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Premium and Cost-Sharing Subsidies under Health Reform: Implications for Coverage, Costs, and Affordability

Timely Analysis of Immediate Health Policy Issues
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Summary

A major task in the effort to craft a final health reform bill that can be passed in both Houses of Congress is to balance government costs against making health insurance affordable for low- and middle-income families. The levels of premium and cost-sharing subsidies greatly determine how affordable insurance coverage and access to medical care would be for families under reform. Affordability in turn would affect compliance with the individual mandate. Without broad compliance, it would be difficult to maintain the proposed insurance reforms that depend on broad risk pools.

Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we estimate the household financial burdens under the America's Healthy Future Act of 2009 (AHFA) proposed by the Senate Finance Committee (including revisions as of October 2, 2009) and under two modifications of the AHFA that use alternative subsidy schedules: those specified in the Patient Protection and Affordable Care Act (PPACA) introduced by the Senate Leadership on November 18, 2009, and those specified in H.R. 3962, passed by the House of Representatives on November 8, 2009. To be specific, we only look at the effects of changing the premium and cost-sharing subsidies that were included in the Senate Finance Committee (SFC) bill, holding all other features of the SFC bill constant. We focus largely on those who would purchase health insurance coverage directly through a new health insurance exchange (the exchange). The vast majority of the subsidies would be spent on these enrollees.

For ease of comparison, these simulations were modeled as if the reforms were fully implemented in 2009, and estimates are for that single year. We find that the number of uninsured would drop from 49 million to about 19 million people under the SFC bill and that the uninsured would decrease by less than half a million more under subsidies of the Senate Leadership bill and by about another 2 million with the subsidies specified in the House bill. Government subsidy costs in 2009 under the SFC bill are estimated at approximately $24 billion. Corresponding costs using the subsidies of the Senate Leadership bill would be $27 billion and costs using subsidies of the House Bill would be approximately $39 billion.

Among those with insurance under reform, people who would obtain nongroup coverage in the exchange would generally face the highest health care cost burdens, so we focus the affordability analysis on them even though they would be a relatively small share of the nonelderly population, about 7 percent. Those eligible for Medicaid or CHIP under reform would face little or no out-of-pocket health care costs after reform if they enroll in those programs. People getting coverage through employers would generally face lower financial burdens than those enrolling in nongroup coverage, even in the exchange, as employers that offer coverage typically contribute significantly to the cost of premiums for their employees.

Family health care costs (premiums plus out-of-pocket spending net of subsidies) for those buying nongroup coverage through the exchange would vary considerably by income and across the reform options. This is because the federal financial assistance provided through subsidies decreases as income increases, and the different reform approaches modeled would provide different levels of subsidization at each income level. Under the SFC bill, the median low-income family (with an income of 133 to 199 percent of the federal poverty level [FPL]) would spend 7 percent of its income on health care, while the median family with somewhat higher income (200 to 299 percent of the FPL) would spend 11 percent of its income. Those at the 90th percentile of the spending distribution, families with greater health care needs and older adults, would face higher burdens due to additional out-of-pocket costs and the effects of 4:1 age rating bands. While premiums generally account for most of household health care costs, the burden of out-of-pocket cost-sharing for those with the highest expenses can reach above 10 percent of income under the SFC bill.

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Compared to SFC bill subsidies, premium subsidies under the Senate Leadership bill are lower for low-income families and higher for eligible higher-income families. At both the median and the 90th percentile of spending, the Senate Leadership bill subsidies would decrease family health care cost burdens by about 1 percent of income for those between 200 to 399 percent of the FPL compared with the SFC bill. Substituting the premium and out-of-pocket subsidy schedules from the House bill, which are both larger than those of the SFC bill, would do more for lower-income families—decreasing median family health care cost burdens by about 2 percent of income for those between 133 and 299 percent of the FPL. Under the House bill subsidies, much larger reductions in financing burden would occur among higher spenders due to the additional cost-sharing subsidies that would be provided. A further targeted increase in cost-sharing subsidies beyond those in the House bill can significantly decrease the burdens faced by the highest health care spenders below 400 percent of the FPL while expanding coverage, at an additional cost of about $4 billion to the government.

Each option presented here would greatly reduce the number of uninsured and make health insurance more affordable for millions of Americans. This analysis shows that health care cost burdens under the Senate Finance Committee bill can be substantial for those with incomes from 200 to 499 percent of the FPL, particularly for those with significant health care needs. Expansions of premium and cost-sharing subsidies could be designed such that the largest burdens are substantially reduced for these groups, and doing so would increase overall coverage as well as government costs. Public support for the reforms will be related to the extent to which coverage and the direct costs of care are considered affordable, making it critical to balance such concerns with the government costs associated with comprehensive health care reform.

Introduction

With the approval of America's Healthy Future Act of 2009 (AHFA) by the Senate Finance Committee, the introduction of the Patient Protection and Affordable Care Act (PPACA) by the Senate Leadership, and the passage of the Affordable Health Care for America Act (H.R. 3962) in the House, final decisions on the key provisions of health reform legislation are under way.[1] A major task in the effort to craft a final health reform bill that can be passed by both Houses of Congress is to balance the budgetary cost to government against making health insurance affordable for low- and middle-income families. Coverage expansions under the AHFA proposal would be less costly to the federal government than under PPACA or H.R. 3962. In part, this is because AHFA has generally lower subsidies to assist families with purchasing health insurance coverage in the new health insurance exchange, as well as lower cost-sharing subsidies that reduce what those families would pay out-of-pocket when they use medical care. The levels of premium and cost-sharing subsidies remain key issues of debate and greatly determine how affordable insurance coverage will be for families under reform.

In this brief, we estimate the tradeoffs between government costs and household affordability for families of different income levels.[2] We examine the effects of AHFA as the base case, and then show what would happen under two variations. The first variation replaces the premium subsidies of AHFA with those specified in PPACA introduced in the Senate on November 18, 2009. The second variation expands both premium and cost-sharing subsidies to those specified under H.R. 3962.[3] Age rating rules, Medicaid eligibility, eligibility rules for purchasing exchange coverage, and other components of reform are held constant and set to be consistent with the AHFA. In each policy simulation, we estimate the effects of the policies on coverage, costs, and family financial burdens for health care (premium and out-of-pocket spending relative to income).

We focus the affordability analysis on people taking nongroup coverage in the proposed health insurance exchange, a new structured market for the purchase of health insurance. Even though this group would constitute a relatively small share of the population—about 7 percent of the nonelderly population—they would face the highest health care cost burdens among those with insurance under reform. Those eligible for Medicaid or CHIP under reform would face little or no out-of-pocket health care costs after reform if they enroll. People getting coverage through employers would generally face lower financial burdens than those taking nongroup coverage because employers typically pay the majority of premium costs. We conclude the analysis by presenting simulated health care burdens in the nongroup exchange under a variation (of our own design) that adds targeted subsidies to those specified in H.R. 3962 to decrease the highest health care cost burdens in the exchange with a relatively small increase in government costs.

