Issue BRIEF

Limited-Benefit Plans: Expanding Coverage or Holding Your State Back?

October 2008

As policy makers and employers seek ways to reduce health insurance costs and decrease the number of people without coverage, some are turning to what are commonly called "limited-benefit," "mandate-lite," or "mandate-free" health plans. These plans, also known as "barebones" plans, are exempted from some or all state requirements to offer coverage for certain health services, such as cancer screenings, mental health care, hospice care, and a variety of other services, depending on the state.[1]

At first glance, limited-benefit plans may seem like a good way to offer previously uninsured people financial protection for a portion of their health care costs. However, the consequences of allowing private insurers to circumvent state benefit mandates can be dire for health care consumers. While some limited-benefit plans only exclude coverage for one or two mandated benefits, others may be extremely skimpy, excluding coverage for many necessary services. This paper describes some of the damaging effects of limited-benefit plans in the private insurance market as well as issues for advocates to consider if policy makers propose to use public dollars to subsidize limited-benefit plans in their state.

The Damaging Effects of Limited-Benefit Plans in the Private Market

■ Limited-Benefit Plans Are Unlikely to Save Money

- States that have analyzed the cost of various benefit mandates have found that most mandates enacted in their states raise premiums by less than 1 percent.[2] In 2000, the Congressional Budget Office (CBO) found that five of the state mandates that policy experts consider to be the most expensive each have a marginal impact on premiums, ranging from 0.28 to 1.15 percent.[3] Further, when looking at the **total** cost of state mandates, one state found that the net cost impact of all 26 of its mandates was only 3-4 percent.[4] These findings suggest that the elimination of mandates from insurance plans would reap little in the way of premium reductions.
- Estimates of the contribution of mandated benefits to premium costs likely overstate their impact. A Minnesota Department of Health brief concluded, "mandated health benefits raise premium costs to some degree; however, these increases are generally more modest than commonly cited figures."[5] This is true for two reasons:

FamiliesUSA
The Voice for Health Care Consumers

- First, commonly cited figures do not account for the cost-savings realized from properly delivering mandated services to individuals who need them and who would later require more intensive and expensive care if they did not receive the mandated services.
- Second, estimates of the cost impact of mandates do not account for the fact that many insurance policies would cover the services regardless of a mandate. A study in one state found that 90 percent of small and large group insurance plans would still cover state-mandated benefits regardless of the existence of mandates, making it unlikely that their elimination would lower premium rates for most employers.[6] However, for those with insurance plans that would drop mandated benefits, legally-protected access to mandated services, such as diabetes supplies, could be the difference between life and death.

- Any true cost-savings produced by limited-benefit plans may be lost if people need services that are not covered by their plan. When needed services aren't covered, people may seek care from public hospitals and clinics, or receive uncompensated care in emergency rooms.[7] Further, the costs of such uncompensated care may be passed on to others through higher insurance premiums.[8]
- Limited-benefit plans do nothing to address the broader problem of rising health care costs.

Limited-Benefit Plans Can Jeopardize the Health of Consumers

- Allowing some insurance plans to eliminate coverage for state-mandated benefits can jeopardize the health and well-being of consumers. When studying its mandated benefits, one state concluded that "The treatments associated with the majority of the mandated benefits are expected to have a positive health status effect and are generally considered by the medical community to be efficacious."[9]
- Limited-benefit plans exclude coverage for a variety of both routine and more intensive necessary services. For example, the limited-benefit plan offered by Colorado's Rocky Mountain Health Plans "does not cover . . . mammography, prostate screenings, mental health, alcoholism, hospice care, and dental anesthesia for children, which the Colorado Revised Statutes usually require group plans to cover."[10] The limited-benefit plan offered by BlueCross BlueShield of Arizona for small businesses excludes coverage for routine physical exams, off-label drug use, and all behavioral and mental health services.[11] Healthy NY, a plan for working New Yorkers and small businesses, excludes coverage for mental health services, hospice, ambulance transportation, durable medical equipment, and more.[12]
- Providing only limited coverage for a particular service or treatment can put people at risk. The limited-benefit CoverTN plan in Tennessee greatly limits coverage for many important services. For example, the plan covers up to either 5 or 6 visits per year for radiation therapy for cancer,[13] but patients with cancers such as breast cancer or prostate cancer generally require 5 visits per week for many weeks if they are receiving radiation therapy.[14]

