2 | Coverage

Overview

America has a patchwork of policies and programs that broadly lead to people receiving insurance coverage through two mechanisms: Public programs (Medicaid, Medicare, Veterans Health Administration, TRICARE, Indian Health Service) or private coverage (employer-sponsored insurance plans or Affordable Care Act Marketplace plans) (See Fig 2.1). While the majority of Americans have health care coverage, the United States has one of the highest uninsurance rates among Organization for Economic Cooperation and Development (OECD)[1] countries. An estimated 10.4% of Americans remain uninsured.

A central principle of insurance coverage financing is that the generosity of offered benefits is always a tradeoff with costs paid either by the person or by taxpayers. The cost of coverage for an individual

[1]An intergovernmental economic organization with 37 member countries that, among other things, produces reports and data sets assessing various policy issues across the world. Learn more at http://www.oecd.org/about/how-we-work/.

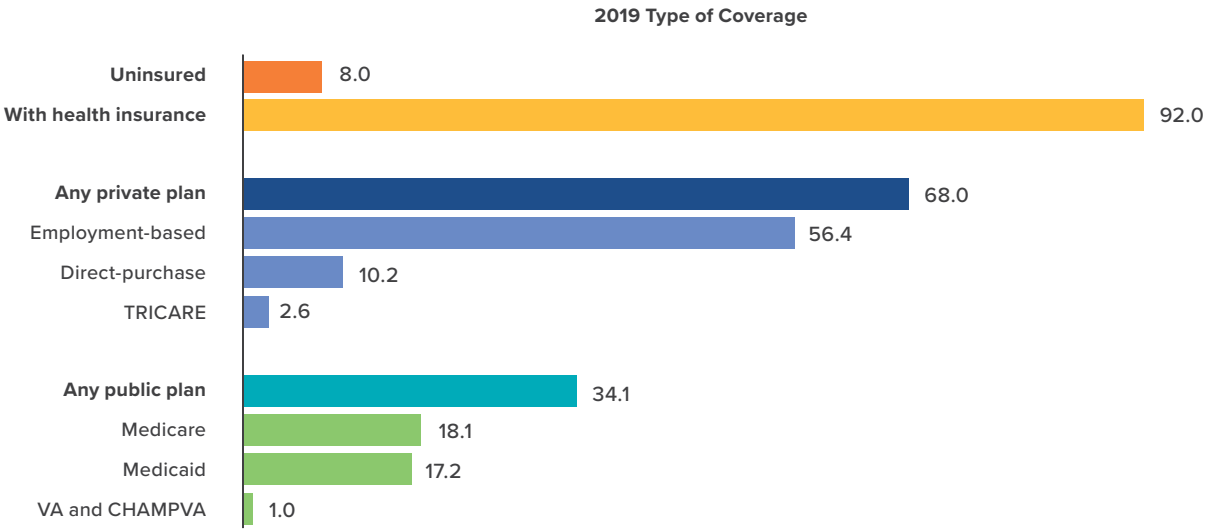
in the U.S. is mainly offset by the government through direct public arrangements or public subsidies (tax preferences for employers that provide coverage and premium subsidies for marketplace coverage). That said, individuals also bear financial responsibility to varying degrees, depending on the program. Therefore, even consumers with insurance are often underinsured, or have difficulty affording all of their health care costs, placing them at significant financial risk if they experience a serious illness.[2] Estimates find that half of those with employer-sponsored insurance (ESI) skipped or delayed care due to costs and the rate of underinsured Americans is only growing. These increases in the uninsured and underinsured populations, coupled with the impacts of COVID-19 on employment rates, have renewed public attention on, and policy interest in, addressing health care coverage and affordability issues.

Health Care Coverage Defined

Health care coverage is best understood in terms of payment for health care services. The cost of health care services can be expensive. The vast majority of Americans have some form of assistance in paying for health care services through a primary payer (the government directly or an insurer paid through an employer). Covered individuals typically have financial responsibility that includes monthly premiums, deductibles, co-pays, and coinsurance. The health care services available (benefits) and the financial obligations required of the individual receiving assistance from the payer capture the broader concept of health care coverage. Americans who do not have insurance coverage are generally described as being uninsured.

Fig. 2.1: Percentage of People by Type of Health Insurance Coverage (2019)

(Population as of March 2020)



Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year. Federal Employee Health Benefits (FEHB) is included in Direct-Purchase.

Source: "Health Insurance Coverage in the United States: 2019." Keisler-Starkey, K., Bunch, L. U.S. Census Bureau. September 15, 2020. Available at http://allh.us/cavT.