Methods

To estimate the effects of the reform options, we use the Urban Institute's Health Insurance Policy Simulation

Actuarial Value

Actuarial value reflects the share of average covered benefits paid by the insurer, where the remaining amount is the responsibility of the enrollee. Using a nationally representative nonelderly population, examples of single coverage plans with different actuarial values are as follows:

70 percent actuarial value

- $1,500 deductible, 15% coinsurance, $5,000 out-of-pocket limit
- $1,250 deductible, 20% coinsurance, $5,000 out-of-pocket limit

85 percent actuarial value

- $250 deductible, 15% coinsurance, $2,200 out-of-pocket limit
- $275 deductible, 10% coinsurance, $5,000 out-of-pocket limit.

For more information and examples, see Karen Pollitz, "Using Actuarial Value to Define Cost Sharing Subsidies," Report submitted to the American Cancer Society Cancer Action Network, September 2009.

Model (HIPSM).[4] HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private costs, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specified reforms.[5]

We first model the comprehensive reforms specified in the AHFA, including revisions as of October 2, 2009. The model captures the basic elements of the AHFA related to the coverage choices of nonelderly Americans, with some simplifications. These elements include the following:

- Medicaid expansion to 133 percent of the federal poverty level (FPL) for all adults, with CHIP remaining in place for children at current levels.
- An individual mandate with a penalty for remaining uninsured, with exemption from the penalty if a family's out-of-pocket premium exceeds 8 percent of income.
- A new health insurance exchange ("the exchange") offering plans constructed to meet actuarial value standards of 70, 80, and 90 percent. Higher actuarial values reflect more comprehensive insurance coverage for a given set of covered services (see box above).[6] The base plan offered through the exchange is the "silver" benefit package which has an actuarial value of 70 percent. Exchange plans are guaranteed issue, and premiums are age rated with 4:1 age bands, meaning the oldest purchasers can be charged premiums up to four times as high as the youngest adult purchasers.[7] Exchange based insurance coverage is available to individuals and families purchasing nongroup coverage independent of an employer and to employer groups with 100 or fewer employees.
- Refundable premium tax credits ("premium subsidies") available to eligible families purchasing insurance through the exchange. The premium subsidies are provided on a sliding scale basis. These subsidies limit the maximum percentage of income that a family would have to spend on its health insurance premium to 2 percent of income for those at 100 percent of the FPL, phasing up to 12 percent of income for those with incomes between 300 and 400 percent of the FPL (see first column of Table 1).[8]
- Employees of large firms that offer coverage would be ineligible for subsidized coverage in the exchange unless the employee's share of the employer coverage premium exceeds 10 percent of income.
- Cost-sharing subsidies available to eligible families purchasing insurance through the exchange. Cost-sharing subsidies would decrease household out-of-pocket medical costs by effectively increasing the actuarial value of a plan from 70 percent in the base exchange plans to 90 percent for those with incomes between 100 percent and 133 percent of the FPL and to 80 percent for those with incomes up to 200 percent of the FPL (see first column of Table 2).
- A small group tax credit for firms with 25 or fewer employees that offer health insurance. The tax credit covers up to 50 percent of the employer's share of the premium for the lowest wage employees in the smallest firms, and phases out for higher-wage employees and larger firms.
- Assessments ("free-rider penalties") on firms with 50 or more employees that do not offer health insurance, for employees receiving premium subsidies through the exchange.[9]

- Auto-enrollment of large firm employees into employer coverage.[10]

In modeling the AHFA, for the purpose of computing exchange premiums, we assume that those enrolling in nongroup exchange coverage are pooled with those enrolling in the employer-sponsored coverage through the exchange. We expect many states will operate their exchange in this way, although under the AFHA states could choose to operate the small employer and nongroup exchanges independently. We also assume that under full implementation of reform, state Medicaid and CHIP eligibility is maintained.[11]

We do not model the policy shift in AHFA where, after the initial year, the AHFA's premium subsidies change to a schedule that defines the percentage of the *premium* that a family is required to pay, rather than a schedule that defines a percentage of *income* that a family is required to pay.[12] To the extent that health insurance premiums grow faster than income, a family receiving premium subsidies in the exchange would pay an increasing percent of income over time.[13] These simplifications, we believe, are not likely to substantially affect our overall findings.

Analysis of Reform

We simulate the effects of two variations on AHFA. The first variation uses the basic reform elements of AHFA but applies the premium subsidy schedules for the health insurance exchange that are specified in PPACA. The cost-sharing subsidy schedule specified in PPACA is unchanged from AHFA. These premium and cost-sharing schedules are shown in the second columns of Tables 1 and 2, respectively. The second variation uses the basic reform elements of AHFA but applies the premium and cost-sharing subsidy schedules for the health insurance exchange that are specified in H.R. 3962, as shown in the third columns of Tables 1 and 2, respectively. Out-of-pocket spending limits specified in PPACA and H.R. 3962 are also applied in each variation, respectively.[14] Finally, we show the results of a targeted increase in cost-sharing subsidies that addresses the high health care cost burdens for those with incomes between 200 and 399 percent of the FPL.

As shown in Table 1, the maximum percentage of income that a family would have to spend on premiums is higher under AHFA than under the H.R. 3962 schedule at every applicable income level. Lower-income families face a slightly higher premium cap under PPACA compared to under AHFA, while higher-income families have a lower cap under PPACA than under AHFA. For those with incomes of 133 percent of the FPL, a family would have its premium contribution capped at 3.7 percent of income under AHFA and at 4.0 percent under PPACA, more than twice as high as under H.R. 3962 with a 1.5 percent of income cap. For those between 300 and 400 percent of the FPL, the AHFA would cap premiums at 12 percent while the PPACA would cap premiums at 9.8 percent. H.R. 3962 would use a cap beginning at 10 percent of income at 300 percent of the FPL and increasing linearly to 12 percent at 400 percent of the FPL. The differences between AHFA and H.R. 3962 are particularly large in relative terms for the lowest income groups.

The alternative cost-sharing subsidy schedules are shown in Table 2. Under both AHFA and the PPACA, families with incomes between 100 and 150 percent of the FPL who buy coverage in the exchange would be subsidized for the purchase of an insurance plan with an actuarial value of 90 percent.