- Many limited-benefit plans impose higher cost-sharing on enrollees, in addition to offering fewer benefits. They may not have out-of-pocket spending maximums to protect consumers from unaffordable bills that exceed the plans' coverage levels,[15] they may impose higher coinsurance and copayments than comprehensive insurance plans,[16] and they may require high deductibles.[17] Such high out-of-pocket spending requirements have been shown to lead consumers, especially those with lower incomes, to delay or forgo necessary health services.[18]

Limited-Benefit Plans Are Generally Unpopular with Consumers

- In most states that permit the sale of limited-benefit plans, enrollment has fallen far short of expectations.[19]
  - For example, during the first year of Montana's mandate-lite health plan, the administrator received 400 requests for applications, but only 53 individuals enrolled. The program, which provided office-based care but no inpatient coverage,[20] could serve up to 1,000 Montanans. According to the Director of Health Care Access for the plan, "After individuals reviewed the plan, they realized that the package didn't cover enough to be of value to them."[21] In 2007, the plan administrator discontinued the program due to low enrollment.[22]
- The high cost-sharing and minimal protection in limited-benefit plans make it questionable as to whether they are even worth purchasing for many consumers. Uninsured individuals may feel that they are better off paying no premiums at all and instead rely on safety-net care.[23] In response to the barebones "Cover Florida" program, one 42-year-old mother replied, "One hundred fifty dollars a month for a policy that doesn't cover anything? I wouldn't pay. If you want to see a doctor, you can go to a walk-in clinic and pay $95 when you are sick.[24]

Limited-Benefit Plans May Not Appeal to Insurers

- Insurance company enthusiasm towards limited-benefit plans varies from state to state.
- Some insurers are reluctant to sell limited-benefit coverage due to fear that consumers will not understand what they are getting or that the plans will attract only the healthiest consumers, destabilizing and raising premiums for other types of coverage. Some insurers have declined to sell limited-benefit plans after finding that premiums could not be reduced significantly even if mandated services were excluded from coverage.[25]
- North Dakota passed a law in 2001 allowing insurers to offer a mandate-lite plan.[26] Although the law is still on the books, no carriers have ever filed to sell the plan.[27]
- In 2005, Minnesota passed a law allowing insurance companies to sell plans that do not provide coverage for state-mandated benefits. Three years later, no insurance companies have chosen to sell such a plan. Proponents of mandate-free plans attempted to enact a law *requiring* insurers to sell the plans in 2008, but the bill failed to pass.[28]

- Limited-Benefit Plans Can Undermine Current Coverage
  - Limited-benefit plans that are touted as an option for covering the uninsured do not necessarily reach their intended audience. Instead, limited-benefit plans can lead individuals or employers who previously had or offered comprehensive health insurance to reduce the breadth of their benefits. For example, in 2006, only 11 percent of enrollees in Texas's limited-benefit plan were previously uninsured.[29]
  - Limited-benefit plans can be much more appealing to young and healthy individuals than they are to older people or those with health care needs. In fact, some policy makers have proposed limited-benefit plans specifically targeted at young adults.[30] These plans may draw low-cost enrollees out of comprehensive coverage, leaving behind only older and sicker enrollees in plans with comprehensive benefits.[31] With fewer young and healthy enrollees to spread the financial risk of illness, the price of comprehensive plans in a state's insurance market may skyrocket.
- Limited-Benefit Plans Hurt Vulnerable Populations
  - Low-income consumers may be more likely than higher-income people to purchase limited-benefit plans due to their low premiums.[32]
  - The skimpy coverage and high cost-sharing of limited-benefit plans leave many low-income enrollees unprotected against out-of-pocket costs that would consume an unaffordable portion of their incomes.[33] Such "underinsurance" could cause lower-income consumers to face catastrophic costs, medical debt, or even bankruptcy.[34]
  - As described in a 2002 Commonwealth Fund report, "Although stripped-down policies are meant to make insurance more affordable for low-income consumers, they do so only with enormous risks."[35] Due to the high cost-sharing in limited-benefit plans, low-income enrollees may delay or forgo necessary medical services, jeopardizing their health and well-being.[36]

State-Supported Limited Benefit Plans: Issues for Advocates

Some states use, or have considered using, public dollars to provide subsidies for consumers to purchase limited-benefit health plans, presumably as a means of expanding "coverage" to uninsured residents. Due to the potential damaging effects of limited-benefit plans described above, advocates must think carefully about *when* to support limited-benefit coverage, if they have to support it at all.

Should You Support a Limited-Benefit Plan?