[2]Note that there is no generally agreed-upon standard for what designates underinsurance.

Types of Direct Government Coverage

Medicaid is the most extensive government coverage program in America, covering more than 75 million people. The program is a federal-state partnership providing benefits to children, pregnant women, elderly adults, and people with disabilities. The Affordable Care Act (ACA) intended to transition Medicaid from a program based on categorical eligibility to a program that covered low-income individuals generally. Initially, the law required the states to expand coverage to low-income adults in exchange for a higher level contribution from the federal government. But in National Federation of Independent Business v. Sebelius (2012), the Supreme Court ruled that states could not be required to expand their Medicaid programs under the ACA. Consequently, covering low-income adults remains an option which states may embrace or forgo as they choose.

Each state and territory administers its own Medicaid program. Still, the benefit structure, individuals covered, and financial responsibility requirements are primarily determined by the federal government through statutory provisions. This includes a statutory floor of requirements often referred to as "mandatory benefits." States have flexibility working in conjunction with the federal government to tailor their Medicaid programs for the state's particular needs. Thus, there is significant variability across each program. States are given the option to offer additional benefits and make benefits available to additional populations. States do so by applying to the Centers for Medicare and Medicaid Services and seeking formal approval for changes to their Medicaid program. Although federal Medicaid funding is considered mandatory and mostly open-ended entitlement spending, it is still subject to the annual budget and appropriations process – i.e., appropriated entitlement.

The Children's Health Insurance Program (CHIP) provides health care coverage to 9.6 million children in families with an income level too great for Medicaid eligibility. Benefits generally mirror those benefits provided through the Medicaid program. States have flexibility in determining the income range of children covered through CHIP. As is the case with Medicaid, CHIP is jointly funded by the federal government and the states. The federal portion of CHIP funding is mandatory spending and is usually appropriated several years at a time. Currently, the program is funded through Fiscal Year (FY) 2027.

Medicare is another extensive government coverage program with more than 60 million Americans. The program provides acute care coverage for seniors and

A central principle of insurance coverage financing is that the generosity of offered benefits is always a tradeoff with costs paid either by the person or by the taxpayers.

GLOSSARY OF TERMS

Premiums: Monthly amount individuals pay to health plans for a benefit period (usually one year). Total premiums are typically shared between individuals and their employers or government purchasers. Note, plans with the lowest premiums are not necessarily the best match for an individual as premiums, deductibles, and out-of-pocket costs are closely related. If one is lower, the others are typically higher.

Cost Sharing (Out-of-Pocket Costs): Expenses an individual will have to pay in a plan year that an insurer does not reimburse. Typically includes deductibles, coinsurance, and copayments for in-network, covered services. Most plans have an out-of-pocket maximum (the most you have to pay in a year). Premiums, payments for out-of-network costs, and non-covered services generally do not count towards that limit.

Deductibles: Fixed dollar amount during a benefit period that an individual must reach before an insurer starts to pay for health care costs. This amount is on top of monthly premiums, as those monthly payments don't typically count towards a deductible.

Coinsurance / Copayments: Type of cost-sharing that an individual pays after meeting their deductible. Copayments are a fixed amount like $20 or $45. Coinsurance is a percentage (usually 10/90, 20/80, or 30/70) where an individual pays 20% of a charge, and their insurer pays the rest (80%). See this helpful visual of how deductibles, coinsurance, and out-of-pocket costs are interrelated.

Network: The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services. These are considered in-network by your insurer. Out-of-network entities are facilities, providers, or suppliers that have not formally contracted with your insurer or plan. These providers are typically more expensive than in-network providers.

specific categories of Americans under 65 – people with disabilities, end-stage renal disease (ESRD), and amyotrophic lateral sclerosis (ALS). Roughly two-thirds of beneficiaries receive their coverage through Medicare's traditional fee-for-service program, which consists of three parts: Part A (inpatient hospital care, skilled nursing facility care, home health care, and hospice care), Part B (physician and other ancillary services in an outpatient setting), and Part D (coverage of prescription drugs). The other third of beneficiaries receive coverage through private insurance plans created through the Medicare Advantage program (Part C).

While Medicare does cover a broad range of services, it is important to note that dental, vision, hearing aids, and long-term services and supports are not covered. The program is funded through general revenue and a dedicated payroll tax going into a trust fund, and for Parts B and D, beneficiary premiums. As described in Chapter 1 of this Handbook, the Medicare Trust Fund's ability to cover the program's promised benefits is projected to fall short in three to five years, likely creating significant pressure in budget negotiations in 2021 and beyond.

