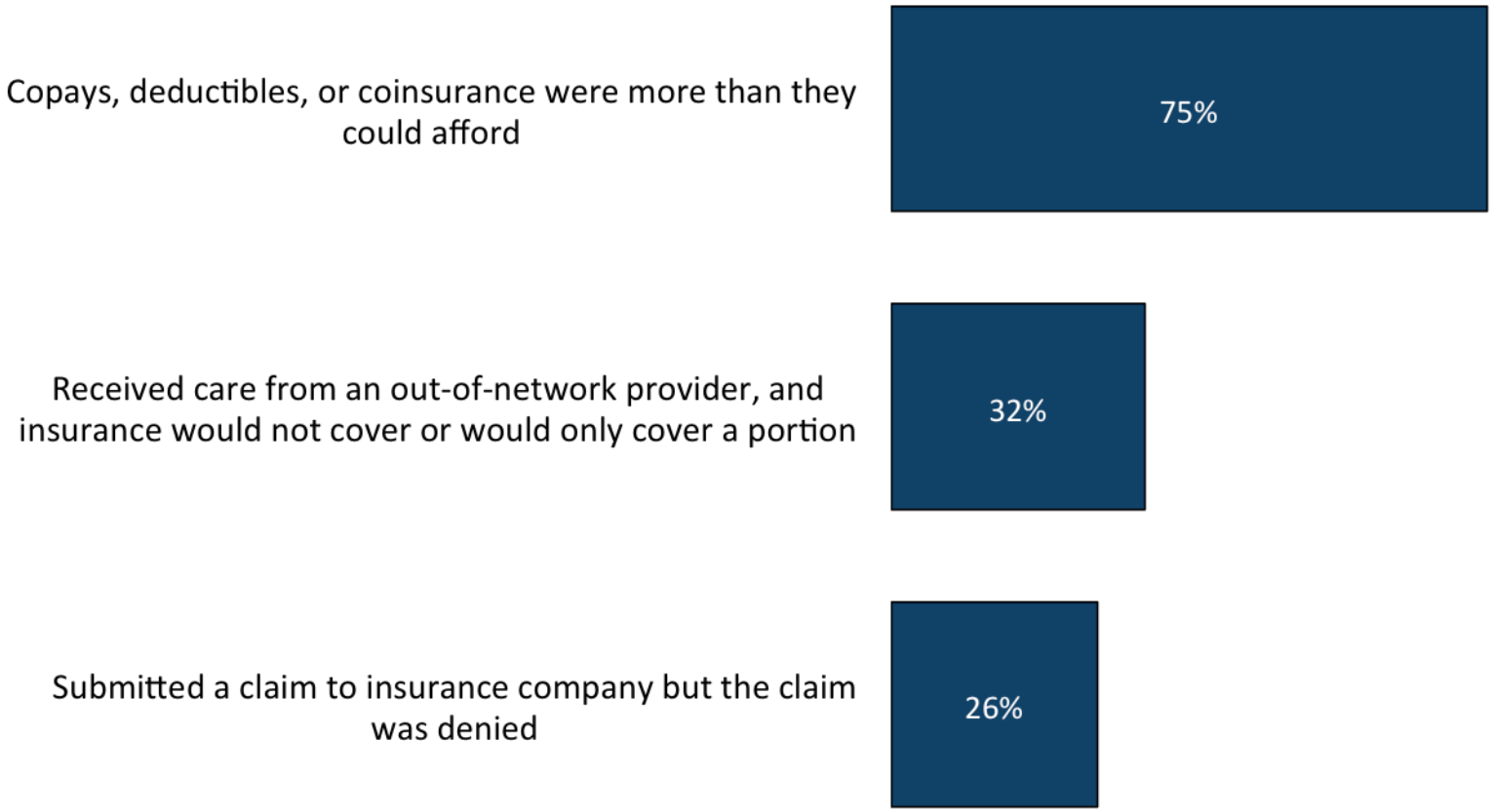
Deductible level of those with employer-sponsored or self-purchased coverage:



NOTE: *High deductibles defined as $1,500 and above for an individual or $3,000 and above for a family.
SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

Most Who Had Problems Paying Medical Bills While Insured Say Cost-Sharing Was More Than They Could Afford

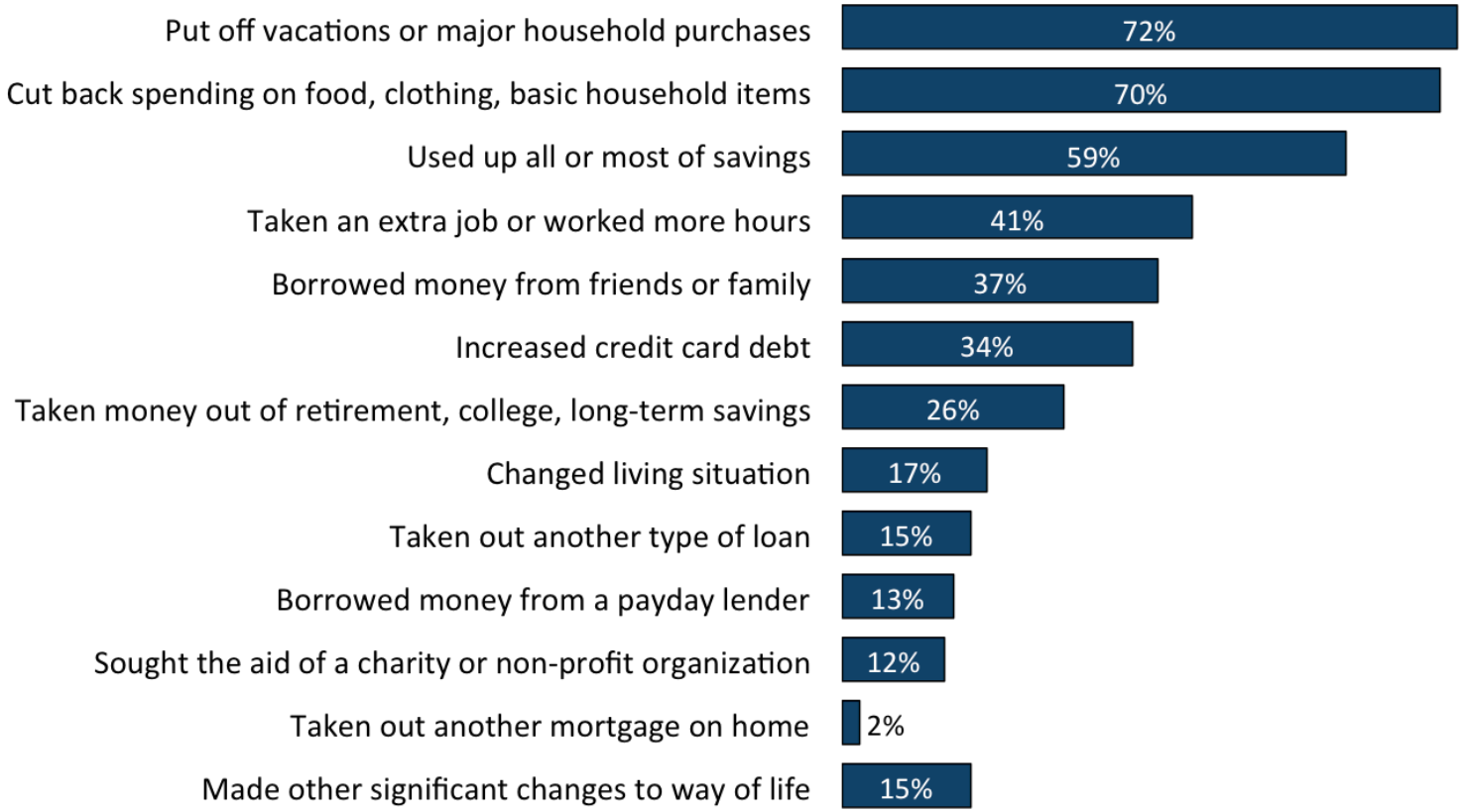
AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS WHO WERE INSURED WHEN TREATMENT BEGAN: Percent who say each of the following was a reason they had problems paying medical bills:



NOTE: Question wording abbreviated. See topline for full question wording.
SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