Limited-benefit plans do not provide sufficient coverage to keep consumers healthy. Other mechanisms for expanding coverage to uninsured residents are likely more effective and efficient uses of your state health care dollars. For example, expanding Medicaid coverage to more state residents could draw down federal dollars for your state to use, in addition to providing a more comprehensive

benefit package to currently uninsured residents. Health care advocates should carefully consider whether a Medicaid expansion—even a small one—is politically feasible in their state before supporting a limited-benefit plan.

Further, advocates should accept limited-benefit plans only when they are an initial step towards broader coverage expansions, and not a step in the wrong direction. It is important to weigh whether, given your state's political climate, a limited-benefit plan would lead to a more comprehensive expansion of coverage. Before accepting a limited-benefit plan, you should have a strategy to create political will for broader reforms and move your state towards a more comprehensive coverage expansion. Otherwise, a limited-benefit expansion may just provide low-income, uninsured residents with inadequate coverage that still exposes them to great financial risks, and it may erode current, more comprehensive coverage in your state.

So, although you may end up supporting a limited-benefit expansion plan, you should do so with great caution and only when:

1. A Medicaid or other more comprehensive expansion is not feasible, and
2. The limited-benefit plan provides a foundation for broader expansions that bring better benefits rather than a future obstacle to expanded coverage.

If you do end up supporting a limited-benefit plan, there are steps you can take to ensure that the plan is held accountable to consumers. For example, Texas requires insurers to annually report whether limited-benefit plans are producing premium savings and how many limited-benefit plan enrollees were previously uninsured. States could also require insurers to report whether limited-benefit plans are destabilizing other insurance plans or are being sold primarily to low-income residents, and whether limited-benefit plan enrollees are using high levels of uncompensated or safety net care. These and other transparency requirements may make it easier for advocates to monitor limited-benefit plans and confront problems that they produce for consumers.[37]

For more information, contact Claire McAndrew at cmcandrew@familiesusa.org.

Endnotes

[1] Susan Laudicina, Joan Gardner, and Angela Crawford, *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans* (Washington: BlueCross BlueShield Association, December 2007); Rocky Mountain Health Plans, *Disclosure Notice for Small Employer Groups*, available at: http://www.rmhp.org/pdf/MK57_R0905_Disclosure_Notice_for_Small_Employers.pdf, accessed on September 11, 2008.

[2] Massachusetts Division of Health Care Finance and Policy, *Comprehensive Review of Mandated Benefits in Massachusetts: Report to the Legislature* (Boston: DHCFP, July 2008); Susan K. Albee, Esther Blount, Mulloy G. Hansen, Tim D. Lee, Mark Litow, and Mike Sturm, *Cost Impact Study of Mandated Benefits in Texas, Report #2* (Austin: Texas Department of Insurance, September 28, 2000); Maryland Health Care Commission, Annual Mandated Health Insurance Services Evaluation (Baltimore: MHCC, January 1, 2008).

[3] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage through Association Health Plans and HealthMarts* (Washington: CBO, January 2000; Government Accountability Office, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses* (Washington: GAO, September 2003). Included mandates: alcoholism treatment, drug abuse treatment, mental health treatment, chiropractor services, and continuation of coverage.

[4] Massachusetts Division of Health Care Finance and Policy, op. cit.

[5] Minnesota Department of Health, Health Economics Program, *Issue Brief: Mandated Health Insurance Benefits and Health Care Costs* (St. Paul: MDH, July, 2001).

[6] Susan K. Albee, et al., op. cit.

[7] Isabel Friedenzohn, *Issue Brief: Limited-Benefit Policies: Public and Private Sector Experiences* (Washington: Academy Health State Coverage Initiatives, July 2004).

[8] Kathleen Stoll, *Paying a Premium: The Added Cost of Care for the Uninsured* (Washington: Families USA, June 2005).

[9] Susan K. Albee, et al., op. cit. For a complete list of services mandated in each state, see Victoria Craig Bunce and JP Wieske, *Health Insurance Mandates in the States 2008* (Alexandria: Council for Affordable Health Insurance, 2008), available at: http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf. Although this provides a complete list of state benefit mandates, the report misconstrues the impact of mandates on costs and coverage.

[10] Rocky Mountain Health Plans, op. cit.

[11] BlueCross BlueShield of Arizona, *BlueSolutions PPO: Summary of Benefits*, November 2007.

[12] New York State, *Healthy New York, Benefit Package* (New York: New York State, 2007), available at: http://www.ins.state.ny.us/website2/hny/english/hnybp.htm, accessed on October 13, 2008.