Table 1. Maximum Percentage of Income a Family Would Pay for Premiums in the Exchange for a Base Plan, by Income as a Percent of the FPL

	Premium Subsidies from America's Healthy Future Act (AHFA)[a]	Premium Subsidies from the Patient Protection and Affordable Care Act (PPACA)[b]	Premium Subsidies from H.R. 3962[c]
Income as a % of the FPL			
100% FPL	2.0%	2.0%	n.a.
133% FPL	3.7%	4.0%	1.5%
150% FPL	4.5%	4.6%	3.0%
200% FPL	7.0%	6.3%	5.5%
250% FPL	9.5%	8.1%	8.0%
300% FPL	12.0%	9.8%	10.0%
350% FPL	12.0%	9.8%	11.0%
400% FPL	12.0%	9.8%	12.0%

n.a. = not applicable, only eligible for Medicaid

Note: Under AHFA, this percentage is constant between 300% and 400% of FPL. Otherwise, the maximum percentage of premium paid increases linearly as income increases under both AHFA and H.R. 3962. "Family" refers to health insurance units, that is, family members who buy insurance coverage as a group, including single individuals.

[a] *Source:* Baucus, Max. America's Healthy Future Act of 2009, Chairman's Mark, Senate Finance Committee. Modified October 2, 2009. Http://www.finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf.

[b] *Source:* These are approximate values. The Patient Protection and Affordable Care Act (H.R. 3590) introduced November 18, 2009. Http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf.

[c] *Source:* Affordable Health Care for America Act (H.R. 3962) introduced October 29, 2009. Http://docs.house.gov/rules/health/111_ahcaa.pdf.

The federal government would pay the difference between the cost of a plan with a 90 percent actuarial value and the base plan which would have an actuarial value of 70 percent. Families with incomes between 150 and 200 percent of the FPL would be subsidized for the purchase of an insurance plan with an actuarial value of 80 percent. No cost-sharing subsidies would be provided to families with incomes exceeding 200 percent of the FPL. Cost-sharing subsidies in H.R. 3962 would raise actuarial values to higher levels than under AHFA or the PPACA for every applicable income group below 350 percent of the FPL. The fourth column of Table 2 shows an enhanced cost-sharing schedule that could be used to target high health care burdens for those between 200 and 400 percent of the FPL; results for this final schedule are presented at the end of the analysis.

Results

Health insurance coverage. Table 3 shows the distribution of health insurance coverage for the nonelderly population prior to reform (the baseline) and the distribution of health insurance coverage under each of the simulated reforms. The number of uninsured would fall from 49.1 million to 19.3 million people under AHFA. Medicaid/CHIP coverage would increase by 17.6 million people. An estimated 13.6 million people would obtain coverage in the employer exchange, and 17.4 million people would obtain coverage in the nongroup exchange.

Under the PPACA subsidies, the number of uninsured would decrease to 18.9 million and the number of enrollees in the nongroup exchange would be 18.1 million, an increase of 0.7 million compared to AHFA (Table 3). The higher premium and cost-sharing subsidies in H.R. 3962 compared with AHFA result in 17.3 million uninsured under H.R. 3962. The number of people obtaining nongroup coverage through the exchange would increase to 20.3 million with the H.R. 3962 subsidies in place. Higher subsidies make coverage more affordable, leading more subsidy-eligible people to prefer to buy coverage within the exchange rather than keep their current coverage or pay a penalty for being uninsured. Also, by increasing the premium subsidies, fewer people are exempted from the requirement to purchase coverage, since fewer face out-of-pocket premiums exceeding 8 percent of income.

Compared to the reduction in uninsured under AHFA, the number of uninsured is reduced by less than half a million people under the subsidies specified in PPACA and by nearly an additional 2 million people under H.R. 3962 subsidies. The additional reduction in the number of uninsured resulting from expanded subsidies is modest because we assume that many people would comply with the individual mandate even under AHFA, which limits the amount of additional impact on coverage

Table 2. Alternative Actuarial Values for the Base Plan in the Exchange for Those Eligible for Subsidies, by Income as a Percent of the FPL

	Actuarial Values from America's Healthy Future Act (AHFA)	Actuarial Values from the Patient Protection and Affordable Care Act (PPACA)	Actuarial Values from H.R. 3962	Actuarial Values for "Enhanced" Cost-Sharing Subsidies
Base Plan*	70%	70%	70%	70%
Income as a % of the FPL				
100% through 133% FPL	90%	90%	n.a.	n.a.
133% through 150% FPL	90%	90%	97%	97%
150% through 200% FPL	80%	80%	93%	93%
200% through 250% FPL	70%*	70%*	85%	85%
250% through 300% FPL	70%*	70%*	78%	85%
300% through 350% FPL	70%*	70%*	72%	85%
350% through 400% FPL	70%*	70%*	70%*	70%*

n.a. = not applicable, only eligible for Medicaid

Note: Cost-sharing subsidies would reduce individual and family cost-sharing such that the average actuarial value (percentage of covered benefits paid by the plan or the government) is equal to the percentage shown. The federal government would provide subsidies to pay for the difference between the actuarial value of 70% in the base exchange plans and the increased actuarial values shown in the table. For those enrolled in a base exchange plan and eligible for subsidies, the plan and the government would together cover the percentage shown of medical costs of a typical population enrolled in that plan. Enrollees would pay the remainder in out-of-pocket cost-sharing.

* Under each option, no plan offered in the exchange would have an actuarial value of less than the base plan. Those eligible for exchange enrollment, but not eligible for cost-sharing subsidies, can enroll in the base plan. Under AHFA, for example, those over 200% FPL who are eligible for enrollment in the exchange are not eligible for cost-sharing subsidies; they have the option of enrolling in the base plan with an actuarial value of 70%.

Table 3. Health Insurance Coverage Distribution of Non-elderly in Baseline and Reform Under AHFA and Alternative Reforms

	Baseline		America's Healthy Future Act (AHFA)		AHFA with Premium Subsidies and Cost-Sharing Subsidies from PPACA		AHFA with Premium Subsidies and Cost-Sharing Subsidies from H.R. 3962	
Coverage (in Millions)								
Employer (Excluding Exchange)	151.0	56.5%	138.8	52.0%	138.8	52.0%	135.4	50.7%
Nongroup (Excluding Exchange)	15.7	5.9%	9.1	3.4%	8.8	3.3%	8.7	3.2%
Exchange Employer	0.0	0.0%	13.6	5.1%	13.4	5.0%	15.9	6.0%
Exchange Nongroup	0.0	0.0%	17.4	6.5%	18.1	6.8%	20.3	7.6%
Medicaid/CHIP	42.9	16.1%	60.6	22.7%	60.6	22.7%	61.0	22.9%
Other (Including Medicare)	8.4	3.2%	8.4	3.2%	8.4	3.2%	8.4	3.2%
Uninsured	49.1	18.4%	19.3	7.2%	18.9	7.1%	17.3	6.5%
Change in Coverage								
Employer (Excluding Exchange)	—	—	-12.2	-4.6%*	-12.2	-4.6%	-15.6	-5.8%
Nongroup (Excluding Exchange)	—	—	-6.6	-2.5%	-6.9	-2.6%	-7.0	-2.6%
Exchange Employer	—	—	13.6	5.1%	13.4	5.0%	15.9	6.0%
Exchange Nongroup	—	—	17.4	6.5%	18.1	6.8%	20.3	7.6%
Medicaid/CHIP	—	—	17.6	6.6%	17.7	6.6%	18.1	6.8%
Other (Including Medicare)	—	—	0.0	0.0%	0.0	0.0%	0.0	0.0%
Uninsured	—	—	-29.8	-11.2%	-30.2	-11.3%	-31.8	-11.9%
Decline in uninsured		—		60.8%		61.4%		64.7%
Covered or eligible for public coverage		86.0%		95.4%		95.6%		96.1%