Many Report Taking Various Actions To Pay Medical Bills

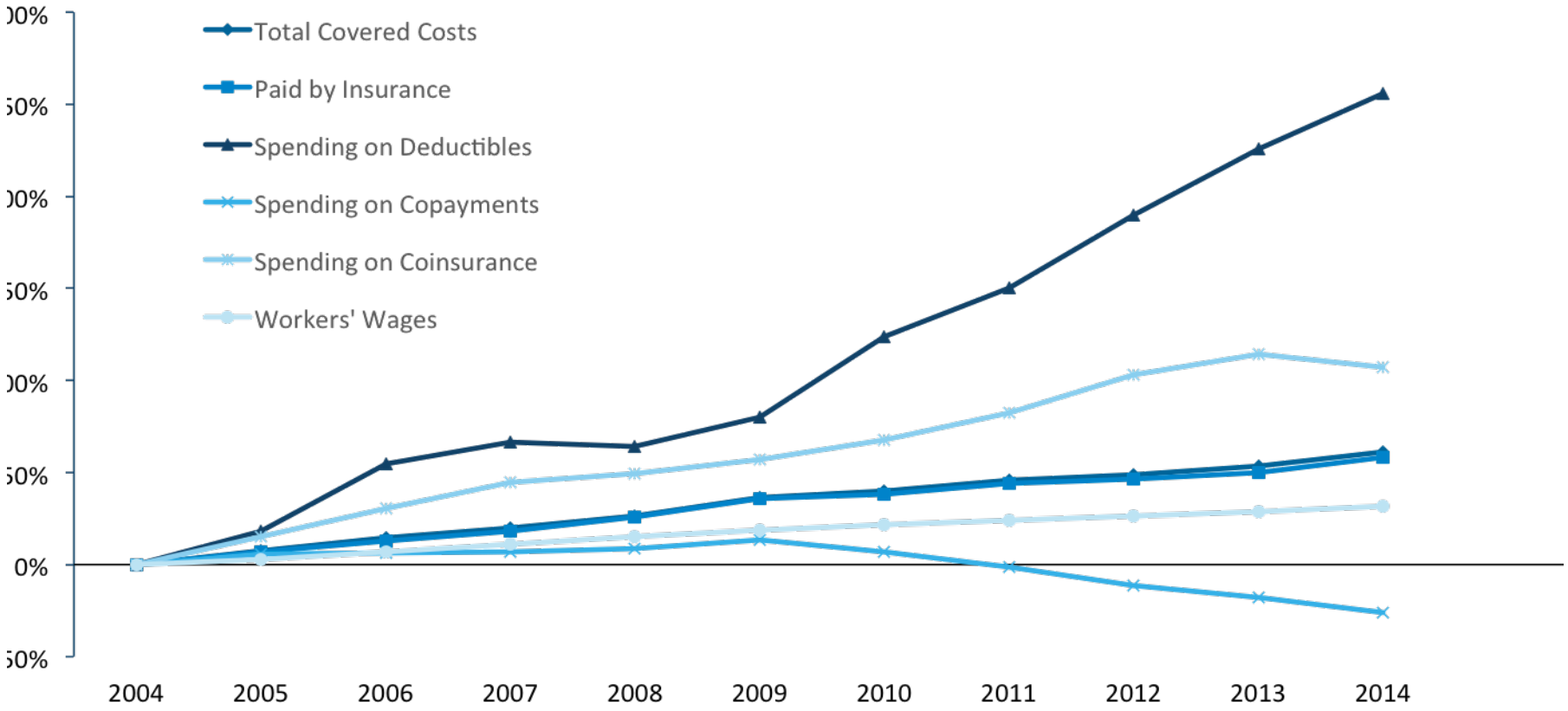
AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS: Percent who say they or someone else in their household has done each of the following in the past 12 months in order to pay medical bills:



NOTE: Question wording abbreviated. See topline for full question wording.
SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

Average Deductible Spending Rises While Average Copayment Spending Falls, 2004-2014

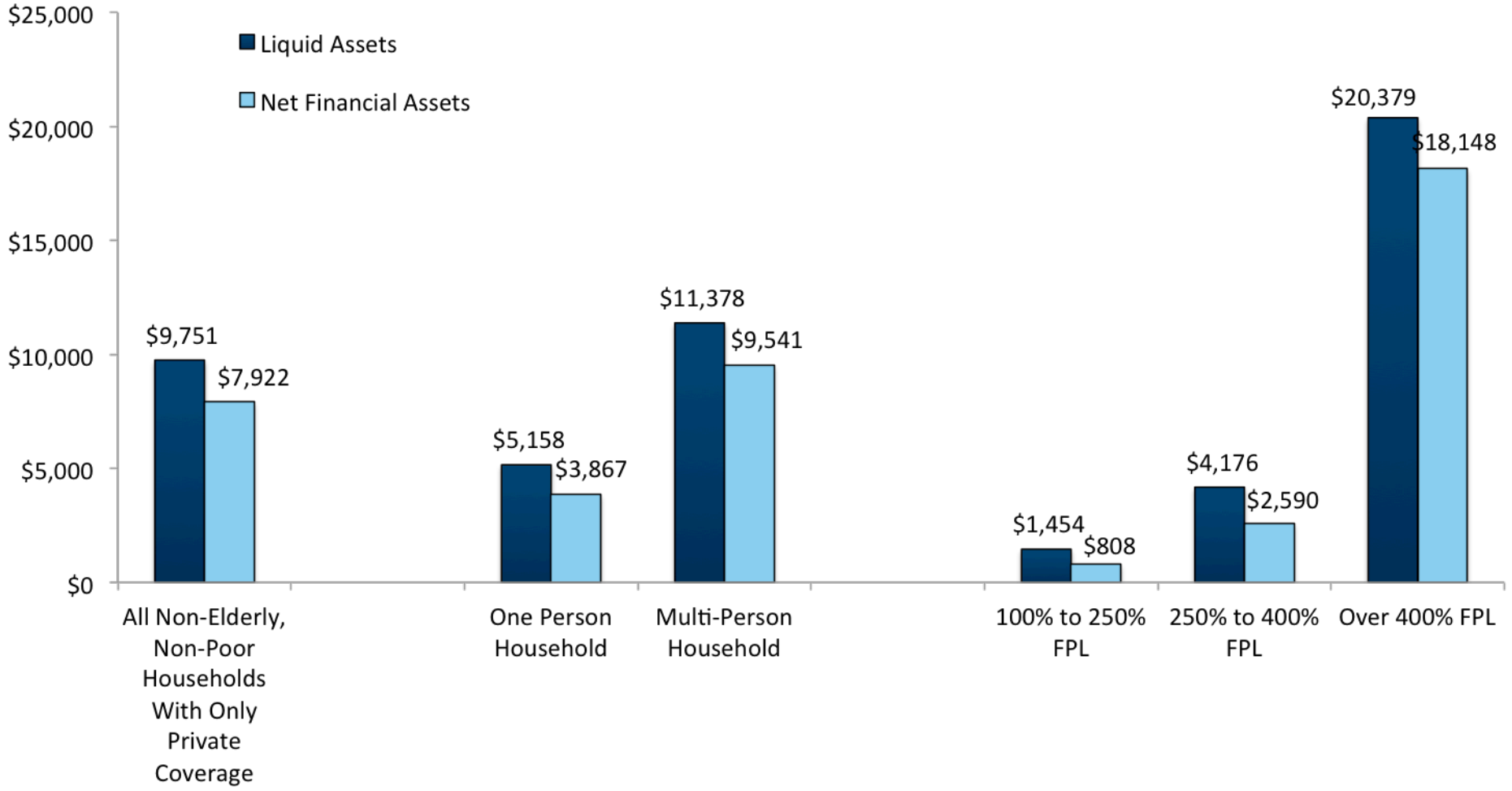
Cumulative increases in health costs, amounts paid by insurance, amounts paid for cost sharing and workers' wages, 2004-2014



Source: Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2004-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2004-2014 (April to April).

Median Liquid and Net Financial Assets

Among All Non-Elderly, Non-Poor Households With Only Private Coverage



NOTES: FPL refers to the 2013 Federal Poverty Level.
SOURCE: Kaiser Family Foundation analysis of 2013 Survey of Consumer Finance (SCF) data.

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Achieving a Uniform Standard