[13] BlueCross BlueShield of Tennessee, *CoverTN Plan A Schedule of Benefits*, available at: http://www.bcbst.com/health-plans/cover-tennessee/covertn/PlanA.pdf, accessed on August 11, 2008; BlueCross BlueShield of Tennessee, *CoverTN Plan B Schedule of Benefits*, available at: http://www.bcbst.com/health-plans/cover-tennessee/covertn/PlanB.pdf, accessed on August 11, 2008.

[14] National Comprehensive Cancer Network and American Cancer Society, *Breast Cancer Treatment*, available at: http://www.nccn.org/patients/patient_gls/_english/_breast/5_treatment.asp, accessed September 8, 2008; National Comprehensive Cancer Network and American Cancer Society, *Prostate Cancer Treatment*, available at: http://www.nccn.org/patients/patient_gls/_english/_prostate/4_treatment.asp, accessed September 8, 2008.

[15] BlueCross BlueShield of Tennessee, *CoverTN Plan A Schedule of Benefits*, available at: http://www.bcbst.com/health-plans/cover-tennessee/covertn/PlanA.pdf, accessed on August 11, 2008; BlueCross BlueShield of Tennessee, C*overTN Plan B Schedule of Benefits*, available at: http://www.bcbst.com/health-plans/cover-tennessee/covertn/PlanB.pdf, accessed on August 11, 2008.

[16] BlueCross BlueShield of Arizona, op. cit.

[17] Susan K. Albee, et al., op. cit.

[18] Albert Siu, et al., "Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans," *New England Journal of Medicine* 315, no. 20 (1986): 1259-66; Michael Chernew, *Cost-Sharing in Health Care Markets*, Testimony before the Subcommittee on Health of the House Committee on Ways and Means, May 14, 2008.

[19] Isabel Friedenzohn, op. cit.

[20] Robert Wood Johnson Foundation State Coverage Initiatives*, Matrix Glossary: Limited-Benefit Plans* (Washington: Academy Health, 2006).

[21] Isabel Friedenzohn, op. cit.

[22] Personal Communication with Dr. Robert Shepard, Medical Director for New West Health Care, July 23, 2008. Dr. Shepard

noted that a dispute between the Montana Department of Insurance and New West Health Care regarding insulin pump coverage also contributed to the discontinuation of the mandate-lite plan, but that regardless of the dispute, enrollment in the plan was too low to continue its operation.

[23] Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards, *Bare-Bones Health Plans: Are They Worth the Money?* (New York: The Commonwealth Fund, May 2002).

[24] Bob LaMendola, "Uninsured? Don't Hold Your Breath for Coverage," *South Florida Sun-Sentinel*, May 10, 2008.

[25] Isabel Friedenzohn, op. cit.; Robert Wood Johnson Foundation State Coverage Initiatives, op. cit.

[26] Isabel Friedenzohn, op. cit.

[27] Personal Communication, North Dakota Department of Insurance, July 23, 2008.

[28] Tom Pender, *House Research Bill Summary: Small Employer Flexible Benefit Health Plans* (St. Paul: Minnesota House of Representatives, March 9, 2008); NFIB Minnesota, *Small Employer Flexible Benefit Plans—Mandatory Offer* (St. Paul: NFIB, 2008).

[29] Dianne Longley, *Health Insurance Market Overview and Expansion Opportunities: Presentation to Senate State Affairs Committee* (Austin: Texas Department of Insurance, March 26, 2008).

[30] Governor David Patterson, *Veto Message No. 171, Senate Bill Number 8357* (New York: New York State, September 26, 2008).

[31] Massachusetts Division of Health Care Finance and Policy, op. cit.

[32] Isabel Friedenzohn, op cit.

[33] Sherry Glied, et al., op. cit.

[34] Cathy Schoen, Michelle Doty, Sara Collins, and Alyssa Holmgren, "Insured but Not Protected: How Many Adults are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005): W5-289- W5-302; David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* Web Exclusive (February 2, 2005): W5-63-W5-73.

[35] Sherry Glied, et al., op cit.

[36] Albert Siu, et al., op. cit.; Michael Chernew, op. cit.

[37] Personal communication with Stacey Pogue, Policy Analyst, Center for Public Policy Priorities, Washington, DC, October 13, 2008.

FamiliesUSA
The Voice for Health Care Consumers

1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005
Phone: 202-628-3030 ■ E-mail: info@familiesusa.org
www.familiesusa.org