Source: Urban Institute analysis, HIPSM 2009.

Note: Reforms are modeled as if they were fully implemented in 2009, and estimates are for that single year.

* Percentage point difference in coverage rate compared to baseline.

that can be obtained from higher subsidies. Furthermore, the main effect of the higher subsidies is only on the subset of people who remain uninsured under the provisions of the AHFA, do not have offers of employer coverage, and are not eligible for Medicaid/CHIP. Of this subset of people, the effects of the additional subsidies are relatively large.

Aggregate Government, Employer, and Household Spending. Table 4 shows the costs to the government of the different components of reform as well as the costs associated with uncompensated care, the costs to employers, and household costs. Medicaid/CHIP spending would remain relatively constant across the three policy options. Total net new costs to the government (federal and state) of AHFA would be $78.0 billion if the reform were fully implemented in 2009. Government spending for premium subsidies for families would be $21.7 billion, while spending for cost-sharing subsidies would be $1.8 billion. Other net government costs (the cost of subsidies to small employers, less revenue from penalties paid by families who remain uninsured and less revenue from "free-rider penalties" paid by employers) would be $3.6 billion.

The amount spent on uncompensated care would fall by $32.3 billion (52.9 percent) under AHFA from $61.1 billion under current law, due to the large reduction in the number of uninsured under the AHFA. On net, employer spending for health care is held relatively constant under AHFA, decreasing by 1.5 percent. Increased employer spending due to more post-reform employer coverage (including employer-sponsored coverage within the exchange) is offset on net by employer premium subsidies. Spending by individuals and families for premiums and out-of-pocket health care costs would increase on net by $21.0 billion, or 6.7 percent.[15]

Compared to AHFA, the premium subsidy schedule of PPACA would increase government premium subsidies by an additional $3.3 billion,

Table 4. Health Care Spending of Government, Employers, Families and Uncompensated Care in Baseline and Reform Under AHFA and Alternative Reforms (in billions)

	Senate Finance Committee's America's Healthy Future Act (AHFA) of 2009	AHFA with Premium Subsidies and Cost-Sharing Subsidies from PPACA	Difference relative to AHFA	AHFA with Premium Subsidies and Cost-Sharing Subsidies from H.R. 3962	Difference relative to AHFA
Total Government Spending (Federal + State)					
Baseline	$246.8	$246.8	—	$246.8	—
Net Change Post Reform	$78.0	$81.7	$3.7	$95.0	$17.0
Medicaid/CHIP	$50.9	$51.2	$0.3	$52.2	$1.3
Premium Subsidies	$21.7	$25.0	$3.3	$31.9	$10.2
Cost-sharing Subsidies	$1.8	$1.8	$0.0	$7.0	$5.2
Other Net Government Costs*	$3.6	$3.7	$0.0	$3.9	$0.3
% Change Post Reform	31.6%	33.1%	1.5%	38.5%	6.9%
Uncompensated Care					
Baseline	$61.1	$61.1	—	$61.1	—
Net Change Post Reform	-$32.3	-$32.4	$0.0	-$33.7	-$1.4
% Change Post Reform	-52.9%	-52.9%	0.0%	-55.2%	-2.3%
Employer Spending					
Baseline	$412.6	$412.6	—	$412.6	—
Net Change Post Reform	-$6.2	-$6.6	-$0.4	-$9.9	-$3.7
% Change Post Reform	-1.5%	-1.6%	-0.1%	-2.4%	-0.9%
Individual and Family Spending					
Baseline	$315.0	$315.0	—	$315.0	—
Net Change Post Reform	$21.0	$19.2	-$1.8	$16.7	-$4.3
% Change Post Reform	6.7%	6.1%	-0.6%	5.3%	-1.4%
Aggregate Change	$60.5	$61.9	$1.5	$68.1	$7.7

Source: Urban Institute analysis, HIPSM 2009.

Note: Reforms are modeled as if they were fully implemented in 2009, and estimates are for that single year.

* Other net government costs include subsidies to employers, less revenues from individual mandate penalties and free-rider penalties.

with decreases in costs for employers, individuals, and families. H.R. 3962 premium and cost-sharing subsidy schedules would increase government premium subsidies by $10.2 billion and government cost-sharing subsidies by $5.2 billion relative to AHFA. The additional subsidies of H.R. 3962 would result in a net decrease in individual and family health care spending by $4.3 billion relative to the AHFA.[16]

Family health care spending, by income group. Table 5 shows the distribution of family health care costs, including both direct spending on premiums and out-of-pocket spending on medical care, for the nonelderly population that would obtain nongroup coverage in the exchange post-reform. These estimates are net of any subsidies for which the families would be eligible. In the results, "families" refers to health insurance units, that is, family members who can buy insurance coverage as a group, including single individuals.[17] We focus on those who would enroll in coverage through the nongroup exchange because, lacking employer premium contributions, they would typically face the highest out-of-pocket health care costs before subsidies, and are thus the group for whom subsidies matter the most.[18] Those obtaining coverage outside the exchange are not eligible for government-funded premium or out-of-pocket subsidies, so including them in the distributional tables would tend to obscure the differences across the subsidy schedules. The table reports the median and 90th percentile of spending, by income group. Those whose health spending is far above the median face higher premiums (being in the higher age-rating categories or having a large family), need high levels of medical care, or both.