Sherry Glied

Dean, Robert F. Wagner School of Public Service, New York University

NYU | WAGNER

Affordability and Health Insurance

Sherry Glied

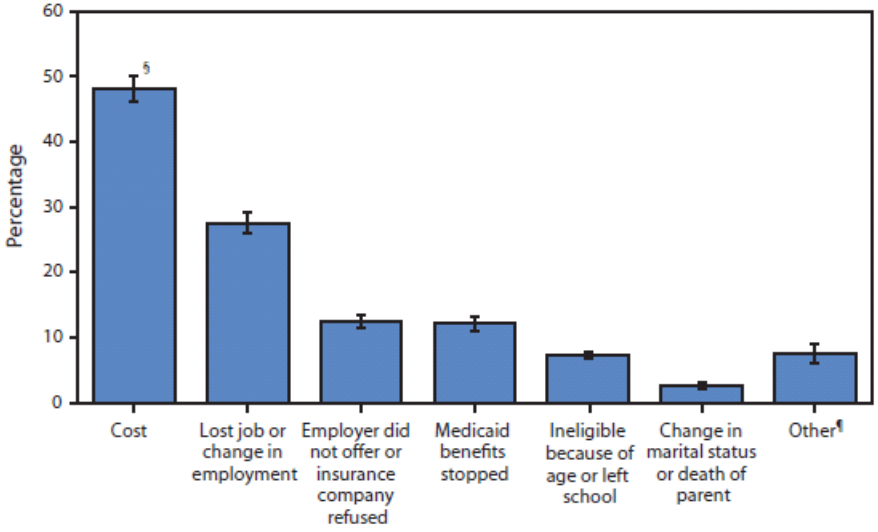
Broad Agreement: Affordability

Paul Ryan: Republicans Working To Ensure Everyone Can Afford Healthcare

Posted By Tim Hains
On Date January 17, 2017

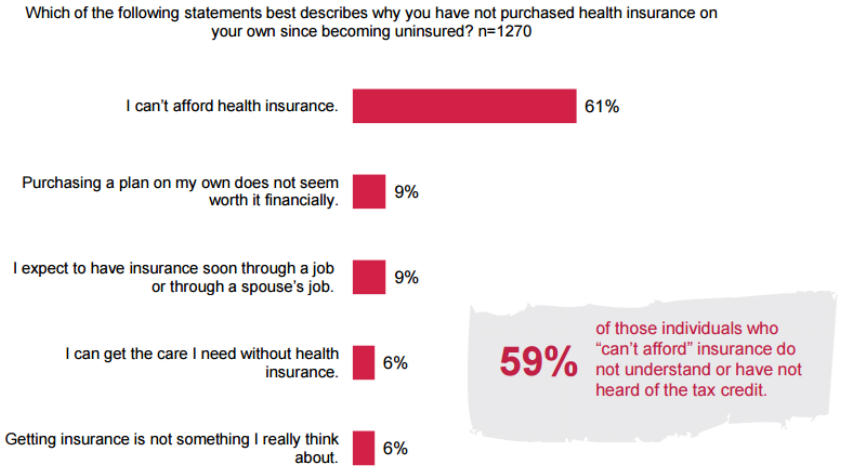
Affordability is Critical to Coverage

Pre-ACA



Post-ACA

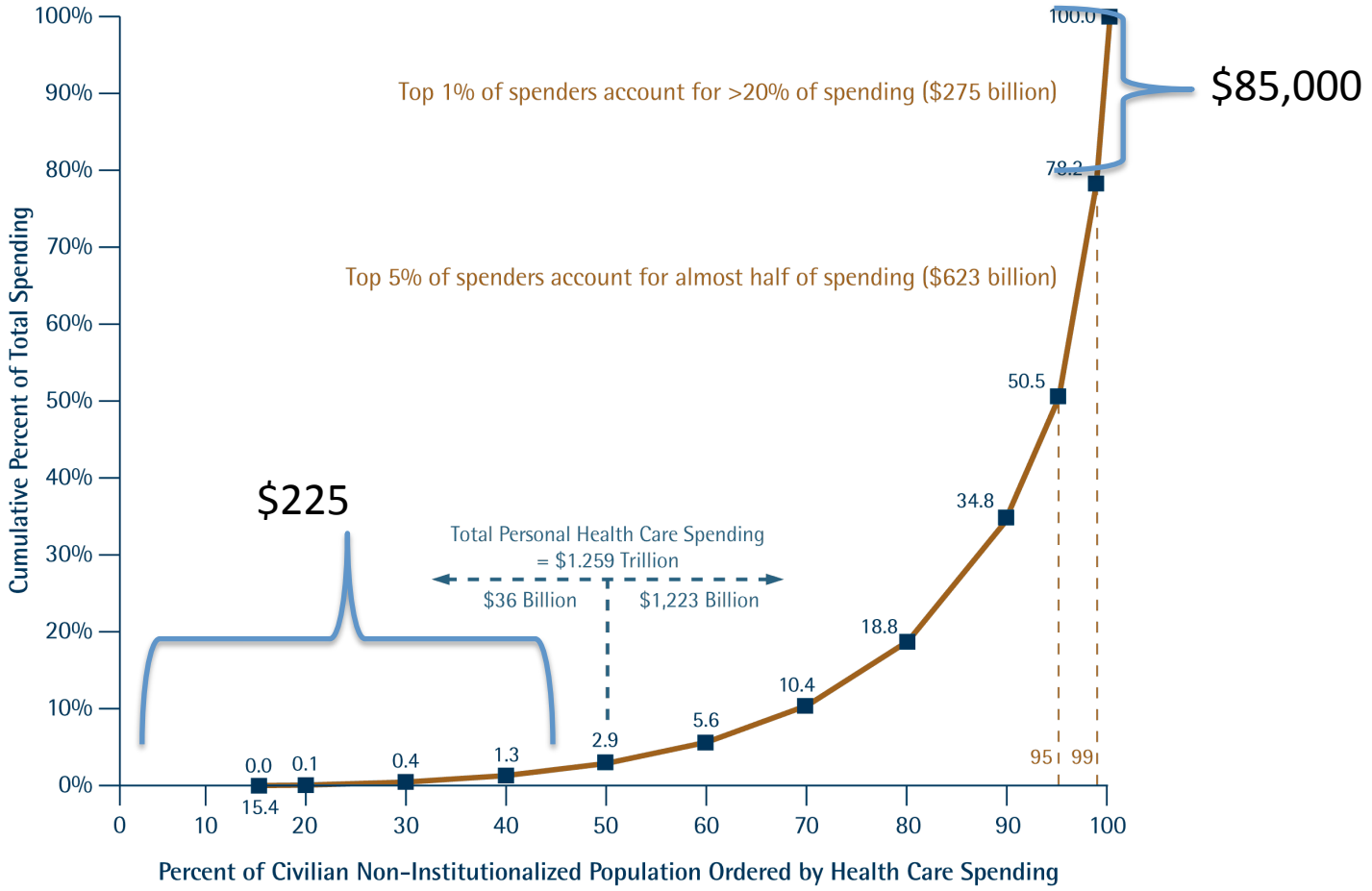
COST IS THE MAIN REASON THEY HAVE NOT SIGNED UP.



http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2015/rwjf420854/subassets/rwjf420854_4