Other federal government coverage programs provide coverage of services for specific populations. The **Veterans Health Administration** (VHA) provides coverage for 9 million veterans. The **TRICARE system** provides coverage for over 9.5 million military personnel and their families. The **Indian Health Service** (IHS) provides coverage for 2.7 million American Indians and Alaska Natives in 574 federally recognized sovereign nations. The benefits provided and payment requirements for individuals covered under each of these programs are determined by federal statute.

Federal employees are eligible to receive coverage through the **Federal Employee Health Benefits** program (FEHB). Covering 9 million people, this program is the largest employer-sponsored plan in the world. FEHB is run by the Office of Personnel Management and makes a number of private insurance coverage options available to federal employees. The benefits provided and payment requirements for individuals covered under FEHB are determined by federal statute.

Every state government and many local governments have coverage arrangements for their collective 7.4 million employees. The benefits provided and payment requirements for individuals covered under those plans are determined by the state and local governments, consistent with applicable federal statutes.

Government-Subsidized Private Coverage

Individuals may also receive coverage through the Affordable Care Act's Marketplace for private insurance plans. Individuals eligible for coverage through Marketplace plans may also qualify for federal subsidies to lower premiums and out-of-pocket costs. The benefits provided and payment requirements for individuals covered through the Marketplace are determined by federal statute. The plans available to individuals are generally similar, but the specific cost of coverage can vary down to the county level. Despite reaching far fewer individuals than other key public programs, Marketplace coverage – its affordability and availability – has been, and will continue to be, a central focus for regulators and Congress over the next two years.

Employer-Based Coverage

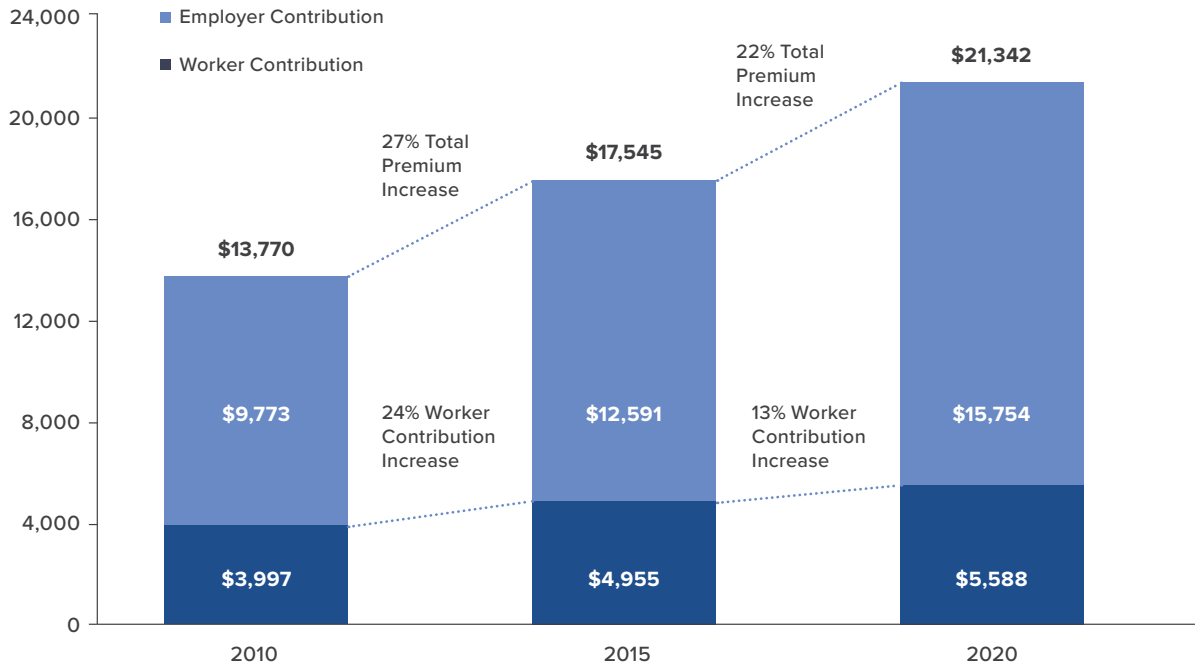
One hundred fifty-eight million Americans in the workplace receive coverage through private insurance plans offered by their employer or union. Starting with the 1942 Stabilization Act, employer-based coverage evolved into the dominant form of health insurance for individuals in the workplace due to employers' tax incentive and the need to attract workers through robust benefits packages. These tax incentives are advantageous to both employers and employees. Employees are not subject to federal income and payroll taxes for the premiums paid by their employer, and employers do not pay Social Security taxes on the premiums paid for health care coverage for their employees. More than 90% of large employers (500 or more employees) make health care coverage available to their employees. Among smaller employers (less than 50 employees), barely half (52%) make health care coverage available to their employees.