Table 5. Total Family Health Care Costs by Income as a Percent of the FPL for Enrollees in the Nongroup Exchange

	America's Healthy Future Act (AHFA)	AHFA with Premium Subsidies and Cost-Sharing Subsidies from PPACA	Difference relative to AHFA	AHFA with Premium Subsidies and Cost-Sharing Subsidies from H.R. 3962	Difference relative to AHFA
Income as a % of the FPL					
133–199% FPL					
Median	$1,381	$1,338	-3.1%	$891	-35.5%
90th percentile	$3,446	$3,299	-4.3%	$2,044	-40.7%
200–299% FPL					
Median	$3,324	$3,004	-9.6%	$2,663	-19.9%
90th percentile	$7,417	$6,903	-6.9%	$6,048	-18.5%
300–399% FPL					
Median	$4,454	$4,441	-0.3%	$4,536	1.8%
90th percentile	$10,726	$9,705	-9.5%	$9,778	-8.8%
400–499% FPL					
Median	$5,387	$5,398	0.2%	$5,326	-1.1%
90th percentile	$11,585	$11,588	0.0%	$11,527	-0.5%
500% FPL or more					
Median	$7,182	$7,147	-0.5%	$7,179	0.0%
90th percentile	$16,465	$16,225	-1.5%	$16,303	-1.0%

Source: Urban Institute analysis, HIPSM 2009.

Note: Total family health care costs include premiums plus out-of-pocket health care spending, less subsidies. "Family" refers to health insurance units, that is, family members who buy insurance coverage as a group, including single individuals. Reforms are modeled as if they were fully implemented in 2009, and estimates are for that single year.

Under AHFA, median family health care costs for the 133 to 199 percent of the FPL income group would be $1,381. For both the median and the 90th percentile, costs for these families are slightly lower under PPACA compared with AHFA. The reason is that the slightly lower premium subsidies specified in PPACA relative to AHFA for this group are offset by small decreases in the average medical expenditures of enrollees in the exchange—resulting, on net, in slightly lower costs under PPACA. In contrast, the premium and cost-sharing subsidies under H.R. 3962 would reduce median costs substantially for these lower-income families to $891, a decrease of more than a third compared with AHFA. Similarly, costs at the 90th percentile would fall from $3,446 under AHFA to $2,044, a decrease of over 40 percent.

For those with incomes from 200 to 299 percent of the FPL, under AHFA, median household health care spending would be $3,324 and spending at the 90th percentile would be $7,417. Under the larger premium subsidies of PPACA for these families, spending at the median and 90th percentile would decrease by 9.6 and 6.9 percent, respectively. With the H.R. 3962 premium and cost-sharing subsidies, median spending would fall to $2,663, a decrease of 20 percent. A similar percentage decrease relative to AHFA is observable at the 90th percentile and would decrease spending at this level to $6,048 under H.R. 3962 subsidies.

Increasing the premium and/or cost-sharing subsidy schedules would have modest effects on median costs for those with income between 300 and 399 percent of the FPL. Costs at the median show only a slight increase under H.R. 3962 due to changes in the composition of people buying coverage in the exchange. Relative to AHFA, costs at the 90th percentile would fall by 9.5 percent under the larger premium subsides of PPACA and 8.8 percent with the premium and cost-sharing subsidies in H.R. 3962. Due to small changes in the composition of people within the exchange, there are very small differences in health care spending across the policy options for the two highest income groups even though they are not directly affected by the premiums subsidies.

Family financial burdens. Tables 6 and 7 show the financial burdens of health care costs for those in the nongroup exchange. We measure financial burdens as the share of income that families spend, net of subsidies, on health insurance premiums, out-of-pocket cost sharing, and total health care costs.

Median financial burdens, by income group. Table 6 shows median burdens by income group and Table 7 shows 90th percentile burdens by income group. The first panel of each table shows the financial burdens of premiums, the second panel shows the financial burdens of cost sharing, and the third panel shows the total financial burden of the two cost components combined.

For the lowest income group (133 to 199 percent of the FPL) enrolled in the nongroup exchange, the median premium burden under the AHFA would be 5.4 percent of income. While this burden is similar under PPACA subsidies (the slight reduction is due to changes in the composition of people in the exchange), the H.R. 3962 subsidies would reduce the burden for these families to 3.9 percent. The median premium burden for families with incomes from 200 to 299 percent of the FPL would be 8.7 percent under AHFA, and would be reduced to 7.8 percent with the larger premium subsidies in PPACA and 7.7 percent with the subsidies in H.R. 3962. Median financial burdens of premiums are highest for those with incomes from 300 to 399 percent of the FPL at 9.5 percent of income under AHFA.[19] For this income group, the median premium burden would not be reduced under the premium caps of AHFA, PPACA, or H.R. 3962, since the unsubsidized median premium burden is already lower than the caps specified in those proposals. In fact, relative to the AHFA, burdens would increase slightly to 9.7 percent of income with the larger PPACA premium subsidies and 9.9 percent with H.R. 3962 subsidies because of changes in the composition of people buying in the exchange. The premium burden for those with incomes between 300 and 399 percent of the FPL would be higher than that of the two higher-income groups because larger incomes reduce the relative financial burden for the higher-income groups.

Cost-sharing burdens would generally be lower than the financial burdens of premiums. Because health care spending is highly skewed across the population in any given year, median health care spending is relatively low.[20] For this reason, median financial burdens of cost-sharing would be modest and range from 1.4 to 1.9 percent across income groups under AHFA. PPACA does not reduce cost-sharing burdens relative to AHFA. Being low to start with, median burdens only fall a small amount with the larger cost-sharing subsidies under H.R. 3962.

Combining both premiums and cost sharing by families in the nongroup exchange, median financial burden under AHFA would be 6.9 percent of income for the lowest income group. While this burden would be largely unchanged under PPACA, it would fall to 4.8 percent with the H.R. 3962 subsidy schedules. Median burdens would fall considerably with greater subsidies for the 200 to 299 percent of the FPL group, from 11.1 percent of income under AHFA to 9.9 percent under PPACA, and

Table 6. Median Financial Burdens of Family Health Care Costs for Enrollees in the Nongroup Exchange, by Income as a Percent of the FPL

	America's Healthy Future Act (AHFA)	AHFA with Premium Subsidies and Cost-Sharing Subsidies from PPACA	AHFA with Premium Subsidies and Cost-Sharing Subsidies from H.R. 3962
Nongroup Exchange Coverage (in Millions)	17.4	18.1	20.3
Out-of-pocket Health Insurance Premiums as a Share of Income			
Median			
133–199% FPL	5.4%	5.2%	3.9%
200–299% FPL	8.7%	7.8%	7.7%
300–399% FPL	9.5%	9.7%	9.9%
400–499% FPL	7.8%	7.8%	8.2%
500% FPL or more	5.7%	5.6%	5.8%
Out-of-pocket Cost-sharing for Health Care as a Share of Income			
Median			
133–199% FPL	1.4%	1.4%	0.6%
200–299% FPL	1.9%	1.9%	1.3%
300–399% FPL	1.8%	1.9%	1.8%
400–499% FPL	1.6%	1.6%	1.6%
500% FPL or more	1.4%	1.3%	1.4%
Total Health Care Costs as a Share of Income			
Median			
133–199% FPL	6.9%	6.7%	4.8%
200–299% FPL	11.1%	9.9%	9.1%
300–399% FPL	12.0%	11.1%	11.6%
400–499% FPL	9.8%	9.8%	10.2%
500% FPL or more	7.6%	7.3%	7.7%

Source: Urban Institute analysis, HIPSM 2009.