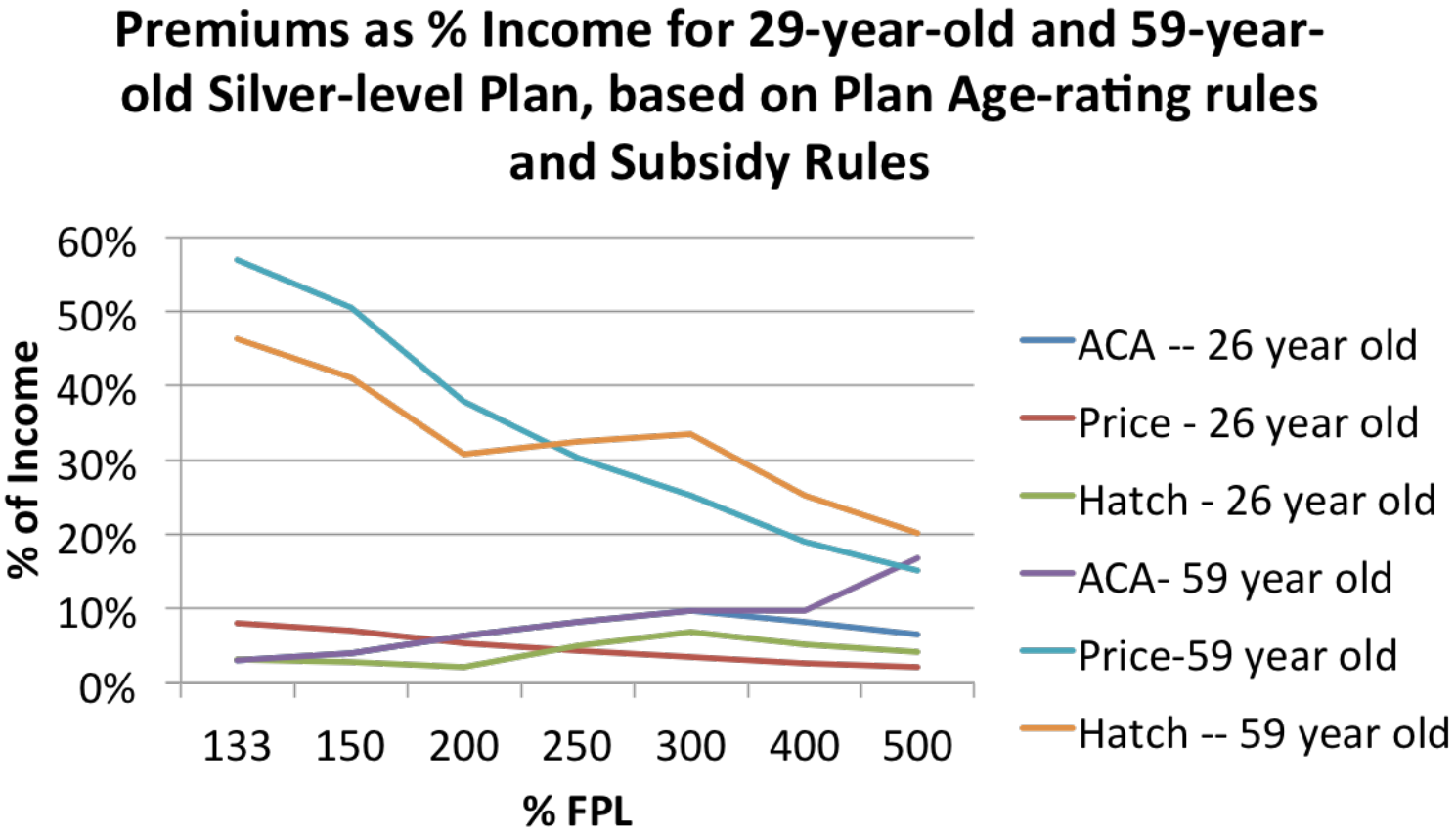
Affordability: Market Stability

FIGURE 1. CUMULATIVE DISTRIBUTION OF PERSONAL HEALTH CARE SPENDING, 2009

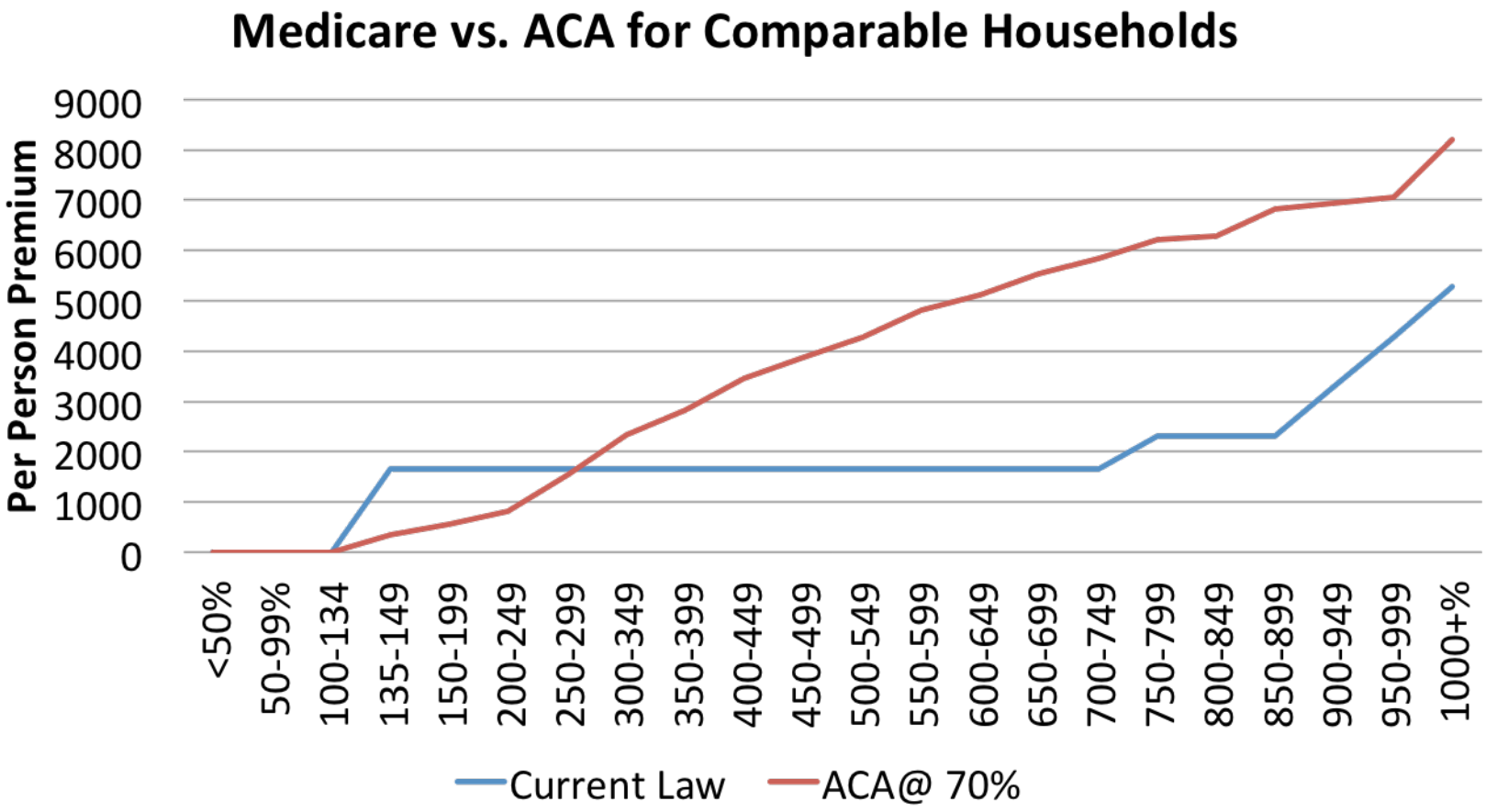


NIHCM Foundation analysis of data from the 2009 Medical Expenditure Panel Survey.

Differing Views



Inconsistent Across Programs

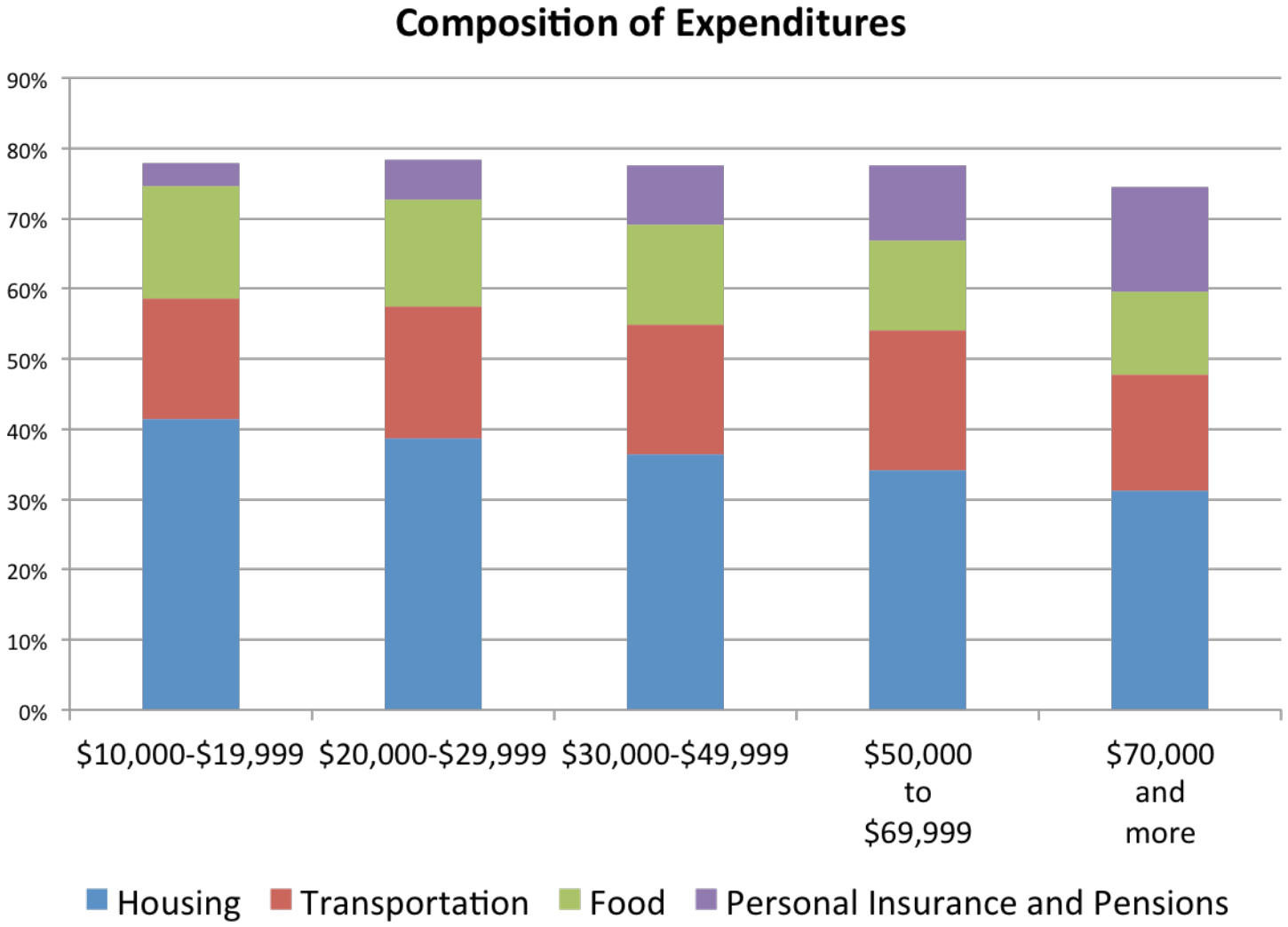


1960s Consensus - Food

"...there is no generally accepted standard of adequacy for essentials of living except food."

The Development of the Orshansky Poverty Thresholds and Their Subsequent History as the Official U.S. Poverty Measure
By Gordon M. Fisher

What Other Priorities?