The benefits provided through employer-based coverage are generally governed by the federal **Employee Retirement Income Security Act** (ERISA). The statute creates a general structure for employer-based coverage and exempts many employer plans from additional state regulation. As a result, many state-led changes and individual market changes do not affect ERISA plans.

KEY COVERAGE ISSUES FOR THE 117TH CONGRESS

- Despite new protections to mitigate "surprise billing," as well as short-term coverage affordability policies in the American Rescue Plan Act, ongoing discussions about **addressing higher out-of-pocket costs** more generally in the form of premiums, co-pays, and deductibles are likely to intensify, especially for moderate-income individuals.
- During COVID-19, Congress and the administration took steps to **make telemedicine more accessible**. Providers and patient advocates will push for those changes to be retained indefinitely.
- Potential movement on the perennial issue of **enforcing mental health coverage parity.**
- Continued discussions about **reducing the overall uninsurance rate and achieving universal coverage.**

Fig 2.2 Average Annual Worker and Employer Premium Contributions for Family Coverage



Source: "2020 Employer Health Benefits Survey." KFF. October 8, 2020. Available at http://allh.us/vHwC.

The Uninsured

The vast majority of Americans (90%) do have some form of health care coverage. However, 29 million Americans are still without coverage. Most uninsured Americans are in families with at least one full-time worker. Half of the uninsured are in families with incomes below 200% of the Federal Poverty Level. Eighty-six percent of the uninsured are nonelderly adults. The uninsured are disproportionately people of color.

Affordability remains a prime driver of the number of uninsured in America. While employed workers may be provided access to health care coverage, they may not be able to afford their share of the premiums. Medicaid eligibility for low-income individuals can vary by state, and in states where coverage through Medicaid is not available, low-income adults are more likely to be uninsured. More than two million Americans fall into a coverage gap affecting those with incomes higher than state Medicaid eligibility yet lower than the benchmark income necessary to qualify for Marketplace premium tax credits.

The Rising Cost of Coverage and Underinsurance

The cost of health care coverage remains an ongoing challenge for many Americans. In 2020, the average premium for an individual or family in an employer-based plan was $7,470 and $21,342, respectively. Premiums continue to increase faster than wages or inflation. Over the last five years, the average premium for family coverage has increased by 22%. Over the last ten years, it has increased by 55% (See Fig. 2.2).

Many Americans with health care coverage nevertheless struggle with the problem of underinsurance and growing financial requirements. Underinsurance is typically defined as when an individual has difficulty affording all of their health care costs. The average deductible for individual coverage has increased by 79% over the last decade. The increasing financial

requirements can impose a significant burden, especially for Americans with lower incomes, driving some to delay needed care because of the concern over out-of-pocket costs. Others who do utilize services can face escalating debt as a result.

Shared Responsibilities and Trade-Offs

It is a central tenet of health care coverage in America that the federal government largely offsets the cost of coverage for an individual. In direct government coverage arrangements, the federal government pays for a significant portion of the individual's health insurance. In employer-based coverage arrangements, the employer's share of the coverage is offset by a federal tax deduction and an employee benefits from tax exclusion. Directly or indirectly, the federal government is paying for almost a third of all health care spending.

That said, individuals also bear financial responsibility to varying degrees, depending on the program. In Medicaid, which is targeted to low-income individuals, financial requirements are nominal. In Medicare, individuals pay up to 20% of the cost of covered Part B benefits. Individuals can purchase supplemental Medigap coverage to insure against additional expenses, but do so out of their own pockets. Low-income Medicare recipients pay significantly less for their own care with subsidies provided by the Medicaid program. (See Chapter 6 of this Handbook for more information on this population.) The ACA Marketplace plans have subsidy structures designed around an individual being responsible for an estimated 30% of their cost of care.

Employer-based coverage has fewer restrictions on financial participation requirements. If an employer provides a uniform set of financial participation requirements for all employees, lower-income employees will be more financially challenged to fund their share of the coverage.