Notes: Total family health care costs include premiums plus out-of-pocket health care spending, less subsidies. "Family" refers to health insurance units, that is, family members who buy insurance coverage as a group, including single individuals. Reforms are modeled as if they were fully implemented in 2009, and estimates are for that single year.

to 9.1 percent under H.R. 3962. Median burdens for the 300 to 399 percent of the FPL group would be reduced from 12 percent under AHFA to 11.1 percent under PPACA, and to 11.6 percent under H.R. 3962.

90th percentile financial burdens, by income group. Some families have health care burdens far above the median due to higher premiums, higher out-of-pocket spending on medical care, or both. At the 90th percentile, the financial burdens of premiums under AHFA are 6.9 percent of income for those with incomes between 133 and 199 percent of the FPL, 11.2 percent for those with incomes between 200 and 299 percent of the FPL, and 12 percent for those with incomes between 300 and 399 percent of the FPL. Under both PPACA and H.R. 3962 subsidies, premium burdens at the 90th percentile would decrease for all subsidized income groups relative to the AHFA. Ninetieth percentile burdens would be highest (13.4 percent) for those with incomes between 400 and 499 percent of the FPL, who are outside of the subsidy range.

The financial burdens of cost-sharing at the 90th percentile are substantial. For the lowest income group, cost-sharing burdens at the 90th percentile would be 6.8 percent of income under AHFA, declining to 2.5 percent with the larger subsidies of H.R. 3962. As at the median, PPACA does not reduce cost-sharing burdens at the 90th percentile relative to AHFA. Under AHFA, 10 percent of families in the 200 to 299 percent of the FPL income range would face cost-sharing burdens of 9.8 percent of income or more. That burden would be reduced to 5.6 percent with H.R. 3962 subsidies. Thus, these higher cost-sharing subsidies of H.R. 3962 would substantially reduce financial burdens for lower-income families with high health care costs.

Ten percent of families with incomes between 200 and 499 percent of the FPL would face health care cost burdens of at least 18.8 percent of income under AHFA. Burdens this high arise for individuals who are older or in poorer health or both, and for families with such members. Comparing PPACA to AHFA, 90th percentile burdens would drop about 1 percentage point for those with incomes between 200 and 399 percent of the FPL.

Under H.R. 3962, 90th percentile burdens are significantly lower than under the Senate proposals for those with incomes less than 300 percent of the FPL. For the lowest income group (133 to 199 percent of the FPL) the 90th percentile would spend 14.0 percent of income under AHFA but only 7.6 percent with H.R. 3962 subsidies. For families with incomes from 200 to 299 percent of the FPL, the 90th percentile burden would be reduced from the AHFA's 19.3 to 14.6 percent of income under the H.R. 3962 subsidies. The reduction in the burden would be smaller for those with incomes from 300 to 399 percent of the FPL. The 90th percentile burden for this income group would still be 18.8 percent of income with the larger subsidies. Ten percent of families with incomes from 400 to 499 percent of the FPL would have burdens of about 19 percent under all options. For the highest income group, the 90th percentile burden is close to 15 percent in all cases.[21]

Table 7. 90th Percentile Financial Burdens of Family Health Care Costs for Enrollees in the Nongroup Exchange, by Income as a Percent of the FPL

	America's Healthy Future Act (AHFA)	AHFA with Premium Subsidies and Cost-Sharing Subsidies from PPACA	AHFA with Premium Subsidies and Cost-Sharing Subsidies from H.R. 3962
Out-of-pocket Health Insurance Premiums as a Share of Income			
90th Percentile			
133–199% FPL	6.9%	6.2%	5.4%
200–299% FPL	11.2%	9.4%	9.6%
300–399% FPL	12.0%	9.9%	11.4%
400–499% FPL	13.4%	13.4%	13.4%
500% FPL or more	10.9%	10.8%	10.9%
Out-of-pocket Cost-sharing for Health Care as a Share of Income			
90th Percentile			
133–199% FPL	6.8%	6.6%	2.5%
200–299% FPL	9.8%	9.8%	5.6%
300–399% FPL	8.5%	8.6%	8.3%
400–499% FPL	7.0%	7.1%	7.1%
500% FPL or more	5.5%	5.5%	5.5%
Total Health Care Costs as a Share of Income			
90th Percentile			
133–199% FPL	14.0%	13.4%	7.6%
200–299% FPL	19.3%	18.1%	14.6%
300–399% FPL	19.6%	18.3%	18.8%
400–499% FPL	18.8%	18.9%	19.4%
500% FPL or more	15.0%	15.0%	14.9%

Source: Urban Institute analysis, HIPSM 2009.

Notes: Total family health care costs include premiums plus out-of-pocket health care spending, less subsidies. "Family" refers to health insurance units, that is, family members who buy insurance coverage as a group, including single individuals. Reforms are modeled as if they were fully implemented in 2009, and estimates are for that single year.

Reducing the highest burdens by expanding cost-sharing subsidies. Given the relatively high burdens that remain at the 90th percentile for those between 200 and 400 percent of the FPL even with higher subsidies, we analyze the effects of a targeted increase in the cost-sharing subsidies beyond those specified in H.R. 3962 (the "enhanced cost-sharing subsidies" shown in column 4 of Table 2) in conjunction with H.R. 3962 premium subsidies. Table 8 shows the effects of the enhanced cost-sharing subsidies, which raise the actuarial value of subsidized plans for those between 250 and 350 percent of the FPL to 85 percent. The number of uninsured would decline by an additional 300,000 people relative to the case using H.R. 3962 subsidies. Nongroup exchange coverage would increase from 20.3 million to 21.4 million people, as more people are attracted to the higher levels of cost-sharing assistance.

The enhanced cost-sharing subsidies would reduce the 90th percentile financial burden for those with incomes from 300 to 399 percent of the FPL from 18.8 to 16.5 percent. There would be some slight reductions in financial burdens for other income groups as well. In terms of dollars, costs at the 90th percentile of spending for those with incomes between 200 and 299 percent of the FPL would fall from $6,048 under the H.R. 3962 subsidies to $5,708 with the enhanced cost-sharing subsidies, a $340 reduction (not shown in the table). The dollar decrease is nearly twice as large for those with incomes between 300 and 399 percent of the FPL, whose costs at the 90th percentile of spending would fall $623, from $9,778 under the H.R. 3962 subsidies to $9,154 with the enhanced cost-sharing subsidies (not shown in table). The decline in financial burdens and increase in coverage is achieved at the cost of $2.5 billion in additional cost-sharing subsidies. Premium subsidies increase by an additional $1.7 billion due to the increase in the number of people obtaining coverage through the exchange.