Experts: FPL, Concave

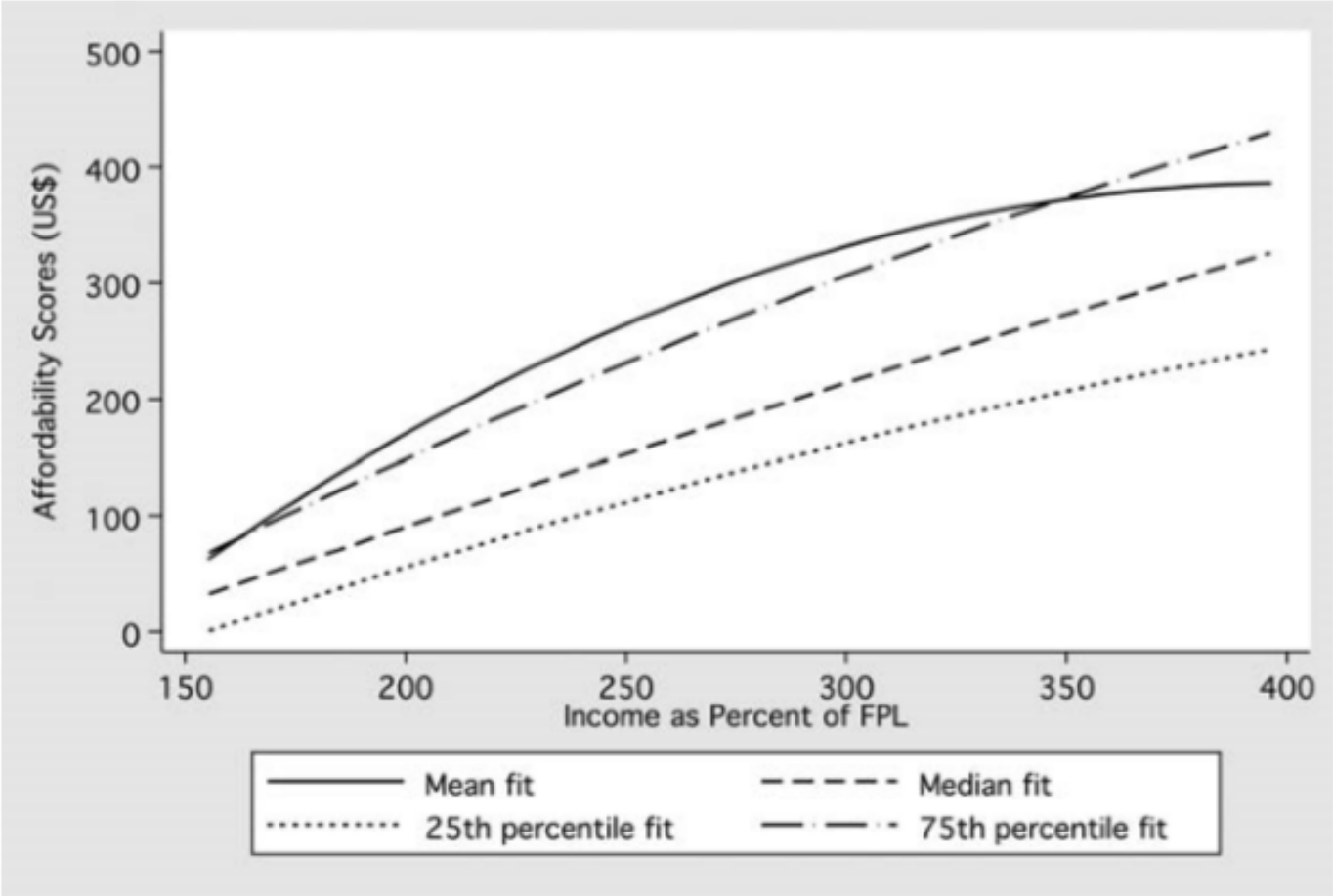
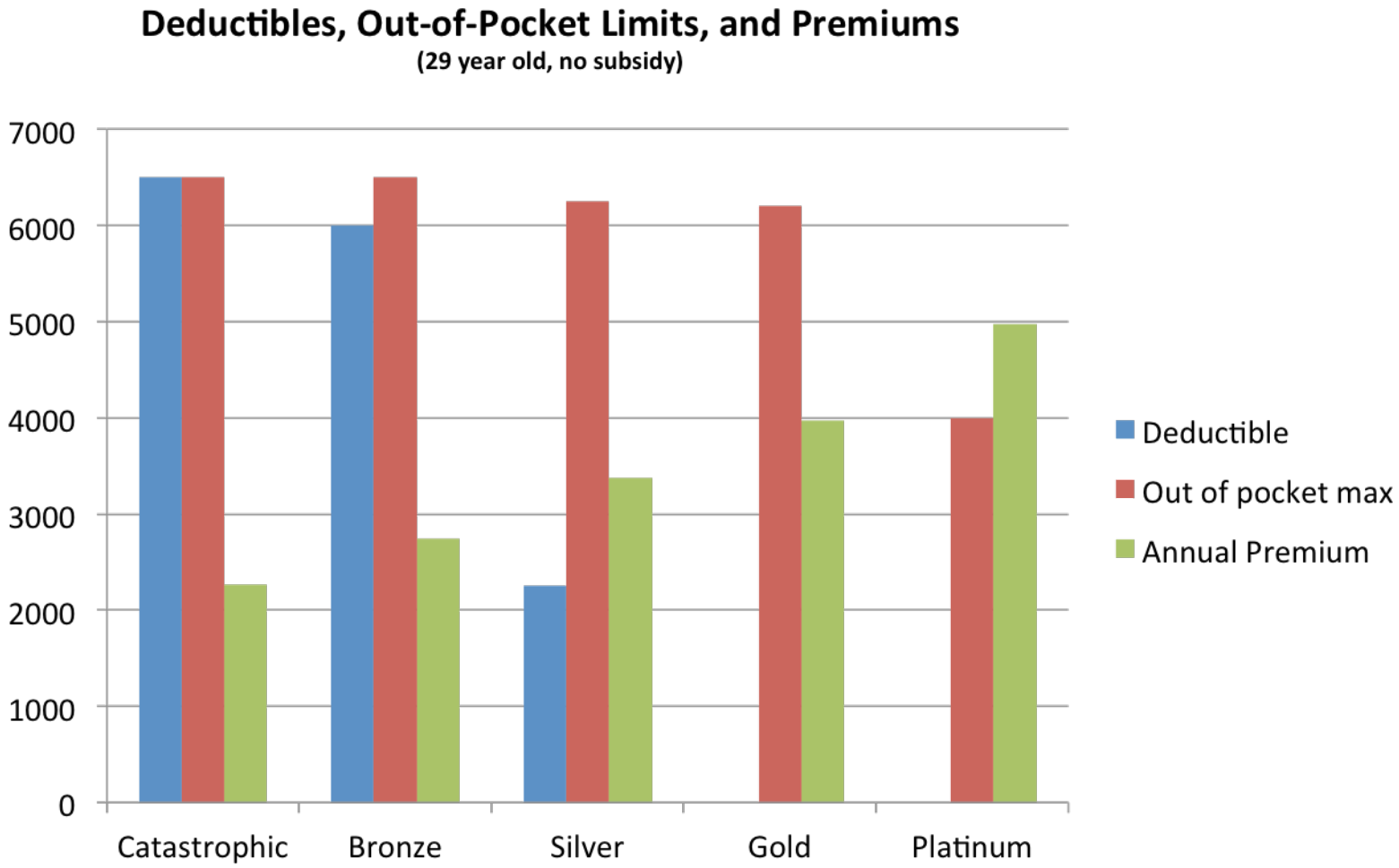


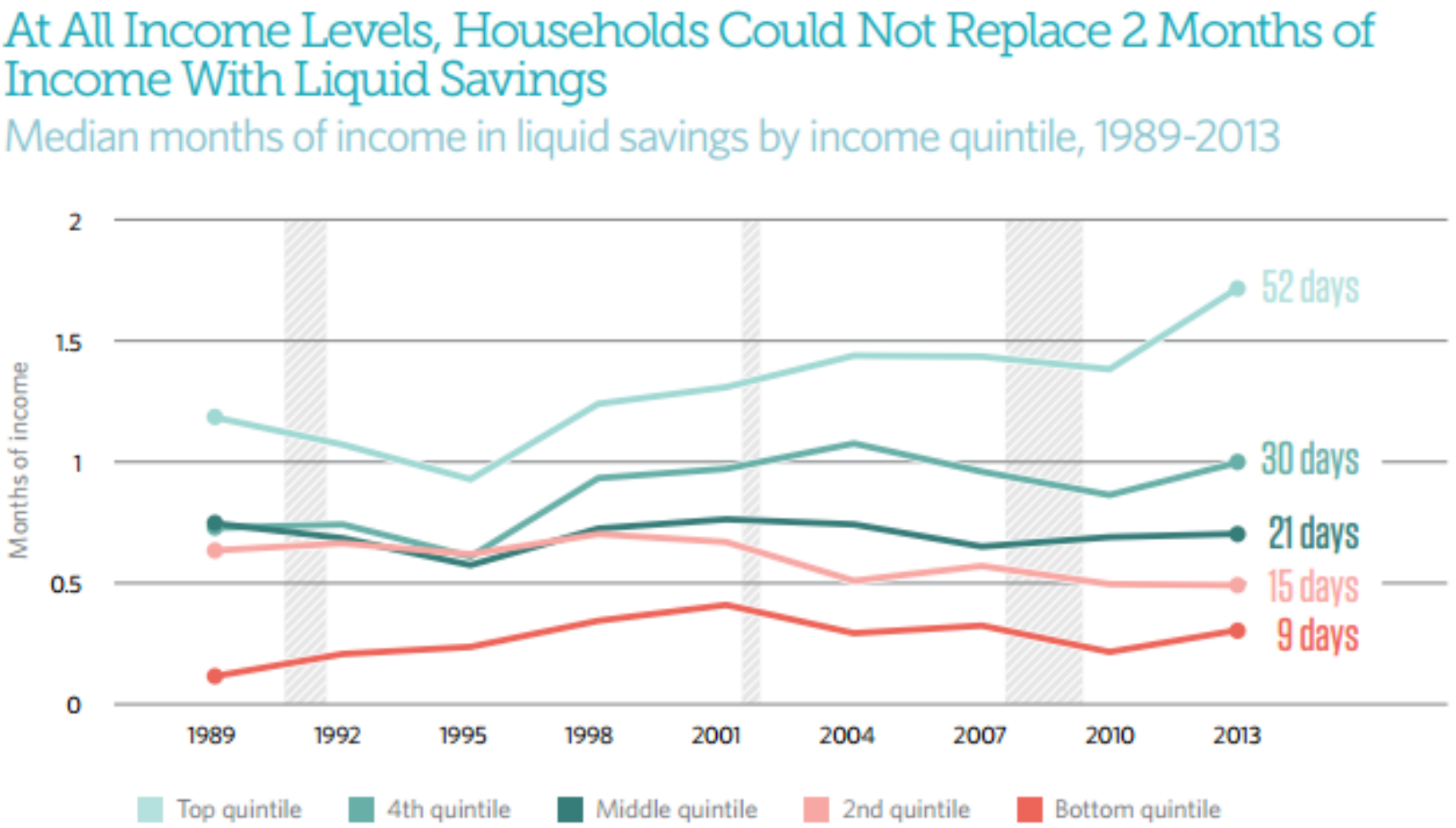
Figure 1A Expert-Generated Affordability Scores by Vignette Character's Household Income Relative to the Federal Poverty Level,

Premiums? Total Costs? Max?