The design of the benefits provided and financial participation requirements in any coverage arrangement requires making trade-offs between coverage generosity and costs paid either by the person or by taxpayers. Many insurance programs also use benefit design approaches like limited provider networks, limitations on services, and utilization review. These tools can be used to reduce prices, control utilization, or both, therefore keeping costs in check without requiring beneficiaries to pay more. But aggressive use of those benefit design tools can only go so far before there is consumer backlash. The Patients' Bill of Rights debates of the early 2000s were in response to benefit limitations. Eventually, coverage arrangements return to the question of how much covered individuals should be expected to contribute financially. The more an individual is required to pay, the greater the likelihood that the individual will face the problem of underinsurance. In turn the conflict between health care costs and other living expenses becomes more acute. The costs to an individual can be lowered considerably by greater financial participation from the government. That, of course, requires additional taxpayer resources.

> Many Americans with health care coverage nevertheless struggle with the problem of underinsurance.

The effort to find an acceptable balance between government subsidization of health care costs and individuals' financial requirements in paying for health care costs eventually drives the policy conversation to consider health care costs (See Chapter 1 of this Handbook for more information on health care costs and spending). The interconnected nature of coverage and costs necessitates they both be considered simultaneously in policy conversations.

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RESOURCES

Chapter 2: Coverage

Listed by the order in which they appear in Chapter 2.

OVERVIEW

Key Facts about the Uninsured Population. http://allh.us/6aHu

Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance. http://allh.us/erJR

Underinsured Rate Rose From 2014-2018, With Greatest Growth Among People in Employer Health Plans. http://allh.us/7Vbe

TYPES OF DIRECT GOVERNMENT COVERAGE

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(Everycrsreport.com) Medicare Primer: http://allh.us/ACTU

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Congressional Research Service: Defense Primer – Military Health System. http://allh.us/bdTX

TRICARE Facts and Figures: http://allh.us/BrTA

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Federal Employees Health Benefits (FEHB) Facts. http://allh.us/h9vU

State Employee Health Benefits, Insurance and Costs. http://allh.us/AeFB

GOVERNMENT-SUBSIDIZED PRIVATE COVERAGE

Overview of Health Insurance Exchanges. http://allh.us/ymbr

EMPLOYER-BASED COVERAGE

Health Insurance Coverage of the Total Population. http://allh.us/ymbr

The Employer-Health Insurance Connection an 'Accident of History'. http://allh.us/Xdw8

Employee Benefits in The United States – March 2020. http://allh.us/jrqv

Summary of the Employee Retirement Income Security Act (ERISA). http://allh.us/BjEM

THE UNINSURED

Health Insurance Coverage of the Total Population. http://allh.us/ymbr

Who Are the Remaining Uninsured, and Why Do They Lack Coverage? http://allh.us/kuyV

THE RISING COST OF COVERAGE AND UNDERINSURANCE

Average Family Premiums Rose 4% to $21,342 in 2020, Benchmark KFF Employer Health Benefit Survey Finds. http://allh.us/QpGC

SHARED RESPONSIBILITIES AND TRADE-OFFS

National Health Expenditures 2019 Highlights. http://allh.us/N9bM

Benefit Designs: How They Work. http://allh.us/cb8J

Box: Glossary of Terms

(HealthCare.gov) Premium. http://allh.us/qTkp

(HealthCare.gov) Out-of-Pocket Costs. http://allh.us/afKG

(HealthCare.gov) Deductible. http://allh.us/afKG

(HealthCare.gov) Coinsurance. http://allh.us/my7q

(HealthCare.gov) Copayment. http://allh.us/vgW3

Coinsurance and Medical Claims. http://allh.us/wpn7

(HealthCare.gov) Network. http://allh.us/M7Nj

Glossary of Health Coverage and Medical Terms. http://allh.us/j9Wc

Box: Key Coverage Issues for the 117th Congress

Unpacking the No Surprises Act: An Opportunity to Protect Millions. http://allh.us/crPF

How the American Rescue Plan Will Improve Affordability of Private Health Coverage. http://allh.us/aqJQ

Road to Universal Coverage: Addressing the Premium Affordability Gap. http://allh.us/FpEa

Telehealth: Delivering Care Safely During COVID-19. http://allh.us/E9jW

Beyond COVID-19: 4 Other Key Health Issues Congress Recently Addressed. http://allh.us/vpr8

Mental Health Parity in the US: Have We Made Any Real Progress? http://allh.us/q6RF

Examining the Continuum of Coverage Proposals. http://allh.us/XFQr