Neither the cost-sharing subsidies in H.R. 3962 nor the enhanced cost-sharing subsidies modeled above apply to families with incomes above 400 percent of the FPL. However, those with income immediately above the level of subsidies (400 to 499 percent of the FPL) also face high burdens at the 90th percentile. Many of those at higher income levels with particularly high burdens are older persons who have a combination of high medical needs and high premiums due to the 4:1 age rating in AHFA. A reduction in age rating to 2:1, as in H.R. 3962, could reduce the health care burdens of this group significantly.[22]

Discussion

The levels of premium and cost-sharing subsidies have important implications for coverage, costs, and the affordability of health care under reform. Larger subsidies draw more people into the exchange and reduce the number of people who remain uninsured. Compared with the subsidies under AHFA, the modified premium subsidies under PPACA are somewhat higher for low-income families and somewhat lower for high-income families in the subsidy-eligible income range. In contrast, the H.R. 3962 subsidies are larger than those under AHFA at every applicable income level. Comparing

Table 8. Effects of a Targeted Increase in Cost-Sharing Subsidies Above Those in H.R. 3962

	AHFA with Premium Subsidies and Cost-Sharing Subsidies from H.R. 3962	AHFA with Premium Subsidies from H.R. 3962 and "Enhanced" Cost-Sharing Subsidies	Difference
Number of Uninsured (in Millions)	17.3	17.0	-0.3
Nongroup Exchange Coverage	20.3	21.4	1.1
Total Government Spending (in Billions)			
Premium Subsidies	$31.9	$33.6	$ 1.7
Cost-Sharing Subsidies	$ 7.0	$ 9.5	$ 2.5
Total Health Care Costs as a Share of Income			
Median			
133–199% FPL	4.8%	4.8%	0.0%
200–299% FPL	9.1%	9.1%	0.0%
300–399% FPL	11.6%	11.3%	-0.3%
400–499% FPL	10.2%	10.1%	-0.1%
500% FPL or more	7.7%	7.7%	0.0%
90th Percentile			
133–199% FPL	7.6%	7.5%	-0.1%
200–299% FPL	14.6%	13.8%	-0.8%
300–399% FPL	18.8%	16.5%	-2.3%
400–499% FPL	19.4%	18.8%	-0.6%
500% FPL or more	14.9%	14.9%	0.0%

Source: Urban Institute analysis, HIPSM 2009.

Notes: Total family health care costs include premiums plus out-of-pocket health care spending, less subsidies. "Family" refers to health insurance units, that is, family members who buy insurance coverage as a group, including single individuals. Reforms are modeled as if they were fully implemented in 2009, and estimates are for that single year.

overall coverage under the PPACA subsidies, we estimate there would be nearly half a million more people with coverage under reform relative to AHFA. With H.R. 3962 subsidies, we estimate there would be 2 million more people with coverage under reform than under AHFA.

Government spending would of course be higher with larger subsidies than those in AHFA. Lower uncompensated care costs would offset some of this higher spending. The main benefit from the higher spending is that more people would gain coverage, and those who have coverage would find their health care costs less financially burdensome; this is particularly true for low-income families. Those in the nongroup market are most affected by the premium and cost-sharing subsidies under reform, since those who are Medicaid or CHIP eligible would be provided with full coverage at little or no cost to the family and workers with employer offers would typically be ineligible for subsidies. Beyond premium costs, covered families are at risk for high out-of-pocket cost burdens when a family member becomes seriously ill. The higher cost-sharing subsidies in H.R. 3962, relative to the AHFA, and the "enhanced" cost-sharing schedule would substantially reduce the financial burden of out-of-pocket costs for those in the upper tail of health care spending.

While any standard of what constitutes an affordable financial burden is subjective and an inherently political decision, it is important to consider not only the impacts on the typical family, but also families in the upper tail of the distribution of burdens. An alternative option for reducing the burdens for those with the highest health care spending in the exchange is to increase the actuarial value of the standard package. This approach would spread costs associated with the higher-cost enrollees more broadly through increases in premiums rather than leaving users of care to pay these costs. Another option for reducing the highest health care burdens in the exchange would be to switch to 2:1 age rating, as in H.R. 3962, which would significantly reduce the highest premiums for older people relative to those under the 4:1 age rating in AHFA.

These strategies would not, however, address a remaining affordability issue beyond the scope of this paper. Low-income workers employed by large firms that offer coverage to their workers would not have access to the same financial assistance in purchasing coverage as similar employees without employer offers. This is a potentially significant issue in AHFA, PPACA, and H.R. 3962.

Despite potentially high burdens for some, the AHFA and other reform options presented here would bring about several major improvements in the health system. They would stem the continuous erosion in the number of Americans with health care coverage by increasing affordability and access for millions of people, decrease financial pressures on the hospitals and clinics that provide care to the uninsured, and reduce many system inefficiencies. Thus, legislation that improves both the health and the financial security of the American people may be within reach. In continuing negotiations over the details of health care reform legislation, policymakers must weigh the implications of high health care financing burdens for families against the additional budgetary costs of larger premium and cost-sharing subsidies. Public support for the reforms will be related to the extent to which coverage and the direct costs of care are considered affordable. Affordability, in turn, will affect compliance with the individual mandate. Without broad compliance, it will be very hard to maintain the proposed insurance reforms, which depend greatly on broad risk pools.

Notes

1 Baucus, Max. America's Healthy Future Act of 2009, Chairman's Mark, Senate Finance Committee. Modified October 2, 2009. http://www.finance.senate.gov/sitepages/leg/LEG%20 2009/100209_Americas_Healthy_Future_Act_AMENDED.pdf. Affordable Health Care for America Act (H.R. 3962) introduced October 29, 2009. http://docs.house.gov/rules/health/111_ahcaa.pdf. Reid, Harry. The Patient Protection and Affordable Care Act, introduced as a "substitute" amendment of H.R. 3590 on November 18, 2009. http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf.

2 The Congressional Budget Office (CBO) also considered the affordability of health care costs in a new health insurance exchange under AHFA in a letter released October 9, 2009 (http://www.cbo.gov/ftpdocs/106xx/doc10692/SFC_Subsidies_Penalties_10-09.pdf). They report financial burdens based on average premiums and cost sharing in the exchange, whereas we report median financial burdens as well as burdens in the upper tail of the distribution (90th percentile). Our mean burdens (not shown) are somewhat lower than what CBO reports. The main reason for the difference is that CBO reports burdens for 2016 and those we report are for 2009. Due to health care costs growing faster than incomes over time, burdens in later years should be higher.