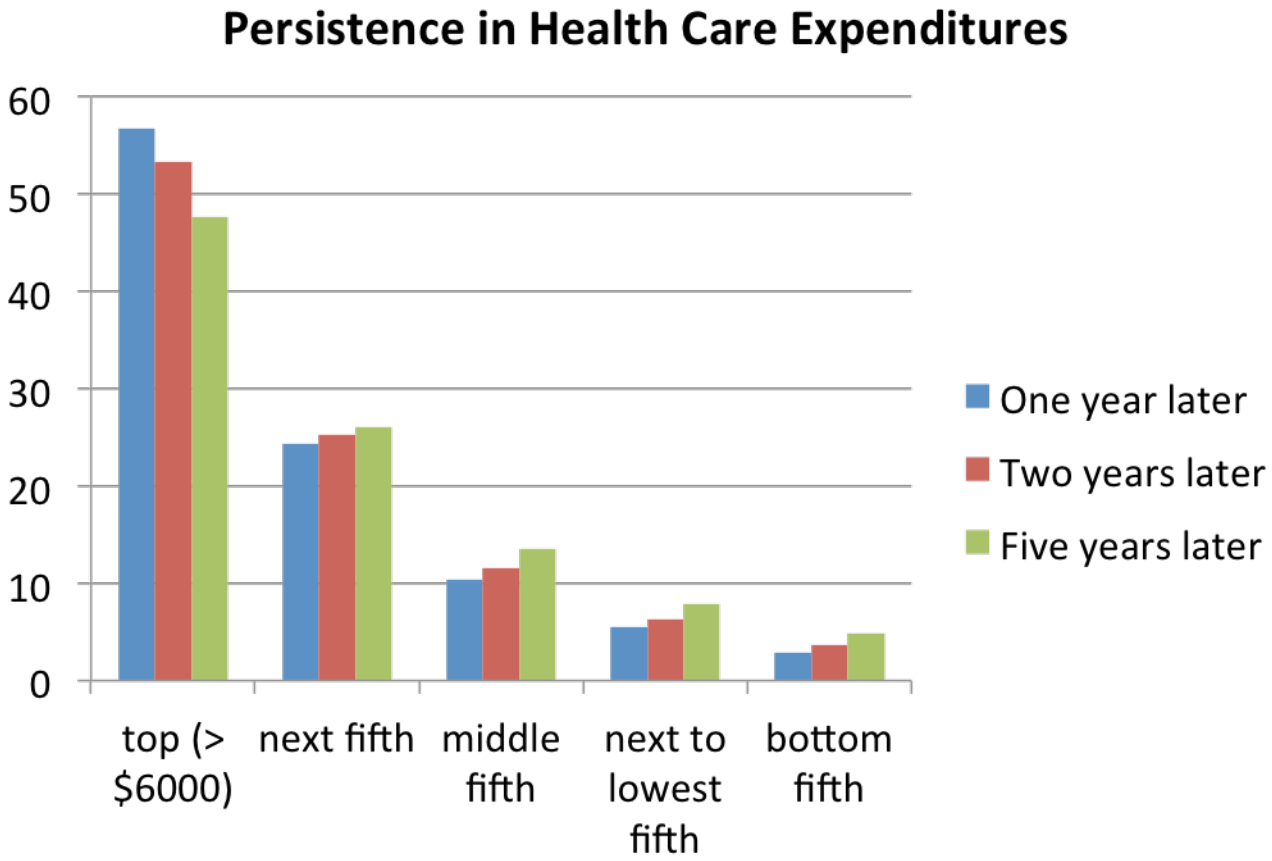
https://www.valuepenguin.com/average-cost-of-health-insurance

Households have Little Savings



http://www.pewtrusts.org/~/media/assets/2015/01/fsm_balance_sheet_report.pdf

Costs Persist



Long-Term Health Spending Persistence among the Privately Insured in the US*

RICHARD A. HIRTH,† SEBASTIAN CALÓNICO,‡ TERESA B. GIBSON,§ HELEN LEVY,◊ JEFFREY SMITH^ and ANUP DAS±

FISCAL STUDIES, vol. 37, no. 3–4, pp. 749–783 (2016) 0143-5671

Affordability Metrics

- Critical to coverage and robustness of markets
- Sensible to think consistently across programs
- Lower income households have less discretionary income
- FPL – income + household size
- Total costs matter
  - Little savings
  - Persistent costs

Thanks!

SHERRY GLIED @NYU.EDU

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State Spotlight: Massachusetts

Marissa Woltmann

Associate Director of Policy and ACA Implementation Specialist, Massachusetts Health Connector

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Defining Affordability in Massachusetts

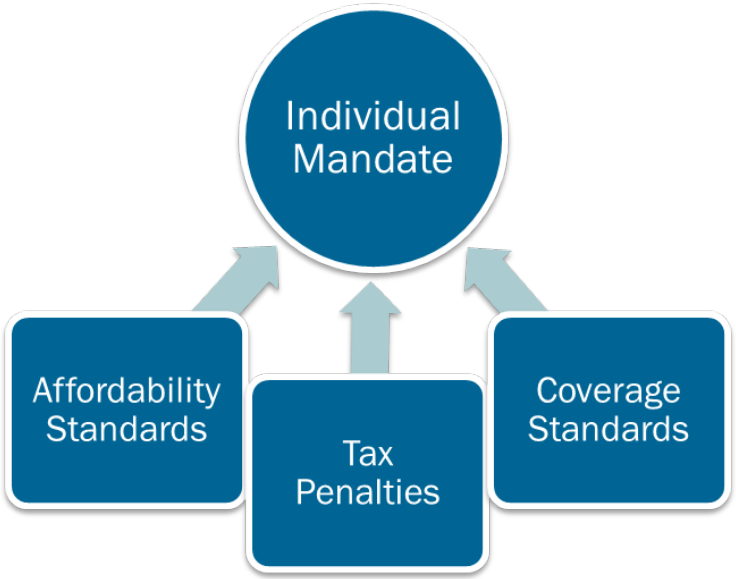
MARISSA WOLTMANN
Associate Director of Policy and ACA Implementation Specialist

January 18, 2017

Background

Massachusetts law includes an "individual mandate" that requires adults to enroll in health insurance or face potential financial penalties

- The structure of the individual mandate involves three key policy elements, set in statute or determined by the Health Connector, with the Department of Revenue (DOR) administering the process
- Penalties arise if an individual forgoes enrollment in an available plan meeting both Minimum Creditable Coverage (MCC) and affordability standards
- The Health Connector is responsible for setting affordability and coverage standards and managing appeals (the penalty formula is set in statute); DOR enforces the mandate through the tax filing process
- The Affordable Care Act (ACA) also includes an individual mandate, but it employs different standards, applies to both adults and children, and is enforced by the Internal Revenue Service (IRS) using a different penalty structure



The Affordability Schedule in Context

The affordability schedule determines whether an individual must pay a penalty for not having Minimum Creditable Coverage (MCC)

- Supports consumers as they make choices about coverage and their household budgets by defining the maximum amount they would be expected to contribute toward coverage or face a penalty

It is independent of other aspects of state and federal health care reform, but it is an important component of the coverage landscape

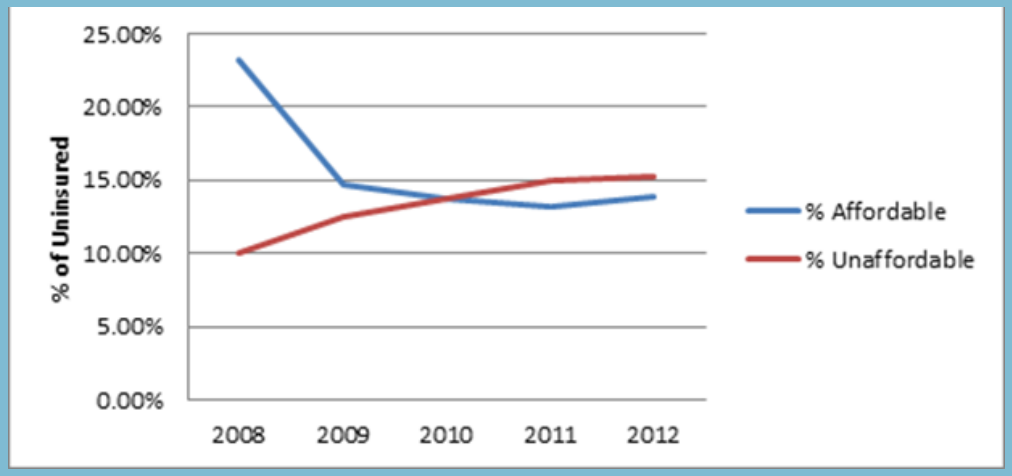
- Does not require employers, issuers or other coverage providers to offer plans deemed affordable by the schedule or subject them to penalties if individuals fail to enroll in the affordable coverage they offered
- The Health Connector has historically aligned base enrollee premiums for subsidized individuals up to 300% FPL with the state's affordability schedule, such that the ConnectorCare program is considered affordable, but it is not required to do so under the law
- Does not affect the assessment of a federal penalty for failing to enroll in coverage

Application of the State Affordability Schedule

The affordability schedule is most relevant for the relatively small portion of Massachusetts residents who are without MCC and therefore potentially subject to a state penalty

- Those who are completely uninsured
  - The most recent (2015) Center for Health Information and Analysis (CHIA) Health Insurance Survey estimates ~97% of Massachusetts residents have health insurance
- Those with coverage that does not meet MCC standards
  - In Tax Year 2012, 92% of tax filers reported having MCC for the entire year

How uninsured taxpayers used the schedule to determine whether they were subject to a penalty



Source: Health Connector and DOR Tax Filers Reports, 2008 - 2012

History of the Affordability Schedule

Affordability standards are closely related to the Health Connector's premiums for subsidized coverage

- Key principles in setting target premiums for the subsidized Commonwealth Care program in 2006 included
  - Making coverage affordable to the eligible population and moving large numbers of Uncompensated Care Pool users into Commonwealth Care
  - Making coverage financially appealing to healthy as well as unhealthy residents at or below 300% of FPL
  - Stretching the Commonwealth Care budget to cover as many eligible residents as possible
  - Avoiding the "crowd-out" of privately financed insurance that would increase the costs (to government) of reducing the number of uninsured residents.
- In setting affordability standards for the individual mandate, policy decision to mandate participation in Commonwealth Care among eligible individuals by deeming it affordable
  - In process of setting mandate standards, adjusted actual subsidized premiums

History of the Affordability Schedule *(cont'd)*

In 2015, the Board approved structural changes to the affordability schedule

- Re-sequenced policy decisions to accommodate changes the ACA brought to program design calendar
- Shifted to a percentage-based affordability standard, rather than fixed-dollar standards
  - Eliminated the regressive nature of the fixed dollar approach, where the affordability standard represented a larger percentage of income for households at the bottom of a bracket and a smaller percentage of income for households at the top of a bracket
  - Eliminated disparities in the percentage of income required of different household types at the same income level
- Updated affordability standards for individuals under 300% FPL in the 2016 schedule, resulting in the first updates to subsidized Health Connector premiums since 2012