3 To facilitate the comparison of different subsidy schedules, comprehensive reforms specified under H.R. 3962 that differ from AHFA, such as the expansion of Medicaid to 150 percent of the FPL, are not modeled here.

4 A description of the construction of the model can be found in Bowen Garrett, John Holahan, Allison Cook, Irene Headen, and Aaron Lucas. "The Coverage and Cost Impacts of Expanding Medicaid." Washington DC: The Kaiser Commission on Medicaid and the Uninsured. May 2009. http://www.kff.org/medicaid/upload7901.pdf.

5 HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File, and the Statistics of US Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount. Behavioral modules in HIPSM represent individual and family demand for health insurance coverage through a utility-based approach in which each individual is assigned a utility value that measures the relative desirability of each health insurance option. These utilities then shape decisions when reform options are introduced. The responsiveness of health insurance decisions to changes in health insurance options and premiums are calibrated in HIPSM to findings in the empirical economics literature.

6 To say that higher actuarial value plans provide more comprehensive coverage is true on average across the insured population. It is important to note, however, that many different plan structures can achieve the same actuarial value. Depending on how plan structure interacts with the characteristics of a particular insured person (e.g., their health conditions and types of medical spending), it is possible to have a plan of higher actuarial value that requires more out-of-pocket spending than a plan with lower actuarial value. See for example the testimony of Karen Pollitz before the House Committee on Energy and Commerce, 25 June 2009. http://energycommerce.house.gov/Press_111/20090625/testimony_pollitz.pdf.

7 For an analysis of the effects of different age rating bands, see Blumberg, Buettgens, and Garrett, "Age Rating under Comprehensive Health Care Reform," Washington DC: The Urban Institute. October 2009, http://www.urban.org/url.cfm?ID=411970

8 Adults with incomes between 100 and 133 percent of the FPL have the option of choosing subsidized exchange coverage or Medicaid.

9 For each employee who enrolls in subsidized coverage through the nongroup exchange, the free-rider penalty is equal to the national average premium subsidy. The total penalty for the firm is capped at $400 times the total number of employees in the firm. While the proposed legislation would apply free-rider penalties only for full-time employees, we simulate this provision as if it applied to all employees. This simplification does not substantively impact the results.

10 Employers are required to enroll employees in a firm-sponsored health insurance plan unless the employee explicitly opts out of coverage. This applies to employees who do not have other coverage and who work in large firms that sponsor a health plan. The proposed legislation applies this provision to firms with 200 or more employees. Since the firm size data from the CPS are reported in ranges, e.g., 100 to 500 employees, we simulate this provision as if it applies to firms with 100 or more employees. Since this affects relatively few employees, and they are generally not eligible for subsidies in the nongroup exchange, this simplification does not substantively impact the results as presented.

11 If states scale back Medicaid or CHIP eligibility, overall coverage under any of the reforms modeled here could be substantially lower.

12 We do not model temporary provisions such as the reinsurance program and make several other simplifications as well. We do not model the rating rules specified in AHFA related to smoking or wellness; consequently, the results understate the financial burdens at the upper end of the distribution in the exchange. We do not model separate state exchanges, the possibility of separate small group and nongroup exchanges in some states, excise taxes on high premium plans, the young invincible exchange plan, and the 65 percent actuarial value exchange plan. Nor do we model cooperatives. We do not model the ESI exchange to include firms with more than 100 employees, although states may choose to allow larger firms to participate starting in 2017. The model does not distinguish documented and undocumented individuals. Unlike other reform proposals, the AHFA does not include a public plan and so one is not modeled here.

13 This shift in indexing could lead to increased adverse selection in the exchange over time.

14 Under PPACA, health plans that satisfy the coverage requirement (other than small-group plans) must have spending limits for annual cost-sharing not greater than those that apply to HSA-qualified high-deductible health plans. In 2009, these limits are set at $5,800/individual and $11,600/family. Under PPACA, out-of-pocket spending in an exchange plan is limited to the following: one-third of the HSA limit ($1,933/individual and $3,867/family in 2009) for those with incomes from 100 to 200 percent of the FPL; one-half of the HSA limit ($2,900/individual and $5,800/family in 2009) for those with incomes from 200 to 300 percent of the FPL; and two-thirds of the HSA limit ($3,867/individual and $7,733/family in 2009) for those with incomes from 300 to 400 percent of the FPL. Under H.R. 3962, all health plans that satisfy the coverage requirement must have spending limits for annual cost-sharing of $5,000/individual and $10,000/family. Under H.R. 3962, out-of-pocket spending in the exchange is limited to the following: $500/individual and $1,000/family for those with incomes from 133 to 150 percent of the FPL; $1,000/individual and $2,000/family for those with incomes from 150 to 200 percent of the FPL; $2,000/individual and $4,000/family for those with incomes from 200 to 250 percent of the FPL; $4,000/individual and $8,000/family for those with incomes from 250 to 300 percent of the FPL; $4,500/individual and $9,000/family for those with incomes from 300 to 350 percent of the FPL; and $5,000/individual and $10,000/family for those with incomes from 350 to 400 percent of the FPL.

15 Most of this additional spending is by those with incomes above 400 percent of the FPL (data not shown). Families with incomes below 133 percent of the FPL spend considerably less under the AHFA compared to current law, mainly as a consequence of expanded Medicaid eligibility for adults. Those with incomes from 133 to 399 percent of the FPL would spend somewhat more on net under the AHFA compared to today, largely due to the increase in the number of people formerly uninsured who would purchase insurance either through an employer or through the exchange.

16 Under the H.R. 3962 subsidies, all subsidy-eligible income groups would see a reduction in health care spending compared to AHFA; those with incomes from 133 to 199 percent of the FPL would also see a reduction in health care spending compared to the baseline (data not shown).

17 A health insurance unit consists of the group of family members that can typically enroll in private health insurance together. This includes married adults, their dependent children up to age 18, and full-time students younger than age 24.

18 Since employers' contributions account for 79 percent of the full premium on average, few employees face premium contributions high enough to qualify for premium subsidies.

19 Even though families are exempted from the individual mandate when premiums are greater than 8 percent of income, many families would (and currently do) pay more than 8 percent to obtain coverage.

20 Zuvekas, Samuel H., and Joel W. Cohen (2007). "Prescription Drugs and the Changing Concentration of Health Care Expenditures." Health Affairs. 26(1): 249–57.

21 Small variations in burdens for the two highest income groups are due to differences in the composition of the exchange pool across the policy options.

22 See Blumberg et al. "Age Rating under Comprehensive Health Care Reform."

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