2012 – Individuals

Income Bracket			Affordability Standard (Maximum Monthly Premium)	Percentage of Income	
% of FPL	Bottom	Top		Bottom	Top
0 - 100%	$0	$11,172	$0		
100.1 - 150%	$11,173	$16,764	$0		
150.1 - 200%	$16,765	$22,344	$40	2.9%	2.1%
200.1 - 250%	$22,345	$27,936	$78	4.2%	3.4%
250.1 - 300%	$27,937	$33,516	$118	5.1%	4.2%

2016 – Individuals

Income Bracket			Affordability Standard (Maximum Monthly Premium)	Dollar Amount	
% of FPL	Bottom	Top		Bottom	Top
0 - 100%	$0	$11,770	0%		
100.1 - 150%	$11,771	$17,655	0%		
150.1 - 200%	$17,656	$23,540	2.90%	$ 43	$ 57
200.1 - 250%	$23,541	$29,425	4.20%	$ 82	$ 103
250.1 - 300%	$29,426	$35,310	5.00%*	$ 123	$ 147

Sample Changes in Affordability

Overall, affordability standards have been relatively stable since implementation

Sample Household	2007 Standard	2017 Standard	Change 2007-2017
Individual @ $18,000	$35 (2.33%)	2.90% ($43.50)	+0.57% / +$8.50
Individual @ $35,000	$150 (5.14%)	5.00% ($145.83)	-0.14% / -$4.17
Individual @ $70,000	"Affordable"	8.16% ($476.00)	variable
Couple @ $25,000	$70 (3.36%)	4.30% ($89.58)	+0.94% / +$19.58
Couple @ $52,000	$360 (8.31%)	7.40% ($320.67)	-0.91% / -$39.33
Couple @ $90,000	"Affordable"	8.16% ($612.00)	variable
Family @ $31,000	$70 (2.71%)	3.45% ($89.13)	+0.74% / +$19.13
Family @ $62,000	$320 (6.19%)	7.40% ($382.33)	+1.21% / +$62.33
Family @ 112,000	"Affordable"	8.16% ($761.60)	variable

Future of Affordability

In response to feedback obtained while developing the affordability schedule, Health Connector staff have investigated whether and how to account for cost sharing in the affordability schedule

- Although cost sharing is a significant burden for consumers, incorporating cost sharing would not reduce out of pocket costs; it would only exempt an uninsured individual from tax penalties if the plan that was offered to them had a combined premium and out of pocket cost deemed unaffordable
- Our research found no straightforward method for determining the cost sharing requirements of a forgone plan
  - The diversity of plan designs and individuals' medical needs makes it difficult to assess how much an uninsured person would have spent on out of pocket costs in the prior year if they had enrolled in coverage available to them
- In addition to not making more affordable plan options available in the market, incorporation of cost sharing into the schedule may have unintended consequences
  - May erode high rates of coverage in the Commonwealth if individuals determine they can forgo coverage without penalty
- We will continue to investigate ways to improve the schedule in future years, in conjunction with the Board, state and federal partners, and other stakeholders

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Universal Standards to Realize the Promise of Healthcare Affordability

Lynn Quincy

Director, Health Care Value Hub

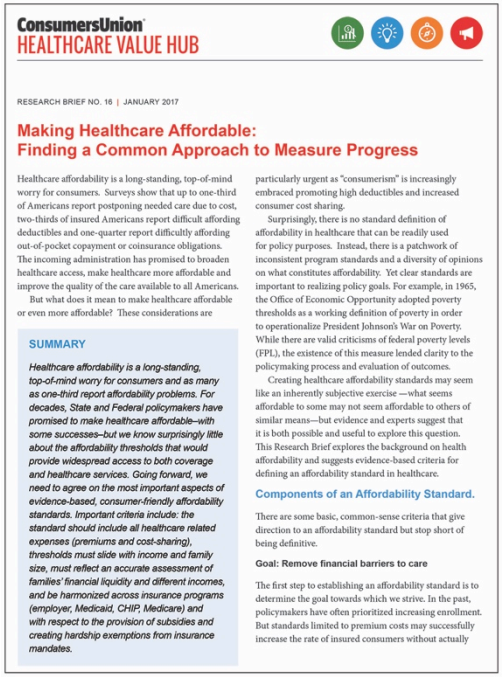
Despite recent progress, healthcare affordability problems remain widespread

Criteria for Healthcare Affordability Standards:

- **Goal: Remove financial barriers to care**
  What is the percentage of income a household can devote to:
  - Cost for coverage (premiums)
  - Cost-sharing for covered services
  - Cost of needed services not included in the benefit package

- **Slides with income and family size**

- **Reflects available program experience**



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RESEARCH BRIEF NO. 16 | JANUARY 2017

Making Healthcare Affordable: Finding a Common Approach to Measure Progress

Healthcare affordability is a long-standing, top-of-mind worry for consumers. Surveys show that up to one-third of Americans report postponing needed care due to cost, two-thirds of insured Americans report difficult affording deductibles and one-quarter report difficultly affording out-of-pocket copayment or coinsurance obligations. The incoming administration has promised to broaden healthcare access, make healthcare more affordable and improve the quality of the care available to all Americans.

But what does it mean to make healthcare affordable or even more affordable? These considerations are particularly urgent as "consumerism" is increasingly embraced promoting high deductibles and increased consumer cost sharing.

Surprisingly, there is no standard definition of affordability in healthcare that can be readily used for policy purposes. Instead, there is a patchwork of inconsistent program standards and a diversity of opinions on what constitutes affordability. Yet clear standards are important to realizing policy goals. For example, in 1965, the Office of Economic Opportunity adopted poverty thresholds as a working definition of poverty in order to operationalize President Johnson's War on Poverty. While there are valid criticisms of federal poverty levels (FPL), the existence of this measure lended clarity to the policymaking process and evaluation of outcomes.

Creating healthcare affordability standards may seem like an inherently subjective exercise —what seems affordable to some may not seem affordable to others of similar means—but evidence and experts suggest that it is both possible and useful to explore this question. This Research Brief explores the background on health affordability and suggests evidence-based criteria for defining an affordability standard in healthcare.

SUMMARY

Healthcare affordability is a long-standing, top-of-mind worry for consumers and as many as one-third report affordability problems. For decades, State and Federal policymakers have promised to make healthcare affordable–with some successes–but we know surprisingly little about the affordability thresholds that would provide widespread access to both coverage and healthcare services. Going forward, we need to agree on the most important aspects of evidence-based, consumer-friendly affordability standards. Important criteria include: the standard should include all healthcare related expenses (premiums and cost-sharing), thresholds must slide with income and family size, must reflect an accurate assessment of families' financial liquidity and different incomes, and be harmonized across insurance programs (employer, Medicaid, CHIP, Medicare) and with respect to the provision of subsidies and creating hardship exemptions from insurance mandates.

Components of an Affordability Standard.

There are some basic, common-sense criteria that give direction to an affordability standard but stop short of being definitive.

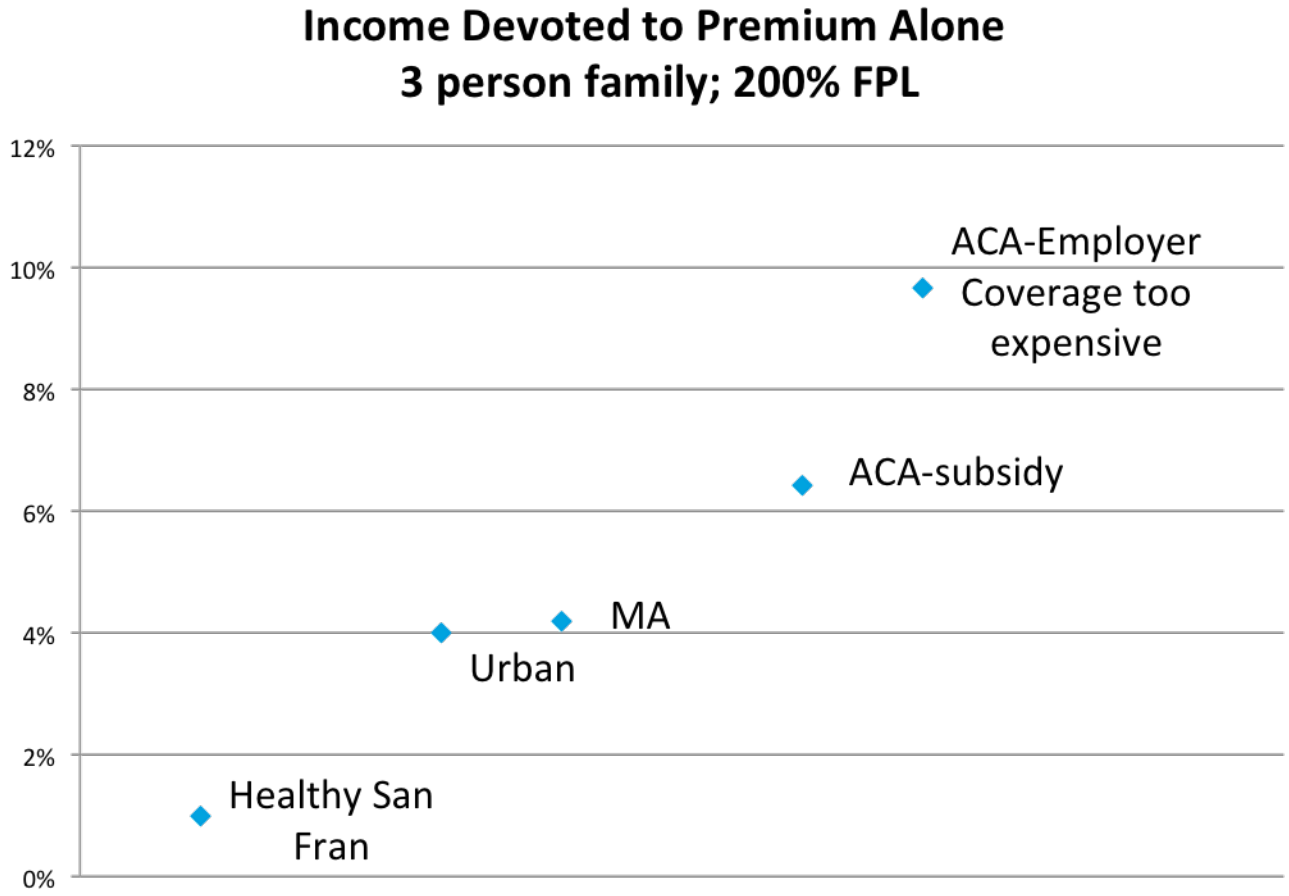
Goal: Remove financial barriers to care

The first step to establishing an affordability standard is to determine the goal towards which we strive. In the past, policymakers have often prioritized increasing enrollment. But standards limited to premium costs may successfully increase the rate of insured consumers without actually

New Hub Research Brief Looks Across Program Standards

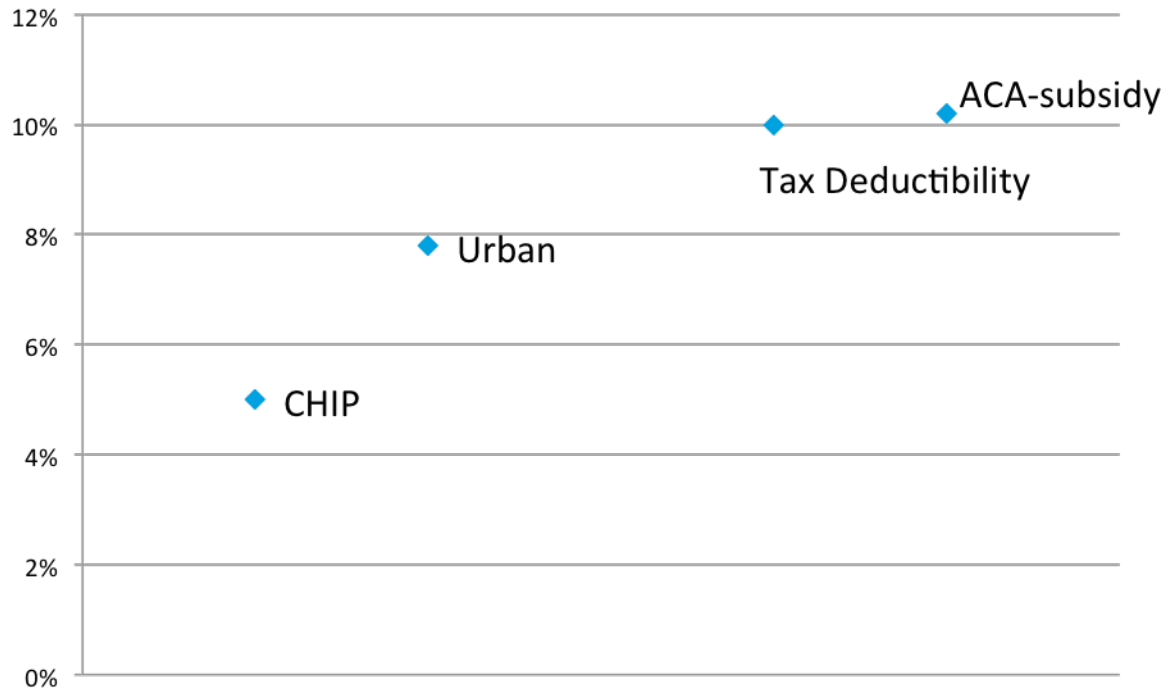
- **Tax Deductibility Threshold**
- **Medicaid**
- **CHIP**
- **Massachusetts (Romneycare)**
- **Healthy San Francisco**
- **ACA**
- **Urban estimates for a more generous thresholds**

Not currently harmonized across programs

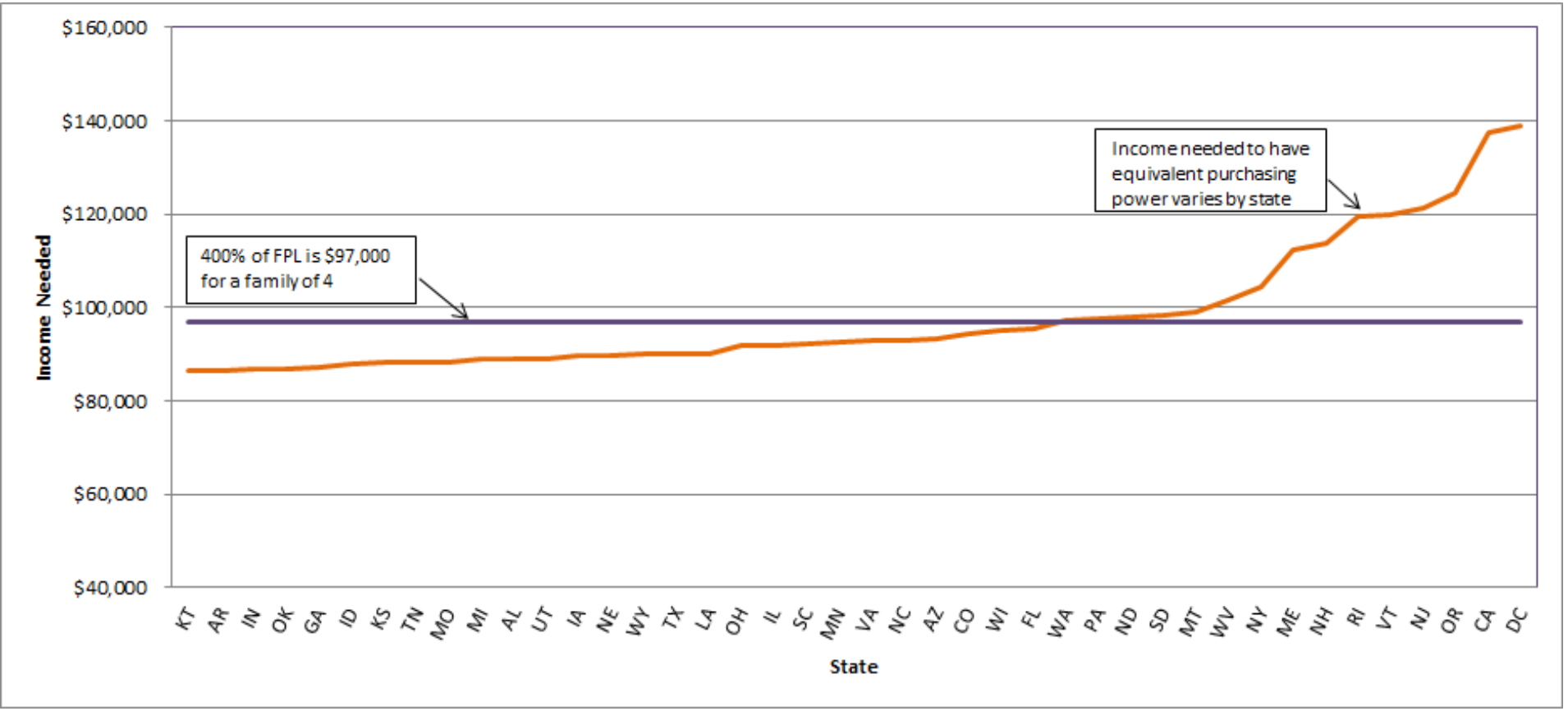


Not harmonized across programs

Income devoted to premium and cost-sharing
3 person family; 200% FPL



Replacement–Income Needed for Equivalent Purchasing Power Associated with 400% of FPL in 2015, by State



Source: Kaiser State Health Facts

Questions for the panelists?

Click the “raise hand” icon at the top of your screen

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Addressing the Unmet Needs of Complex Patients

Feb. 24, 2017
2:00pm E.T.

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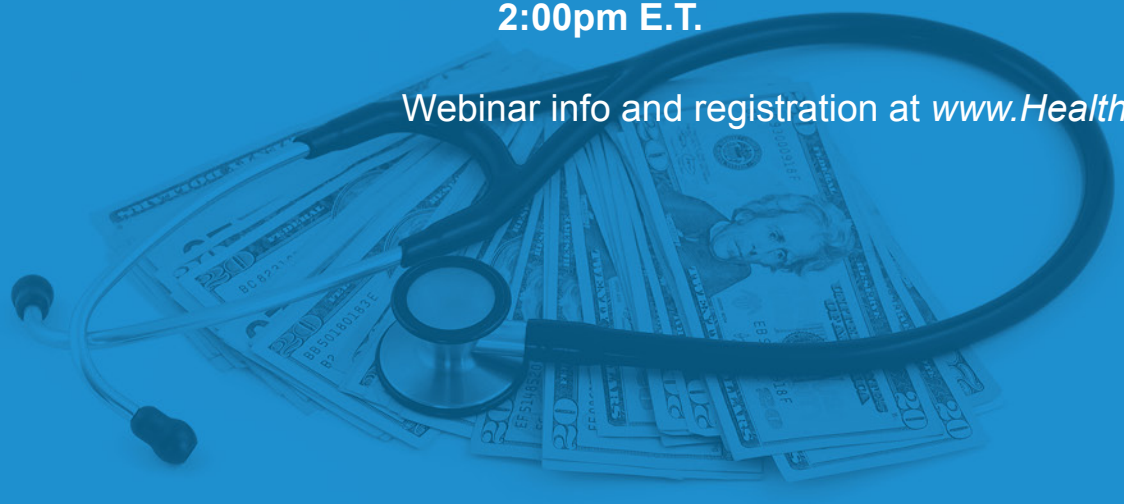

Thank you!

Robert Wood Johnson Foundation
Guest Speakers

Contact Lynn Quincy at lquincy@consumer.org
or any member of the Hub team with your follow-up questions.

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